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Transforming Primary Care
Coordinated Care
4th February 2016

01

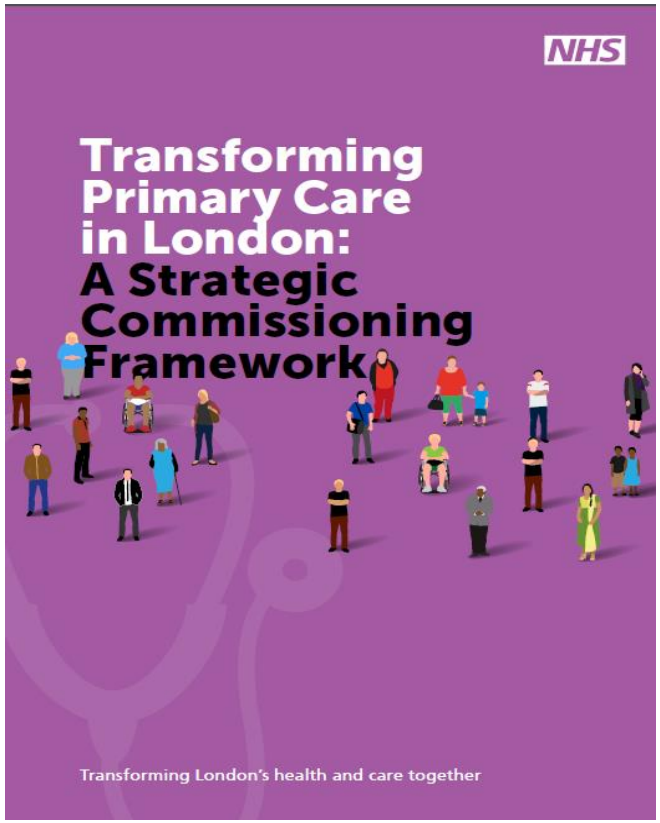
Welcome and Introduction

Welcome and introduction

Liz Wise, *Director of Primary Care Commissioning & Programme Director, Transforming Primary Care, Healthy London Partnership*

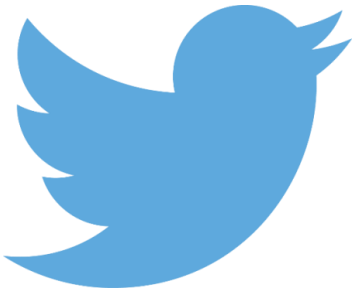
Jane Lindo, *Deputy Programme Director, Transforming Primary Care, Healthy London Partnership*

The Transforming Primary Care programme



- The **Healthy London Partnerships** is a joint venture between **NHS England and the London CCGs**
- The **Strategic Commissioning Framework** was published in March 2015
- Following consultation with **over 1,500 patients, clinicians, commissioners and others**, this sets out a new vision for Primary Care in London
- This has been **supported by all CCGs across London**, and the focus is now on how it is delivered…

Welcome and introduction



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NHS
Transforming
Primary Care

Using your App

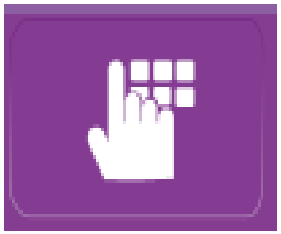
You can download the app by searching for '**Transforming Primary Care**' in either app or google store

Features to enhance your time at the event, such as:

- Programme and general information
- Speaker biographies
- Access to presentations, including the ability to save, email and make notes alongside them
- Voting and question submitting
- Networking functionality
- Note taking functionality

Through each session you can

Make Notes



Vote

Raise a question

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How many London CCGs received a patient satisfaction score above the English average (63%) for the following question

In the last 6 months, have you had enough support from local services or organisations to help manage your long-term health condition(s)?

(GP Patient Survey 2015)

Register your vote in the Welcome and Introductions session tab

A. 0

B. 4

C. 10

D. 23

http://www.im-cms.co.uk/application/assets/81/KeypadVotingTimeFilter/KeypadVotingChart.php?Title=13:00:%20Welcome%20and%20introductions%20&ID=17180

Agenda for today

12:00	**ARRIVAL, LUNCH AND NETWORKING**	
13:00	**WELCOME AND INTRODUCTIONS** • Objectives of the day	Liz Wise Jane Lindo
13:15	**SESSION ONE** • The Coordinated Care Specification • Primary Care Home • Transforming Care Across the System: A Case Study Using Children's Asthma • A Whole System Approach To Chronic Kidney Disease	 Dr Rebecca Rosen Dr Nav Chana Dr Richard Iles/ Sara Nelson Dr Neil Ashman
14:30	BREAK	
14:40	**SESSION TWO: *BREAKOUT SESSIONS*** • Identifying your patient cohorts: A London approach to Atrial Fibrillation • Beyond integrated care and admissions avoidance- delivering coordinated care for complex patients in Tower Hamlets. • Delivering Integrated care and MDT's • Digital Solutions to Co-Ordinated Care	Dr John Robson Dr Isabel Hodkinson Clare Henderson/ Dr Katie Coleman Jane Barnacle /Dave Gunner
16:25	SESSION THREE • What's ahead • Closing Summary	Dr Asiya Yunus Jane Lindo
17:00	CLOSE	
NETWORKING DRINKS RECEPTION		

02
SESSION ONE

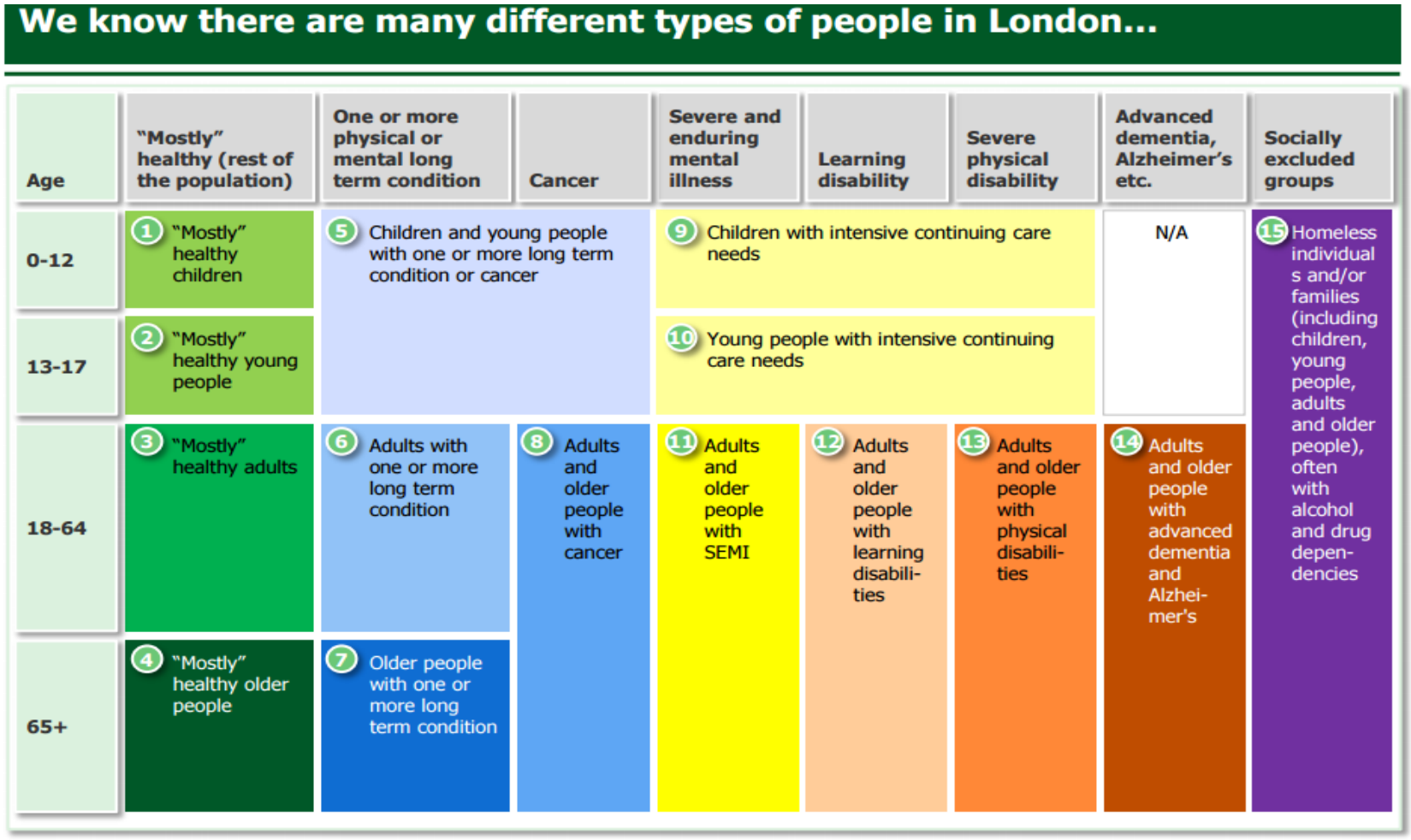
WHAT IS THE VISION FOR COORDINATED CARE?

Dr Rebecca Rosen, *Senior Fellow, Nuffield Trust. General Practitioner in Greenwich*

An overview of the coordinated care specification

Dr Rebecca Rosen
Chair of the Coordinated Care Group
GP in Woolwich, SE London

Many different types of patient



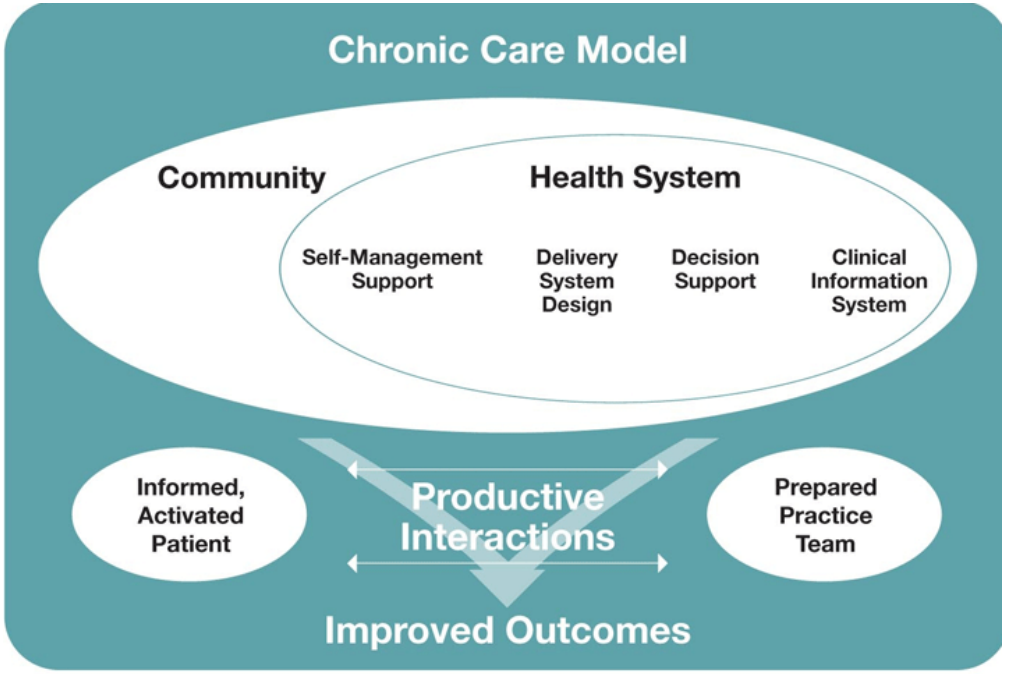
SOURCE: NWL WSIC; SLIC; Team Analysis

LONDON HEALTH COMMISSION

Underlying principles for the coordinated care specification

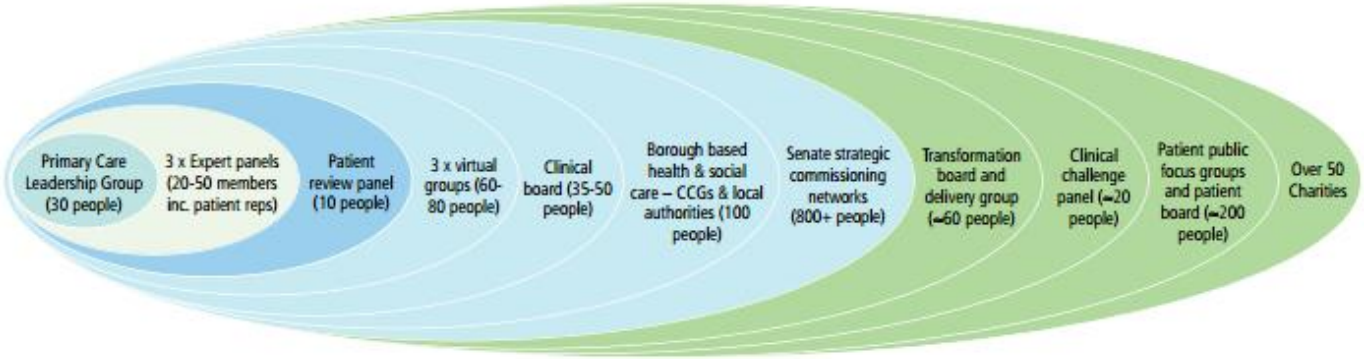
Rooted in the chronic care model:

- 'informed, activated patients'
- Productive interactions with:
- 'prepared, proactive' clinical team.



ner, EH (1998) *Chronic disease management: What will it take to improve care for chronic*
Effective Clinical Practice, 1:2-4

Many people involved in developing the coordinate care specification



- Three expert panel meetings involving clinicians from general practice, pharmacy, mental health services, community nursing and therapies; patient representatives; social care providers; commissioners; managers;
- Draft text circulated widely for comment
- Consultation meetings across NHS and local government
- Patient and public focus groups
- Clinical Challenge Panel

Coordinated primary care in London

1. **Identify patients who will benefit from coordination**
   - Older people with multiple chronic conditions and many others too
   - People with mental health issues and /or complex social circumstances and lifestyle issues best addressed though coordinated care.

2. **Have a named clinician(s) who routinely provides the patient's care**
   - Continuity and developing a strong, trusting relationship
   - Acts as an advocate and guide
   - Liaises with the extended practice team and wider multi-disciplinary teams

3. **Develop personalised care plans**
   - Each person actively involved in determining its aims and content
   - Focused on shared goals and accessing the support needed to achieve them.

Coordinated primary care in London

4. **Support patients to maximise peoples' potential to self-care and stay well,**

   Lifestyle changes

   Strengthen knowledge to contribute to their own health and wellbeing.

5. **Reviews and input from a wider primary care team**

   'Micro-teams' of practice staff, working with pharmacists and community nursing

   Wider team of local health, social care and third sector providers.

   A network of other providers who deliver seamless services to patients .

PRIMARY CARE HOME

Dr Nav Chana, *Chairman, National Association of Primary Care*

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napc

national association of primary care

NHS CONFEDERATION

Primary Care Home programme

An introduction

Core characteristics of the Primary Care Home

- The provision of care to a defined, optimal registered population size which would be not less than 30,000, but normally not more than 50,000 people - working at this scale ensures everyone within the team knows everyone else and the patient has a more consistent experience of care, similar to having a named GP

- A combined focus on personalisation of care with improvements in population health planning, provision and outcomes

- An integrated, multi-disciplinary workforce, with a strong focus on partnerships spanning primary, secondary and social care

- Aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards.

Vision and objectives for the programme

VISION

By 2020 the Primary Care Home (PCH) will be a core delivery model for health and social care services in the NHS, delivering the triple aims of the Five Year Forward View. The PCH will deliver a population based approach to health planning and delivery, a business vehicle for multidisciplinary clinical partnerships, an integrated multi-professional workforce and manage population based capitated budgets.

OBJECTIVES

- Develop a Primary Care Home (PCH) model that enables the delivery of the triple aims in the Five Year Forward View;
- Co – design a support toolkit that will enable any aspirant local health networks to implement the PCH model;
- Spread the PCH model across the health system such that it becomes a core delivery model for health and social care services in the NHS.

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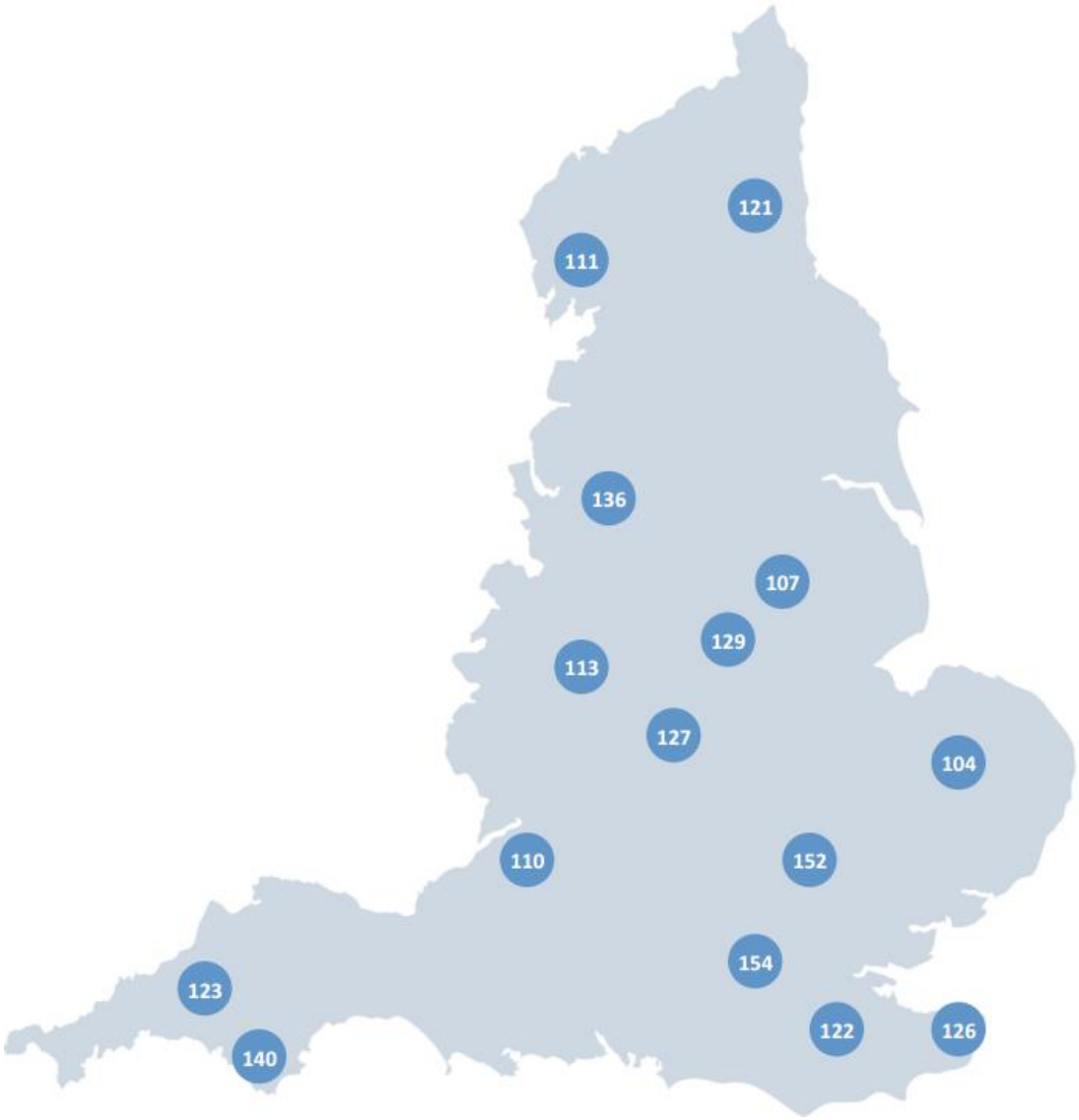
In December 2015 15 Rapid Test Sites were selected from 67 applicants to develop and test the Primary Care Home model



15 Rapid Test Sites

104 - The Breckland Alliance
107 - Larwood & Bawtry
110 - South Bristol Primary Care Collaborative
111 - 1st Care Cumbria
113 - Rugeley Practices PCH
121 - South Durham Health CIC
122 - The Healthy East Grinstead Partnership
123 - St Austell Healthcare
126 - Thanet Central CIC
127 - Wolverhampton Total Health Care
129 - Nottingham North & East Community Alliance
136 - The Winsford Group
140 - Beacon Medical Group
152 - Luton Primary Care Cluster
154 - Richmond

NHS CONFEDERATION napc

Between January – March 2016 the programme is supporting rapid test sites to plan their development of the PCH model and identify support needs

- During January:
  - Worked with the New Care Models evaluation team to introduce rapid test sites to the concept of 'logic models'. These help the sites to describe the outcomes, activities and resources that are needed to develop their PCH model
  - Held a workshop with all rapid test sites to share their plans and identify collective and individual support needs
- During February rapid test sites will be iterating their logic models to underpin requests for local funding to support the set up of their PCH
- We are currently seeking further funding to support the programme in 2016/17.

The programme will facilitate access to existing sources of support wherever possible

Rapid test site collective support needs: Communications, organisation development, workforce, technology, information management, finance and legal

New care models programme

Rapid test site expertise

- Rapid test sites will have access to New Models of Care programme support packages
- Rapid test sites themselves have expertise that can be shared.

NAPC and NHS Confed networks

Industry partners

- Industry partners and NAPC/NHS Confed's networks may provide support to rapid test sites at minimal cost

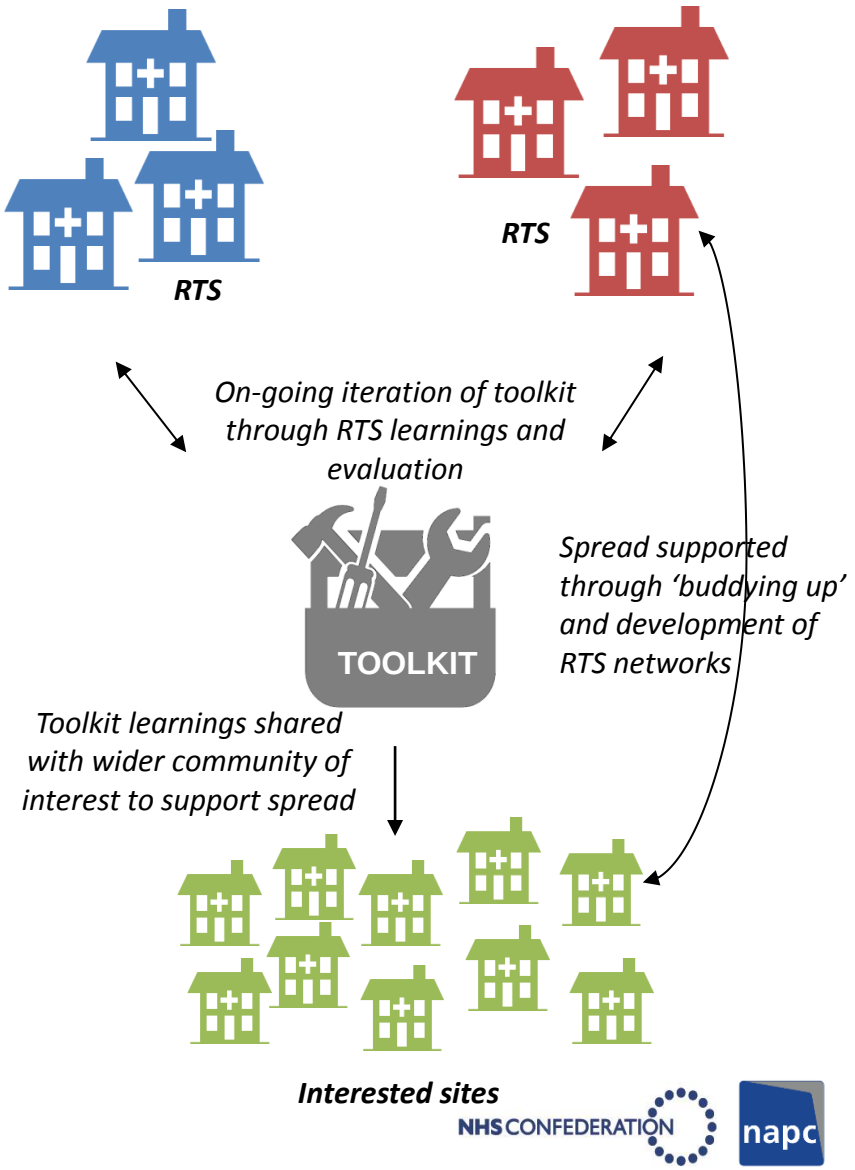
PCH programme support

- Remaining support needs to be funded via the programme
- Support may be commissioned centrally or done on a site-by-site basis.

NHS CONFEDERATION napc

The Rapid Test Sites will develop a toolkit of learnings, which will be used to support the spread of the PCH model to other sites

- The programme will work with the rapid test sites to evaluate their approach to development of the PCH and any enablers or barriers
- The outcomes of the evaluation will be used to co-develop a PCH support toolkit (informed by the New Care Models programme, the NAPC and NHS Confederation's networks and other best practice).
- The toolkit will be made available to other interested sites as soon as valuable learning is available to share. The toolkit will be updated and iterated as the RTS further develop the model.
- The programme will simultaneously spread the learning from their work on the PCH model with a wider network of interested sites through the 'buddying up' of sites, national conferences and workshops .



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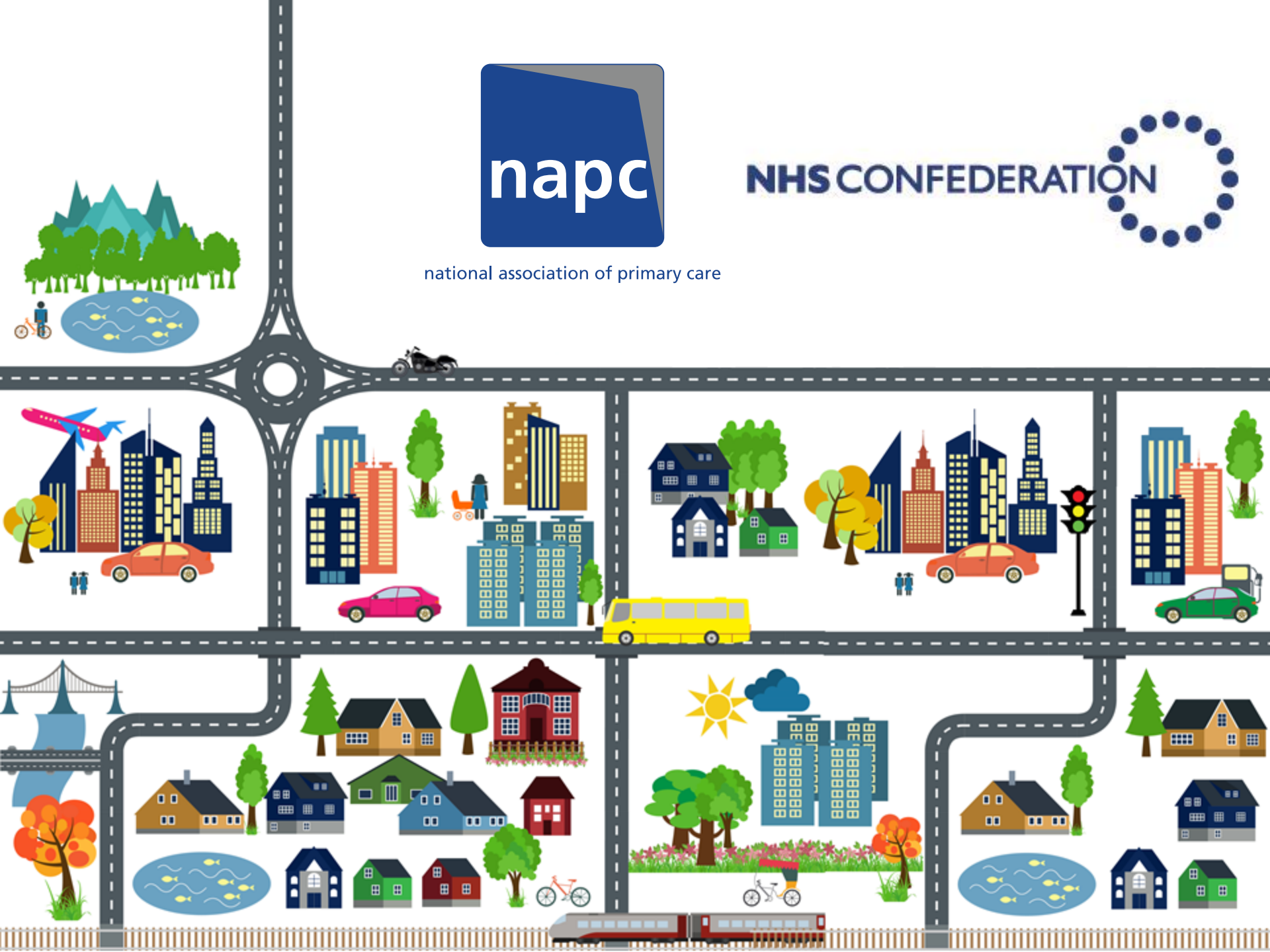

Transforming Care Across the System: A Case Study Using Children's Asthma

Dr Richard Iles, *Consultant Paediatrician, Evelina Children's Hospital*

Sara Nelson, *Children and Young People Programme Lead, Healthy London Partnership*

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Transforming care across the system: a case study using children's asthma

NHS
London
Strategic Clinical Networks

The importance of co-ordinated care and management for children and young people

01

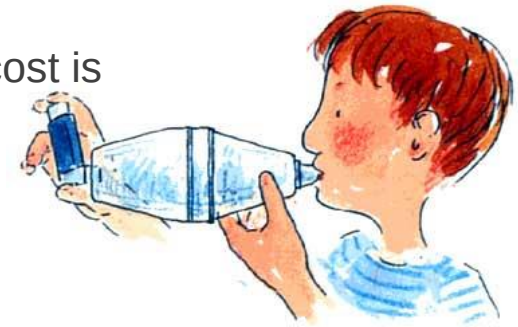
Why is co-ordinated care for asthma in CYP important?

The problem, The evidence and the solution

Dr Richard Iles and Sara Nelson

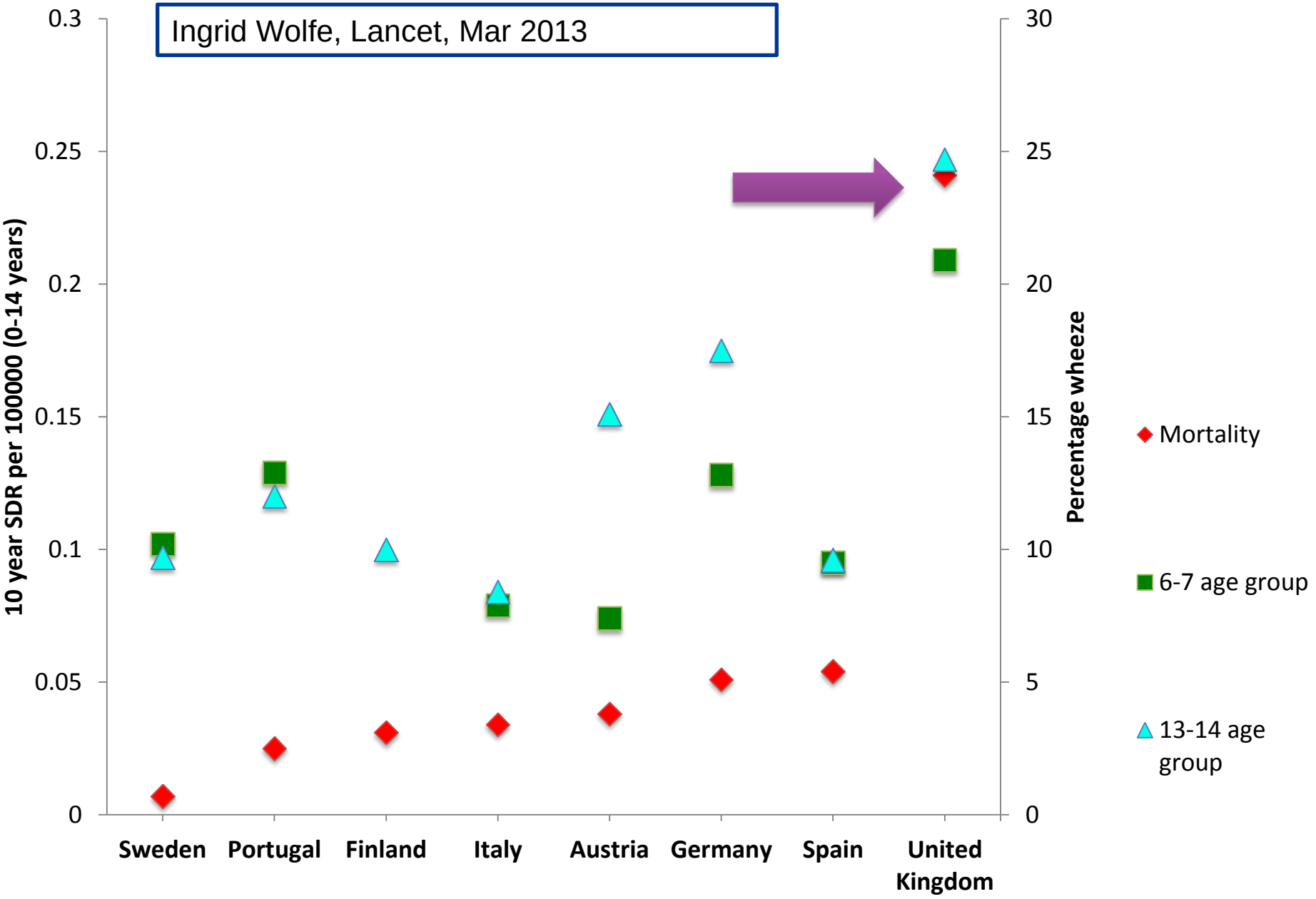
The Evidence: Facts about asthma in the UK

- Asthma is **common:**1 in 11 children have it, on average, there are **two children with asthma in every classroom**.
- **High mortality, large variation** in care across the capital
- **High emergency admissions and variation**, average cost is £951
- There were 25,073 emergency hospital admissions for children in 2011-2012. **On average that's one every 21 minutes.**
- There were 1,167 **deaths** from asthma in 2011 (**18 of these were children aged 14** and under).
- **90%** of the deaths from asthma are **preventable**.
- **Patients with a personal asthma action plan (PAAP) were 4 times less likely to die** from an asthma attack.
- **77%** of patients **had no record** of having **a PAAP** (*National Review of Asthma Deaths)*
- **75% of hospital admissions for asthma** are avoidable.



Source http://www.asthma.org.uk/asthma-facts-and-statistics

Asthma mortality and children with wheeze



Over the last 20 years the NHS has failed to improve

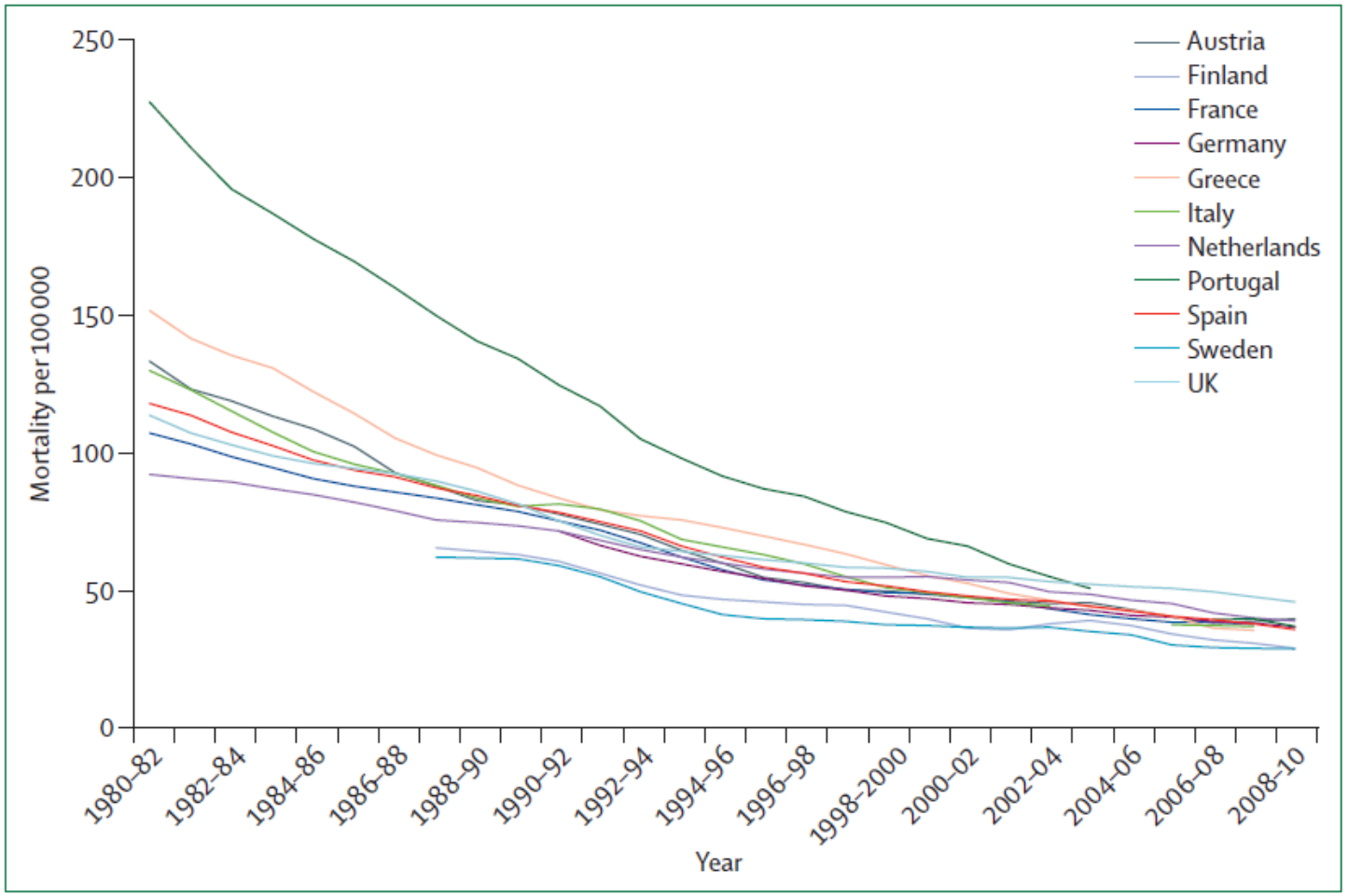
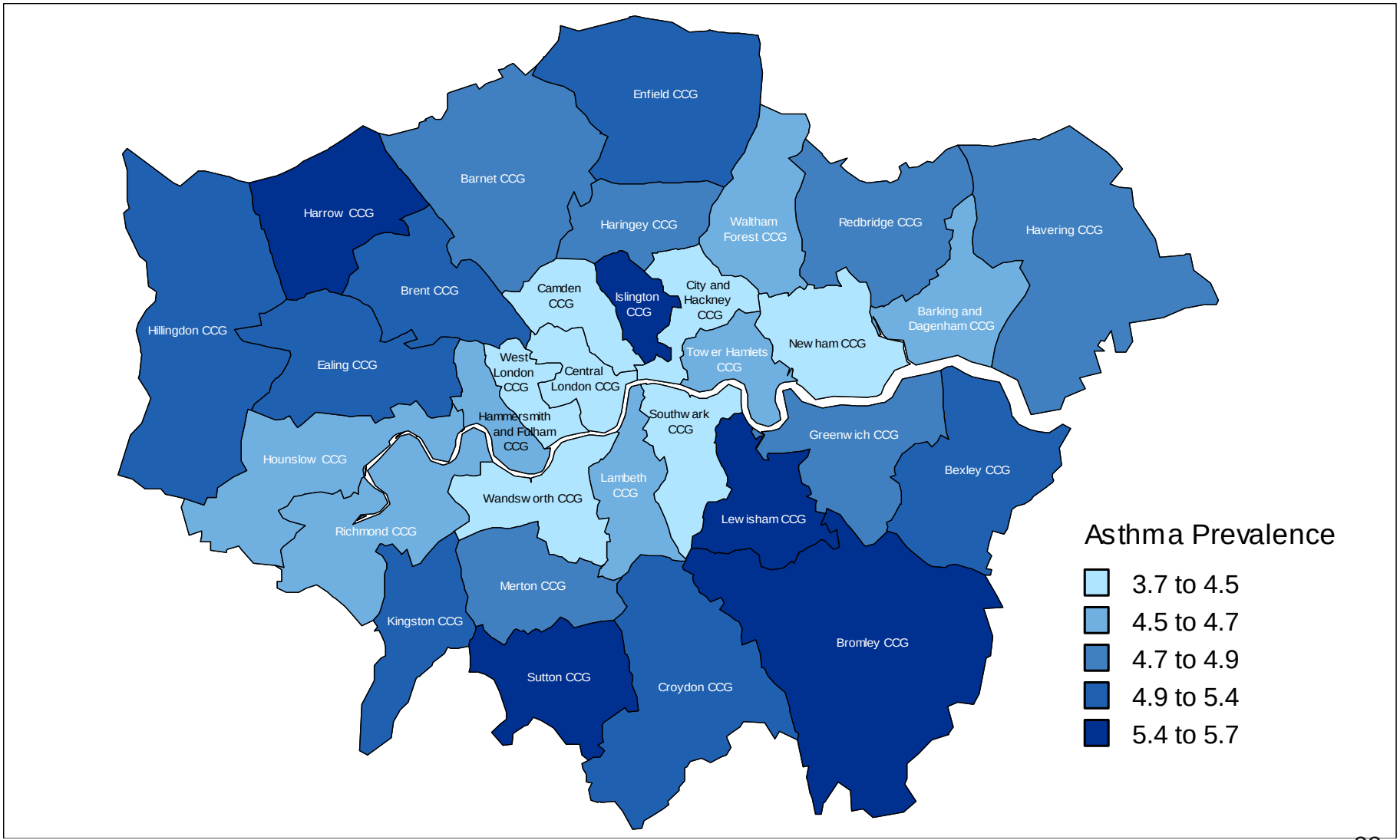


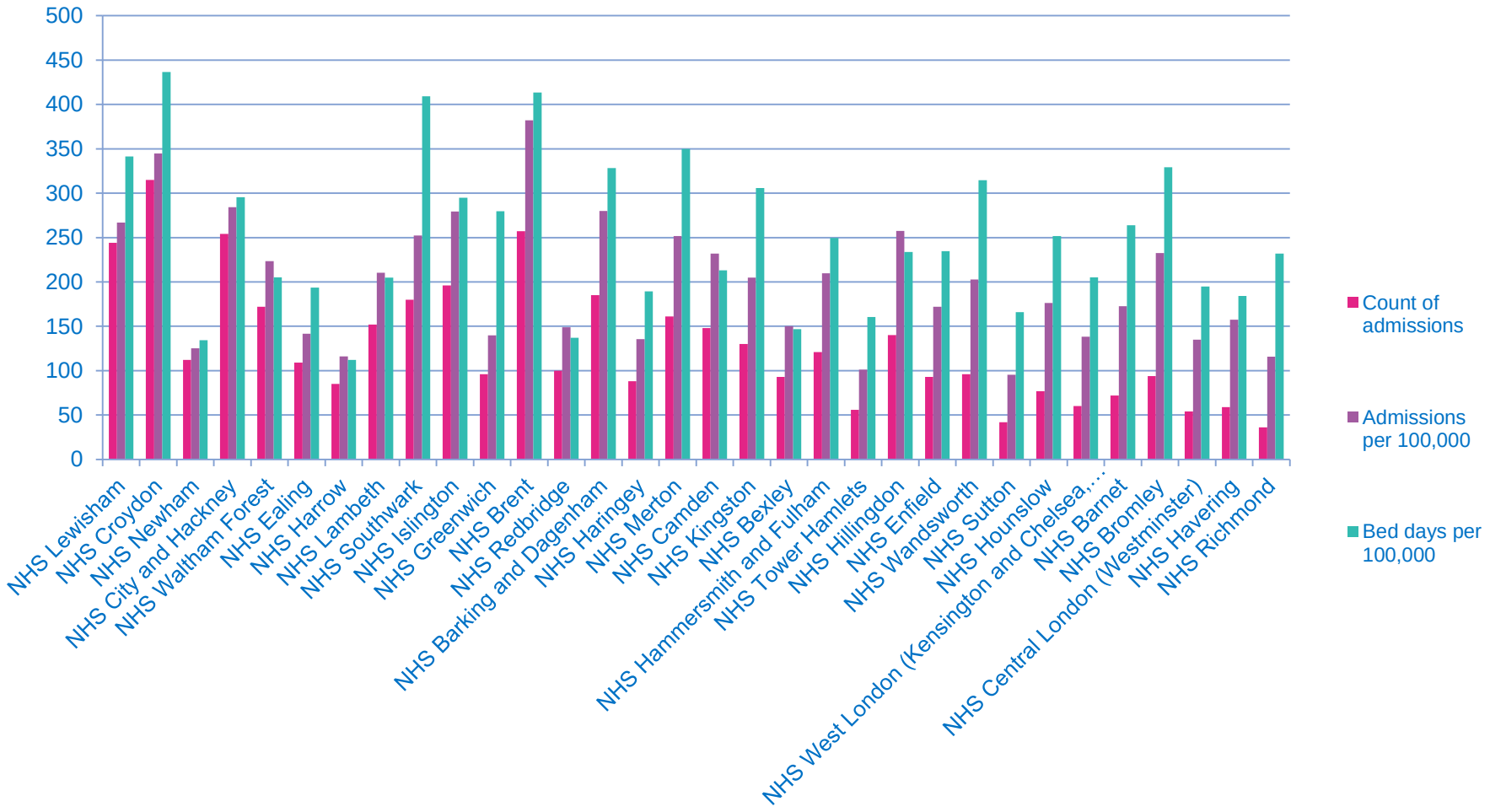
Figure 1: Trends in mortality in children aged 0–14 years in 11 European Union countries, 1980–2010
Source: WHO Mortality Database, 2012.[2] Data are directly standardised rates.

Asthma prevalence in London

Recorded prevalence of asthma in London (all ages) 2011/12 (Quality and Outcomes Framework)

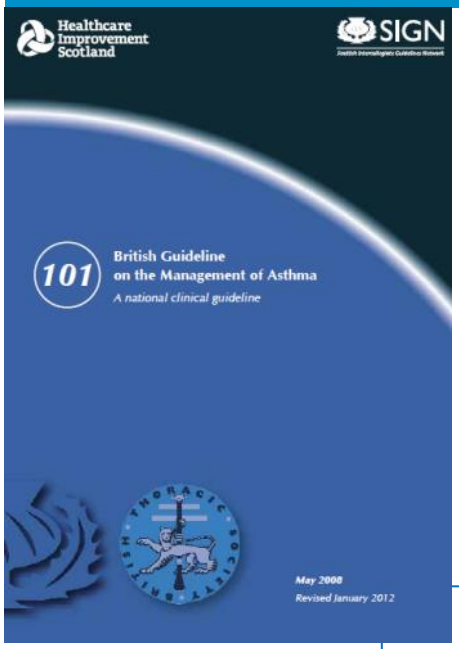


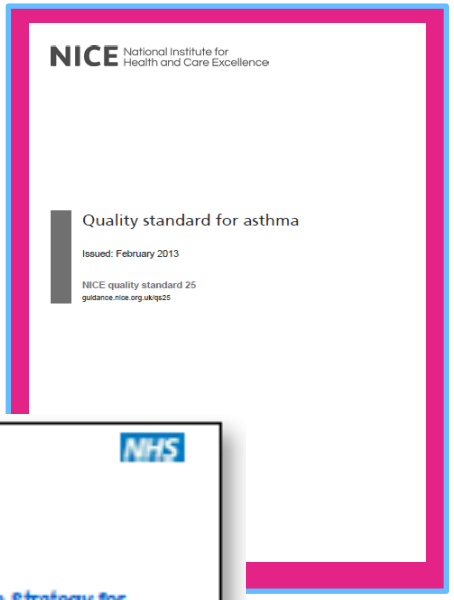
London emergency admissions for asthma

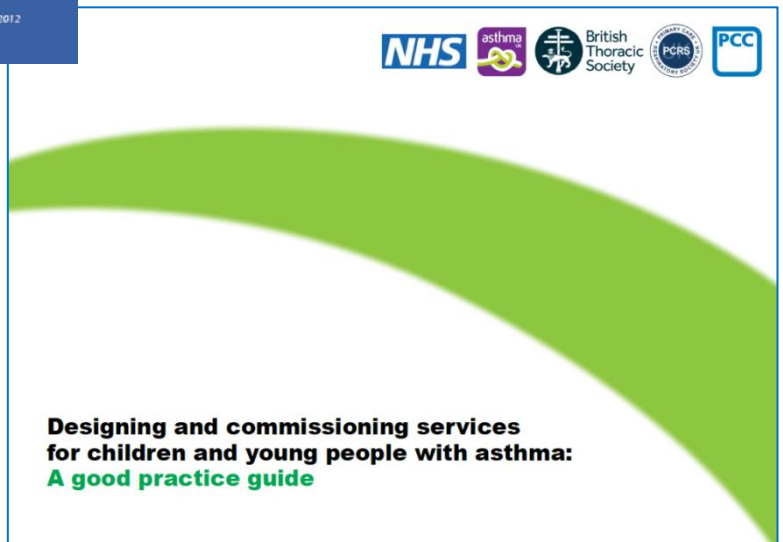


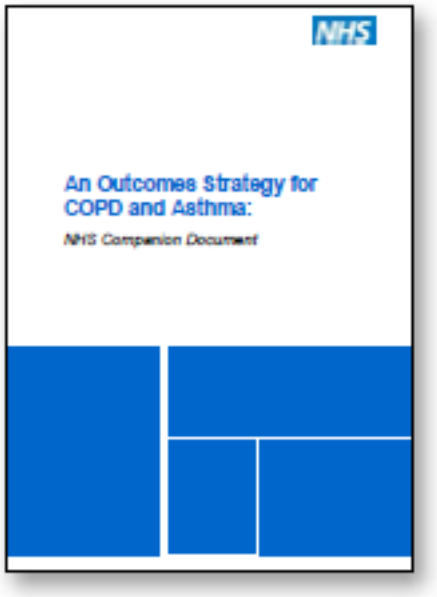
Source: Hospital Episode Statistics (HES) Copyright © 2013, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Data are for 2012/13, and relate to emergency admissions for asthma ; ICD10: J45 or J46

Despite >16 documents in the last 5 years, still high mortality, emergency admissions and variation in care: we don't need more









London asthma standards

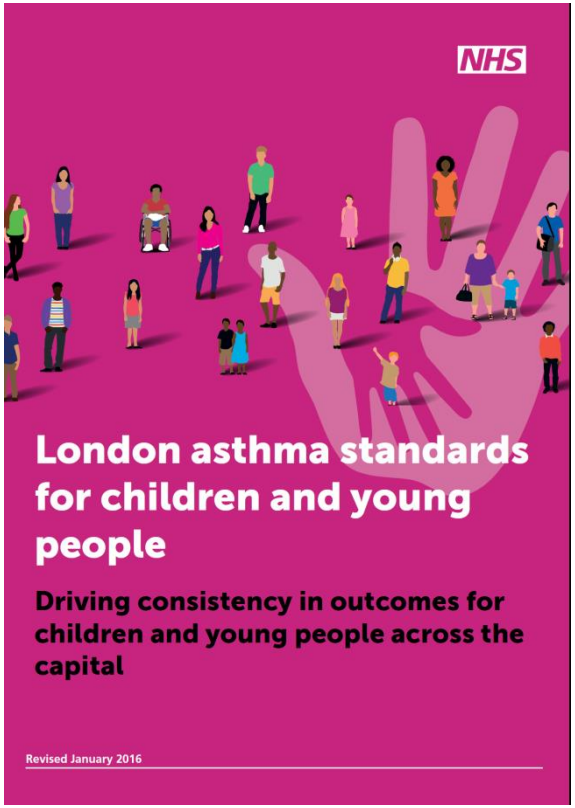
For children and young people (CYP)

- Developed through the children and young people's asthma leadership group
- Prepared by collating a collection of standards already in existence, building on London Quality Standards, Primary Care Strategic Commissioning Framework and London Acute Care Standards for CYP

Purpose

- Essential **guide for commissioners and providers**
- Ensure **responsible lead** for asthma in each organisation
- Improve **consistency and quality** in CYP services and **reduce variation**
- **Minimum standards** of care in one place

It cuts across all organisations and covers: patient and family support; schools; acute and high risk care; integration and co-ordination; discharge planning; transition; effective and consistent prescribing; workforce education and training



Visit https://www.myhealth.london.nhs.uk/healthy-london/children-and-young-people/resources to find out more

London's Ambitions for asthma care in CYP

Proactive care

Every child with asthma should:

- Have access to a **named set of professionals working in a network** who will ensure that they receive holistic integrated care which must include their physical, mental and social health needs.
- **Be supported to manage their own asthma** with the help of their family including access to advice and support so they are able to lead lives free from symptoms.
- Grow up in an **environment** that has **clean air that is smoke free**.
- Have access to an **environment** that is **rich with opportunities to exercise**.

Accessible care

Every child with asthma should:

- Have their **diagnosis** and severity of wheeze established in a timely fashion.
- Have **prompt access to their inhaler device** and other medicines and asthma care advice from trained named professionals or asthma champions in school.
- Have access to **immediate medical care, advice and medicines** in an emergency.
- Have access to **high quality, evidence based care** from primary, secondary and tertiary healthcare professionals within a timely manner, 24 hours a day, seven days a week.

Co-ordinated care

Every child with asthma should:

- Be enabled to manage their own asthma by having access to a personalised, interactive, evidenced based **asthma management plan** linked to their medical record which they understand.
- Have a **regular structured review** by trained healthcare professionals at least yearly or every three months, depending on control, and within two working days after an exacerbation.
- Have access to a **commissioned package of care** which includes educational packages, self-management tools and access to peer support.
- Be able to expect all professionals involved in their care to **share clinical information** in real time to ensure **seamless care**.
- Have access to a **structured, formalised transition processes** from child to adult care to ensure children don't fall between the gaps.

A Proposal for Paediatric asthma as a model for Transformation

NHS England

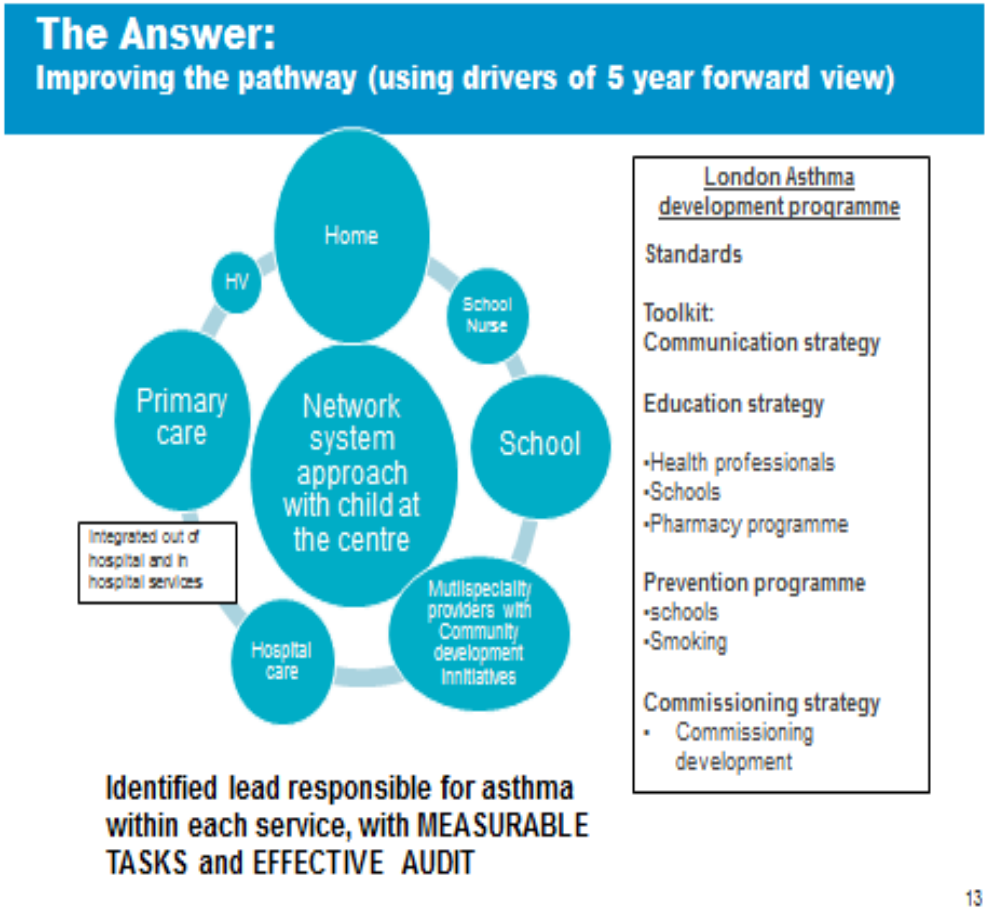
National Paediatric Asthma Collaborative: 5YFV proposal

- The formation of a critical mass of well-educated professionals dedicated to the continuous improvements in care of CYP with asthma is essential.
- As a consequence patients and families would benefit from an earlier diagnosis, more confident treatment, the early identification of risks, and the sharing of expertise at a local level.
- Good asthma control in childhood would have a knock-on benefit in the adult years.
- Paediatric asthma could also be seen as a pivot point around which acute paediatrics in a primary care setting could be developed, and likewise could augment the skill sets of the adult focused respiratory team.

Co-ordinated Care The Answer:
Improving the pathway (using drivers of 5 Year Forward View)

All elements of the London asthma standards

- Case Finding and review
- Named lead responsible and accountable for care
- Care Planning – Use of asthma management plans
- Support – for parent and child (incl. transition)
- MDT working in a networked model of care using pharmacy and schools



Background

Community pharmacy public health campaign 2015

- There are **1,858** pharmacies across London.
- All London pharmacies were asked to take part in a campaign To provide key public health messages in relation to asthma management and gather information on current levels of awareness of asthma management in children and young people in London **between 24 July and 2 October 2015**
- They were asked to carry out a mandatory, brief intervention for a young person (**0 to 18**), when their parent or carer visited their pharmacy to request a prescription be filled or repeated, purchased an over-the-counter medicine, required emergency supplies or asked for advice on general health and wellbeing.
- An additional, voluntary element - to record the responses of a brief intervention using online survey - was also requested.

Governance: Pharmacy Asthma Steering Group

Membership:
Pharmacists, Nurses, Doctors, NHS England (London), HLP representative, LPC representative

Aim
To provide support and advise on the role of pharmacy and medicines optimisation in the delivery of London asthma standards for children and young people.

Highlights

Interim results

1,865
Community pharmacies across the whole of London were invited to a take part

Campaign extended to 10 weeks till 2 October

1,225
Pharmacies responded

65.7%
of the total number of pharmacies

32
boroughs (all) took part

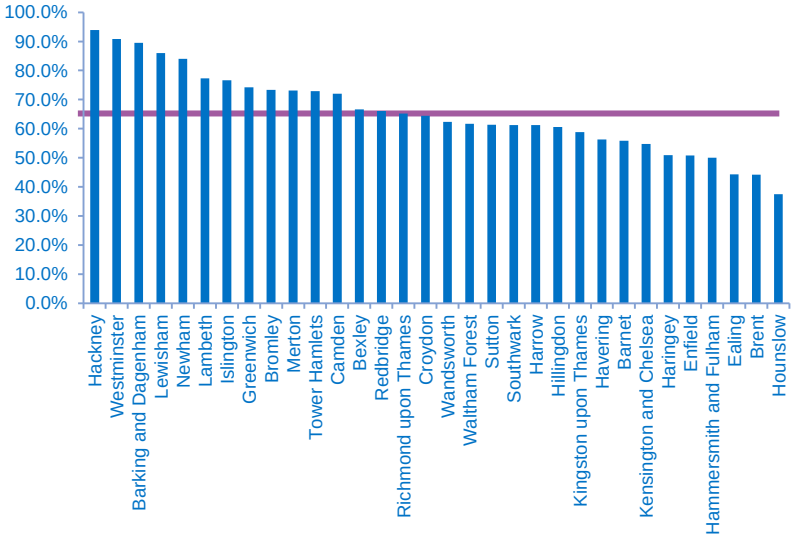
9,690
responses

9.4
Average age of participant

9
Average entry per pharmacy

1 in 4
Entries were using a smart device

Participation per borough



Results

64%
Did **not** have a flu jab last year

25%
Had to make an emergency request for an inhaler in the last 12 months

48%
Do have an asthma action plan or wheeze plan

70%
Had a inhaler technique assessment in the last 12 months

64%
Have a spacer device

23%
Live with someone who smokes

96%
Do **not** smoke

Next steps: Three Key Messages:

If we want to stop children dying-

1. **We identify specific individuals in all contexts as asthma champions, with specific tasks which are audited**
2. **We collaborate to introduce best practice (from the toolkit)**
3. **We focus on outcomes**

Plan:

- ❖ Baseline audit of standards during February
- ❖ Development of toolkits to aid implementation to be launched **World Asthma Day 3rd May**
- ❖ **Toolkit = Best Practice – how to do it**

The Toolkit of Toolkits!

Asthma Implementation Plan - Delivery Timelines Toolkit 2016

		RAG	Lead	Jan				Feb				March				April				May				
4	**Asthma standards baseline**																							
	Baseline circulated to all organisations																							
	Analysis of data																							
1.00	**Prevention**											CLG						CLG						
	Smoking cessation																							
	?? Weather alerts																							
1.00	**Workforce and Education**											CLG						CLG						
1.02	Asthma education funding bid to HEE describing the asthma education required across London to deliver transformational change		SN/TP				29																	
	Healthcare professionals online education package - Education for health (E4H)		SN/RI																					
1.03	Links to education packages currently available E4H ie schools onlimne tool, Respiratory Furtures, videos from Soputh West.		SN/RI																					
	Develop a community of practice from existing students in 3 sector																							
2	**Home**																							
2.01	Management plan		RI																					
2.02	Educational content for teaching parents/ carers and peers		NR																					
3	**Standardisation across pathway**																							
3.01	Assessment		RI																					
	Diagnosis		RI																					
3.02	Referral		RI																					
3.03	Discharge		RI																					
3.04	Communication		RI																					
3.05	Audit tools		RI																					
4	**Ambulance**																							
4.01	Lead Roles and responsibilities		RI																					
5	**Schools Toolkit**																							
5.1	Asthma policy guidance for schools		SN/NR					2																
5.2	Emergency Inhaler in schools pack (incl procurement)		NR/DM					2																
5.3	Education package		SN/NR					2																
5.4	Asthma plan for schools		SN/NR					2																
6	**PharmacyToolkit**																							
6.1	Roll out of pharmacy audit		SN/DM																					
6.2	Inhaler techniques and training education package with HEE		DM																					
13.1	Virtual Learning and development hub to include Inhaler technique and asthma training package		DM																					
13.2	Tips on using pharmacists to reduce burden on primary		DM																					
6.3	Toolkit for medicine use review for CYP		DM																					
7	**Development of networks/ new model**																							

- Networks
- Primary
- Secondary
- Tertiary
- Acute Ambulance
- Commissioning
- Finance Evaluation

- And communication

Any questions?

For further information please contact:

Richard Iles, National Paediatric Asthma Collaborative lead
r.iles@nhs.net

David Finch, GP, Clinical chair SCN asthma group, dfinch@nhs.net

or

Sara Nelson, Healthy London Partnership, Asthma Programme Lead
sara.nelson@nhs.net

A Whole System Approach To Chronic Kidney Disease

Dr Neil Ashman, *Clinical Director for Renal & Diabetes at Barts Health*

East London Community Kidney Service
Improving prevention & care

Barts Health NHS
NHS Trust

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Clinical Effectiveness Group

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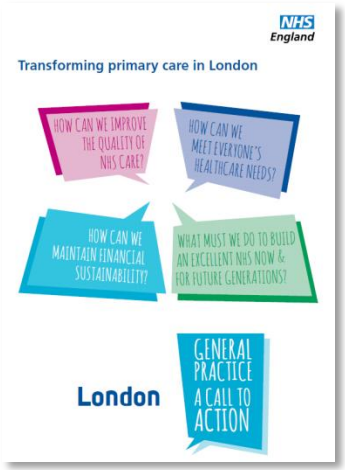
Tower Hamlets
Clinical Commissioning Group

- **Booming population – London is expected to grow by 1 million people by 2020**
- **The number of over 65 year olds in London is set to increase by 19% by 2020**
- **A high number of short term residents in the capital and homeless**
- **Stark health inequalities across London**
- **Lower patient satisfaction with services than the rest of country**



Public Health England

The National Cardiovascular Disease Intelligence Network

Kidney Disease Profile

- In 2011/12 there were just under 183,000 people aged 18+ years on London CKD QOF registers, and it is estimated that there could be a further 150,000 people with CKD in the SCN who are currently undiagnosed.
- Recorded CKD QOF prevalence varies from 1.5% to 4.2% by CCG within the SCN. Westminster, Wandsworth, West London, Haringey and Hammersmith and Fulham have particularly low prevalence when compared to expected (which might indicate high levels of under-diagnosis and/or under-recording of CKD in these CCGs).

Over a long patient pathway, Renal Units focus care on ESRD. Although **incident** numbers are stabilising across the UK, this is less the case for England – mainly due to London.

Many more patients that are currently known to primary care have undiagnosed CKD.

Despite ever-increasing transplant rates, better survival, particularly in London, has led to ever-growing **prevalent** numbers of treated ESRD dialysis patients.

What would better look like?

1. Easy and accurate identification of those with CKD or at risk

2. Simpler guidance
3. Integrated long-pathway care
4. Better patient information & education

5. More advice & less referral
6. Primary care record as default
7. Joined-up management of overlapping chronic conditions

8. A surveillance system to find those most at risk
9. Ever more intelligent algorithms…

Aims:

- Single integrated pathway managed in primary care by secondary care clinicians & GP's
- Reduce unnecessary referrals and increase discharges from secondary care
- Increase skills in CKD management within primary care
- Improve care & experience for patients in East London with CKD
- Reduce incident ESRD growth by 2020
- Stabilise prevalent ESRD cohort in East London (from 7.5% growth in 13/14)
- Opportunity to review historical cases of "crash landers" – those ending up on renal replacement previously unknown to the service – to learn lessons.

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1. Community CKD eClinic

Using standardised CEG template, with updates

Community-based Nephrologist doing e-clinic in EMIS Web

ALL referrals electronic (through C&B) - unless urgent

ALL reviews and opinions in EMIS Web

Locally relevant guidelines, including sick day rules

Educational package for GPs and MDT discussion

Education package
Clear guidelines

2. Community CKD surveillance

Anonymized, practice-based searches run by CEG

Better identification and coding of CKD

Identify at risk patients with rapid decline in eGFR year-on-year

'Trigger tools' to alert GPs to patients at risk

'Pull' into virtual clinics for advice and guidance

Practice dashboards for key performance indicators – BP/ statins

Dashboards from CEG

3. Patient information

Monthly, sector-wide expert patient & clinician-led sessions

Website to include videos translated into East London's leading languages

E-advice for patients

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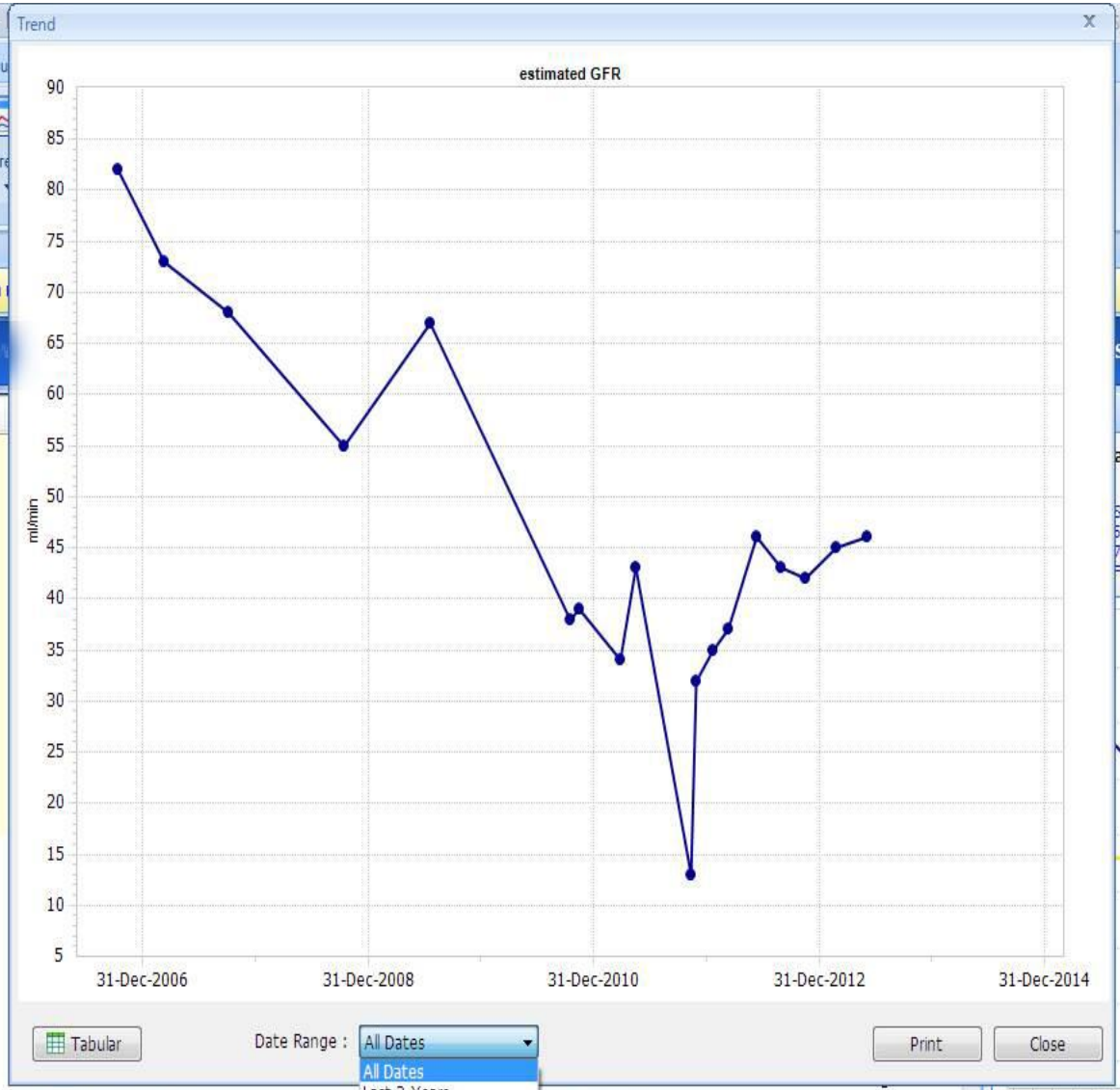
Trend
estimated GFR
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
ml/min
31-Dec-2006
31-Dec-2008
31-Dec-2010
31-Dec-2012
31-Dec-2014
Tabular
Date Range :
All Dates
All Dates
Last 2 Years
Last Year
Last 6 Months
Last 3 Months
Last Month
Print
Close

System - JUBILEE STREET PRACTICE - 112
Summary
Edit
Delete
Sharing
Add
Add/Edit
Report Management - 1
You have 2 screen
Active
Salma (Dr)
Detailed View
abbreviatd MDRD
System User ()
61E
76481000006110
FR calculated abbreviated MDRD
Date
29-Nov-2013
Text truncated
Double click
to view
21-Oct-2013
21-Oct-2013
30-Sep-2013
30-Sep-2013
30-Sep-2013
30-Sep-2013
Thyroid function test
Serum free T4 level
Serum TSH level
30-Sep-2013
Liver function test
(SA112) - Normal - No Action
Serum albumin
43 g/L (35 - 50)
Serum total bilirubin level
19 umol/L (1 - 21)
View -> My Record (No shared data.)
Date
Value
29-Nov-2011
For Afro-Caribbean patients multiply eGFR by 1.21
14-Nov-2011
13 ml/min
14-Nov-2011
For Afro-Caribbean patients multiply eGFR by 1.21
17-May-2011
43 ml/min
Higher Level GP (SJR002)
HULL, S. (Dr)
JUBILEE STREET PRACTICE
In Consultation
Alerts
11:01
05/02/2015

Practice trigger tool for patients with a falling eGFR

ceg Clinical Effectiveness Group

Barts and The London Queen Mary's School of Medicine and Dentistry

Import Report File | Add latest data | Export to xls | Email to CCG

The latest patients are added to the top of the list

June 2015

Full Name	EMIS no.	Usual GP	Latest eGFR		Previous eGFR		Fall in eGFR	Referral to CKD community clinic?	Reflection on clinical management
			Value	Date	Value	Date			
Patient Name - 1	EMIS no. 1	SH	45	11-May-2015	55	02-Apr-2015	10	○ Yes ○ No	
Patient Name - 2	EMIS no. 2	JP	38	15-May-2015	50	13-Dec-2014	12	○ Yes ○ No	
Patient Name - 3	EMIS no. 3	KB	40	23-May-2015	51	19-Aug-2014	11	○ Yes ○ No	

May 2015

Full Name	EMIS no.	Usual GP	Latest eGFR		Previous eGFR		Fall in eGFR	Referral to CKD community clinic?	Reflection on clinical management
			Value	Date	Value	Date			
Patient Name - 1	EMIS no. 1	SH	45	02-Apr-2015	55	02-Apr-2015	10	○ Yes ○ No	
Patient Name - 2	EMIS no. 2	JP	38	13-Apr-2015	50	13-Dec-2014	12	○ Yes ○ No	
Patient Name - 3	EMIS no. 3	KB	40	19-Apr-2015	51	19-Aug-2014	11	○ Yes ○ No	

Pilot Launched December 2015

Proforma EMIS template
(Clinical Effectiveness Group)
Patient demographics
Variables to include interval eGFR, uPCR, dipstix, BP & DM, diabetic control, medication

500 FA p.a.
Encourage even more 'disuccions'
1,000 discharges back to GP

Borough-based, virtual CKD **Hub**
Nephrology, GIPSI, nursing, CEG
All referrals & advice done in EMIS. Able to link to Trust software.

Clinical advice or FA at CKD Clinic
Discharge with forward plan.
Offer annual e-review for at risk

At risk patients
> 10 ml/min/yr
automated
trigger

112 referrals/month
Around 4 trigger alerts per practice
Many will be known to GP anyway

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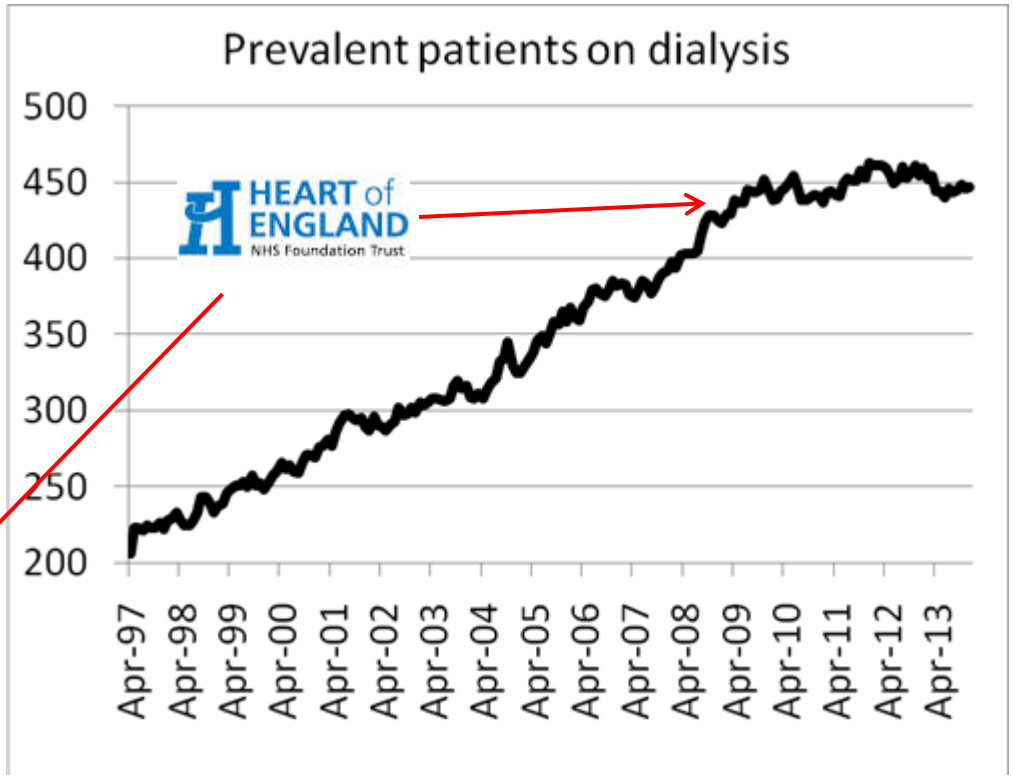
Will this work?



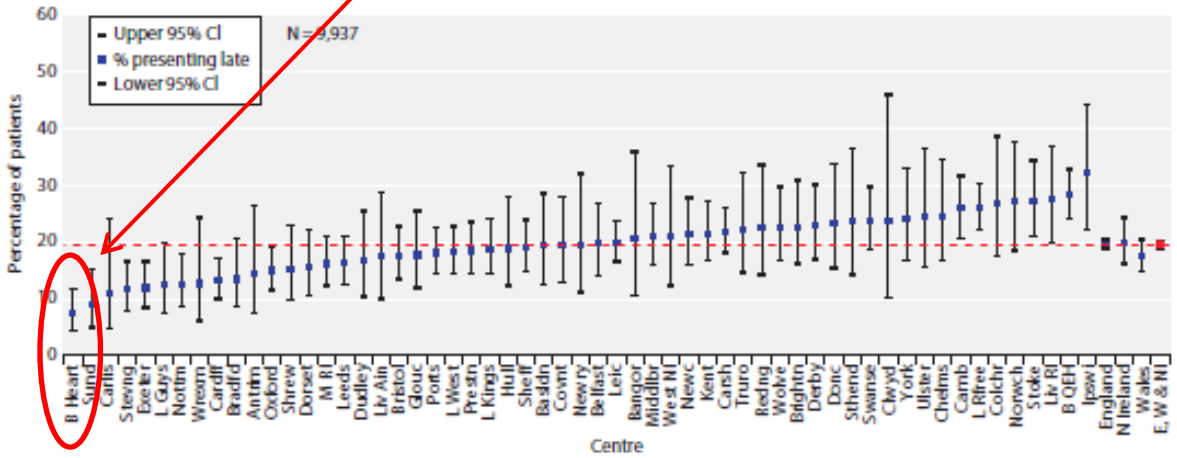


Fig. 1.11. Percentage presenting late (2011/2012)

How will we know this works?

1. Number of inward specialist referrals to secondary care NOT seen in OPD
2. Monthly virtual clinic referral by Network
3. GP & patient satisfaction with system
4. Capitate annual spend on Nephrology over last 3 years and **re-invest balance back in primary care along with workload**

5. Unknown to service ESRD patients from TH
6. Actual numbers of patients with ESRD starting dialysis

7. **A portal for other chronic diseases? A virtual hospital?**

East London Community Kidney Service

A single integrated system of kidney care in East London

An example of IT-driven integrated care that reduces cost in primary & secondary care

Every patient with CKD identified
Every patient at risk reviewed ('known knowns')

A portal for all or other long-term conditions?

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03

Next Session

Breakout sessions on Coordinated Care

1. When the alarm rings please move to your first session You will have **40 minutes** to hear about this area and ask questions

2. **40 minutes later**… The alarm will ring again, and please move to your next breakout

3. The alarm will ring a **third time**, as a signal to move back to your tables

Breakout Rooms

Don't forget to tweet us at @HealthyLDN
#HealthyLDN

Digital Solutions to Coordinated Care

Double Executive Box 1
3rd floor
Speaker: Jane Barnacle & Dave Gunner

Beyond integrated care and admissions avoidance - delivering coordinated care for complex patients in Tower Hamlets

Pakistan Suite
Speaker: Dr Isabel Hodkinson

Identifying your patient cohorts: A London approach to Atrial Fibrillation

Double Executive Box 2
3rd floor
Speaker: Dr John Robson

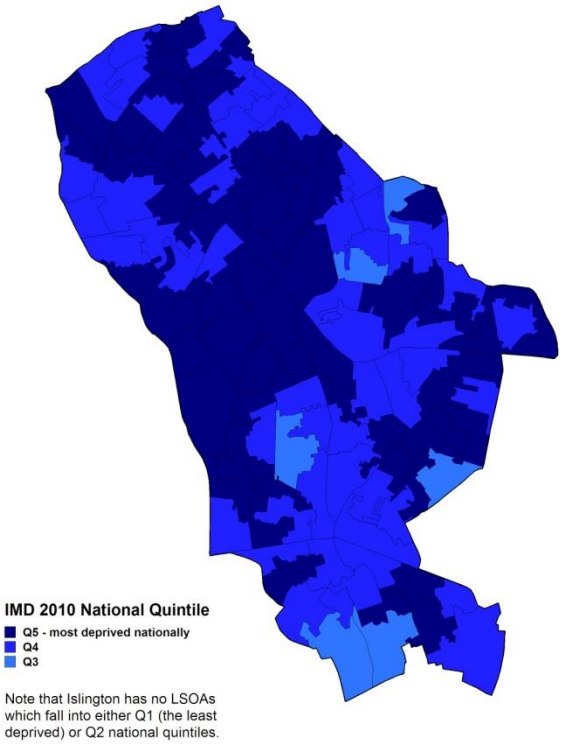
Delivering Integrated care and MDT's

Debenture Lounge
Speaker: Clare Henderson & Dr Katie Coleman

Integrated care and MDT's

Katie Coleman, GP and Vice Chair Islington CCG

Clare Henderson, Assistant Director Primary Care



Integrated care programme

- Work streams include:
  - Setting up integrated approaches eg.
    - Integrated networks
    - Primary care mental health
    - Islington community ageing team
  - Building on our model of supported self management
  - Prevention and early intervention
  - New contracting models – VBC
  - Workforce – skills mix, recruitment and retention, new roles
  - IT – integrated digital care record

Developing integrated networks

- August 2014 IC Board called for expressions of interest to become a test and learn site
- 8 GP practices volunteered
- Joined by core team members from social care, mental health, community nursing and locality navigator – supported via the BCF
- Launch October 2014

What we were trying to achieve

- Our hypothesis was that integrated working leads to:

- Better outcomes for patients
- Improved staff satisfaction
- A system that is more financially efficient

- We wanted to test whether new models of delivery could achieve this

Key characteristics

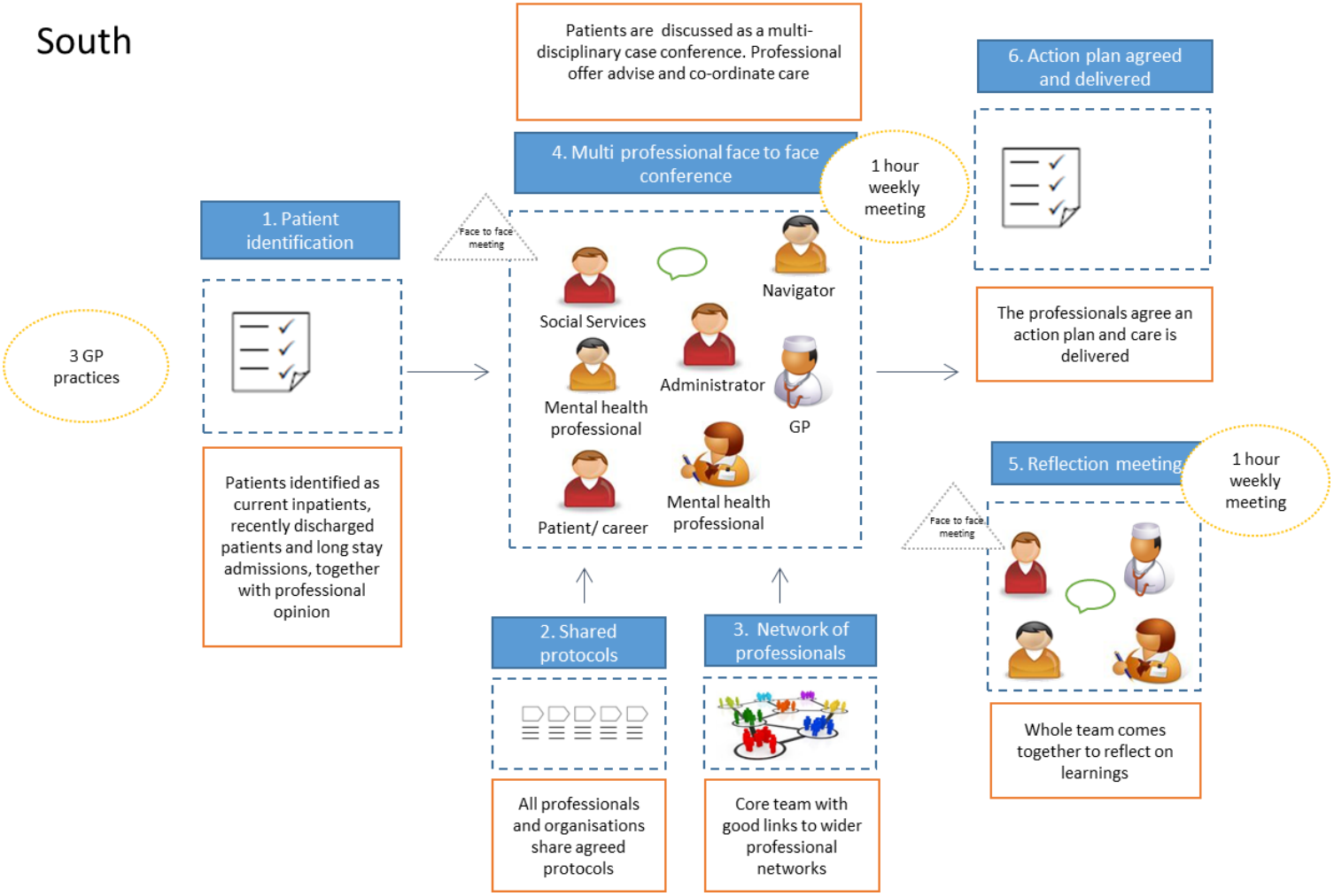
- We looked at components of successful models;
- Having a core team
- Holding case conferences
- Value of meeting together (relationships)
- Agreed population cohort
- Care plans
- Primary/secondary interface
- Joint visits/assessments
- Patient/user input

How the models developed

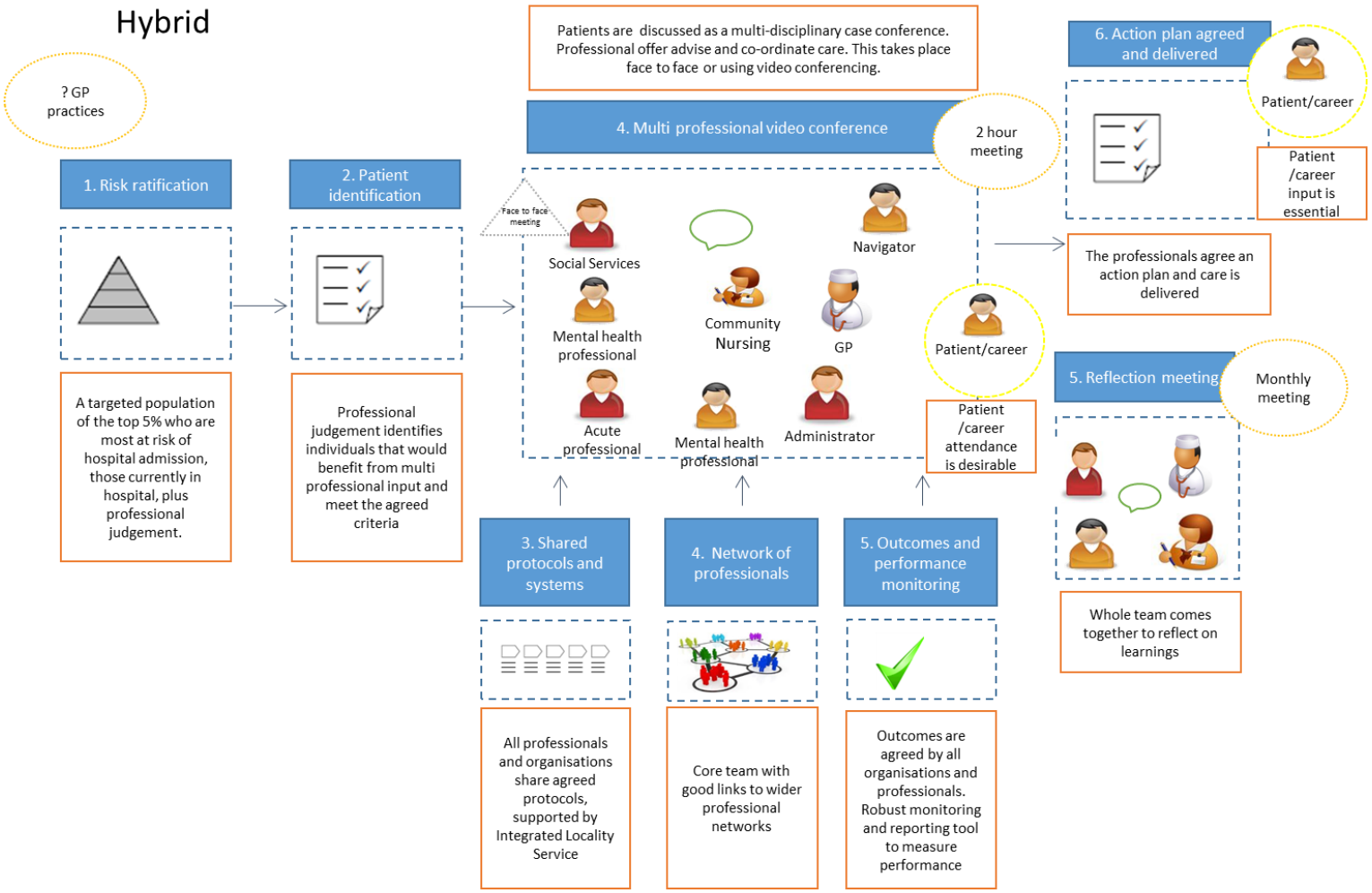
- Co-produced and bottom up approach
- Person centred care that is joined up - aspiration
- Cycles of improvement – test and learn
- 3 models bringing services around general practice
- Sharing approaches across the three models

Our model

South



Our model


Hybrid
? GP practices
1. Risk ratification
A targeted population of the top 5% who are most at risk of hospital admission, those currently in hospital, plus professional judgement.
2. Patient identification
Professional judgement identifies individuals that would benefit from multi professional input and meet the agreed criteria
Patients are discussed as a multi-disciplinary case conference. Professional offer advise and co-ordinate care. This takes place face to face or using video conferencing.
4. Multi professional video conference
2 hour meeting
Face to face meeting
Social Services
Navigator
Mental health professional
Community Nursing
GP
Patient/career
Acute professional
Mental health professional
Administrator
Patient /career attendance is desirable
6. Action plan agreed and delivered
Patient/career
Patient /career input is essential
The professionals agree an action plan and care is delivered
5. Reflection meeting
Monthly meeting
Whole team comes together to reflect on learnings
3. Shared protocols and systems
All professionals and organisations share agreed protocols, supported by Integrated Locality Service
4. Network of professionals
Core team with good links to wider professional networks
5. Outcomes and performance monitoring
Outcomes are agreed by all organisations and professionals. Robust monitoring and reporting tool to measure performance

Supported by the House of Care approach

Organisational & Supporting Processes

Engaged, informed individuals and carers

Health & care professionals committed to partnership working

Commissioning

Does it support the SCF?

C1 – Case finding and review – within our scope is the top 5% at risk plus patients/users where they would benefit from a co-ordinated approach

C2 – Named professional – often the GP but usually patient "chooses"

C3 –Care planning - underway – shared care plan will come with shared care record

C4 – Patients supported to self manage – health navigators support this along with self care programme (LTC LCS)

C5 – Regular MDT reviews – weekly meetings, review date agreed during the MDT meeting

Thank you

The London Digital Programme

Using digital to enable coordinated care

Jane Barnacle, Regional Director of Patients and Information (London Region)

Putting the citizen in control

- **Data** is typically organised around organisations. For people to be more active In the **coordination of their care** they need safe, real-time, at-scale data sharing and access to connected applications.
- Circa 2000 organisations in London carry the NHS brand. Impossible to currently have electronic data sharing agreements across all these organisations.
- Patients don't stay in one place.
- In London we are developing a **citizen – centric**, standards based interoperability architecture, rather like a telephone exchange.
- This is essential for a global city like London where people move around and for ensuring that coordination of care continues when people are in a crisis (U&EC)

The London Digital Programme

3 missing capabilities for a London Information Exchange that will enable coordinated care:

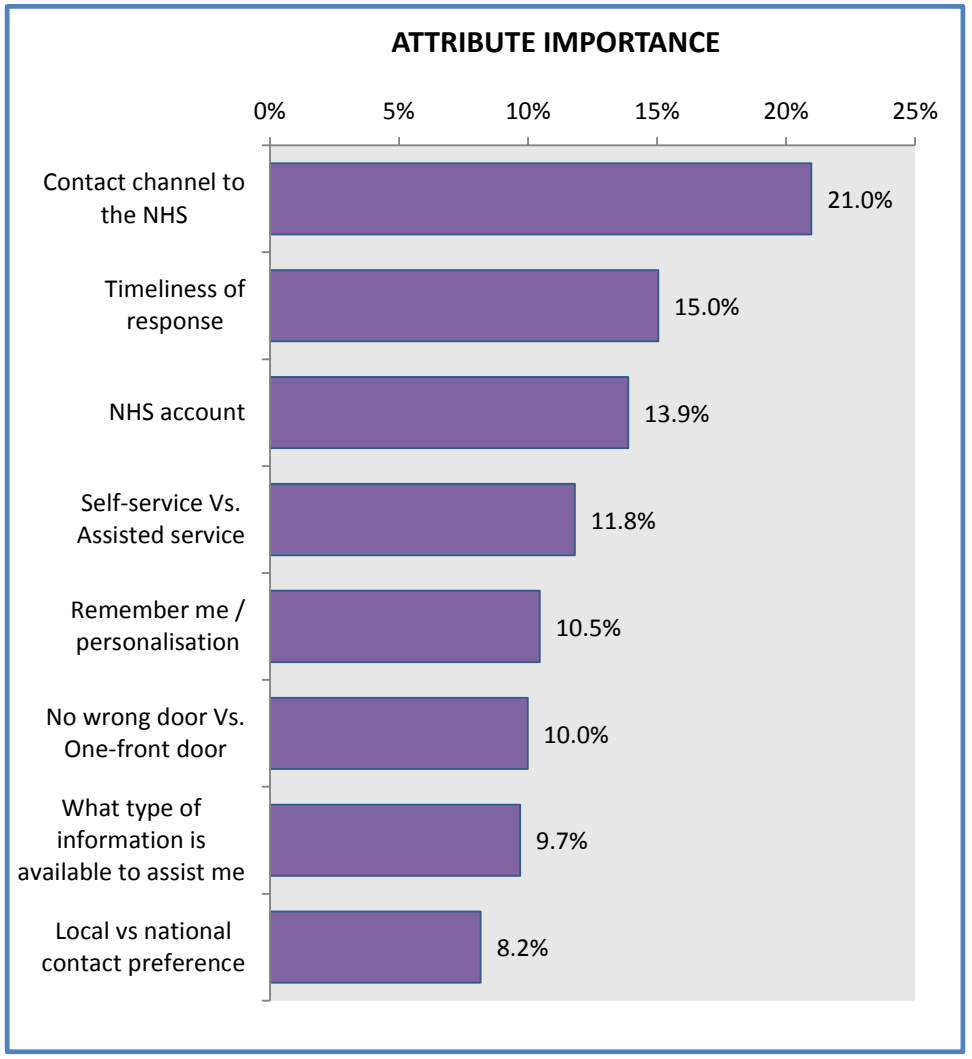
- Tools that provide **data controllers** with the means to manage information sharing (between organisations and the patient)
- Standards and ‘interoperability services’ that enable the **location and exchange** of data/records
- A **citizen account** ‘service’ that allows the citizen/patient to connect to the NHS ‘once’ and the NHS to remember them.

What people told us

People have told us they want an online account with the NHS and the ability to self serve (Mandate)

Conjoint research about customer service in the NHS was conducted using a representative sample of England's population – 3,762 responses

Consistent findings - no significant variation across all population groups



Activated citizen

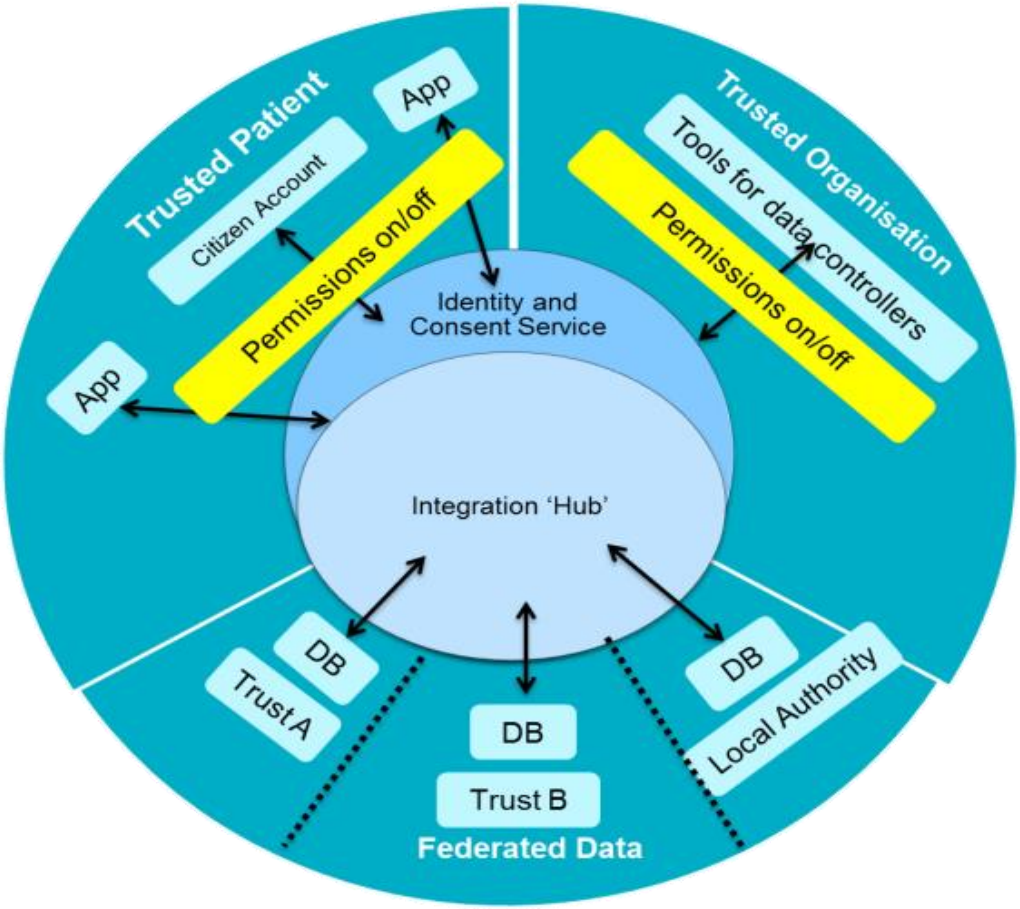
General enquiries	Access to directory of services, self-serve information, comparative data	Common health information, symptom checkers	Book appointments, order repeat prescriptions, access to records and test results, monitor and track progress, alerts and reminders, social prescribing	Contributing to care plans, decision aids, health apps and environmental controls, remote monitoring, video consultations and web-chat and peer to peer	Integrated Personal Commissioning-managing an integrated budget for the totality of my health and care needs

Cloud based services

Directory of Services	Transact-ions	Identity	Consent	Alerting	Content Manage-ment	Record Location	Access Control

Multi channel access

Citizen Account and Identity Hub



Citizen Account – Prototype kick off 18 Feb

Workstream 1 - Define and test a set of workflows and user experience for an end to end process for registering with a Citizen Account

Workstream 2 - Design and test the verification /authentication process and how citizen preferences and consent will be administered

Workstream 3 - Test the Identity Hub implementation and configuration for the data controllers for online information sharing processes, flows, data access and control

Workstream 4 - in-depth customer research to continually learn and understand behaviours, motivations and usability in relation to a Citizen Account and the associated functionality and features - across a broad spectrum of user types and user states

The Digital Institute (Digital Accelerator) / Supplier Club
A pipeline of suppliers able to adopt the standards and create meaningful connected apps

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The NHS Summary Care Record

Supporting Person Centred Co-ordinated Care

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Contents

- Digital solutions to co-ordinated care
- Access To Data
- Detailed Data Sets
- SCR Benefits & Local Information Sharing
- Patient Groups – Additional Information
- Care Settings – Additional Information
- What’s next?

hscic Health & Social Care Information Centre

Digital Solutions to Co-Ordinated Care

What is required?

Access to data

- SCRs are an electronic record of **key information from the patient's GP practice and a**s a minimum contain **medication, allergies and adverse reactions.**

96% of patients now have a summary care record created.

55.1 million.

3.3 million

SCRs were accessed last year to support urgent and emergency care.

Over **71,000** SCRs viewed in a week across **900** different viewing sites.

1 SCR is viewed every **9** seconds.

Detailed Data Sets

- Over **85%** of GP practices now have capability to enrich SCRs with a set of additional information with patient consent.
- Includes individual coded items and associated free text as recorded in the GP record.
- Ability to manually include further items.
- Expands the scope of SCR

SCRs with additional information include:

- **Reason for medication**
- **Significant medical history *(past and present)***
- **Anticipatory care information *(including information about the management of long term conditions)***
- **Communication preferences**
- **End of life care information**
- **Immunisations**

Benefits and Local Data Sharing

Safety

40% of patients have a medication error identified when an SCR is used.

Feedback from A&E clinicians

Effectiveness

49% of patients identified to a more appropriate pathway when an SCR is used.

Feedback from OOH clinicians

Efficiency

29 minutes saved per patient using SCRs for medicines reconciliation.

Audit results 2014

The SCR, now and in the future, will:

- Provide a **nationwide data sharing solution** – a foundation for access to a key set of common information that all care settings need to access.
- **Complement local data sharing** - complex care co-ordination will still occur at a local level using local systems.
- Provide a cost effective solution for settings that have lower digital maturity and where local solutions are not available.
- Provide a cost effective opportunity for health communities to **accelerate local record sharing by enriching SCRs with additional information.**

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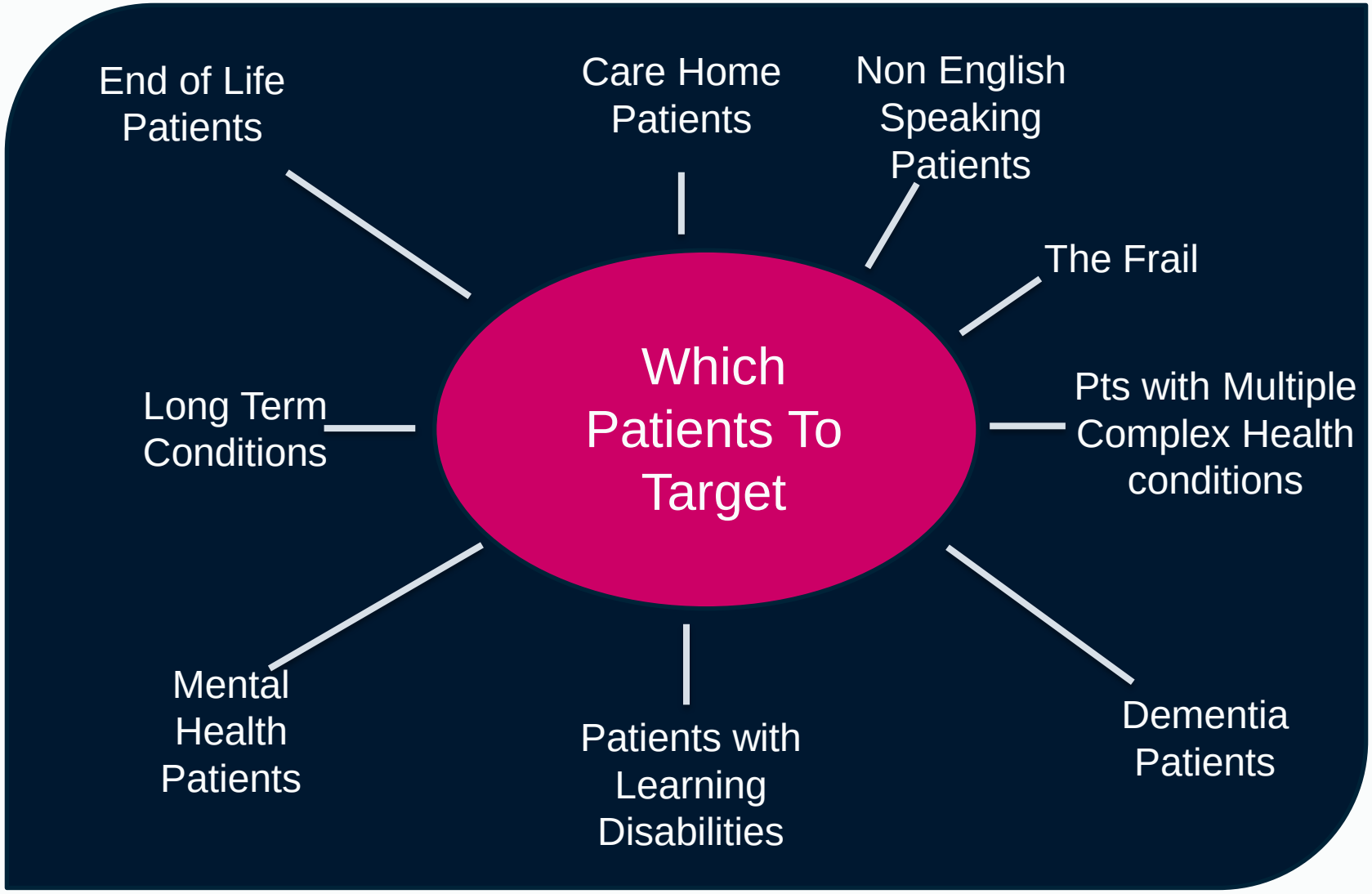
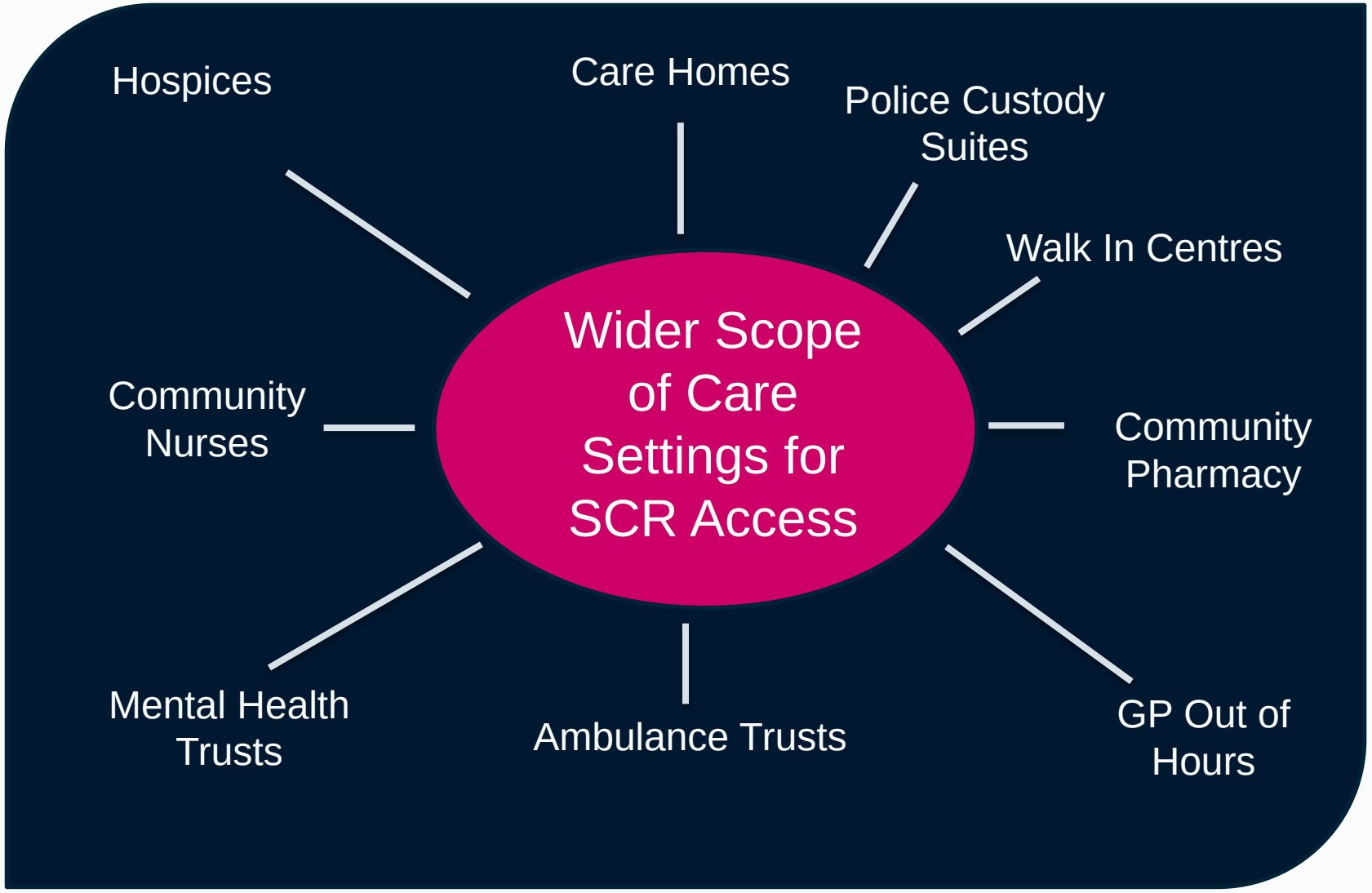
Digital Solutions to Co-Ordinated Care

Who are key groups?

Patient Groups - Additional Information



Care Settings - Additional Information



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Digital Solutions to Co-Ordinated Care

What's next?

Using digital to support coordinated care

Where next for the SCR?

Extend the benefits to more care professionals	• **Delivery** into key areas such as community pharmacy, scheduled care in hospitals, and dedicated medical room in police custody suites • **Discovery** work in new environments such as care homes and social care
Improve usability and user experience	• Further integration with core systems used by care professionals • Improved ‘look and feel’ • Mobile access
Provide access to further critical information	• Signpost or hold information from other sources - where it is appropriate to be held on the SCR • Flag key information (e.g. learning disability, SPNs)

Contact the Programme

Web:

www.hscic.gov.uk/scr

Email:

scr.comms@hscic.gov.uk

Twitter:

@NHSSCR

Sign up to the SCR bulletin:
http://systems.hscic.gov.uk/scr/signup

ATRIAL FIBRILLATION:

A London approach

- **Why** is change necessary?
- **What** will change achieve?
- **How** will change be delivered?

Dr John Robson

On behalf of Pan London Primary Care AF Improvement Programme

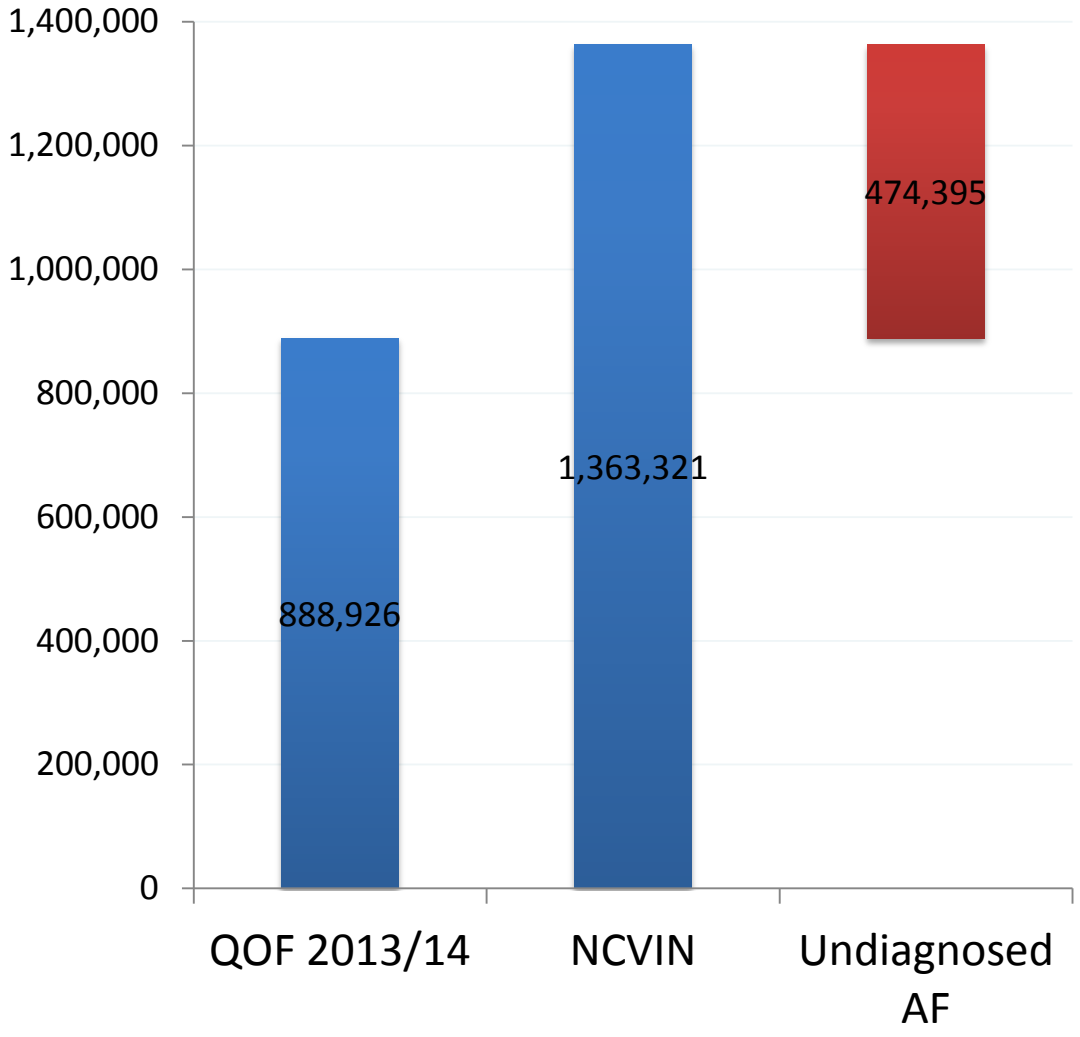
20th January 2016

Vision for London

To prevent AF-related stroke and associated mortality through better identification and management of people with atrial fibrillation

1. **Increasing anticoagulation of untreated high risk AF**
2. **Improving the quality of anticoagulation**
3. **Increasing the detection of undiagnosed AF in high ri**

Atrial fibrillation in England



- 1.4 million people in England are estimated to have AF (prevalence 2.4%)
- Almost 900,000 recorded AF cases (prevalence 1.6%)
- **Over a third are undiagnosed**

AF and stroke

AF is common: 1 in 10 people over age 70 years

AF contributes to 1 in 5 of all strokes and 1 in 3 age over 80 years

AF strokes more severe and disabling

Anticoagulation reduces strokes by 64%

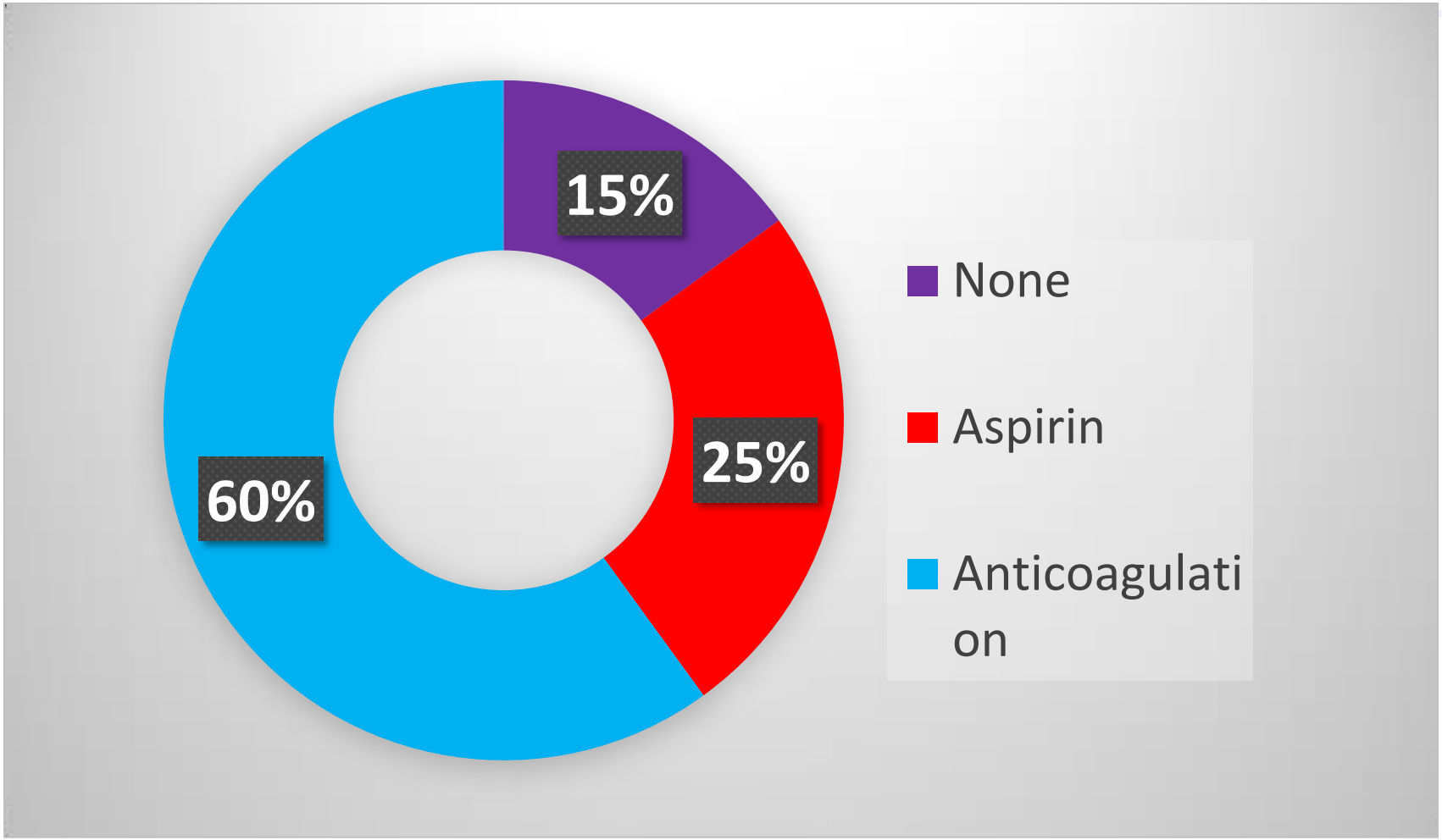
Aspirin does not effectively reduce stroke in people with AF

AF Quality Standards

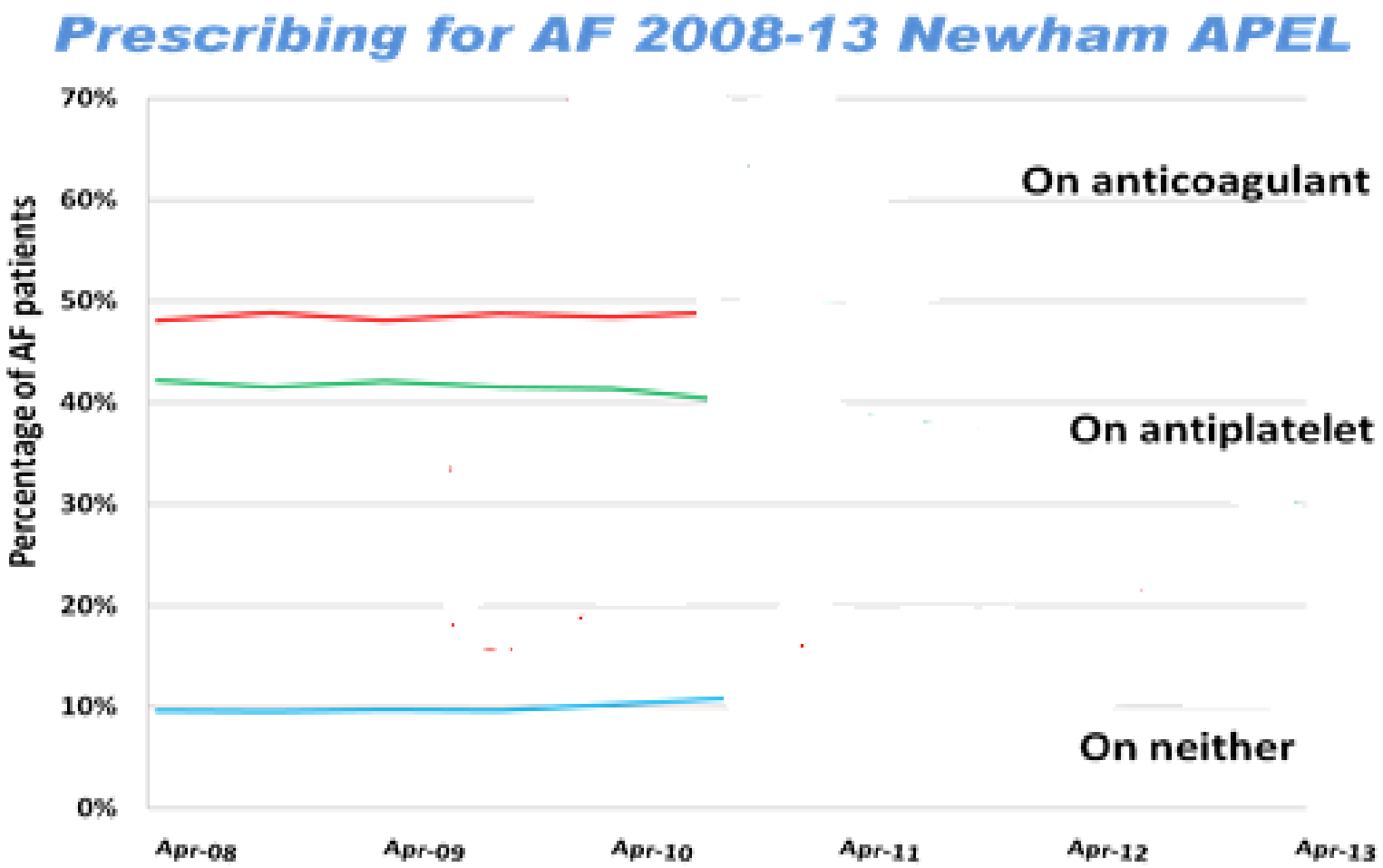
- % CHA_2DS_2VASc score ≥ 2 on anticoagulation AIM > 80% (no exceptions)
- % CHA_2DS_2VASc score ≥ 2 on anti-platelet AIM < 10% (no exceptions)
- % on warfarin with a TTR < 65% AIM = 100%
- % people age 65+ with pulse check in 5 years AIM > 90%

The AF problem

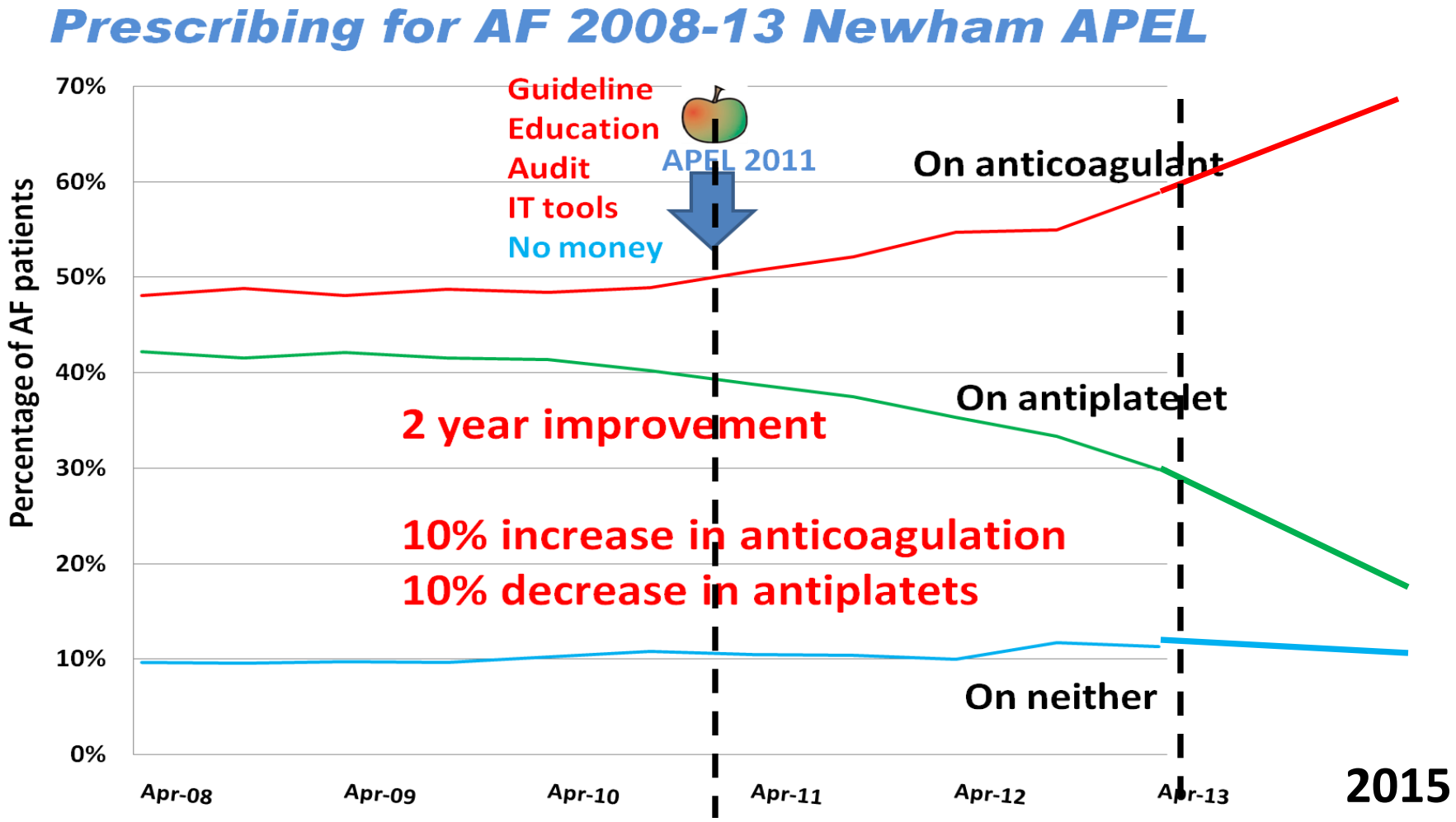
Current management of stroke prevention in AF in clinical practice in England



Examples of improvement



APEL:
Examples of improvement



Pulse checks

Newham, City and Hackney and Tower Hamlets

80% people ≥ 65 years within 5 yrs

70% people ≥ 65 years with CVD/diab/COPD in 1 yr

3 ducks in a row

Health Innovation Network South London

IMPERIAL COLLEGE HEALTH PARTNERS

NHS London Strategic Clinical Networks

UCLPartners Academic Health Science Partnership

Belief

Guideline

Education

Act

Review & recall

IT Decision Prompts

Near pt tests New agents

Motivate

Comparative Feedback

Incentives

System change

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Health Innovation Network South London

IMPERIAL COLLEGE HEALTH PARTNERS

NHS London Strategic Clinical Networks

UCLPartners Academic Health Science Partnership

Belie

Motivate

:t

Evidence Stakeholders Consensus Guidance and KPIs Education	IT support On screen prompts Script switch Trigger tools Patient recall nd review lists	Financial targets Dashboards Peer performance

Learning

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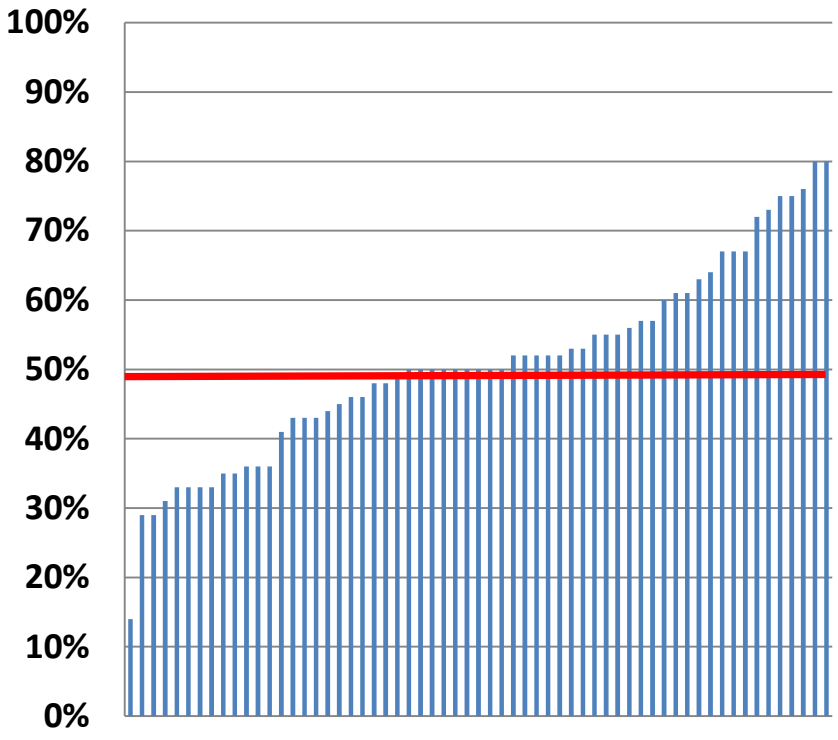
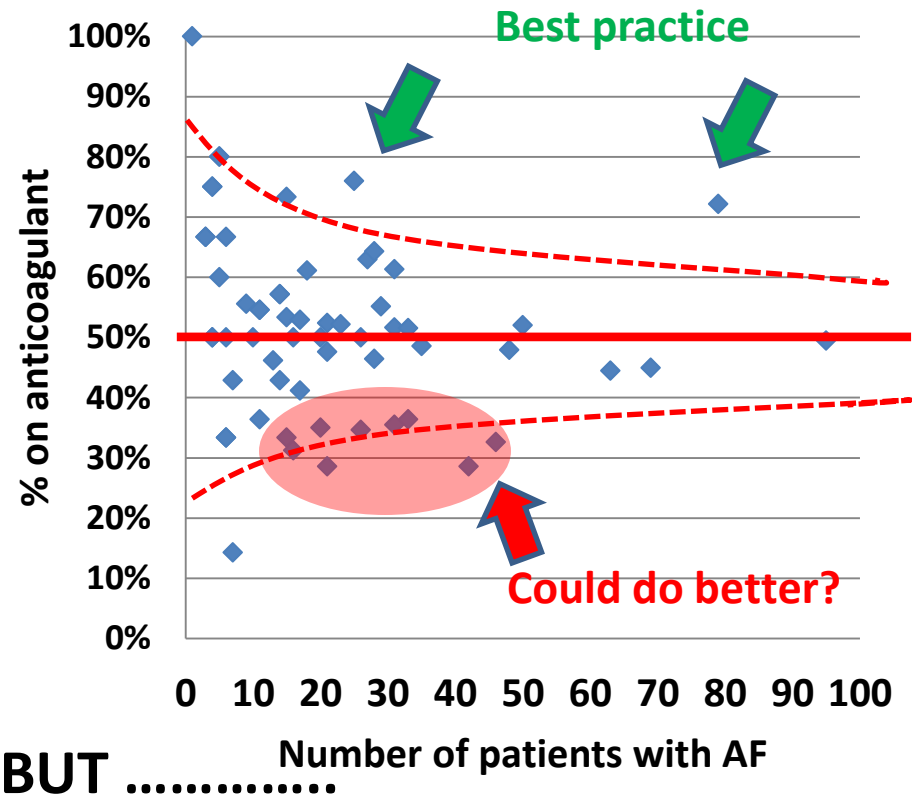
Data for improvement

Newham practices May 2011
% AF on anticoagulant

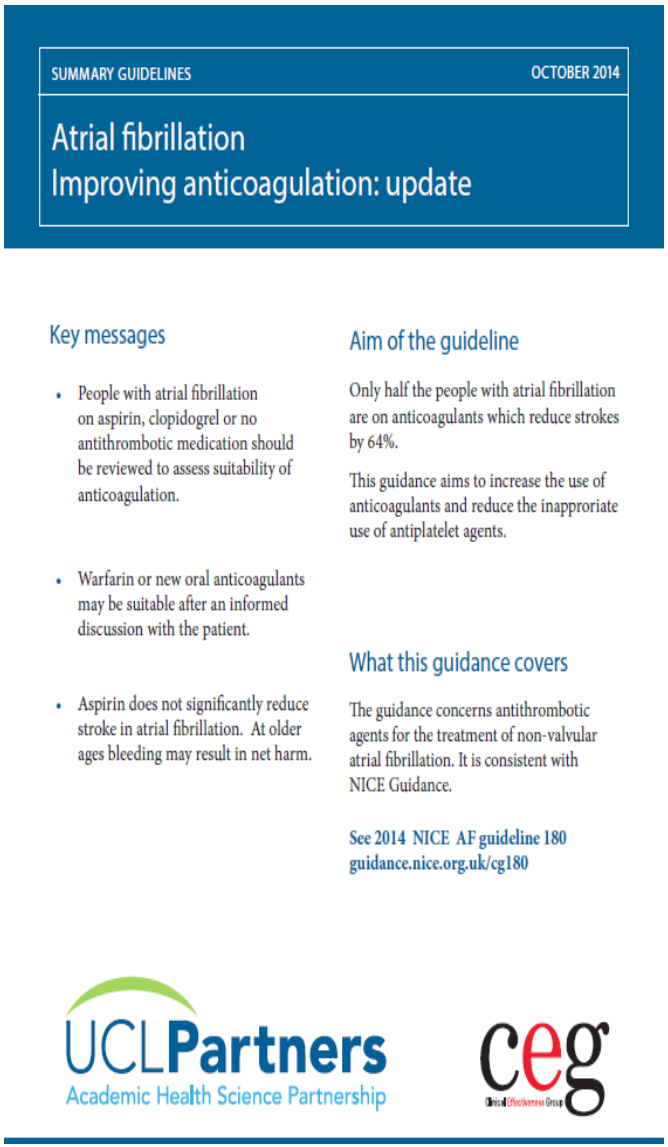


Newham practices May 2011
AF register size and anticoagulation



2 fold variation 30-70% ….. BUT ……

Guideline



SUMMARY GUIDELINES OCTOBER 2014

Atrial fibrillation
Improving anticoagulation: update

Key messages

- People with atrial fibrillation on aspirin, clopidogrel or no antithrombotic medication should be reviewed to assess suitability of anticoagulation.
- Warfarin or new oral anticoagulants may be suitable after an informed discussion with the patient.
- Aspirin does not significantly reduce stroke in atrial fibrillation. At older ages bleeding may result in net harm.

Aim of the guideline

Only half the people with atrial fibrillation are on anticoagulants which reduce strokes by 64%.

This guidance aims to increase the use of anticoagulants and reduce the inappropriate use of antiplatelet agents.

What this guidance covers

The guidance concerns antithrombotic agents for the treatment of non-valvular atrial fibrillation. It is consistent with NICE Guidance.

See 2014 NICE AF guideline 180
guidance.nice.org.uk/cg180

Dashboard

Health Innovation Network South London

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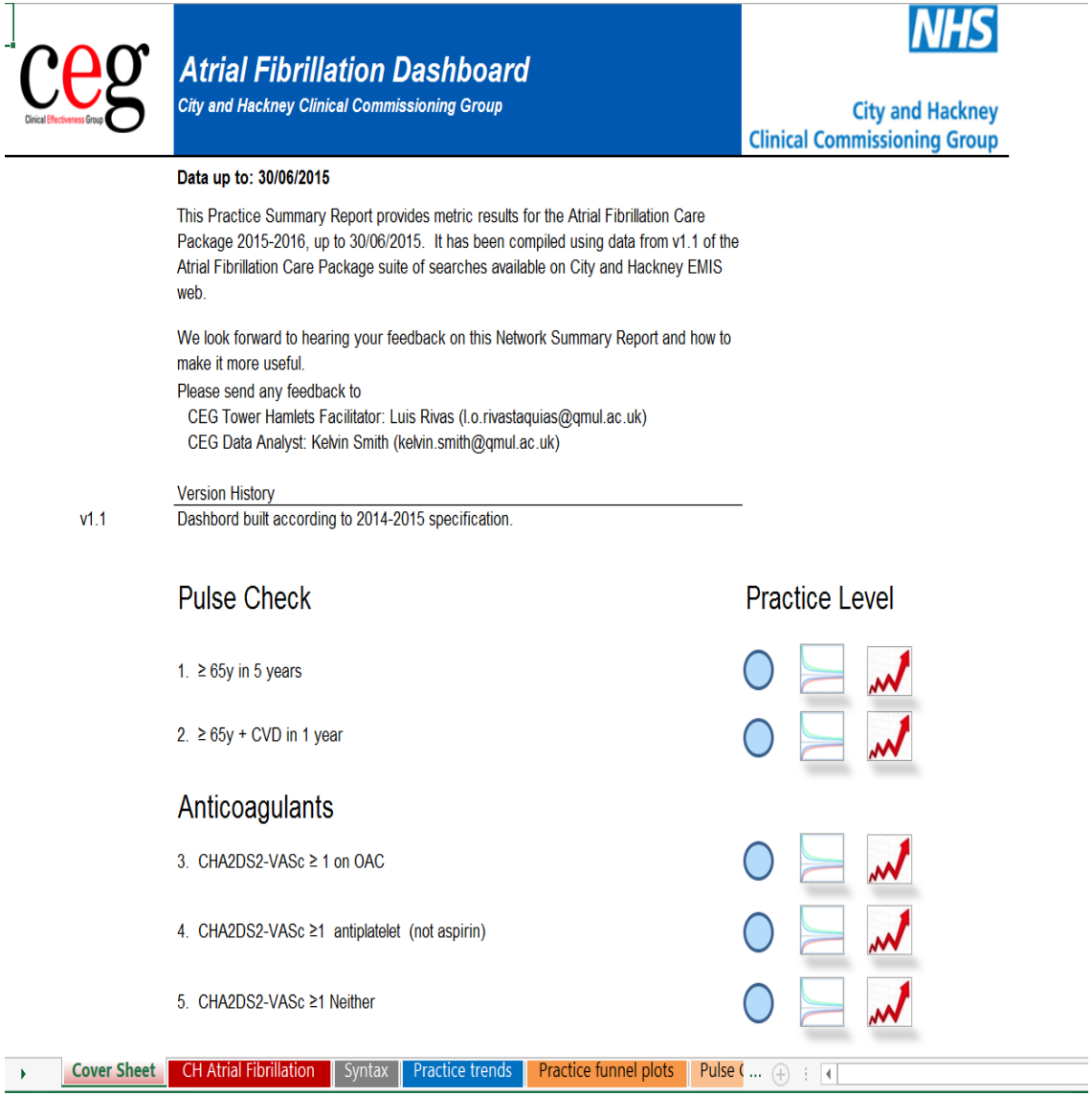
NHS London Strategic Clinical Networks

UCLPartners Academic Health Science Partnership



ceg Clinical Effectiveness Group

Atrial Fibrillation Dashboard

City and Hackney Clinical Commissioning Group

NHS City and Hackney Clinical Commissioning Group

Data up to: 30/06/2015

This Practice Summary Report provides metric results for the Atrial Fibrillation Care Package 2015-2016, up to 30/06/2015. It has been compiled using data from v1.1 of the Atrial Fibrillation Care Package suite of searches available on City and Hackney EMIS web.

We look forward to hearing your feedback on this Network Summary Report and how to make it more useful.

Please send any feedback to

CEG Tower Hamlets Facilitator: Luis Rivas (l.o.rivastaquias@qmul.ac.uk)

CEG Data Analyst: Kelvin Smith (kelvin.smith@qmul.ac.uk)

Version History

v1.1	Dashbord built according to 2014-2015 specification.

Pulse Check

Practice Level

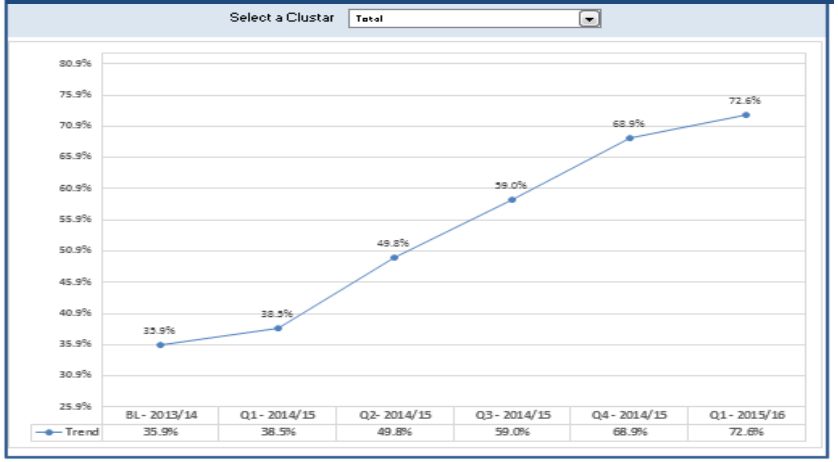
1. ≥ 65y in 5 years
2. ≥ 65y + CVD in 1 year

Anticoagulants

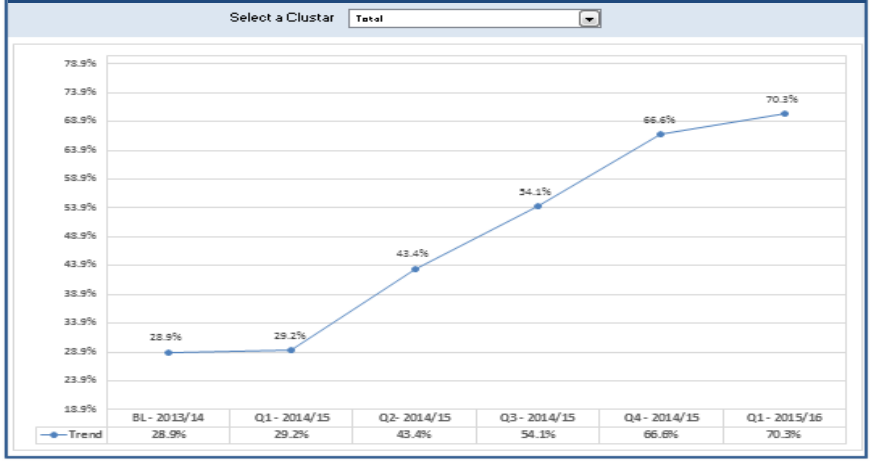
3. CHA2DS2-VASc ≥ 1 on OAC
4. CHA2DS2-VASc ≥1 antiplatelet (not aspirin)
5. CHA2DS2-VASc ≥1 Neither

Cover Sheet | CH Atrial Fibrillation | Syntax | Practice trends | Practice funnel plots | Pulse (...

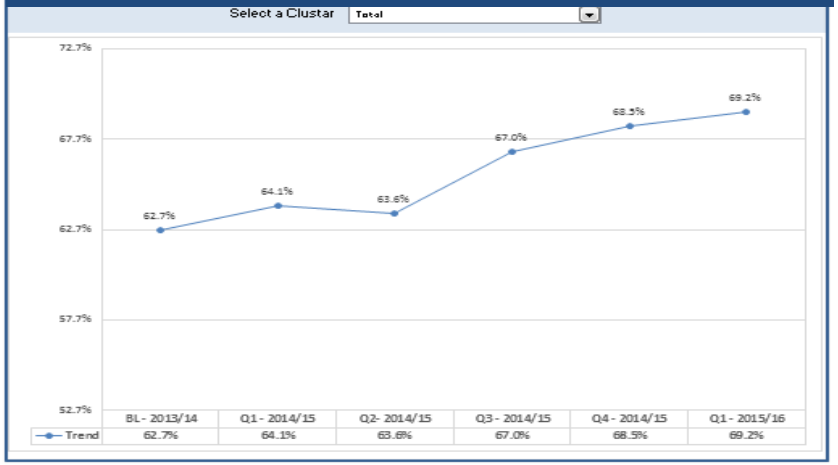
Age ≥ 65 years Pulse Check in 5 years



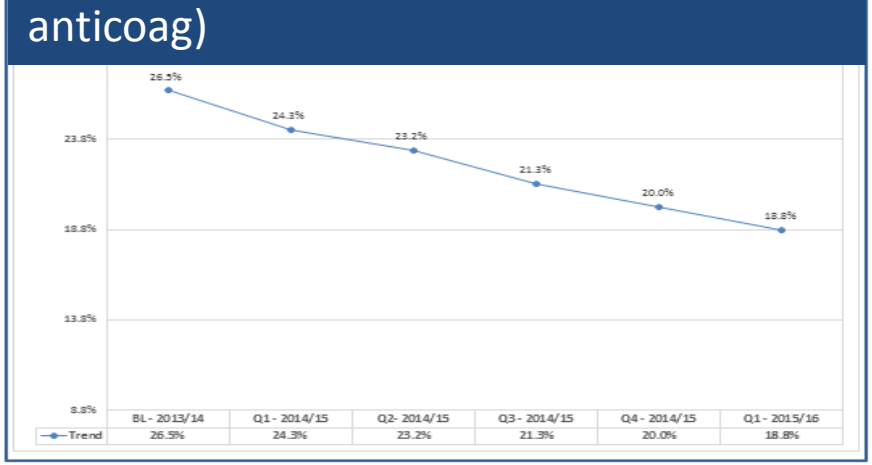
Age ≥ 65 years + LTC Pulse Check in 1 year



CHADSVASC ≥1 on anticoagulant



CHADSVASC ≥1 on antiplatelet (no anticoag)



Jan 2014-June 15 Newham CCG AF dashboard (quarterly data)

Vision for London

To prevent AF-related stroke and associated mortality through better identification and

1. Increase anticoagulation of high risk AF patients
2. Improve the quality of anticoagulation
3. Increase detection of undiagnosed AF in

Model for improvement

Compelling case for change

Commissioning levers

Primary care support tools

Measurement for improvement

Peer and organisational learning

Pan-London Primary care Improvement Programme

BENEFITS

- **Prevent 1500 - 2000 strokes** over 5 years
- **Net savings of ~£5m** over 5 years to health economy due to lower acute stroke and social care costs

RESOURCE IMPLICATIONS

- **£500k investment** from AHSNs and SCN
- **Transformation Fund of £1.8m** for GP leadership, local practice facilitators, data licence & analysis
- Annual **drug costs of circa**

CCG Resource

Resource	Cost per CCG	London cost (32 CCGs)
CCG clinical leadership 0.2wte	**£27,650**	**£884,800**
CCG Practice Facilitator 0.2wte	**£9,870**	**£315,830**
IT licence and data analysis	**£18,250**	**£584,000**
TOTAL	**£55,770**	**£1,784,630**

Stakeholder engagement
Education

Use existing IT effectively
Decision support, recall lists

Peer performance dashboards, targets, incentives

A learning health system

Health Innovation Network South London

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NHS London Strategic Clinical Networks

UCLPartners Academic Health Science Partnership

Diabetes | CVD | Imms | COPD

2008

bottom quartile performance

4 yrs top in UK and London

QOF Performance

QOF 2013-14 east London CVD

All figures are WITHOUT exceptions unless stated. All England = 211 Rank (%)

NEWHAM

- 1st BP recorded in people >40 years in 5 yrs. (92.8%)
- 2nd Peripheral vascular disease BP<150 (90.4%)
- 2nd Diabetes BP<150 (91.5%)
- 2nd Diabetes foot exam (89.5%)

- CITY AND HACKNEY
- 1st Atrial fibrillation on anticoagulants (92.0%) with exceptions
- 1st Diabetes Foot exam (90.3%)
- 2nd CHD BP <150 (92.0%)
- 2nd Stroke BP<150 (89.6%)

- TOWER HAMLETS
- 1st CHD BP<150 (93%)
- 1st Diabetes BP <150 (92.2%)
- 1st Diabetes Cholesterol<5 (81.6%)
- 2nd Hypertension CVD risk >20% on statin (84.5%)

These three CCGs came in the top 20% in England and top in London on a range of other metrics.

National QOF Performance no exceptions. 2014/15

C&H

1st BP Target CHD, stroke, PAD 1st CKD BP 3rd Hyptn
1st AF anticoagulated (*with exceptions*)
1st COPD x spiro;MRC;FEV1 1st Asthma review
1st Diab exam; 2nd Diab eductn 3rd Diab BP 4th Diab cholesterol
2nd Dementia review

Tower Hamlets

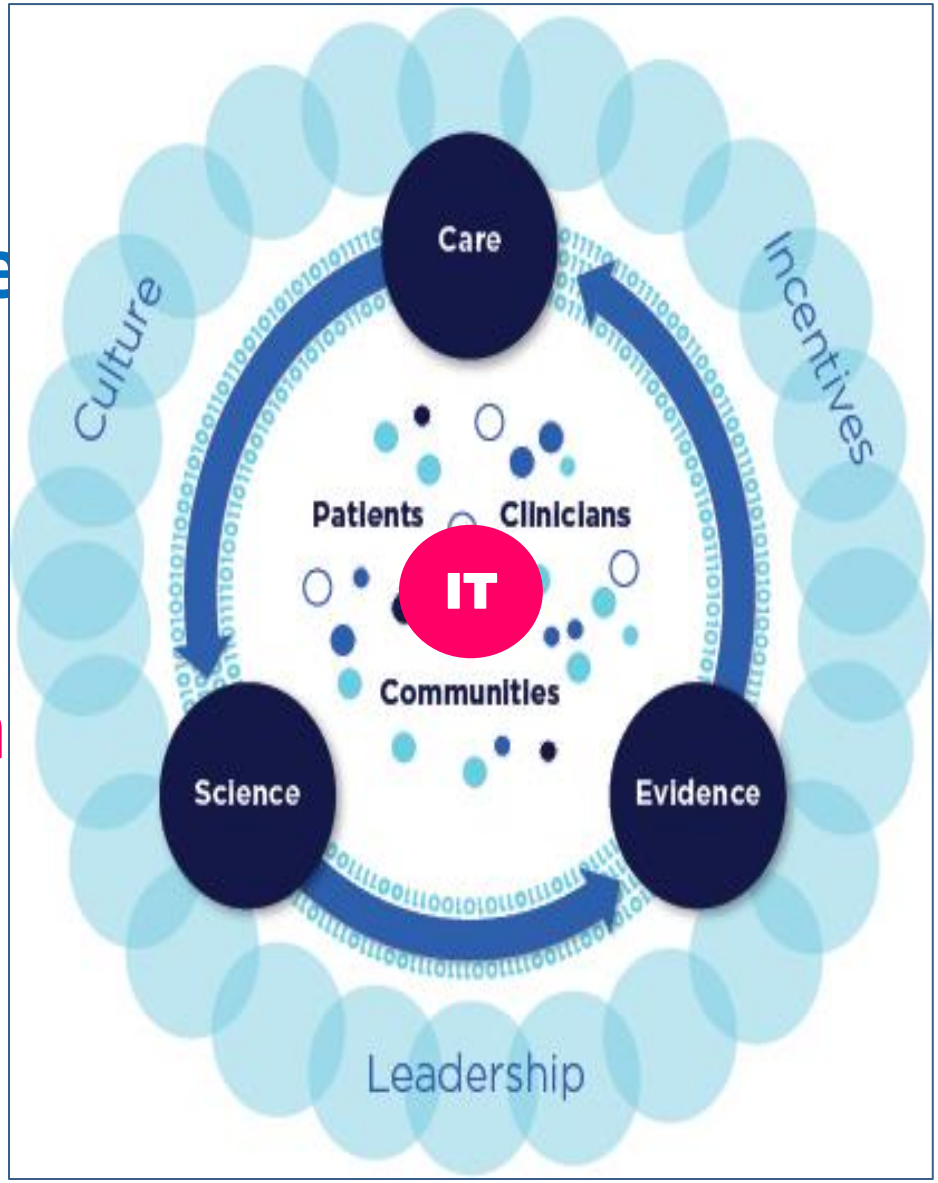
1st Hyptn BP target 1st BP recorded in people >45 yrs 1st Diab BP 2nd CHD BP target
1st Diab cholesterol
3rd COPD spiro

Newham

3rd BP recorded >45 years; 3rd Diab Eductn 5th Asthma review 6th DM BP 9th Diab exam

A learning health syste

AF exempla number 1



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Coordinated care

Isabel Hodkinson

GP and Principal Clinical lead

Former RCGP Clinical Champion for Collaborative Care and Support planning

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WHAT ARE YOUR BEST HOPES FOR THIS SESSION??

SUGGEST THAT YOU USE YOUR PLANNING SHEET

PERSONAL REFLECTION- 2 MINUTES

Coordination of care for people with complex needs

If we are getting this right what would it look like?

- Care- what is the scope?
- Coordination- who are we coordinating with and for?
- Over what time frames?

BUZZ IN GROUPS OF 2-3 FOR 5 MINUTES

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Transforming Primary Care in London

Coordinated care specification:

C1: Case finding and review

C2: Named professional

C3: Care planning

C4: Patients supported to manage their health and wellbeing

C5: Multidisciplinary working

Concepts to support effective coodinated care

What's important to me:

- The person's story
- What do I find helpful/ how I cope
- My hopes and fears for the future

Relationship Continuity of care

What's important for me?

- Medical generalism and challenges to over medicalisation now and in the future
- Person centred evidence informed medicine
- Effective multidisciplinary working

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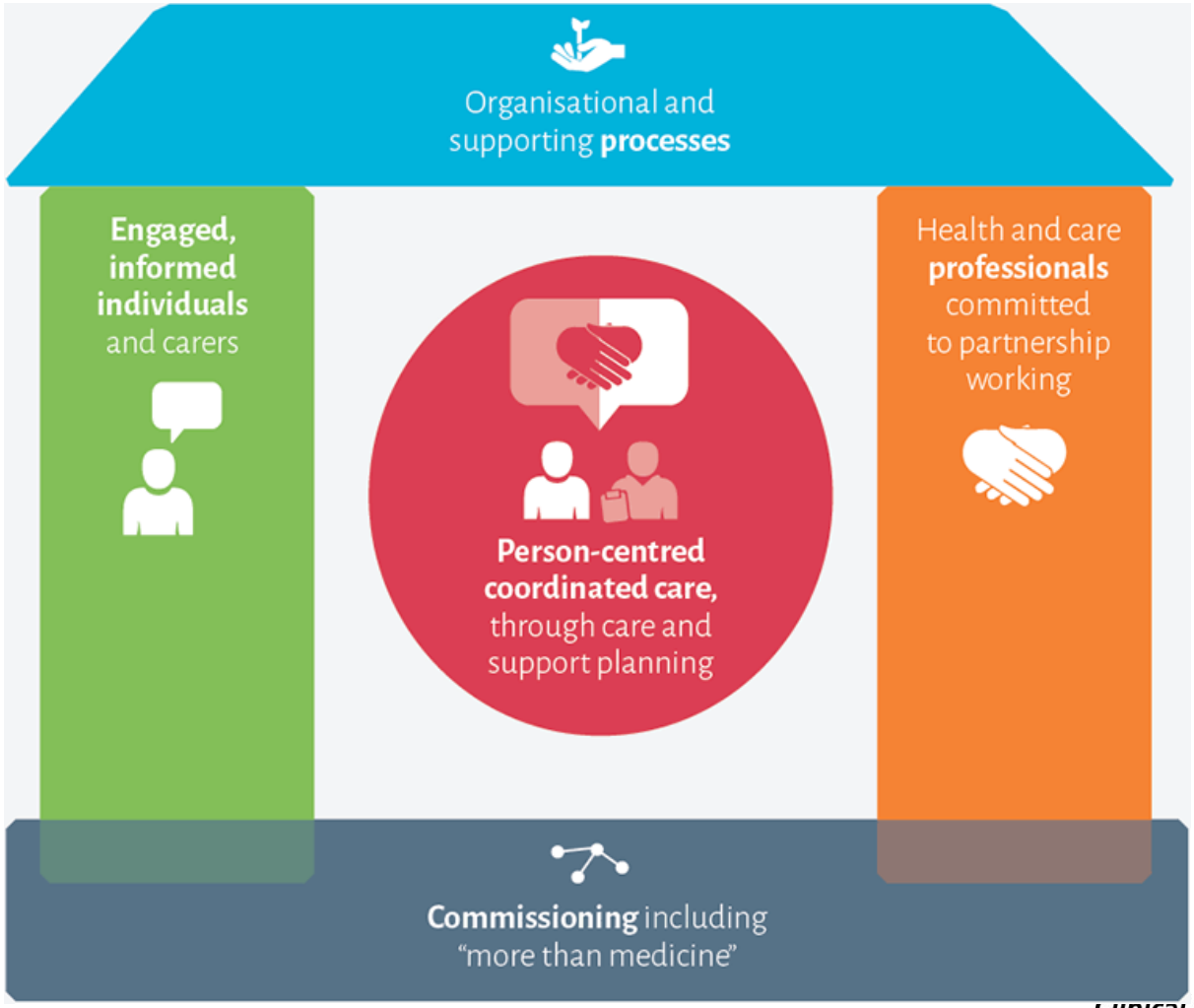
Changing culture- “What matters to me” rather than “what is the matter with you?”

Outcomes- the person defines at least some of them

Supporting medical management		Enabling self management
Disease centred	**Model**	Person-centred
Deficit-based	**Approach**	Asset-based
Biomedical	**Outcomes**	Personal
Quantitative	**Measures**	Qualitative & Quantitative
Transmission/didactic	**Process**	Enablement/Coaching
Evidence-based (narrative informed)	**Paradigm**	Narrative-based (evidence informed)
Clinician (one expert)	**Locus**	Co-production (2 experts)
£££££££s	**Economic**	££s
Health Service	**Resource**	Individuals & community
Single disease	**Focus**	Multiple
Passive dependent	**Person**	Active lead

SYSTEMS thinking essential- the House of Care a useful checklist



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The learning health care system:

Science and informatics	Real-time access to knowledge
	Digital capture of the care experience
Patient–clinician partnerships	Engaged, empowered patients
Incentives	Incentives aligned for value
	Full transparency
Continuous learning culture	Leadership-instilled culture of learning
	Supportive system competencies

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HOW DOES YOUR SYSTEM LOOK?

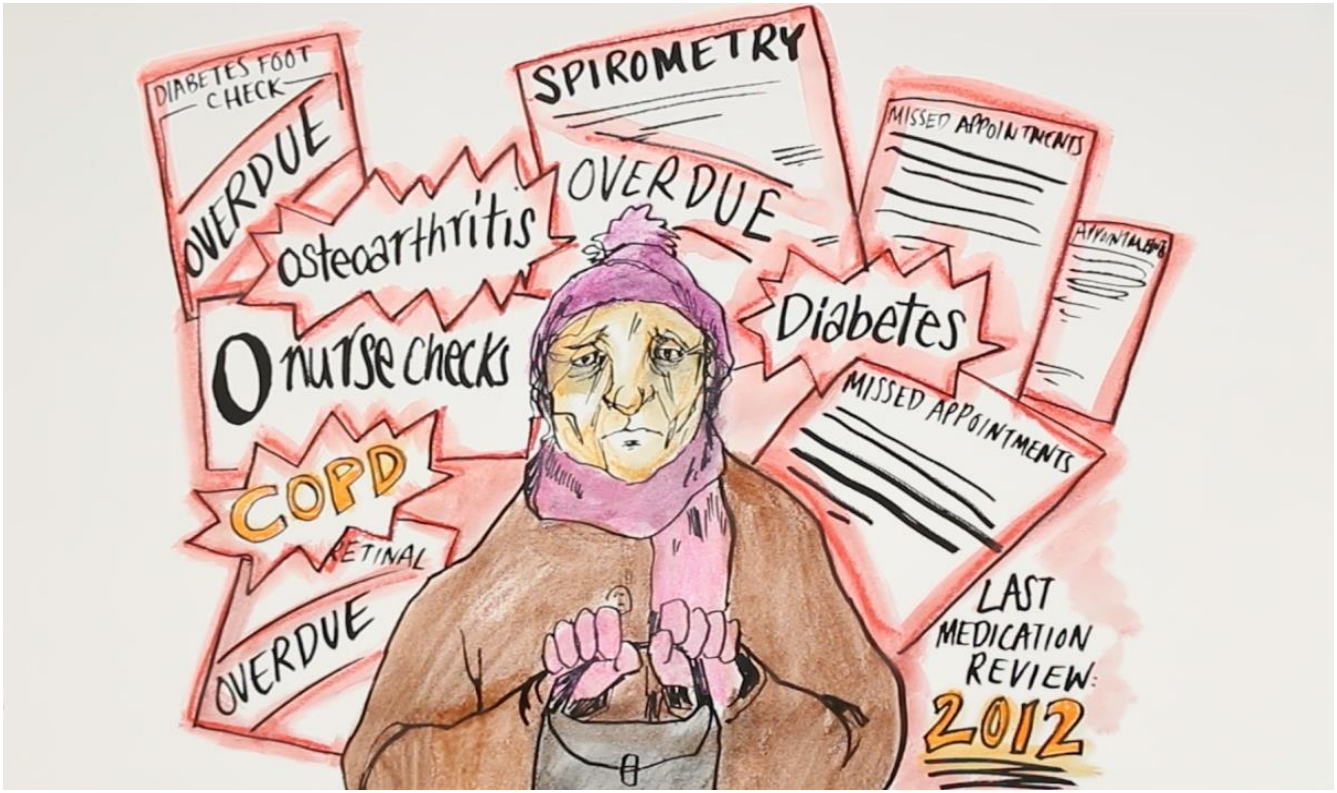
HOW DO YOU LOOK AT YOUR SYSTEM?

BUZZ IN GROUPS OF 2-3 FOR 5 MINUTES

From disease to person

- 2007-2010: Diabetes Year of Care pilot site
- 2009: DH integrated care pilot site- development of networks and extended enhanced care contracts- Network Improved Services- diabetes care package the first, have had up to 31 packages via networks now rationalised to 26
- 2013: Pioneer (sector-wide) integrated care programme- integrated tier team development with a focus on those at risk of admission
- PLUS local rationalisation of packages for individuals with complex comorbidities/ in last years of life into the Coordinated Care NIS- now Level 2 Integrated Care
- 2015: Integrated Personalised Commissioning pilot site and Vanguard MCP site

The challenges of multimorbidity



2013- developing the Coordinated Care NIS- a single package of GP delivered proactive care for people with Long Term Conditions. Entry criteria- palliative care, dementia, nursing home, heart failure, discretionary

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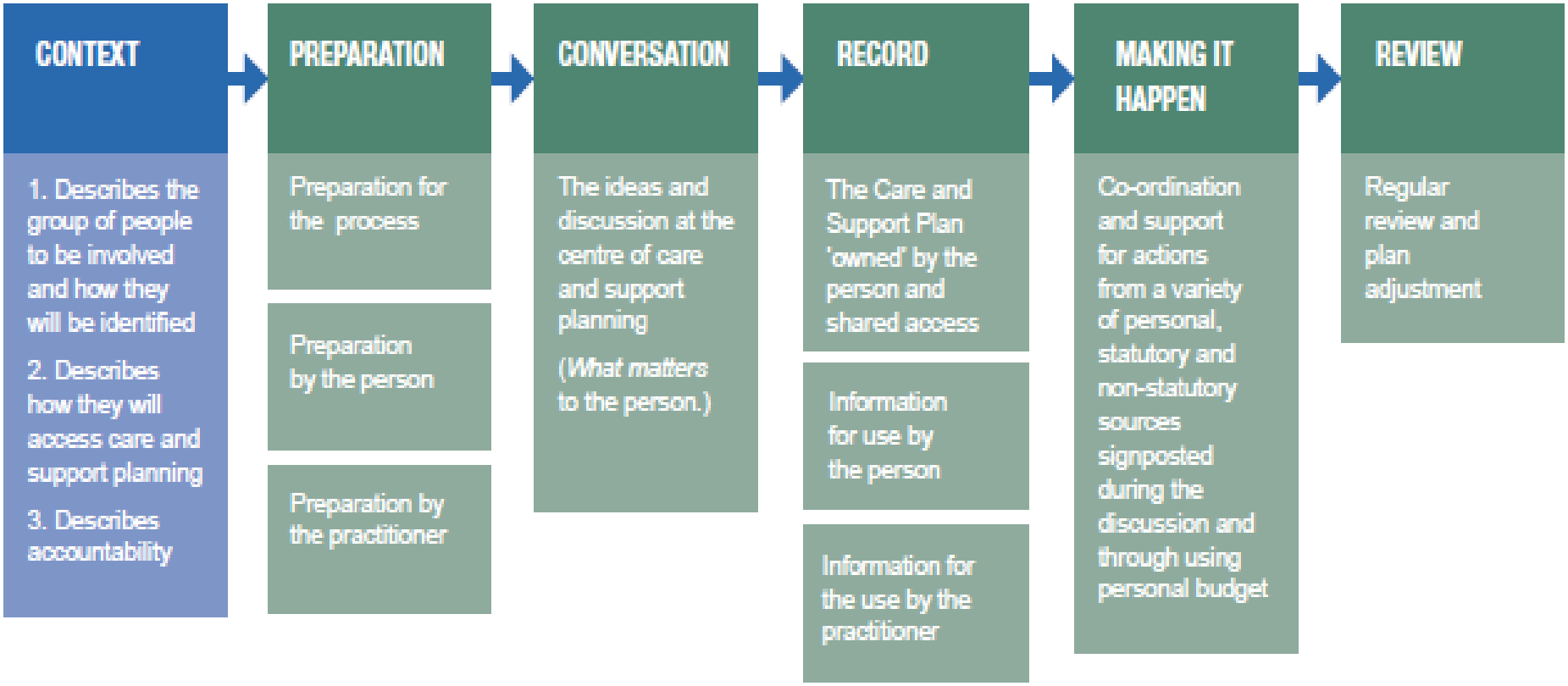
Care and support planning

http://www.rcgp.org.uk/clinical-and-research/our-programmes/collaborative-care-and-support-planning.aspx

Royal College of General Practitioners

Care and support planning post Care Act/ for Integrated Personal Commissioning



http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/context/

DO YOU HAVE A VISION FOR THE DELIVERY OF COORDINATED CARE?

HOW PERSON-CENTRED IS YOUR VISION?

PERSONAL REFLECTION- 2 MINUTES

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Stepping forward

Stepping forward- Commissioning principles for collaborative care and support planning

http://www.rcgp.org.uk/clinical-and-research/our-programmes/~/media/Files/CIRC/Care%20Planning/stepping-forward-web-061015a.ashx

RC GP Royal College of General Practitioners

5 core principles of CC&SP

- Plan around the person not the disease
- CC&SP is the core delivery model
- CC&SP requires a whole system approach
- Encourage a flexible approach to evidence –based guidelines
- Reinforce primary care as a person-centred system with general practice delivering relational based care at its core

Network of Champions

Objectives:

- Promote care and support planning
- Collect evidence and case studies
- Support and mentor implementers

Visit www.rcgp.org.uk/care-planning for more information

NHS England

The Health Foundation Inspiring Improvement

RCGP Royal College of General Practitioners

My take home messages are-

- Care and support- Focus wider than disease- especially mental wellbeing, ability to function autonomously. Care is not just about statutory providers
- Coordination- Value and work with the supports and resources the person has- their own skills, knowledge and confidence, family, carers, housing and community PLUS bring the team together round the person- good IT helps enormously
- Time frames- LONG TERM conditions..

Q+A and Evaluation

Any questions?

To what extent were your best hopes met?

0-5 scale

0= not at all

5= completely

SHOW OF HANDS- 2-3, 0-1, 4-5

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Appendix slides

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Effective delivery system at scale

Standardising network level processes NOT practices

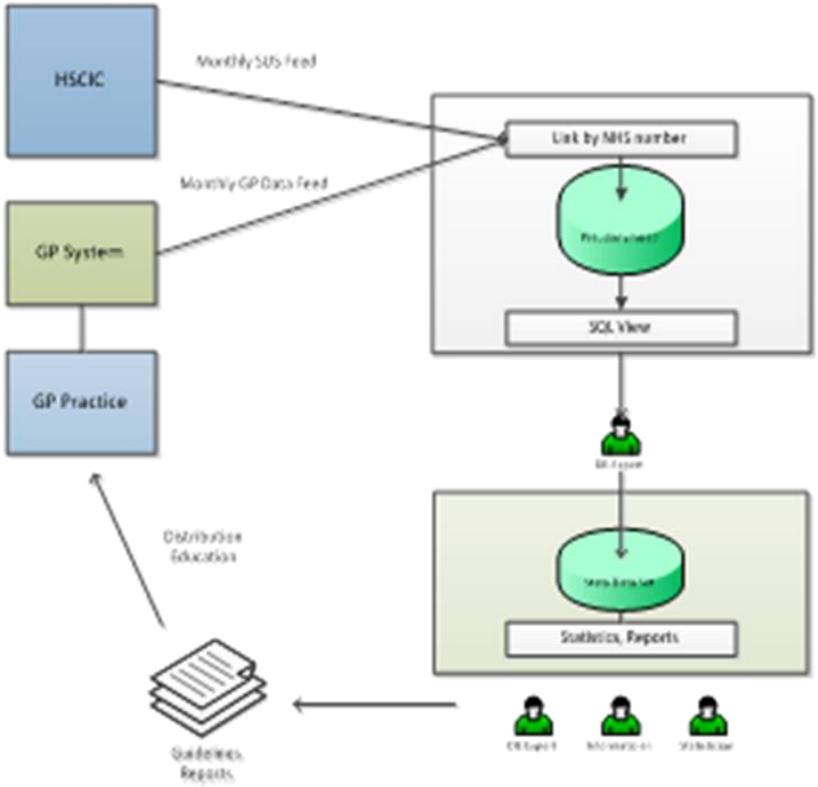
2007-2010: Diabetes Year of Care pilot:

- Main weakness in the ‘roof’
- ‘one size fits all’ education offer
- Lack of knowledge about or engagement with community resources

NOW: GP infrastructure for proactive care for defined populations-

FUTURE- proactive care across the system

- All practices EMIS
- Clinical Effectiveness Group trusted data processor
- Single **centrally** written data entry templates and searches powering call and recall, and payment
- Monthly performance dashboards to networks
- Monthly network meetings with specialist support



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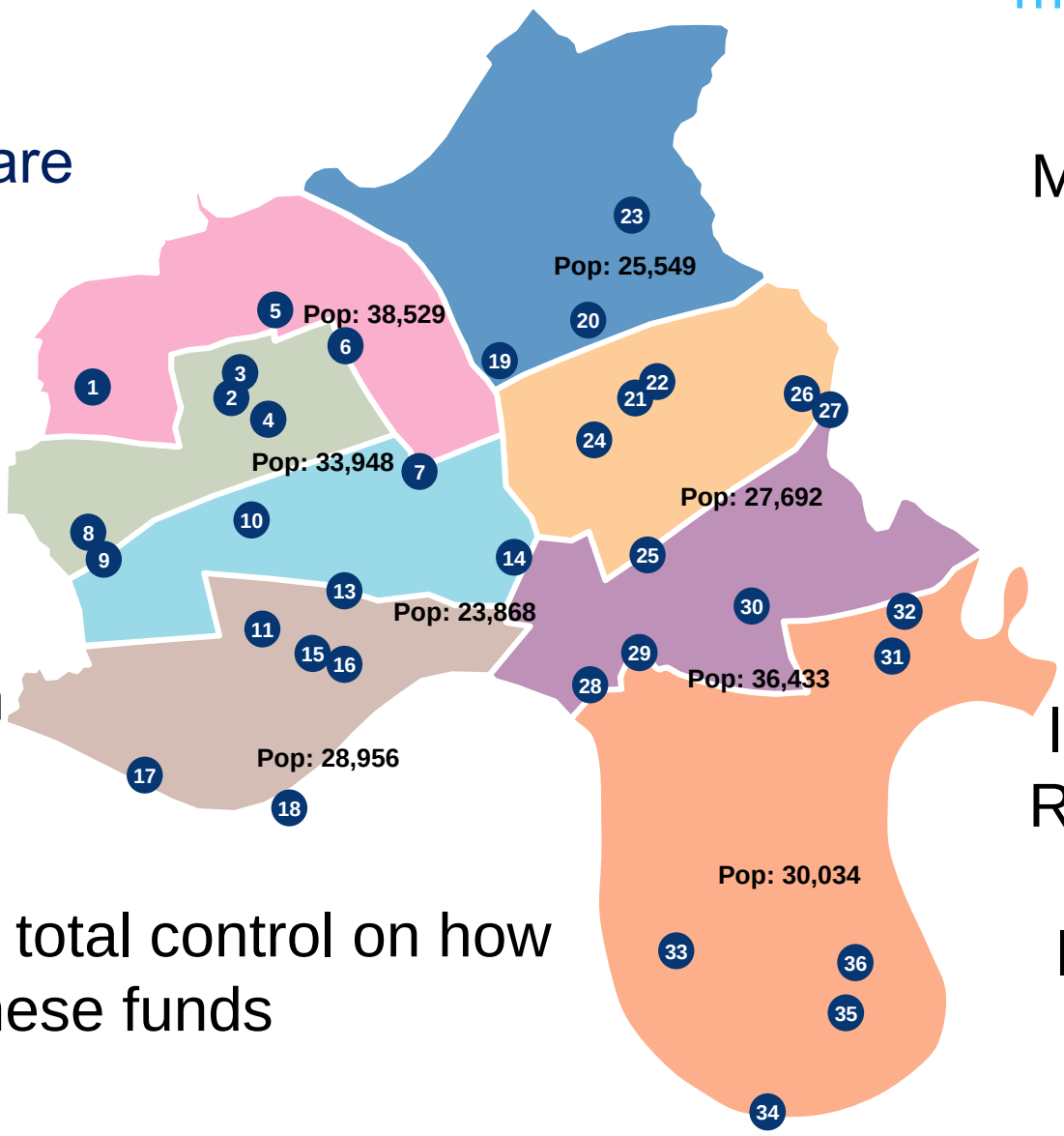
Delivering ‘care packages’:

Priced on ‘ideal delivery’ 70% payment up front 30% on year end performance

Network has total control on how to allocate these funds



Network management structure:

Management resource - 150K per network

Networks initially not legal entities Requirements for network level clinical leadership

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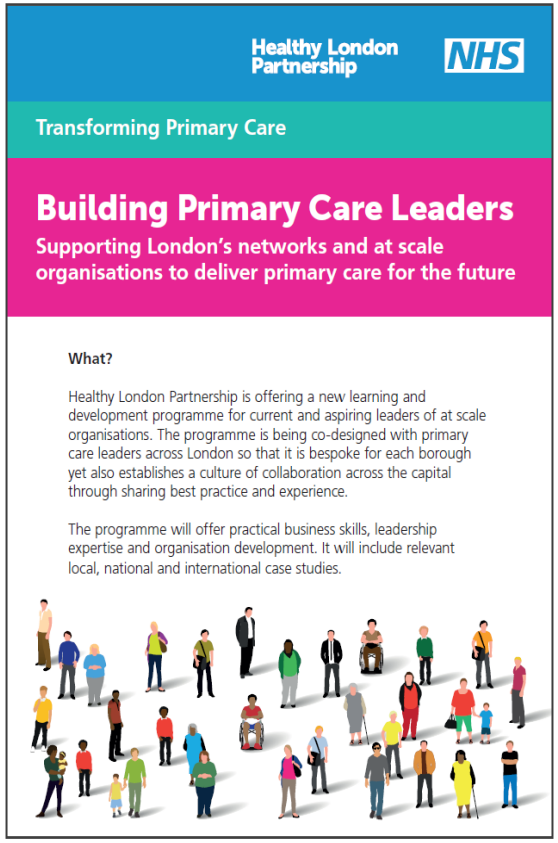
Summary and Close

What's Ahead

Provider Development Support

- SPG Workshops
- Action Learning Sets
- Joint Londonwide LMCs Masterclasses in April 2016
- Bi – monthly SPG Networking events
- London wide provider event



13th April, The Kia Oval

Transforming Primary Care: Proactive Care Event

Thank You

england.londonprimarycaretransformation@nhs.net