London Clinical Senate

Clinical Senate Forum

Developing high quality, value based care out of hospital

Summary report

26 January 2017 at The King's Fund, London.

Developing high quality, value based care out of hospital

Expanding and enhancing out of hospital care is one of the most important enablers for the delivery of high quality, sustainable health and care services over the coming years. The *NHS Five Year Forward View* (FYFV) highlights the benefits a coordinated multidisciplinary approach can have on patient outcomes and system resilience, and efficiency. Consequently, developing out of hospital care is a core element in each of London's five Sustainability and Transformation Plans (STPs).

Redesigning out of hospital care aims to deliver several benefits, for example: reducing pressures and reliance on hospital care; providing more personalised, proactive, coordinated and accessible care closer to home; improving people's experience of care; reducing inequalities, improving value and reducing costs, and can involve significant change in ways of working. Outputs from local and regional good practice have demonstrated how the implementation of new or enhanced out of hospital services and care models can transform health and care systems but also pose challenges that need to be overcome to have the intended population impacts.

This Clinical Senate Forum aimed to support development of value based out of hospital care by sharing different initiatives that have or are being implemented across London and exploring delivery approaches, lessons learnt, benefits and impact, identifying factors that enable successful and sustainable change.

Comprehensive out of hospital care encompasses a wide range of services. Pressure experienced across the health and care system over the winter period illustrates the need to redesign out of hospital care at greater pace and scale. This Forum focused on initiatives which support the urgent and emergency care pathway for example offering alternatives to hospital attendance and admission and facilitating timely discharge. We were particularly keen to understand what patients and clinicians identify as the most important issues to take into account as we place increasing emphasis on delivering care out of hospital and how we can make sure that the breadth of skills and experience available in our multi-professional workforce are recognised and utilised.

The meeting was structured around two main sessions. In the first, colleagues leading out of hospital care services "hosted" two round table sessions to present and discuss each initiative. Participants then re-grouped into STP geographies to consider opportunities for developing out of hospital care in their STP area and what would enable this most, informed by views and learning from the different initiatives they had considered.

This report includes information about the initiatives shared and discussed on the day, with contact details of colleagues leading their delivery and links to supporting information. It sets out what participants identified as the most important issues, opportunities and enablers for improving out of hospital care, drawing out key themes.

We recognise that many other initiatives exist across London in addition to those that we considered. Some colleagues who wished to share their work were not available on the day and some participants highlighted other initiatives that they are involved in or aware of. Information about other out of hospital care services or projects are is included at the end of the report.

We would like to thank everyone who participated and particularly those who shared information, experiences and learning from the work and services they are leading. They encompassed an array of innovative models and approaches which have improved, or are improving, the way care is provided and the experience of both patients and staff. This stimulated positive discussion about opportunities for developing out of hospital care and what enables it, as well as barriers that need to be overcome. Different initiatives are at different stages and some have ongoing evaluation which will add to learning over time.

At the end of the meeting participants were asked to make a commitment to take forward actions to support development of out of hospital care in their locality. Of the 100 attendees, 45 made 92 commitments overall. We will follow these up in three months' time to ask whether actions have been taken to help inform learning about enablers and barriers to change.

Actions and recommendations

1. Participants and Forum members are encouraged to **consider the initiatives shared in this report**, **cascade more widely and explore the opportunities to apply learning** in their local settings.

2. **STP Leads should consider how the issues that participants identified as the most important to address supporting development of out of hospital care could be tackled in their STP area** and to build on the feedback from participants in each STP footprint about opportunities and enablers, promoting and adopting innovation and support that would add most value.

3. **The Healthy London Partnership, Academic Health Science Networks, Clinical Networks have been asked to take account of the feedback from participants in shaping the work they do to support delivery of STPs**.

4. **Participants should take forward the actions they committed to do and to share progress** when requested in 3 months' time to help build an understanding of how change can be enabled.

Transforming London's health and care systems - setting the context

Dr Vin Diwakar, Medical Director, NHS England London Region, set the scene for the Forum's discussions by reflecting on some of the main drivers and opportunities for expanding and enhancing care out of hospital.

Expanding out of hospital care is important for a variety of reasons (see point above).The NHS Five Year Forward View is clear that out-of-hospital care needs to become a much larger part of what the NHS does and this is reflected in supporting strategies that have been published over the last two years.

STPs, as overarching plans for developing place based health and care systems, offer real opportunities to shape care around patients and populations, rather than institutions. All five London STPs include ambitious plans for developing out of hospital care.

Addressing pressures in the urgent and emergency care pathway is by no means the only reason for expanding and enhancing care out of hospital, which is a key enabler of wider transformation of health and care systems. However in view of recent challenges and media focus – **there is significant value in this being an area for early focus**, building on significant work that is already taking place (with examples presented at this meeting).

Data shows increasing numbers of calls to NHS 111, emergency department attendances, ambulance conveyances, emergency admissions and delayed transfers of care over recent years – and a wide range of initiatives taking place to address these e.g. extended primary care access, integrated urgent care and developments in 111, increased support to care homes, 7 day services.

The real challenge is how to create an environment in which we can share and learn from good practice to identify what will have the greatest impact, **understand factors essential to success**, including breaking through barriers, and to then **scale up innovation rapidly to deliver real change** across health and social care in London.

With the strategic direction for the NHS now set through the FYFV **NHS England**, working closely with NHS Improvement, **will focus more on supporting delivery** over the next few years, and how we transform health care and services utilising the resources we have as effectively as possible.

A new operating model in London is being established in London to maximise the collective contribution of support, which includes the Healthy London Partnership, Strategic Clinical Networks, Academic Health Science Networks, to deliver cross system change aligning national and local priorities to deliver real and sustainable improvements for patients

The Clinical Senate is also a key resource in London and makes an important contribution by providing clinical leadership and independent advice to help deliver change in the system. Future Forum meetings will focus on key themes to support STP delivery.

Transforming out of hospital care in practice: learning from developments taking place across London

This session was designed to raise awareness of different initiatives, stimulate thinking about how learning could be applied elsewhere and help identify and spread innovation. The tables below provide an overview of each initiative shared and discussed, contact details of colleagues leading their delivery and links to supporting information.

Health 1000: The Wellness Practice

Health 1000: The Wellness Practice provides focused, **coordinated care for patients living with multiple long term conditions**. It is a primary care practice, providing joined up health and social care services to the 1000 highest end users of services locally ensuring a 'one-stop-practice' for people with complex health needs (defined as having five or more of long-term conditions including: coronary heart disease; high blood pressure; heart failure; stroke or mini stroke; diabetes; COPD; depression; dementia. The model of care is drawn from best practice in the UK, USA and Europe - adapted for the people of North East London. It has a dedicated multidisciplinary team who work with patients/carers to co-design their own care programme. It is ***being run as a pilot for two years and is being evaluated for clinical effectiveness, patient experience and value for money***.

Contact: Dr Mike Gill, Medical Director: michael.gill1@nhs.net
Further information: Overview, Q&A, www.health1000practice.nhs.uk

The Camden & Islington Psychosis & Long Term Conditions Integrated Practice Unit

This unit aims to reduce the wide gap in mortality between the population with psychosis and the general population by integrating care for the common co-morbidities of psychosis, COPD, cardiovascular disease and diabetes. People with schizophrenia experience greater exposure to risk factors (e.g. smoking prevalence of 55-85% depending on the psychosis sub-group) and inequitable access to physical health services leading to a massive health inequality, dying up to 25 years younger than the general population. The objective of the IPU is to establish points of integration between the psychosis and physical health care pathways. Over the last year, the IPU has set up well-being/physical health clinics, a mandatory physical health training program for mental health staff and instituted a system of annual physical health screening for patients with psychosis. Links have been made with other specialist providers in Respiratory Medicine, Diabetes and Cardiology to build joint clinical initiatives and the IPU is beginning to work with GPs to reach those patients with SMI who are not treated in secondary care. ***A comprehensive set of outcomes will be tracked over five years.***

Contact: Dr Ian Prenelle, Consultant Psychiatrist & Divisional Clinical Director Recovery & Rehabilitation, Camden & Islington Rehabilitation & Recovery Service: Ian.Prenelle@candi.nhs.uk
Further information: click here

Children and young people's health partnership (CYPHP)

The CYPHP aims to improve children and young people's health, improve the quality of healthcare, and strengthen the health system for all children and young people in Lambeth and Southwark by developing and testing a new model of comprehensively integrated care, as part of a strengthened child-centred health system. The service model is designed to improve Everyday Healthcare and services for children and young people with long term conditions. ***CYPHP has a comprehensive evaluation plan which will measure health, healthcare, and health system outcomes throughout the 4-year programme***.

Contact: Sue Malkin, Management Lead, Children and Young People's Health Partnership: Susan.Malkin@gstt.nhs.uk Ingrid Wolfe, Programme Director, Ingrid.Wolfe@kcl.ac.uk
Further information: click here, www.cyphp.org

ESCAPE-pain

Osteoarthritis is a major cause of pain and suffering, and is often associated with poor physical and mental health. It is much more prevalent, but receives much less attention, than other long term conditions such as diabetes. ESCAPE-pain is an evidence-based Programme for people with chronic joint pain/osteoarthritis of the knee or hip which aims to reduce pain and improve physical function. Run in groups, it combines information, advice and exercise. Participants come to appreciate exercise is a safe, beneficial self-management strategy and an alternative to medication, thereby developing an "exercise habit" which has wide health benefits. ***The Programme is clinically and cost-effective, easy to implement and reduces healthcare utilisation***.

Contact: Andrea Carter, Programme Director, Musculoskeletal Clinical Theme, Health Innovation Network: andrea.carter@nhs.net and Professor Michael Hurley, Clinical Director, Musculoskeletal Programme, Health Innovation Network: michael.hurley@sgul.kingston.ac.uk
Further information: click here, www.escape-pain.org

The East London primary care mental health service

This service provides primary care based support to people with a serious but stable mental illness. With a recovery based philosophy, GPs working with Community Psychiatric Nurses support people who may have been receiving a secondary care service for some time to access mainstream services and support, with a particular focus on healthy lifestyles. ***The service has supported approximately 5,000 people since 2013, providing cost effectiveness through reducing the number of people on CPA and in secondary care mental health services, whilst improving patient experience and outcomes***. The team also discussed an emerging primary care mental health service model encompassing a wider range of mental health problems.

Contact: Dr Rhiannon England, GP Clinical Lead for Mental Health, City & Hackney CCG rhiannon.england@nhs.net and Dr Karl Marlowe, Clinical Director, East London NHS Foundation Trust karl.marlowe@elft.nhs.uk
Further information: click here

Islington Children's Hospital @ Home service

This service aims to reduce length of stay and facilitate early discharge for children with an acute illness. The nurses visit children at home up to three times daily between the hours of 8 am and 10 pm, 7 days per week to administer IV medications, perform clinical assessments and work with referring consultants to ensure the best outcomes. ***A recent evaluation of the service showed excellent feedback from patients and families, reduced attendances to ED, reduced length of stay in hospital as well as a sustainable, cost neutral model***. The next stage of development will aim to increase cost effectiveness of the service and therefore possible expansion going forward, by exploring more efficient ways of working and admission avoidance pathways

Contact: Zoe Tribble, Community Matron, Whittington Health NHS Trust zoe.tribble1@nhs.net and Catherine Lad, Children's Commissioner, Islington Clinical Commissioning Group Catherine.Lad@islington.gov.uk
Further information: Overview, service evaluation.

Falls Specialist Response Car

The Falls Specialist Response Car was developed through a learning collaborative of community nurses and paramedics to try and to reduce unnecessary ED attendances for frail older people in North East London. Around one third of all LAS conveyances to Queen's emergency department in Romford are patients aged 75yrs and over. A significant proportion of attendances is due to falls and could have been better cared for at home. The collaborative use d its combined expertise to set up a service to respond to low acuity fallers, to assess and treat on scene, with the aim of keeping the patient at home wherever safe to do so. The Falls Specialist Response Car is staffed by a Community Treatment team nurse and a paramedic. ***The scheme aims to keep 20 patients at home, per week to reduce attendance and admissions***.

Contact: Lea Agambar, Nurse Practitioner, North East London, NHS Foundation Trust Lea.Agambar@nelft.nhs.uk and Neil Kendrick, Clinical Team Leader, London Ambulance Service NHS Trust
Further information: click here

Islington Practice based mental health team (PBMH)

This co-produced initiative offers service users in Islington the ability to access specialist mental health expertise and support in a timely way in a non-stigmatising primary care setting. Each PBMH team consists of a Consultant Psychiatrist led specialist mental health MDT, co-located in primary care, working alongside GP partners and integrated within the practice team. Local relationships between partners are key and practitioners work at the interface between primary care and secondary care mental health services in order to provide seamless links and smooth care pathways for service users. They are aligned with Islington Integrated Health Networks and are uniquely placed to support communication and co-operation between multiple health, social care and voluntary sector services. Benefits have already been realised with significant improvements in service user and GP satisfaction ratings ***(+95% positive ratings excellent/v.good), significant reductions in referrals on to secondary care specialist mental health teams (+60% reduction) and reduced A+E and acute pathway usage (+30%)***.

Contact: Dr Chris Curtis, Clinical Director, Community Division, Camden and Islington, NHS Foundation Trust chris.curtis@candi.nhs.uk
Further information: click here

Community Independence Service (CIS)

This service is about integrating care faster and more thoroughly by drawing on the talents and experience of all in health and social care across the Triborough in north west London (City of Westminster, Kensington & Chelsea and Hammersmith and Fulham). With a comprehensive multi-professional team the focus of CIS is to timely intervention. CIS comprises rapid response nursing services to ***prevent people with urgent care needs either attending or being admitted to hospital; in-reach which speeds hospital discharge, hospital liaison to prevent admissions and rehabilitation and regalement, enabling peopling to regain or retain their independence***.

Contact: Senel Arkut, Strategic Lead for 3Borough – CIS and Hospitals, Hammersmith and Fulham Council Senel.Arkut@lbhf.gov.uk
Further information: click here

Connecting Care for Children (CC4C)

CC4C is a 'Whole Population' model of care, covering children and young people across six segments, including the healthy child, children with complex health needs, vulnerable children with social needs and children with long term conditions. This programme Developed with extensive stakeholder consultation and co-design is all about developing connections and relationships across the system. ***The evaluation to date has shown that there are significant efficiency and quality improvements to be gained from this approach, despite the significant financial disincentives in the system***.

Contact: Dr Bob Klaber, Consultant Paediatrician & Associate Medical Director, Imperial College Healthcare NHS Trust Robert.Klaber@imperial.nhs.uk and Dr Mando Watson, Consultant Paediatrician, and Clinical Lead Connecting Care for Children Mando.Watson@imperial.nhs.uk
Further information: Overview, Whole population integrated child health: moving beyond pathways, Child Health General Practice Hubs: a service evaluation

The Living Well Network

The Living Well Network is a collaboration of health, social and voluntary sector organisations in Lambeth working together to facilitate mental health support. It is based on the principles of coproduction. At the centre of the network is the Hub, which is now the 'front door' to mental health services. Secondary and primary care mental health clinicians, social workers and support workers work in partnership with GP's to support citizens to manage their wellbeing facilitating an up to 12 week reablement package focusing on the assets of the person and resources in the local community. ***The Network has demonstrated an impact on the number of referrals going into secondary care reducing them significantly***.

Contact: Stacey Hemphill, Hub Coordinator , Lambeth Living Well Collaborative stacey.hemphill@lwnhub.net and Emma Willing, PAG Programme Manager, Lambeth Living Well Collaborative emma.willing@lwnhub.net
Further information: click here

Innovation in medicines optimisation

Lewisham Integrated Medicines Optimisation Service and **Guy's and St Thomas' Pharmacy-led Integrated approach to medicines optimisation in frail older people**. These pharmacy-led initiatives work across both health and social care and primary and secondary care interfaces to support patients who are identified as having or are at high risk of medicine related problems. The services help patients to manage their own medicines and remain as independent as possible. ***The demonstrated impact includes improved patient outcomes, reducing A&E attendances and hospital admissions, supporting safe use of medicines and preventing unnecessary waste***. Outcomes from these approaches, including financial savings, occur across systems; colleagues below will be happy to discuss the impact in further detail.

Contact: Kath Howes, Lead Pharmacist, Community Health Services/LIMOS, Lewisham and Greenwich NHS Trust katherine.howes@nhs.net and Lelly Oboh, Consultant Pharmacist, Care of Older People, Guy's and St Thomas' NHS Foundation Trust lelly.oboh@gstt.nhs.uk
Further information: Lewisham Integrated Medicines Optimisation Service, Guy's and St Thomas' NHS Foundation Trust Pharmacy Model for frail older people

Bromley-by-Bow, DIY Health

DIY Health is a co-produced health education delivery model to empower parents in managing children's health. It was noted that parents of children under the age of 5 were frequently re-attending St Andrew's Health Centre (one of three surgeries run by the Bromley-by-Bow Health Partnership) for support with managing self-limiting childhood problems. Group learning sessions provide an opportunity to practice skills in a peer-led environment and aim to empower parents with knowledge, confidence and skills to manage minor ailments at home. ***Preliminary quantitative results from an evaluation showed a reduction in GP attendances for parents who attended DIY Health sessions***.

Contact: Emma Cassells, Well Programme Manager, Bromley by Bow Health Partnership emma.cassells@nhs.net and Francesca Pisanu, Project Coordinator, Bromley by Bow Health Partnership mariafrancesca.pisanu@nhs.net
Further information: Compendium - new models of care for acutely unwell children and young people, Healthy London Partnership

Meeting the needs of frequent service users

The challenge of identifying and managing frequent service users is prevalent throughout health and social care. These patients are acknowledged to consume resources vastly disproportionate to their number which generates a huge impact to the health and social care economy. The successful management of frequent service users requires providers to effectively manage psycho-social and clinical complexity. The frequent caller management strategy provides a system wide solution to this challenge by mitigating compartmentalised care delivery and supporting patient centred collaborative practice. The transformational, co-designed approach stratifies the system risk generated by high intensity users and promotes system wide solutions. ***Outcomes are demonstrated to improve clinical quality, patient satisfaction, resource efficiency and collaboration throughout the health and social care system***.

Comtact: David Fletcher, Frequent Flyer Frequent Caller Darzi Fellow david.fletcher7@nhs.net
Further information: Overview, Darzi Fellowship Project (detail), summary of approach, a patient's story

The Royal Free Care Homes Outreach Service

This is a consultant-led service covering 10 care homes in borough of Camden. The service aims to improve the delivery of care of frail and complex older persons in care homes through proactive care planning, supporting and managing deteriorating patients as well as better medicines management. We also support GP's and community teams; as well as building on the competency capabilities of the workforce in care homes. ***The service has improved uptake of anticipatory care planning and reduced unscheduled emergency department attendances***.

Contact: Dr Khai Lee Cheah, Consultant Geriatrician, Royal Free London NHS Foundation Trust khailee.cheah@nhs.net
Further information: click here

Improving Care Home Access to Urgent Care

Data from the London Ambulance Service (LAS) shows that there are a significant number of care homes across London that frequently ring 999 when another service may meet a person's needs better. The ratio for conveyance of these calls to emergency departments is high. The Healthy London Partnership shared further information on these challenges as well as ways that Integrated Urgent Care can help support care homes when they are unable to get in contact with the care home resident's GP. ***A number of Winter Improvement Pilots are helping to support care homes accessing Urgent Care and we must ensure that learning from the Sutton Homes of Care Vanguard is shared and embedded***.

Contact: Eileen Sutton, Healthy London Partnership Integrated Urgent Care Programme
Further information: click here

The Senate Forum identified several issues as the most important to address in supporting development of out of hospital care

Key themes from the discussions are noted below. These are not presented in any order of priority – all were considered to be important.

It is essential to build strong relationships, trust and mutual understanding is essential at all levels of the system. This theme was raised most frequently to help build confidence and enable collaboration between partners, to break down barriers, to enable more flexible use of resources.

Staff need to be supported and empowered to identify opportunities and lead change at all levels across the health and care system and need time to do this. These points were frequently raised during the meeting. As well as utilising and enhancing existing skills, training is also needed e.g. in use of QI tools and methodologies and in a multi-disciplinary context to facilitate collaborative working. Giving staff time to get involved in innovative projects was strongly emphasised.

Be realistic about the time it takes to deliver real, sustainable change and enable greater financial flexibility. Several participants highlighted the need to balance ambition and the desire to introduce changes and deliver improvements at pace and realism about the time that needs to be allowed for some changes to be introduced, tested and embedded and about expectations about the timescale in which impact will be felt. Benefits of financial flexibility were also flagged e.g. financial freedom and pump priming for smaller scale pilots.

Be more prepared to accept that change and innovation carries risks. Several participants felt the need for greater tolerance of higher risks associated with the introduction of change and the needs for more of a shared approach to accepting and managing risk (and also benefits) across a system. Accepting risks includes being more relaxed about "targets" whilst maintaining a clear focus on improving patient care.

STPs provide the opportunity for a genuine whole systems approach, engaging all partners; system leadership is essential. Clear whole system thinking and planning for out of hospital care is important to create consistent, scaled up and understood service change. STPs need to break down barriers and spread good practice, particular identify and scaling up good practice that already exists in the area. Some participants emphasised the need to strengthen collaboration across health and social care. They felt that social care is still often regarded separately and needs to be given the same priority as healthcare and included all thinking, planning and networks across the system.

Share clear, accessible information about services, promote (and provoke) change and good practice – don't reinvent the wheel. Similar points were raised at the Senate Forum in October 2016, which focused on transforming care through adoption and spread of innovation. Understanding and sharing information about services currently available and how to access them, standardising information and keeping it simple (for patients and staff), sharing and celebrating good examples (many services still work in silos) were all noted to be important.

Consistency of alternative pathways and improvement measures to support care closer to home. Borough to borough inconsistencies are extremely challenging for services that span boroughs and make it difficult to convey information about services and access to London's relatively mobile population.

Facilitate development of primary care. A commitment to building, growing and supporting general practice was emphasised by many, increasing resources, developing the primary care model, strengthening connections across the system. Opportunities to develop QI in primary care, were highlighted building on successful examples (e.g. in NEL). Patients' access to medicines support irrespective of the setting in which they present is also important.

Taking forward local plans

After exploring different examples of out of hospital care and innovations participants re-grouped into respective STP geographies to share views and learning from the earlier discussions and, drawing on these, to identify what they felt to be the greatest opportunities for developing out of hospital care in their respective STP areas and what would enable this most of all. Each group was asked to record key points. Whilst all discussions were lively and engaging there was variation in the extent to which group's view were captured and not all written feedback was articulated clearly. The points below reflect the main points of feedback received. There are a number of common issues, which reiterate some of the overarching themes on the previous page.

North East London

Opportunities and enablers
• Reablement - health and local authority working together towards integration, enabled by shared metrics, true pathways across primary and secondary care, patient focus and incentives • Focus on the patient at the centre and do not think about individual systems e.g. primary, secondary care, enabled by agreement on shared responsibilities • Consistency across all areas of NEL, enabled by shared pathways across the sector • Reduce the bed base e.g. mental health (better in outer east London) and enhanced community care (better in inner east London) enabled by sharing and spreading practice • Workforce involvement to provide ideas and solutions , engaging and empowering grass roots staff groups, enabled by learning from the Falls/LAS innovation example and staff development
Promoting and adopting innovation more widely
• Falls care – sharing costs if innovations show savings across the STP regardless of where the saving is made; have a system wide approach to "invest to save" and break down funding barriers • Medicines optimisation – be realistic about the drivers and accept the need to manage increased risk e.g. reduce reliance on prescribing medications • Frequent attenders - remove barriers (investment in front end and back end of system), share records, involve all clinical teams across the system (GP, community, primary care, secondary care), engage the public to change culture and expectation about the quality of care (e.g. perception of better care and more tests in hospitals), promote primary care with the public, enhance GP services (e.g. Tower Hamlets model), GP at the centre, relax challenges about financial deficit, allow time to do this and be realistic about timescale, improve access and better response for things like diagnostics, therapy etc.
Support that would add most value
• QI training • Business management costing skills • Build on the principles of "expert patient" programmes – engage patients and the public in the QI process • Cascade areas of good practice across the sector e.g. public involvement at BHRUT

North Central London

Opportunities and enablers
• Harness the value of networks to identify the engaged and empower them to act • Reduce the inhibiting impact of information governance by introducing STP wide information sharing agreements and agreeing an approach to sharing risks and benefits • Develop new services and schemes to reduce attendance at EDs/improve clinical quality by utilising the STP to enable cross organisational collaboration • Integration of mental health and primary care resulting in management of patients in a less acute environment, enabled by shared funding • Adoption of more proactive rather than reactive care delivery approaches • Some services are improving and changing e.g. 111 – direct experience may be some years ago and people may not appreciate that quality has improved significantly
Promoting and adopting innovation more widely
• There are lots of individual initiatives around out of hospital care that not everyone understands or is aware of within the STP geography • Having lots of pieces of a jigsaw makes it difficult to see the opportunities to make change at scale and make efficient use of clinical time – what are the activities that will make the most impact? Need to understanding the impacts that the range of initiatives are having on the overall system • Involvement of social care as a strategic partner and reframe current debate about health and social care to one about what services/interventions are needed • Leadership challenge - skills for changing systems, developing relationships and promoting change (in a risk adverse culture) • North Central London colleagues liked CC4C and Living Well Network
Support that would add most value
• Addressing the challenge of managing business as usual and trying to innovate at the same time • Being less risk adverse across the system • A clear narrative within the STP that helps professionals understand how the system is working as a whole to achieve improvements • Building both a systems approach and developing relationships to secure best patient outcomes • Coherent commissioning strategy • Clear communication strategy for local people • Targeted training for key staff groups e.g. residential homes and building confidence.

South East London

Opportunities and enablers
• Local care network development, involve and empower residents to take ownership and be active in driving their own health and care, enabled by participative consultation • Information governance and IT support to enable integration • Social care and health care integrated working, including the voluntary sector, enabled by shared language and systems that “talk” in real time • Co-produce services which meet local needs and create shared principles across the STP, enabled by applying approaches used in successful pilots , in turn enabled by patient and public involvement/active participation, encouraging risk management and ownership
Promoting and adopting innovation more widely
• Co-production/breakfast networks to address common issues and problems • Never take no for an answer with organisational support for change and the risk involved • Establish platforms to coordinate sharing of good practice • Removing eligibility criteria will not result in a floodgate of people – they are responsible • Science is slow moving in evaluation – innovative approaches need to be implemented then reviewed to help build the evidence base

Support that would add most value
• Greater tolerance of risk including the risk of failure and learning from it • Removal of barriers which exist between partners to encourage and support difficult conversations • Involve and empower people on the ground to identify and design change; it's not just money but time, recognition and enthusiasm • Ring-fenced space and support to deliver the service to support change • Communities of collective voice; building time into a person's work plan to reflect and develop relationships • Greater collaboration and consultation is needed with social care across the STP • Emphasis should be on moving to a patient centred approach – how can co-production/co-design be achieved locally across the footprint? • The STP should be a shared process enabler used to encourage change • Being clearer about how the Better Care Fund links with STP – there is a lack of guidance

South West London

Opportunities and enablers
• Agreeing must haves across SWL enabled by standardisation of pathways and criteria • Improve outcomes for patients through advocacy schemes, care coordination, enabled by data sharing agreements/protocols and relationship building • Intermediate care stepping stone, triangulation of information and training, enabled by breaking down the bureaucratic barriers and having a contracting model that incentivises working together • Newer, lower cost ways of delivering care e.g. social prescribing, enabled by doing what you do in your time but doing it differently, identifying what's needed with the right conversation, making patients our best resources • Solving the small problems which cause a huge problem, enabled by identifying the willing, understanding of systems thinking (engineering process); joining the networks • Agencies working across the areas = given a voice and how to improve the system, enabled by SPOA (single point of advice) for SWL system – help identify the right place, consistent approach to pathways across SWL
Promoting and adopting innovation more widely
• Social prescribing, patient activation – making every contact count, need to take some time to understand what the public needs • Data sharing • Richmond (Croydon) rapid response system, standardise across the pathways x SWL, understanding (the data) when dips happen • Right care initiative, sharing best practice across the region
Support that would add most value
• Clear direction on social services and medical services on financing • Trust in the systems we are creating • Resilience support for staff • Devolution pilots – information and advice • Public communications –this is for you! This is the right pathway of care for you. • Education, message to the public – MECC - raised awareness – understanding of the wider health system

North West London

Opportunities and enablers
• Long history of collaborative working in NWL, • Can build on the fact that the health economy has successfully delivered reconfiguration in Shaping a healthier future but much more to do, but at least we know 'it can be done' • History of coproduction in NWL but needs to go further and faster • The STP concept… has the potential to bring real change across a system • The well-established and functional Clinical Board could be used to lead change
Promoting and adopting innovation more widely
• Find mechanism for multispecialty collaboration to clarify generic principles underlying the success of pilots • Persist in linking up my local teams with London wide projects to share and learn from experiences • Share our learning and questions from children's work with colleagues doing out of hospital care work with adults
Support that would add most value
• Need to find ways of building collaborative answers at system level • Need to find ways to help CCGs and Trusts to find headspace to not be 'dominated by firefighting' and short term crises • Help in finding ways to help the system take 'risks' together to implement bold good ideas… of which there are many • To help foster understanding of the challenges in each part of the system ie to use collaboration to solve 'everyone's problem' and to understand why 'obvious' solutions are often not quickly adopted… rather than just leading to frustration

Other out of hospital care initiatives

In preparing for this Forum we identified several other examples of good practice and related work being undertaken across London. Links to this work are provided below.

- The Healthy London Partnership Urgent and Emergency Care Programme has carried out two rapid reviews: (1) A&E avoidance schemes across London and (2) Delayed transfers of care and the discharge process
- The Healthy London Partnership Children and Young People's compendium on new models of care for acutely unwell children and young people includes information on 30 different out of hospital initiatives including the four shared at the Forum). Please click here.