Healthy London Partnership

directors of adass adult social services

Setting the scene: the ambition for London

Dr Emma Whicher

Supported by and delivering for:

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NHS

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London's NHS organisations include all of London's CCGs, NI

Healthy London Partnership

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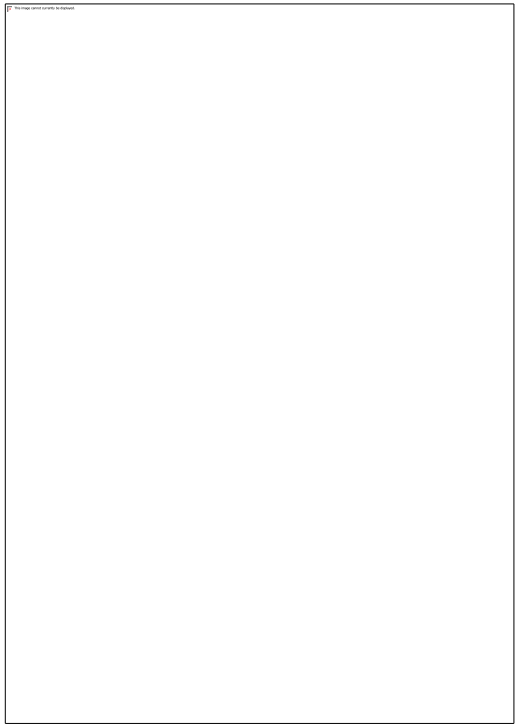
The Next Steps plan sets out the national expectations and tangible deliverables to be implemented over 2017/18 and 2018/19

NHS Five Year Forward View



The NHS Five Year Forward View set out **why improvements** were needed across **better health, better care, and better value**

Next steps on the NHS Five Year Forward View

Next steps on the
NHS Five Year Forward View

- This Plan concentrates on **what will be achieved over the next two years**, and **how the Forward View's goals will be implemented.**
- The Plan highlights **three 2017/18 national service improvement priorities** within the constraints of **delivering financial balance - one of these three priorities is Urgent and Emergency Care (UEC)**
- The Plan sets out a **commitment to offer a broader range of improvement support to frontline staff to achieve the priorities set out for UEC**
- **Together with work to ensure the right enablers are in place including workforce development and technology**

The Next Steps plan - Getting Urgent and Emergency Care Back on Track

NHS 111 Online

- **Online triage** services that enable patients to enter their symptoms and receive **tailored advice or a call back from a healthcare professional** offering an increasingly personalised experience to patients

NHS 111 Calls

- **Increased calls transferred to a clinician**
- Better support for patients to **'self-care'**
- NHS 111 Care Home Line will enable **dedicated access for healthcare professionals to get urgent advice** from a GP out of hours

GP Access

- **Continued provision of urgent care services by general practice**
- **Access to pre-bookable evening & weekend appointments** with general practice
- Step change in use of **digital technologies**

Urgent Treatment Centres

Urgent Treatment Centres across the country:

- Open at least **12 hours a day**
- **Staffed by doctors and nurses**
- With **diagnostic facilities**
- **Ability to book appointments** via NHS 111, GP, or walk in
- Ability to **prescribe**

Ambulances

- More **clinically focused response for patients**
- **Quicker recognition of life threatening conditions**
- **Telephone advice, treatment on scene or conveyance**
- **End to long waits** for an ambulance and handover delays at hospitals

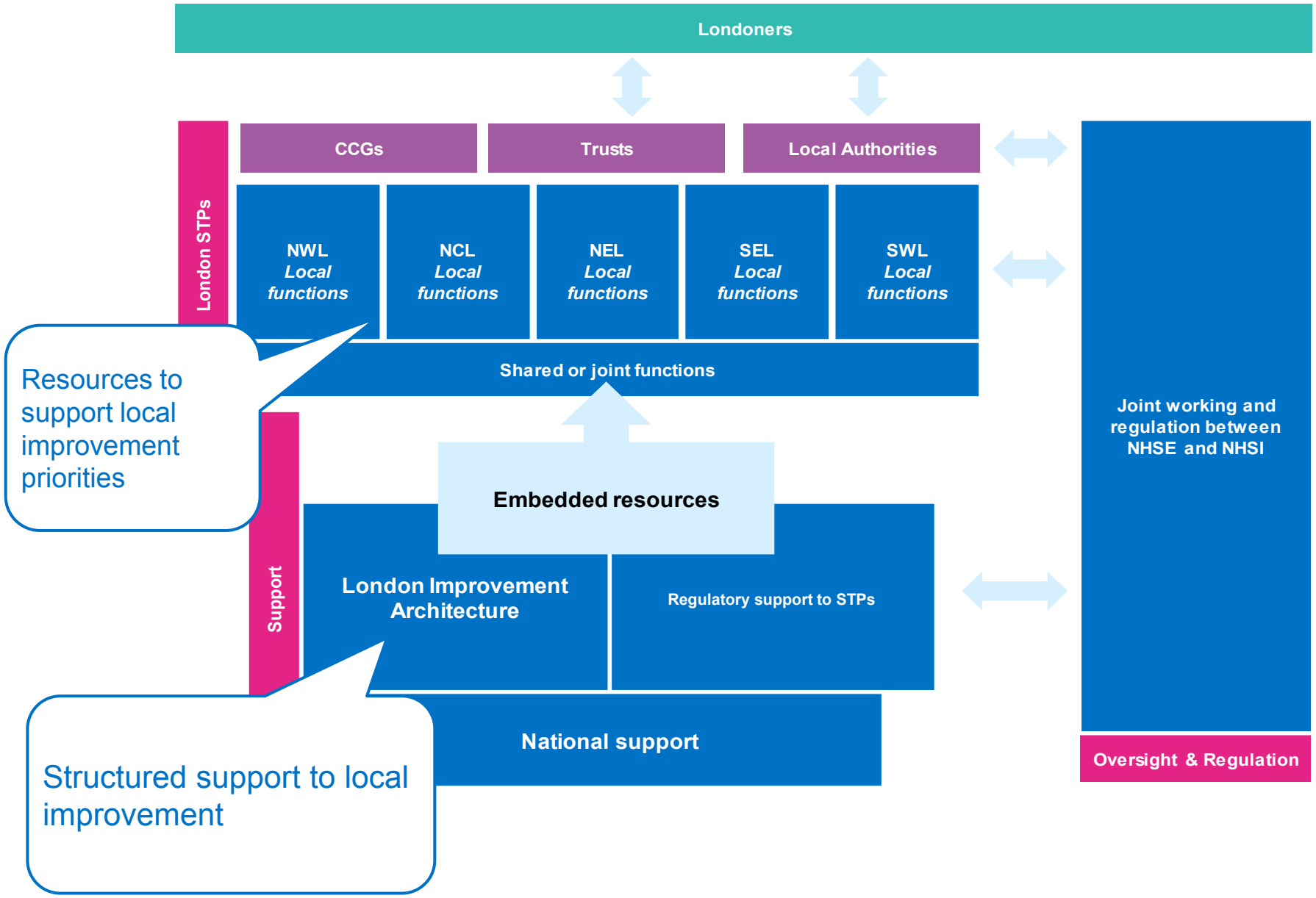
Hospitals

- **Highly skilled emergency department workforce** to deliver life-saving care for our most sick patients
- **Variation between hospitals reduced**
- **Patients streamed to the most appropriate service** by a highly trained clinician
- Use of a wide **range of ambulatory care services**.

Hospital to Home

- Patients **only stay in hospital for as long as they need** to be
- **Earlier planning of discharge** and further **joint working across different sectors**
- Coordinated and **timely transfer of care from hospital to the most appropriate setting**
- Provide patients with **comprehensive packages of health and social care**

STPs will be the vehicle through which we deliver these priorities and the London NHS is re-orientating itself to support them



London has a strong track record of collaboration and delivery to build on

90% of Londoners have access to extended general practice

3,400 fewer emergency admissions from care homes over the last 6 months due to clinical support provided through 111

World class models of care for Stroke, Trauma and Heart attacks saving hundreds of lives each year

27,000 less referrals from 111 to 999 in the last 6 months due to increased clinical support in 111

Sutton Vanguard - 31% reduction in A&E attendances and 25% reduction in unplanned admissions

Agreed London Section 136 pathway across health, care and police partners to improve care for those in mental health crisis

Healthy London Partnership

Dr Vin Diwakar

Medical Director, NHS England (London)

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There is always great interest in the UEC system

News › UK

London Bridge attack: NHS staff praised for preventing death toll rising after dozens critically hurt

Doctors revealed they were able to keep the
dealing with stab wounds seen during Londo

News

A&E crisis deepens with 65 hospital trusts issuing emergency alerts

News › UK › UK Politics

UK on brink of 'social care crisis', government warned

Figures show 48 councils have seen at least one c
close in the last six months

NHS workers praised for their `superb´ response

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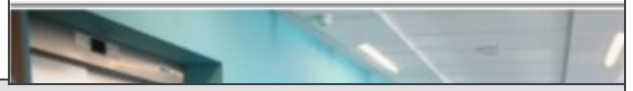
Health

NHS Health Check: A&E waits for January 'worst ever'

HOME › NEWS › NHS

Hospitals issue 'black alerts' as high winter demand leaves A&E departments at breaking point

NHS hospitals up and down the country turn patients away just days before a strike by thousands of junior doctors



News › Health

Every London NHS trust misses A&E waiting target as winter crisis bites

Budget's £2bn for social care is welcome but crisis is about more than money

Bob Hudson

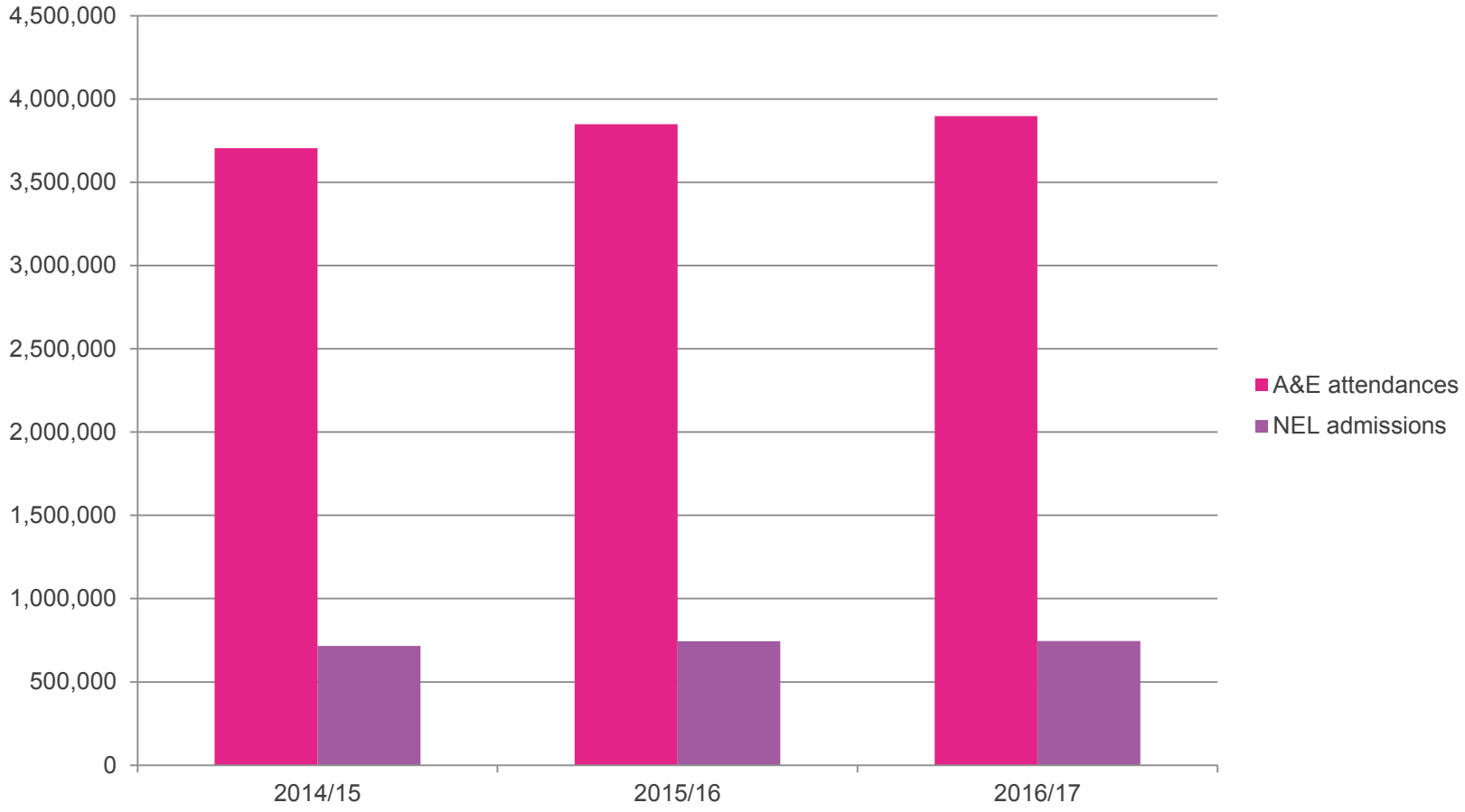
Philip Hammond's emergency funding has not changed the issues the sector faces – social care is at tipping point and needs a long-term strategy

Home / News / NHS and emergency services praised for response to terror attack

NHS and emergency services praised for response to terror attack

The pressure on services is increasing

More people are using urgent and emergency services than ever before with year on year increases in A&E attendances



The patient and public view of our system

The patient and public view of our system

- **More people use urgent and emergency services in London than ever before** and the numbers are growing every year
- **15-25% people attending A&E could use another service**, however we know they go to A&E, often because they do not know what else to do
- There is **high awareness of the range of urgent and emergency services but confusion over which one is most appropriate**, which means people often 'default' to A&E
- **Londoners have told us they want to have confidence they will be seen quickly by the right person, the first time around**.
- **People are willing to go elsewhere if they think they can get help, however the complexity of the system is key** - although time is precious people are willing to trade four hours for knowing they will have their complaint dealt with.

The views from professionals in our system

Every health care provider should play a role in promoting self-care and should educate patients to self-care

If patients come to an ED they know they are **likely to get seen promptly at an hour that suits them** and will get prompt tests etc.

When **patients** do present to an ED they **often claim they have no reasonable alternative**

Patients are not willing to wait

'NHS 111, posters etc. **The system is confusing** and patients commonly come to the ED just to be on the safe side

Material support i.e. leaflets, **availability of capacity elsewhere in the community to redirect the patients to…all lead patient to A&E**

Patients vote with their feet. They constantly tell me they can't get GP appointments.

What citizens want from our system

We need to change the way we improve quality…

Current capacity and capability to deliver quality improvement

"The NHS cannot meet the health care needs of the population without a sustained and comprehensive commitment to quality improvement as its principal strategy".

"The gap between what we know and what we do, between best practice and common practice, is often significant"

"The quality of clinical care is not matched by its ability to identify, assess, and manage its staff consistently"

"challenges to implementing the LQS include marked deficiencies within hospitals around complex change management and a disconnect between frontline clinicians and senior management staff" "Where the LQS have been implemented this was driven from bottom-up approach rather than top down processes or commissioning mechanisms"

"There is insufficient management and leadership capability to deal effectively with the scale of change (in the FYFV)"

"Through no fault of their own people are often ill-prepared or ill-equipped to mplement changes asked of them".

"Each organisation often operates in its own, often short term self interest - organisations compete rather than collaborate"

Adopting a collaborative approach

What is a collaborative?

- Quality improvement collaboratives involve **groups of professionals coming together, either from within an organisation or across multiple organisations, to learn from and motivate each other to improve the quality of health services**
- Collaboratives often use a structured approach, such as setting goals and undertaking rapid cycles of change
- Collaboratives **support and celebrate change at a local level**

Do collaboratives work?

- The broad theory behind collaboratives is that, **by collaborating and comparing practice, professionals. leaders and teams will be motivated to do things differently**, which in turn improves people's lives and ultimately improves service use and costs
- There is more empirical evidence about the impact of collaboratives on **direct changes to professional behaviour or care processes** than on impacts on the quality of care for service users or health users
- A number of uncontrolled studies have found **improvements in symptoms, safety incidents, death rates and other patient outcomes**

The London UEC Improvement Collaborative

Overarching UEC Improvement Collaborative*

Chaired by external expert, includes SROs and Programme Leads and other key partners Focuses on the rigour and fidelity to improvement methodologies, as well as a safe space for discussing challenges and barriers to impact.

Collaborative domains

Being supported at home

High quality emergency care when needed

Overseen by Clinical leads and programme Leads with dedicated Improvement Collaborative leads to provide support and engagement that model suggests. IC leads to liaise across the two domains to ensure synergies and alignment

Domain scope

- 8 high impact changes for hospital to home
- Continuing Health Care
- End of Life Care
- Ambulance standards
- Hear and Treat
- See and Treat

- Discharge to assess
- Continuing Healthcare assessments
- Trusted assessor
- Managing patient choice

- Emergency Department
- Clinical streaming and redirection
- Urgent Treatment Centres
- Ambulance handovers
- Ambulance direct access to UTCs
- Emergency Department systems and flow
- Ambulatory emergency care

- Optimising patient flow
- Consistent services
- Managing complex patients (including frail elderly and those with co-morbid mental and physical health issues)
- Hospital discharge processes

Emerging thinking – being tested with 8 high impact changes – is to mirror the IC methodology for each of these areas.

* Future branding work may result in a new name for the Collaborative, one that is engaging and exciting for the full range of stakeholders

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Urgent and Emergency Care Collaborative

Grainne Siggins

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It’s about people – and communities

1 in 3 people are in touch with social care. Good care and support is **distinctive, valued** and **personal**. Effective social care should:

- transform lives
- enhance health and wellbeing
- increase independence
- increase choice and control.

Social care is much more than a **supportive adjunct to the NHS**. Social care nurtures **resilient**, **healthy families** and **communities** that can **reduce** and **prevent** the need for formal services by:

- supporting people to live better, more fulfilled lives
- providing essential services to those of us who need them.

Local authorities are democratically accountable to their populations. The social care systems supporting them are structured differently to the NHS, so an **open dialogue** is vital to improving people’s lives.

The ADASS network exists to achieve this vision for social care by supporting local authorities, workforce and partner organisations to **work together**.

Social care and the NHS must work together

What

As system leaders we need to:

- plan effectively as a system to prevent people from going into hospital unless they have a medical need to do so
- support patients to come home when they are clinically ready to do so
- plan together at a local level to enable this to happen
- make difficult decisions about patients, taking risks so long as we learn from failures

How

We do this by:

- looking at good practice and testing things out, accepting that some things might fail
- understanding local population needs
- evaluating interventions that are put in place and making changes where that evaluation shows us we are not achieving our outcomes
- using the data that we have to much greater effect
- fostering the highest quality and most effective workforce for the future

Through the Better Care Fund we are already doing some of this, but we can always improve

The 8 High Impact Changes in urgent and emergency care

As a system we have agreed eight areas of change that would have a significant impact on our goals to support people to remain at home:

Change 1

Early discharge planning. In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.

Change 3

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

Change 4

Home first/discharge to access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5

Seven-day service. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.

Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

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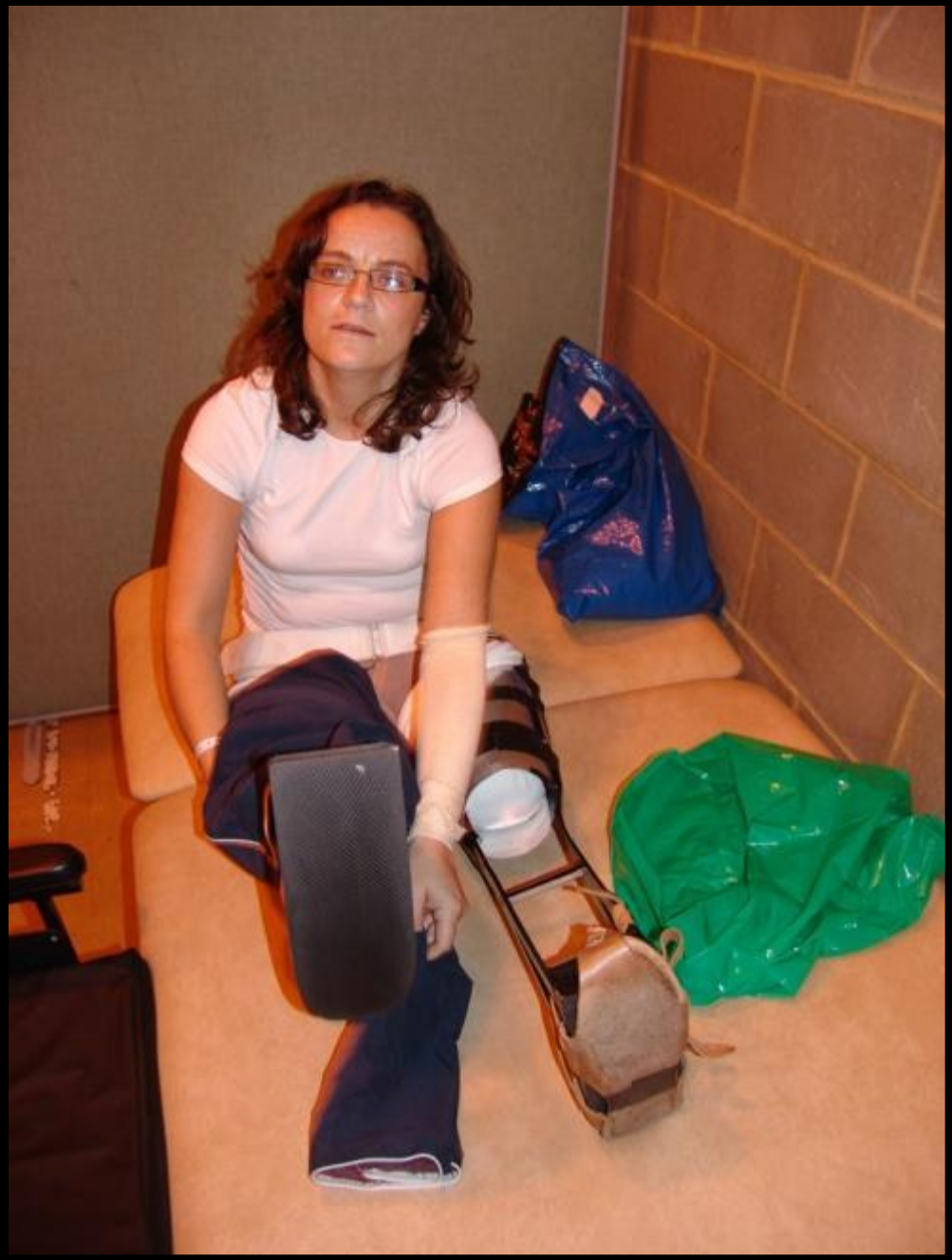
4th July 2017

Twitter:@ martine_wright




Keep
clear


SP12
BBC SPORTS PERSONALITY OF THE YEAR


SPORT
RELIEF


POLO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ROGERS
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GREAT BRITAIN


london
Paralympic Games
Welcome to the
Paralympic Village


AV5


MARTINE WRIGHT
GO GIRL
GOOD LUCK
AND TEAM GB
VOLLEYBALL
FROM THE
GO MUMMY GO!!


GO MUMMY GO!!


WRIGHT
7


London 2012

UNBROKEN

Martine Wright

OUT 13 JULY

Healthy London Partnership

directors of adass
adult social services

Challenges & Opportunities: hearing from you

Professor Oliver Shanley OBE and Dr Tom Woodcock

Supported by and delivering for:

Public Health England

NHS

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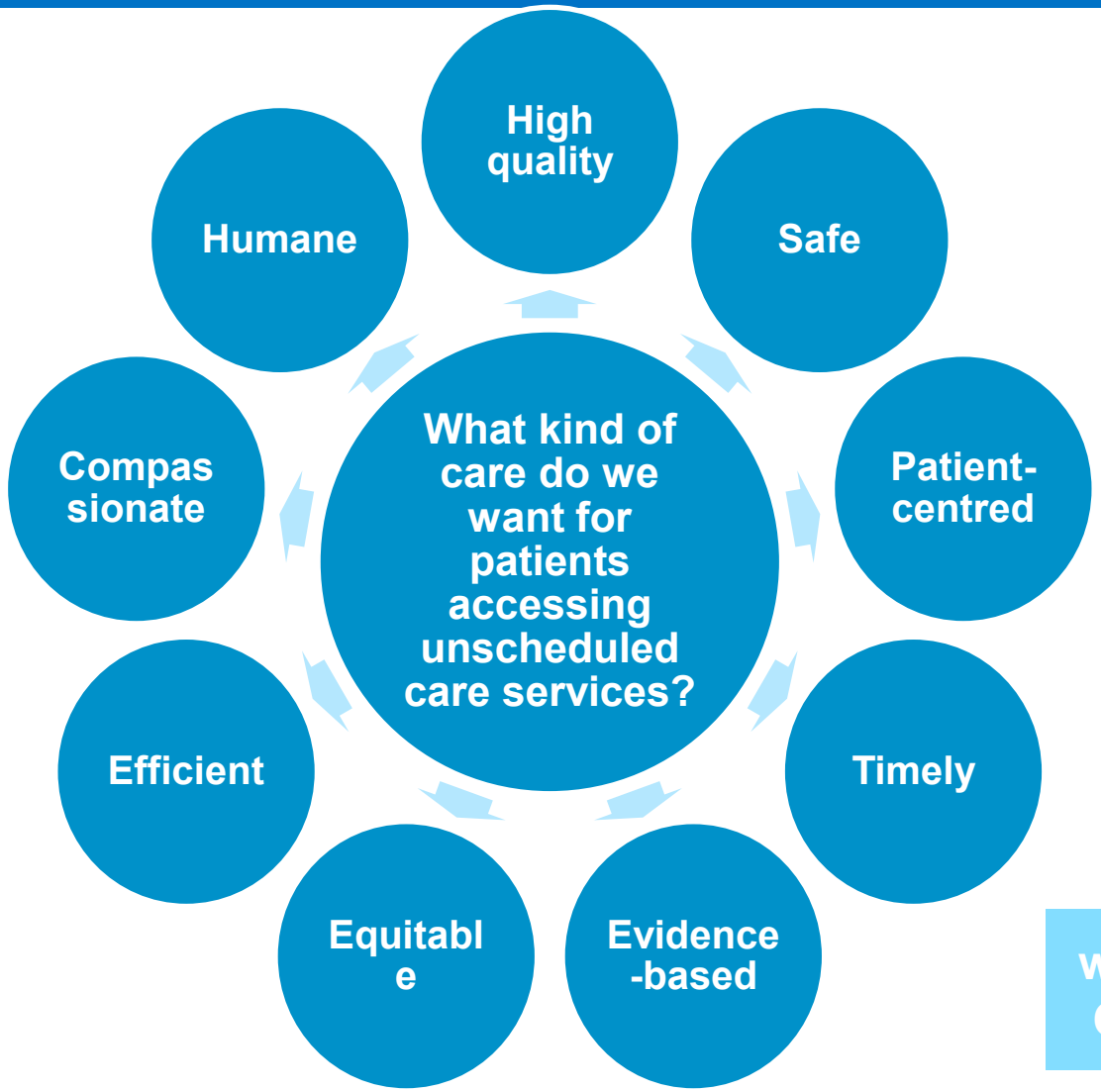
London's NHS organisations include all of London's CCGs, NI

Hearing from you..



www.menti.com
Code: 51 67 03

1. What are the challenges/barriers to providing such care?
2. What are the enablers/opportunities to providing such care?

Healthy London Partnership

directors of adass
adult social services

Refreshment break

Supported by and delivering for:

Public Health England

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Healthy London Partnership

directors of adass adult social services

Taster sessions

- Patient Journey - Debenture Lounge
- Interface of care/ discharge – Australia Suite
- Data for diagnostics and measuring improvement – Ashes Suite
- The importance of weekends – Ashes Suite

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Public Health England

NHS

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Healthy London Partnership

directors of adass
adult social services

What next?
Bringing the Collaborative to life

Professor Derek Bell

Supported by and delivering for:

Public Health England

NHS

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MAYOR OF LONDON

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Emergency care flow is critical for patient experience, clinical outcomes & quality of care

- Assessing & treating patients who require emergency care is time critical for good patient experience and outcomes
- Efficiently managing all patient groups accessing emergency care will improve patient flow
- Evidence suggests the sooner patients moved to the right clinical environment, the better the overall outcomes

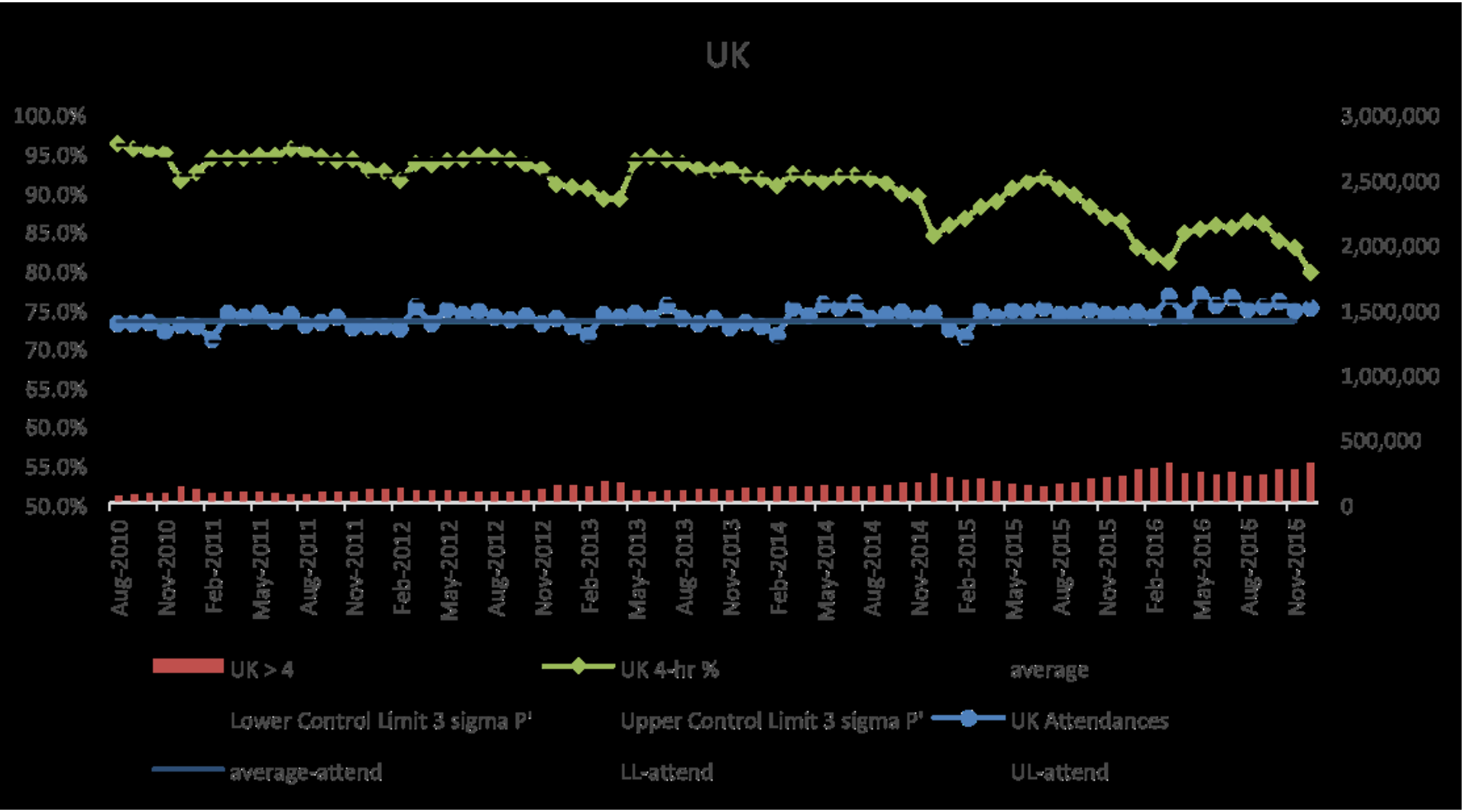
The 4-hour measure: powerful marker of overall system function

- Evidence suggests patients with longer waits have poorer clinical outcomes and poorer patient experience
- 4hr standard acts as a barometer or pulse, but we need other measures

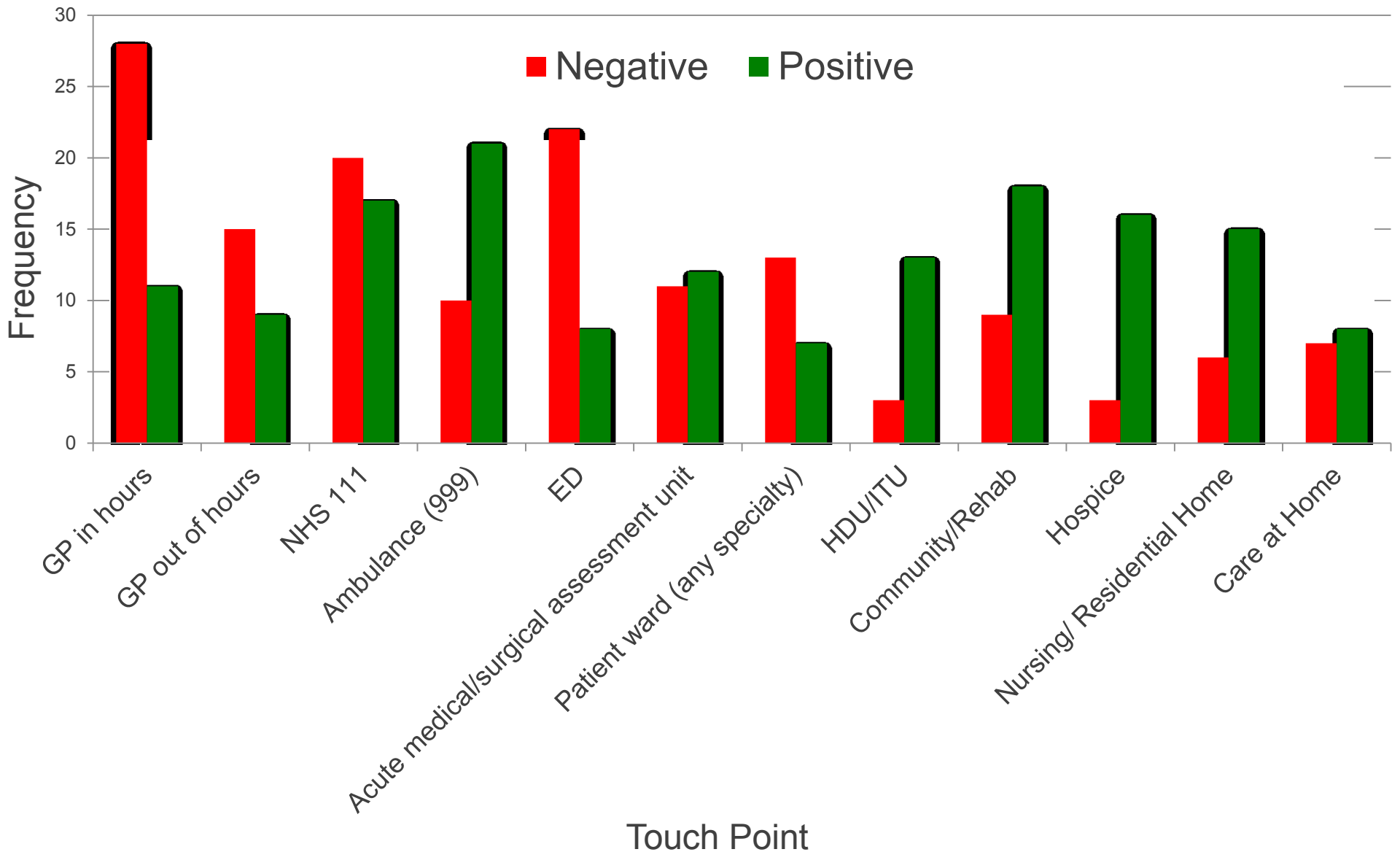
Access Standard: Designed to improve patient & carer experience and outcomes

UK overall performing poorly

→ 4hr standard progressively deteriorating since September 2013



Emotions at different parts of the pathway…



Your Wordle from morning exercise

Hearing from you: Your challenges & Opportunities

Challenges

- Too many cooks/ lack of focus/ constant change
- Financial: constraints & moving money around
- Workforce: recruitment and retention
- Consistency & dedication
- Ensuring a single, shared vision & its understanding
- Prioritisation difficulties: differing priorities, time demands of initiatives, pace
- Time: lack of to focus on improvement
- Frailty
- Greater public awareness
- Sharing effectively: resources, practices & capabilities
- Complexity of the system
- Data challenges: complex metrics, not joined up
- Communication: between acute & social care
- Keeping pace with increasing demand
- Space & opportunity to facilitate change: Individuals, teams and systems
- Perversity of current initiatives that don’t work
- Patient expectation and changing patient behaviour

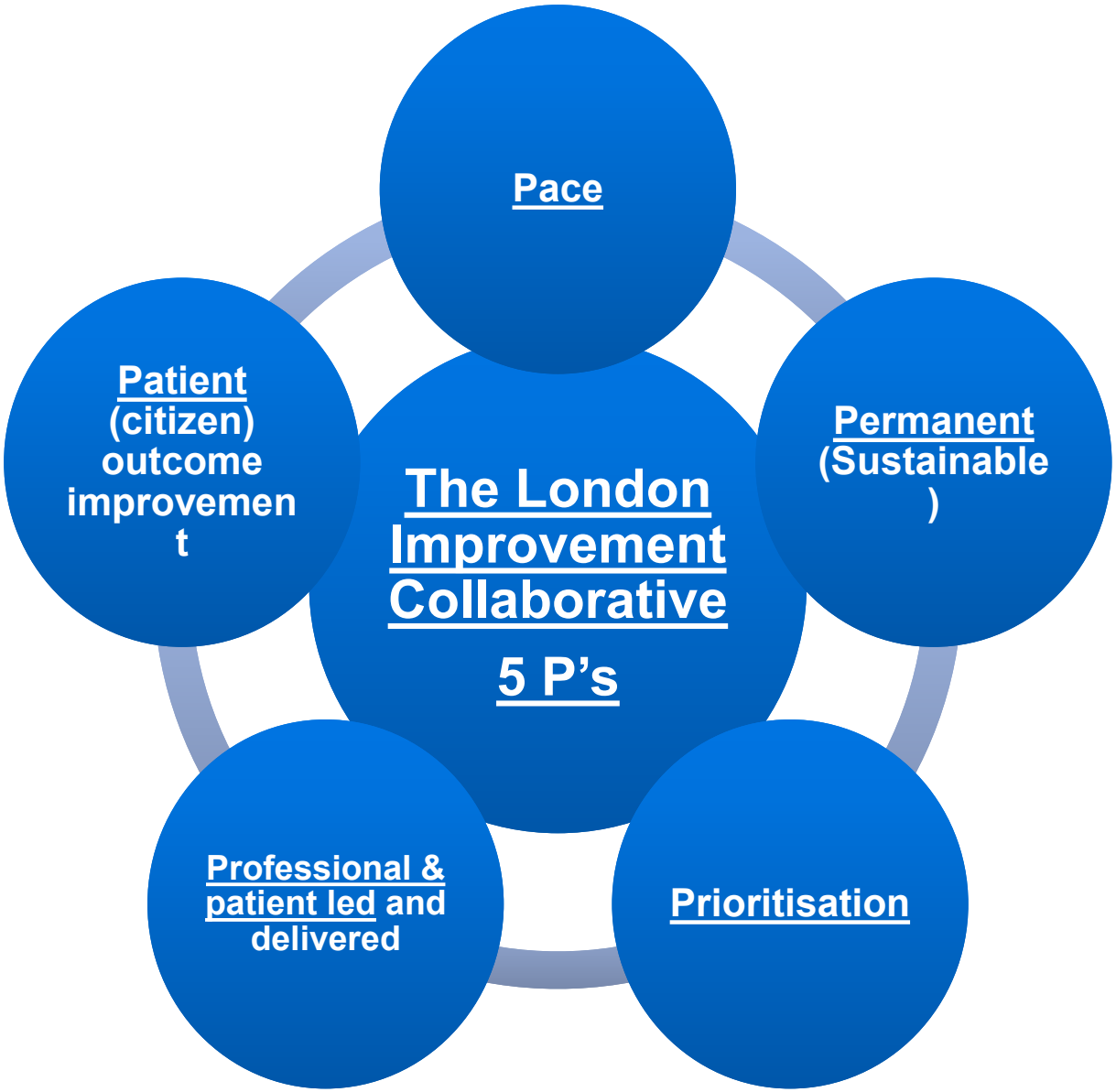
Opportunities

- Patients & staff want it!
- Support & buy in from London! Belief in change!
- Working together and cross speciality learning
- An agreed system wide, single, shared vision
- Personal and organisational commitment to make a change
- Data: one unified approach for capturing data
- Equity of sharing ideas and practice. No limits to exploring ways & means to achieve outcomes
- A collaborative that involves all parties.
- Shared learning on a level-playing field, i.e. all members treated as equal
- Leadership commitment at all levels across health & social care economy
- Reducing duplication &freeing up people to do their jobs
- Shared passion for improving patient care and embracing new ways of working.
- Listening to patients"
- Technology
- Breaking organisational barriers
- Time: to test, trial, pilot, engage, embed

Consider: What is or isn’t within the collaborative scope?

The London Collaborative Programme Approach

A structured improvement methodology which will be influenced by the 5 P's:



How to begin

Leading change:

Connecting your aims and aspirations to the tasks and actions that will deliver change.

"The secret of getting ahead is getting started.

The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks,

and then starting on the first one." - *Mark Twain*

PACE: The half-life concept

→ Setting time-based improvement targets

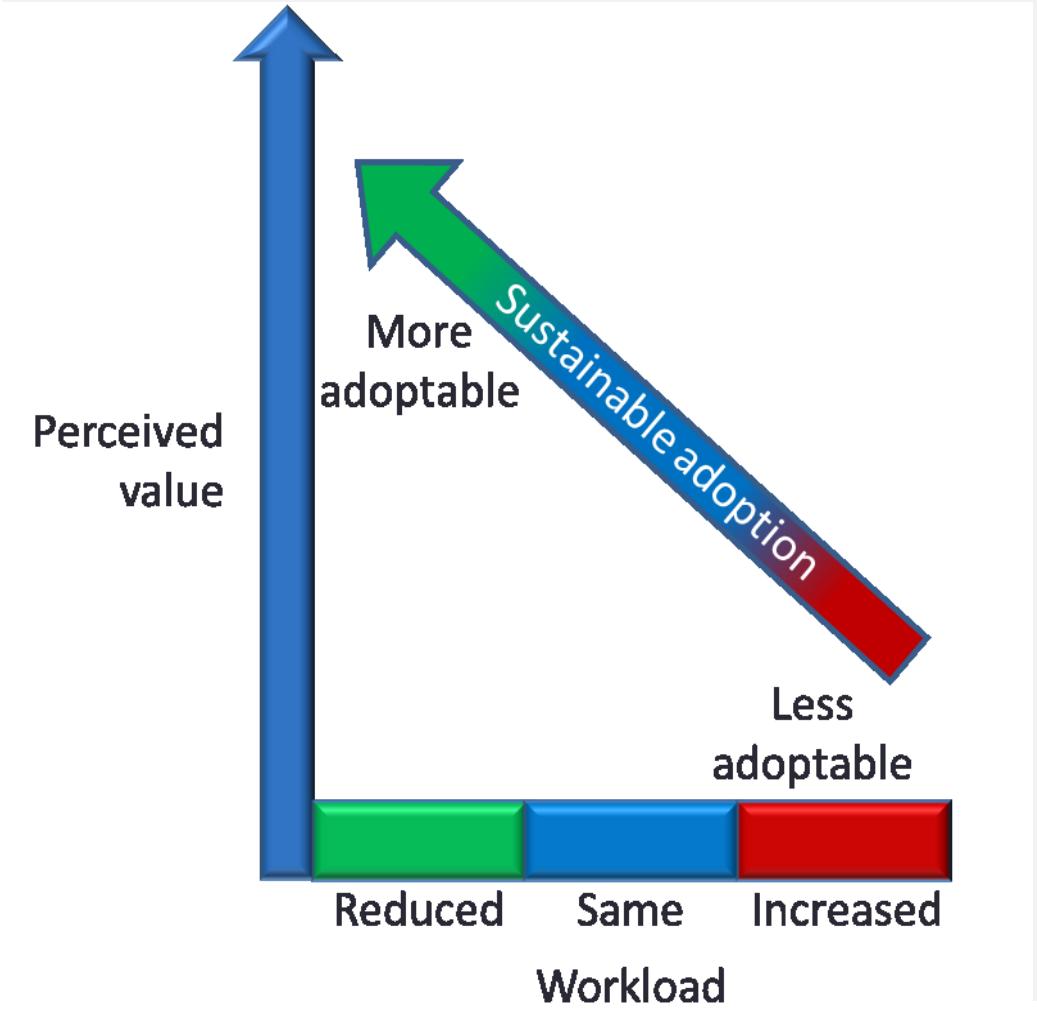
- Goal setting around the length of time it will take to reduce defects (or close a gap) by 50 percent.
- “half-life” accommodates notion of perfection, yet accepts that it is achievable only in infinite time.“
- If the goal is to achieve 98% and current operational performance is 93% then gap is 5% so how long to achieve 2.5% as first stage – set achievable time trajectory based on data
- Effective framework for long-term planning

PRIORITISATION: Maximally Adoptable Improvement

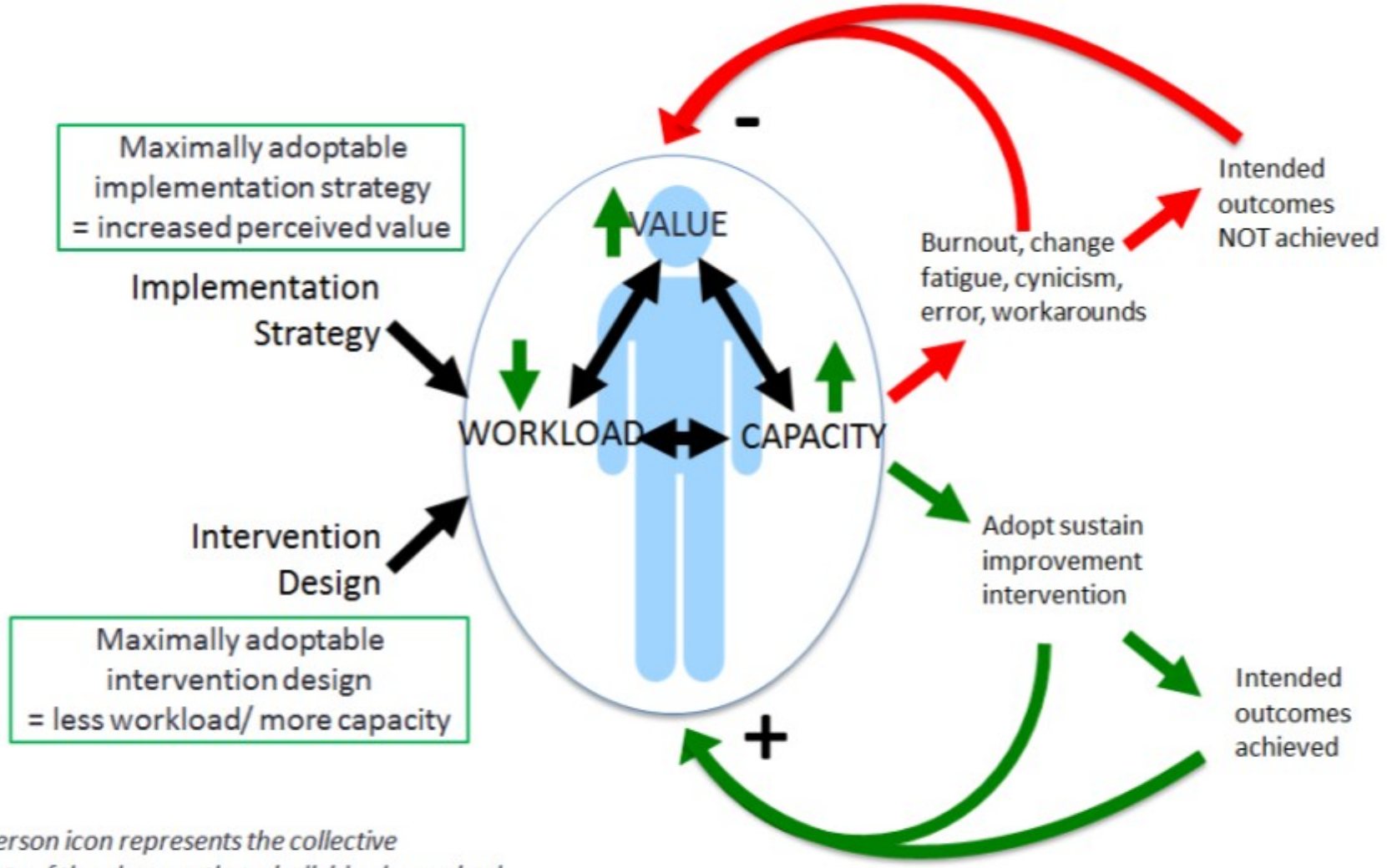
Hypothesis

Change initiatives that do not add additional workload & have high perceived value are:

- ➢more likely to be adopted
- ➢cause less workplace burden
- ➢achieve the intended outcomes



PERMANENT: Maximally Adoptable Improvement



** The person icon represents the collective recipients of the change; those individuals required to carry out the tasks associated with the intervention*

PROFESSIONAL & PATIENT LED

Principles for Improvement

6 ESSENTIAL ACTIONS
Unscheduled Care

Increasing in complexity & difficulty

Our London Improvement Collaborative

The key elements of the Improvement Collaborative are drawn from evidence, developed through engagement and timed to ensure pace and early support to challenged systems.

1 Pan-London Events

July 2017	Oct 2017	Jan 2018	April 2018	July 2018	Oct 2018
Launch Event 4 July	Collaborative Event 2	Collaborative Event 3	Collaborative Event 4	Collaborative Event 5	Collaborative Event 6

2 System action periods

Between events there will be 3 month system action periods taking learning from events, applying this to improvement areas locally and feeding back at the next event. **Action periods will be supported throughout by the central collaborative functions** with monthly system reporting.

3 System peer visits

System peer visits **scheduled throughout the life cycle of the Improvement Collaborative** with **challenged systems prioritised.** The scope of visits is the whole system – **in and out of hospital.**

4 Work-stream activity

Specific work streams to support capacity building around topics to measurably improve the patient journey

Plan-Do-Study-Act → Sequential cycles

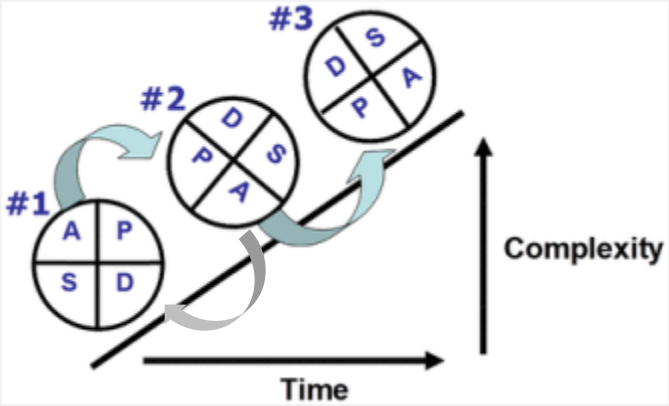
The PDSA cycle to test a change idea

- what changes are to be made to the next cycle?
- can the change be implemented?

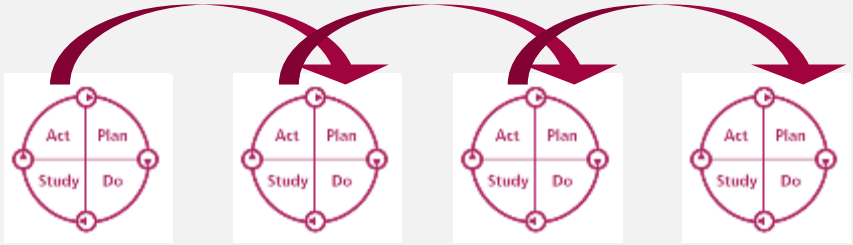
- set objectives
- ask questions
- make predictions
- plan to answer the questions (who, where, when)
- plan to collect data to answer questions

- complete the analysis of the data
- compare data to predictions
- summarise what was learned

- carry out the plan
- collect the data
- begin analysis of the data



- Increasing in complexity



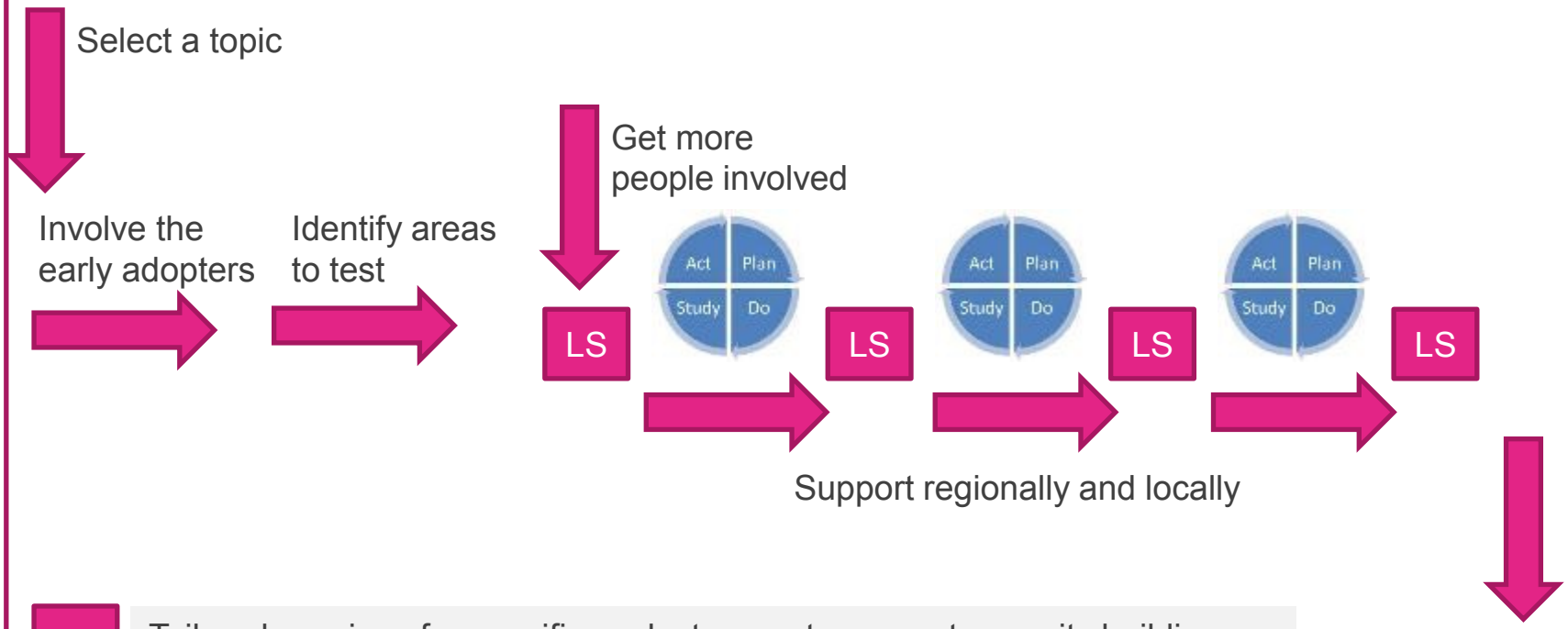
- "Act"ing on learning
- Form of trial and error
- Learning what works and what doesn't
- Stop doing what doesn't!

Taylor et al, Systematic review of the application of the plan-do-study-act method to improve quality in healthcare, *BMJ QUALITY & SAFETY*, 2014

An Improvement Collaborative: how it works

The Improvement Collaborative methodology is tried and tested best practice in improvement with a recognised evidence base when applied effectively

Improvement collaborative methodology



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Tailored sessions for specific work streams to support capacity building around local issues to measurably improve the patient journey:
E.g. measurement for improvement, long term success, process mapping, stakeholder engagement, diagnosing patient flow system

SUPPORT available during action periods

Data hub

- Data analytical support
- Software for measurement for improvement

Capability building hub

- QI tools & techniques:
  - Process mapping
  - PDSA cycles
  - Sustainability
- Improvement coaching
- Online learning sets

Communications hub

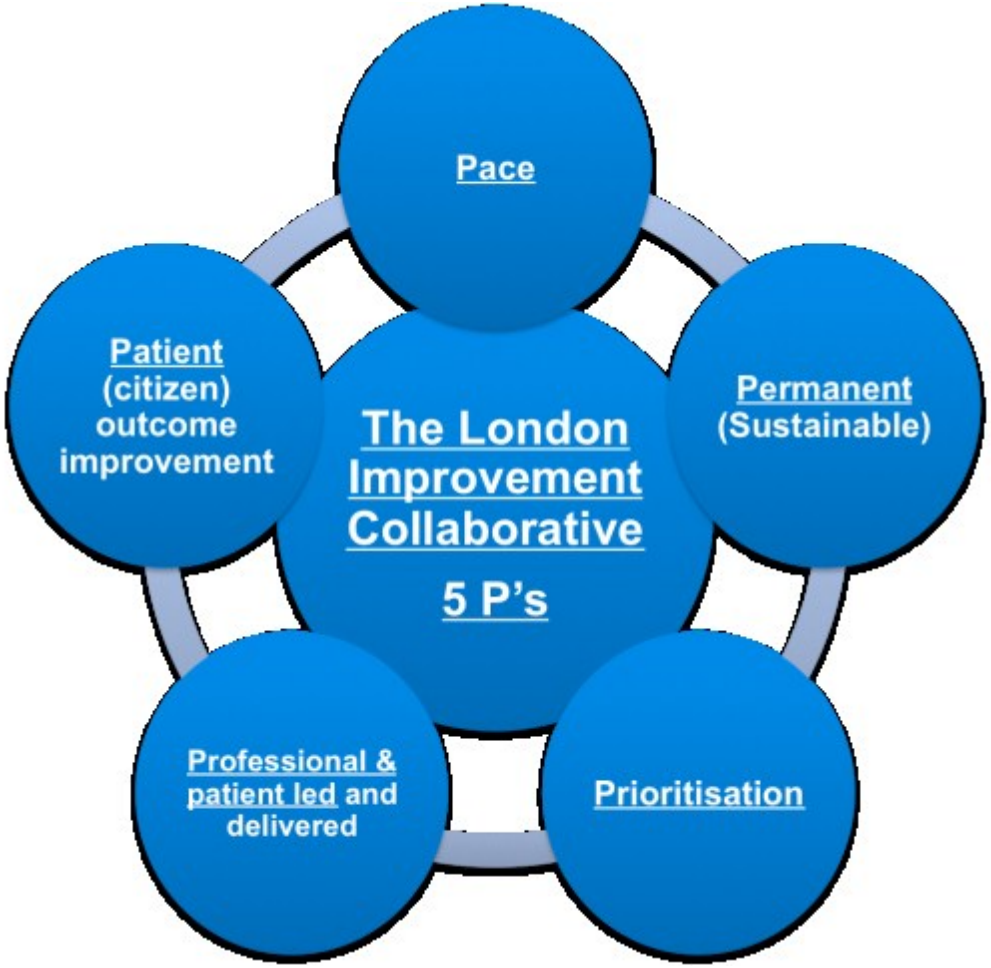
- Online communities of practice
- Continuous 2-way
- feedback

Knowledge & Evaluation hub

- Central repository of evidence & best practice
- Improvement science & emergency flow expertise

Programme benefits in three areas

A structured improvement methodology which will be influenced by the 5 P's:



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Next steps..

Your 14-day Challenge

Who are the leads for collaborative initiatives?

Flow Baseline

Organisation / System level

- Clinical/professional lead
- Information Analyst
- Improvement Facilitator
- Non-executive Director
- Accountable Executive

Email names to: england.serviceredesign@nhs.net

The London UEC Improvement Collaborative

We can do this together!