12. Focused work on improvements to care for those with learning disabilities and autism

We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across North Central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents and communities have told us is important to them.

This draft plan builds on existing plans and work already underway across NCL and sets out how we will deliver the commitments in the Long Term Plan. It has been developed by, and with the insights from, representatives working in NCL, including staff working in health and social care, and clinical leaders and managers, patients and residents, and our partner organisations from across the NHS, social care, voluntary sector and beyond. Local leaders across our partner organisations, including NHS trusts, general practice, commissioners and local authorities have been closely involved in shaping and overseeing the development of these plans. We are continuing to work closely with all of these groups as we refine the plans and move into delivery and implementation of the commitments.

If you would like to feedback or contribute to this work as we further develop our plans and implementation, please see the 'Listening to residents and communities' section for more details on how to get involved.

Introduction

Over the next five years partners across North Central London (NCL) will work together to reduce health inequalities and improve health and care services for people with learning disabilities and autistic spectrum disorder so that more people can live well in the community with the right support and closer to home.

Building on the success of the existing NCL Transforming Care Partnership (TCP), we will broaden the scope of our local programme to have a holistic approach in ensuring the overall care needs of our population are addressed. The expanded programme will include the oversight of continued inpatient bed reduction; the prevention of admission to hospital; annual health checks in primary care; Learning Disability Mortality Reviews (LeDeR); as well as integrating Learning Disability & Autism into mainstream health programmes. This coordinated approach will improve links and learning across services to improve health outcomes for people with learning disabilities and autism. Building on the existing multi-agency Transforming Care Board, which includes strong family carer representation, NCL will establish a new Learning Disabilities and Autism Programme Board to oversee the implementation of the plan.

Secondary Care - Further reduction of inpatient bed use

Simon, aged 35, has a mild learning disability, autism, epilepsy and behaviour that challenges services. He was successfully discharged to a bespoke community setting in 2018 and is now living independently following a 21 year hospital admission;

Kate is 13, she has autism and an eating disorder. A Tier 4 hospital admission was successfully avoided this year through the deployment of intensive community support and creative use of a personal budget to help her stay at home

These are just two examples of how our Transforming Care work has positively impacted on individual lives. Over the initial three years of the Programme, ending March 2019, we successfully achieved a 33% reduction in inpatient bed use, which is a significant achievement and higher than the national and London average. We will continue this work over the next five years and our ambition is to work toward a minimum target of 40 adult inpatients by March 2024, which represents a 47% reduction in inpatient bed use over the lifetime of the programme. We will work toward an average of four CYP admissions by March 2024, a reduction 50% from the current activity levels.

North Central London has a number of individuals who are likely to remain in hospital for some time, including those patients currently in high and medium secure care who are highly unlikely to be discharged by 2024 as well as other complex patients, some of whom are subject to legal restriction in relation to any future planning. Our focus over the next five years is to support people to live well in the community and, where there is a clinical need for an inpatient bed, ensure the admission is as short as possible.

We have well established dynamic at risk of admission registers and robust Admission Avoidance protocols/processes to prevent further hospital admissions which facilitate effective joint work across health, education and social care. Our readmission rate is very low, reflecting the successful work of local teams in assessing and maintaining the right level of care to support individuals in the community. We will capture admission avoidance data on through Care (Education) Treatment Reviews (C(E)TRs) to further understand how pathways are working. Specifically, we will improve pre-admission CTR performance to 75% for adults and 90% for children by March 2020 and maintain this level over the following four years. Investment will be targeted in 2019/20 to develop a CTR Co-ordinator role to lead on this work and ensure C(E)TR recommendations and quality issues are followed up and good practice is embedded across the system during year two of the Programme which will support a sustainable approach in the follow three years.

Recent admission data demonstrates a significant reduction in admissions for people with learning disabilities and behaviour that challenges and an increase in admissions for adults with autism and mental health issues. We will work more closely with mental health colleagues (commissioners and services) during 2019/20 and the following years to raise awareness of the programme and support the development of the TCP processes such as Risk of Admission Registers/Admission avoidance processes to become similarly embedded in mental health services as they are within learning disability.

In addition to inpatient reduction numbers, NCL will continue to focus on the quality assurance of individual placements, particularly those out of area. We are cognisant of the new requirement to review out of borough placements every 6-8 weeks and will co-ordinate an NCL approach 2019/20 and into the following years.

Primary Care for people with Learning Disabilities and Autism

We know from extensive engagement with people with learning disabilities their families, paid carers and support workers that there are inconsistencies in both the quality of and access to primary care and Annual Health Checks (AHCs). Feedback through Healthwatch also tells us that, whilst there is good practice in some areas, overall there is a lack of clear, easily understandable information in the form of Easy Read to support the Health Check

process. A similar picture is reflected in the learning from the local Mortality Review Programme (LeDeR).

We will use good practice examples to make the required improvements and reduce inconsistencies across NCL. Further work is needed over the next few years to improve both the number of people with a learning disability on GP registers by 10% each year and to improve the uptake of current AHC performance to at least 75% each year of this plan.

As part of the work to improve outcomes and increase the completion of physical health checks, we are exploring a proposed Learning Disabilities registry for our population health analytics tool HealtheIntent.

Performance will be overseen by NCL Programme Board, building on areas of existing good practice:

- Work in Camden has seen the number of people with learning disabilities registered grow from 788 in April 2018 to 1016 in February 2019 which is just 59 short of Camden's estimated prevalence. Focussed awareness raising and support for the five practices with the furthest to travel in AHC take up will be a priority for 2019/20.
- In Islington, the Quality Improvement Support Team is working with Primary Care Networks to focus on annual health checks during 2019/20. The project will make recommendations and support the bedding in of good practice to improve performance on a sustainable basis during 2020/21 and beyond. Central to the project is the involvement of people with learning disabilities and their carers into the development of best practice in the call/recall system. Learning will be rolled out across NCL
- Haringey are presenting performance information by practice at GP forums and using the opportunity to tie in reasonable adjustments; STOMP/STAMP and constipation awareness
- Barnet have two dedicated GP Liaison nurses working closely with practices to raise awareness and provide support, in conjunction with the local community learning disability team which also runs health check training for practices alongside GP leads for learning Disabilities and Autism.
- Enfield similarly have a range of activities to increase the uptake of annual health checks, including a specialist nurse supporting individual practices.

Islington has developed an innovative Locally Commissioned Service (LCS) to deliver health checks specifically for people with Autism, initially funded for one year. The LCS has four areas: autism training for all staff; EMIS coding; the annual health check and GP Practice environment checks led by parent consultants visiting individual practices to review how autism friendly the environment is and make suggestions for improvements. The LCS will be evaluated, linking with NHSE and Autistica to support further roll out into future years.

Two further learning disability/autism programmes interlinking with primary care will be captured as part of the new NCL Learning Disabilities and Autism Programme:

- The Learning Disability Mortality Review (LeDeR) programme, which is firmly embedded in NCL with strong governance in place – each CCG has a steering group and nominated Local Area Coordinator and completed reviews are analysed with themes and recommendations incorporated into local action plans. An NCL-wide steering group oversees the coordination of learning into action by sharing ideas and initiatives, ensuring optimum use of resources across the patch. NCL has achieved a

48% review completion rate against the 50% target and we will continue to improve on this performance over the next five years.

In response to local learning from LeDeR reviews, Camden CCG held a Mental Capacity Act (MCA) masterclass for GPs alongside a legal professional to help build on the existing knowledge base around the support for understanding and application of the MCA
Barnet Learning Disability Service is raising awareness of early warning signs - rolling out the 'Stop and Watch' campaign across borough through eye catching promotional material to carers, families and providers.

As with the rest of London, capacity and resourcing issues across the system are a challenge in meeting review completion targets, with sustained investment needed to continue programme momentum. We will work with the new Primary Care Networks in driving service improvements through the learning into action work.

- Stopping the over medication of people with learning disabilities (STOMP/STAMP). Both Islington and Barnet are working toward developing an all-age disability STOMP/STAMP action plan, linking with Positive Behaviour Support initiatives, further embedding the reviews in C(E)TRs and annual health checks as well as planning engagement with people with lived experience. Draft plans will be shared across NCL to capture best practice across the patch. STOMP/STAMP is included in the Primary Care Network (PCN) Service Specification and we will bid for targeted funding in 2020/21 to support the PCNs roll out of this programme

Adult Community services

We know there are gaps across NCL for people requiring Neurodevelopmental Disorder (NDD) assessment and treatment; with long waits and a variable offer for residents across the north and south of the patch. NCL plan to commission a more local service for our population; an NDD business case is currently in development to address this to improve waits over the next five years.

Most areas across NCL have well embedded adult crisis pathways: Enfield and Haringey have crisis intervention teams; Barnet has procured an emergency crash pad service with dedicated intensive 6 weeks support. We will review where there are gaps across these pathways and work toward developing a more consistent and equitable approach across the patch. NCL has good access to Community forensic services, commissioned by NHSE in April 2019 and provided by Barnet, Enfield and Haringey Mental Health Trust, through the North London Forensic Consortium. NCL has good access to Community forensic services, commissioned by NHSE in April 2019 and provided by Barnet, Enfield and Haringey Mental Health Trust, through the North London Forensic Consortium. We will work closely with the emerging Provider Collaborative as the work transfers from NHS England.

To support individuals with complex needs in the community over 100 frontline staff have been trained as part of NCL's adult Positive Behaviour Support (PBS) strategy. Again, there is variable PBS provision across the patch and investment will be targeted to address this over the next five years. Initially we plan to secure resource to accredit the PBS training offer and commission a sustainable delivery option for the training across both adult and children's services.

NCL's Transforming Care Housing Plan March 2019 lays out our approach to the provision of appropriate accommodation for people with learning disabilities and autism. A priority is

to implement the action plan, along with the outcomes of the NCL Private Rented Sector project. Local Authority housing pipelines over the next five years will be overseen by the NCL Board, which has senior representation from our Local Authority partners.

A further key objective of the Programme will be to raise awareness of the needs of this population and ensure they are captured as part of mainstream health pathways/programmes and supporting and advising on reasonable adjustments including clear and accessible information. For example, we know that people with learning disabilities are at risk of developing young onset dementia (YoD). Due to the small number of people with young onset dementia (YoD) across NCL, we are looking at working across the patch to increase the dementia diagnosis rate including those with YoD, streamlining diagnosis pathways and increasing post diagnostic support specifically for patients with YoD.

Children's Community services

A comprehensive NCL Transforming Care CYP plan, reporting to the NCL Transforming Care Board and rated Green/Amber by NHSE, co-ordinates the range of initiatives for CYP with learning disabilities and autism across the patch. Each Borough has their local Transforming care offer on their websites, the Islington link below is used as an example

https://directory.islington.gov.uk/kb5/islington/directory/advice.page?id=mKr5B36UXCM

The Transforming Care Prevention and Support (TCaPS) service is an NHS England Accelerator site initiative, with 12 months pilot funding, co-produced with parent carers. Using a keyworker model the service provides flexible early intervention and crisis prevention support for young people and their families rated green and/or amber on the At Risk of Admission registers. It includes funding for Personal Health Budgets (PHBs) which have been particularly successful in supporting the needs of people with autism and no learning disability. The service will be formally evaluated but early indications are positive, as illustrated below

Chris has autism and anorexia; TCaPs has helped increase his calorie intake, support independence in accessing community activities and personal care and helped reduce anxiety. The service has provided support to his parent, improved the young person's mental health, improved health in relation to anorexia and helped him develop friendships and remain out of hospital

Building on the evaluation of this keyworker model NCL will invest in the service over year 2 of the Programme and plan to extend the keyworker model into supporting young people in inpatient mental health units using the targeted funds available in 2020/21. Embedding the keyworker model across NCL will positively impact on inpatient numbers over years 3 and 4 of the Programme. .

Some of our admissions of young people into Tier 4 services may have been avoided with better community crisis/intensive support provision. In response to this gap a business case, led by Haringey, is in development to explore options for a building-based NCL respite and crisis 'crash pad' facility. The service will provide planned short breaks which will sit alongside key worker roles to reduce family breakdown at home which can result in unplanned admission and children and young people being taken into care. Targeted capital investment 2020/21 will be required to support the development of this innovative service; discussions are taking place with NHS England. The service is likely to come on-stream in 2021/22, which should be reflected in lower inpatient admissions in year 3 and beyond of the Programme.

Significant work has been undertaken across NCL to upskill the workforce to support CYP with learning disabilities and autism. Ambitious About Autism have been commissioned to deliver autism training to groups such as social workers; foster carers; health practitioners; Early Years; Youth Offending services, SEN Keyworkers. Work has taken place with NCL CAMHS teams around autism to support alternative interventions and Positive Behaviour Support (PBS) training has been extensively delivered across CYP as well as adult services, helping to support local STOMP/STAMP initiatives. Building on this strong base, NCL children's commissioners are planning further market development work with providers and support workers being available to support those young people with autism and mental health, linking with each area's SEND plans.

In children's services we know there is a gap in Positive Behavioiur Support (PBS) provision across NCL. Enfield have an established PBS service and Islington have a service funded for two years, to be formally evaluated by January 2020. Further investment over time through the roll out of the Long Term Plan priorities will be needed to ensure there is equitable coverage of PBS for all age groups across NCL.

Care Education and Treatment Review (CETR) processes are well established in NCL with a shared protocol in place to ensure a consistent approach in line with NHS England guidance. A number of the children and young people who are part of the Transforming Care cohort will be accessing support through an Education, Health and Care Plan (EHCP) and/or social care support services and our Admission Avoidance Register meetings and CETRs help join up provision for individuals.

NCL's annual Operating Plan will further develop workforce plans across both children and adults services, based on our key deliverables and enhancing community support to sustain people living closer to home.

In addition to the work co-ordinated at NCL level, work at Borough level is tailored to the needs of the local population. All areas have dedicated mental health provision provided into youth offending services and the Liaison and Diversion Model is also established across NCL. Typically for Youth Offending Services providers are commissioned to in reach to services to support and encourage engagement. Increasingly as we look across the North Central London footprint we will want to ensure a consistent and equitable approach to meeting the mental health needs of young people on or on the edge of criminal justice pathways and learn from models that have had success in engagement of young people and impact on health outcomes.

The development of the CAMHS Forensic Team across North Central and North East London provided by the Tavistock and Portman has been well received and local professionals across all areas have made use of the service and started to develop good working links. The model has also supported capacity building locally to consider the needs of this specific group of young people that present with significant challenges. As the service continues to establish itself and work alongside our local CAMHS providers knowledge skills and confidence in working with the Young People who present with significant challenge and risk will increase and, again, will be reflected in reduced inpatient numbers in the latter half of the Programme.

13. Coordinated and proactive care for people with long term conditions

We have been working together to consider what the requirements set out in the NHS Long Term Plan mean for our residents, staff and health and care partner organisations across North Central London (NCL). We have a collective commitment to deliver changes that will improve the health and wellbeing of residents and have listened to what residents and communities have told us is important to them.

This draft plan builds on existing plans and work already underway across NCL and sets out how we will deliver the commitments in the Long Term Plan. It has been developed by, and with the insights from, representatives working in NCL, including staff working in health and social care, and clinical leaders and managers, patients and residents, and our partner organisations from across the NHS, social care, voluntary sector and beyond. Local leaders across our partner organisations, including NHS trusts, general practice, commissioners and local authorities have been closely involved in shaping and overseeing the development of these plans. We are continuing to work closely with all of these groups as we refine the plans and move into delivery and implementation of the commitments.

If you would like to feedback or contribute to this work as we further develop our plans and implementation, please see the 'Listening to residents and communities' section for more details on how to get involved.

Introduction

The latest Global Burden of Disease study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.

The Long Term Plan sets out an ambition to improve earlier detection and optimise treatment to prevent further ill-health, tackling some of the biggest causes of premature mortality, including for more deprived areas.

Our NCL plan for long term conditions sets out the actions that we are taking forward to meet ambition in the Long Term Plan, improving outcomes for NCL patients with cardiovascular and respiratory conditions, diabetes and improving care and rehabilitation for those who suffer a stroke or heart attack.

Across the LTP commitments for long term conditions, NCL has contributed to pan-London work to identify priorities and agree ambitions for improving patient outcomes. The diabetes programme is well established, and our priorities build on progress that we have made in recent years. There is good practice across NCL for Cardiovascular Disease (CVD), stroke and respiratory services. We are working with the London clinical networks and taking forward NCL implementation plans. Work is advanced on CVD prevention, and we are in the process of establishing the next steps on respiratory and cardiology. We have further work planned throughout the autumn to continue to develop our plans to meet the LTP priorities over the next few years, which included a workshop on AF in early October.

In addition, through our population health management platform, HealtheIntent, we will be working to enable front line health and care professionals to use near real time data to identify gaps in CVD and diabetes care, improve case finding and address unwarranted variation from early 2020 onwards (see the population health management chapter for more details).

Cardiovascular Disease (CVD) and Stroke

CVD affects the blood vessels and heart, including heart attacks and strokes. They are the second biggest cause of early death after cancer and a key driver of the gap in life expectancy between affluent and deprived parts of NCL. Stroke is the leading cause of complex disability in adults

Most strokes and heart attacks can be prevented by taking action on the main risk factors, e.g.:

- Behavioural: physical inactivity, smoking, poor diet, excess alcohol use (see prevention chapter)
- Clinical: earlier detection and optimal management of atrial fibrillation and hypertension

While there has been progress on reducing CVD mortality since 2001, this has slowed down in recent years. Across NCL there are opportunities to improve health outcomes and the cost of care, highlighted by opportunities from RightCare analysis in NCL where we:

- spend £95 million per annum on hospital care and prescribing for cardiovascular disease
- spend £5 million more on emergency care, elective care and prescribing for CVD when benchmarked against 5 best CCGs from 10 comparator CCGs
- have 10,000 excess bed days as result of CVD admissions

NCL has an established steering group, which is chaired by a Director of Public Health which is supported by operational and CCG leads on CVD, strong clinical leadership from the CVD lead in the STP and CCG clinical leads, RightCare and UCLP.

A programme has been established to build on existing best practice within NCL and target actions to make sustainable improvements in care to *protect* (treating those with a diagnosis); *detect* (finding those who don't have a diagnosis yet[1]); and *perfect* (optimising diagnosis and treatment pathways[2]). This includes targeting those groups where mortality is highest, including men, people with serious mental illness, people from Black Caribbean and Black African backgrounds, and those from the most deprived areas of NCL.

This work is linked with additional work in planned care on clinical pathway reviews and outpatient transformation, as well as wider work on workforce development.

Identifying and treating risk factors

The programme builds on existing local good practice within NCL, such as:

- Community blood pressure checks in Haringey and Islington which started in February 2018 for 2 years with funding from the British Heart Foundation. Five Voluntary and Community Sector (VCS) organisations have been trained to delivery blood pressure checks in community settings with a focus on Black and Minority Ethnic (BME) communities. People are given lifestyle advice and those requiring follow-up are linked to primary care. Over 75 staff and volunteers have been trained.

[1] targeting those with specific risk factors for stroke – diagnosis of high blood pressure, atrial fibrillation and hypertension

[2] including independence for people who have a stroke, e.g. through rehabilitation and reablement

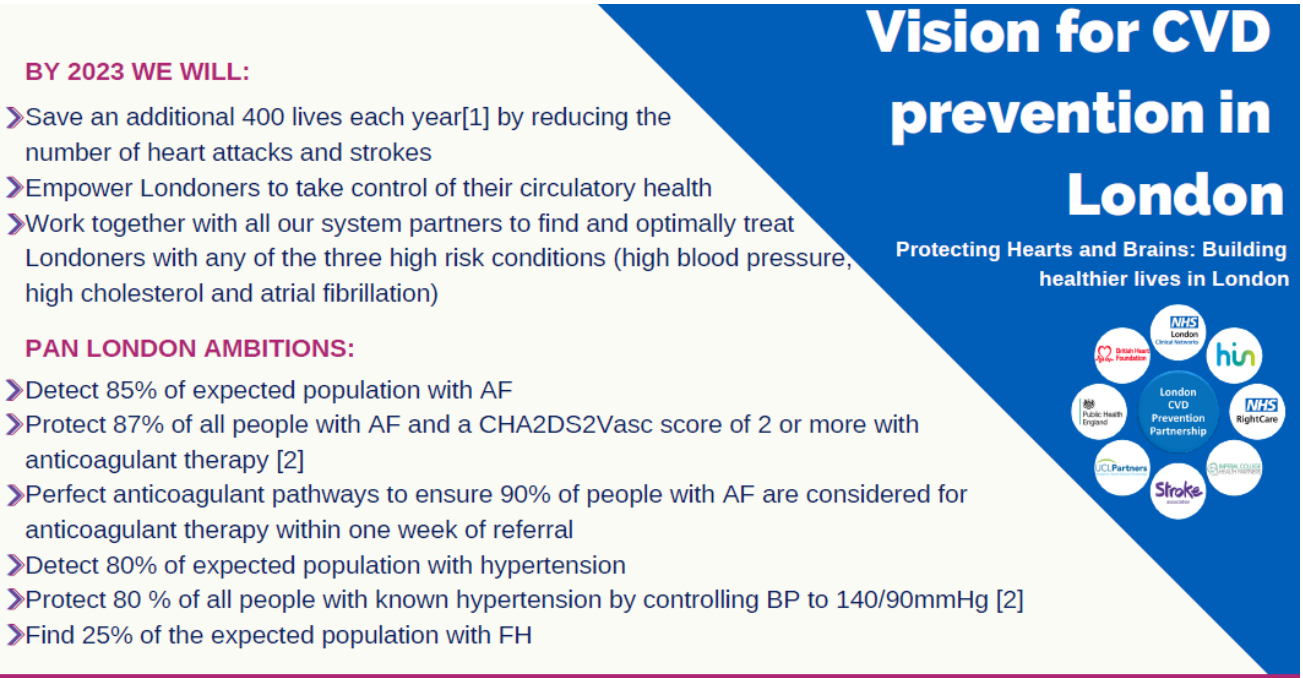
- Enfield commissioned a service to focus on identification and improved management of atrial fibrillation (AF), and has seen the biggest improvement in NCL in both diagnosis and management the condition. Anticoagulation rates for high risk patients with AF increased from 74% to 78%.
- Barnet community pharmacists are implementing a new service targeting Black, Asian and Minority Ethnic (BAME) groups, smokers and people over 55 to undertake opportunistic screening for hypertension.
- Camden general practices are developing new services to improve consistency of identification and proactive management of long term conditions, including CVD. One of the key successes is setting neighbourhood targets for groups of general practices which has led to an increase in anticoagulation rates in their areas and led to a reduction in variation in care between practices.

There has been strong progress to date on atrial fibrillation management.

- There are borough specific plans with local partners to increase anticoagulation rates, and work is in place to work with clinical leads and local trainees/registrars to support audits to gather information on AF best practice and lessons learned, to be collated and evaluated. There are activities in place to support learning across NCL, including an NCL consensus statement, a community of practice and regular STP workshops to encourage cross borough learning, and a template is in development for an AF NCL locally commissioned service agreement.
- We are embedding digital tools in primary care, such as the Clinical Effectiveness Group (CEG) Advanced Practice Link (APL)-AF tool to enable a search for patients with CHA2DS2-VASc2[3] or more who are not anticoagulated, an NCL AF optimisation dashboard to monitor progress of AF initiatives over time, and working with the HealtheIntent team to develop the AF registry.
- NCL has received funding from NHS England to implement the AF virtual clinic model. The funding covers the cost of clinicians providing the service and clinics with GPs and a contribution towards the additional drug costs. The clinics utilise specialist clinical staff (usually an anticoagulation specialist pharmacist) to facilitate a clinical discussion with GPs of all patients who have been diagnosed with AF who are not currently receiving optimal treatment. All five CCGs are being supported to deliver the programme, due to end in March 2020, including developing local clinical pathways, communication plans, identifying specialist pharmacist support from secondary care teams[4].
- Practice Based Pharmacists (PBP) training to upskill local PBP to support GPs to increase anticoagulation for patients on the AF register. CCGs are also offer training to other healthcare professionals e.g. practice nurses. There has been successful delivery of the ABC Cardiovascular training for 24 PBP from across NCL, with further training planned. Further training on the "Initiation and monitoring of DOAC[5]" will also be rolled out for prescribers in October 2019.

NCL work is aligned to, and supporting, delivery of the London vision for CVD prevention. Recently the London CVD Prevention partnership has set the London Vision for CVD in line with the Long Term Plan as shown in the figure below:

[3] Risk stratification tool
[4] including Whittington Hospital, UCLH, Kings College and Barts Health
[5] Direct Oral Anticoagulation



Collectively as an STP over the next two years the CVD steering group has decided to focus on AF Detection and Hypertension Management. This would mean finding nearly 5,000 patients across NCL with undiagnosed atrial fibrillation and starting or improving treatment for nearly 31,000 people with hypertension. A delivery plan for achieving these ambitious targets is currently being developed at a pan NCL CVD workshop on 1st October where partners will identify borough level actions and NCL wide projects. Our partners in NHS RightCare are supporting the development of this delivery plan. In addition, we will continue to monitor and support the AF management programme initiated last year.

Some of the key initiatives that will be reviewed as part of the next phase of delivery include:
a) AF Detection

- Review the cost-effectiveness of the current commissioning levers for GPs via CCG locally commissioned services (LCSs)
- Revise the current use of mobile devices in primary care to aide AF diagnostics
- Assess the feasibility and cost-effectiveness of setting up case finding initiatives in community pharmacies
- Review the usefulness and model the potential return on investment of setting up opportunistic pulse checks on admission in the NCL hospitals

b) AF management:

- Review the financial feasibility of continuing to commission virtual clinics for AF anticoagulation in NCL using current and alternative models of delivery
- Evaluate the current models of AF management via QIST, assess their cost-effectiveness and review alternative options for delivery

c) Hypertension (HTN) management:

- Review the cost-effectiveness of CCG LCSs and QIST initiatives based in primary care

- Review the practicability and potential ROI of self-monitoring supported in primary care
- Assess the feasibility of setting up Virtual Clinics with specialist advice for the GPs
- Revise the current use of New Medicine Service in NCL's community pharmacies to support HTN management and the potential to build on the work

Support for people with heart failure and heart valve disease

A pan-London heart failure diagnostic pathway has been developed to support earlier detection of heart failure and valve disease in primary care. Part of this relies on greater access to echocardiography in primary care – an audit will be undertaken to ensure appropriate access and usage in clinical settings. Work is also underway to standardise lab results across London to reduce variation and misinterpretation of results, leading to misdiagnosis of heart failure.

Across NCL, there is good access to NT-proBNP test – the recommended test in NICE guidelines. However, it is expected that there is a high level of undiagnosed heart failure in NCL. In addition to the work across London, NCL will look review access to heart failure nurses and support to PCNs.

Cardiac rehabilitation

Cardiac rehabilitation results in improved exercise capacity and improved quality of life for patients that successfully complete a programme. The London Cardiac Clinical Network will be supporting services to map current services against the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) and National Audit of Cardiac Rehabilitation (NACR) national standards to identify service improvement opportunities. Within NCL, we will review capacity and commissioning to understand where there are opportunities to reduce variation in access and uptake of services and share best practice between services where they are already meeting all the standards.

Stroke care

In London there is a well-established Stroke Clinical Network, hosted by NHS England, which has worked with CCGs to ensure continuation of the London model. It is recognised that there are improvements to be made across the stroke pathway in London, but with an ongoing emphasis in unity across stroke services. There will continue to be a pan London approach, which will take on the Long Term Plan concept of an Integrated Stroke Delivery Network (ISDN), led by the Stroke Clinical Network and ratified by the London Cardiac an Stroke Transformation Board, where STPs are represented.

NCL hosts one of four thrombectomy units in London, at the National Hospital of Neurology and Neurosurgery and UCLH. The London Stroke Clinical Network is monitoring performance of all London thrombectomy units.

The timeliness of thrombolysis can prevent more severe complications and disability from stroke. NCL performs above the national average for patients thrombolysed within 1 hour. However, there is some variation across NCL in ensuring that all eligible patients receive thrombolysis.

Stroke rehabilitation supports patients to have improved outcomes and can reduce hospital admissions and the need for ongoing healthcare. There is more to do to ensure that best practice is in place to ensure timely access to services, including for vocational rehabilitation to help appropriate stroke survivors return to employment or gainful occupation, where possible.

Respiratory

The Long Term Plan sets an ambition to improve the diagnosis and treatment of people living with respiratory conditions. For example, breathlessness is thought to affect up to 10% of the adult population in the UK, increasing to 30% of older adults[6]. Approximately two thirds of cases of breathlessness in adults are due to a pulmonary or cardiac disorder. 5.4 million people are estimated to be living with asthma in the UK – 1.1 million children and 4.3 million adults[7]. And 1.2 million people are living with a diagnosis of COPD in the UK with 115,000 people receiving a new diagnosis each year[8]. Over two million people in the UK are estimated to be undiagnosed and so receive no treatment

We know there are opportunities to improve diagnosis and care for people with these conditions across NCL. For example, across NCL there are 18,273 people on the COPD register, but an estimated 47,598 people with COPD. And there are opportunities to strengthen our care for these patients, for example by increasing the number of people referred for pulmonary rehabilitation and uptake of seasonal flu vaccinations for at risk patients and those aged 65 and over. Smoking prevalence in this group is unacceptably high (typically 40% of patients admitted to hospital are still smoking).

Tackling this priority in NCL is linked to our work on planned care (redesign of clinical pathways and outpatient redesign), prevention and care closer to home. Our work on services for children and young people sets out what we have already achieved on, for example, improving asthma care for children.

NCL is working as part of the London Respiratory Clinical Networks, which has launched a London Respiratory Programmes in April / May 2019 to oversee the commitments in the Long Term Plan. The programme has four key priorities:

1. **Accurate and timely diagnosis** – ensure more patients have access to quality assured diagnostic services, including spirometry testing, so that respiratory problems are diagnosed earlier and more accurately to improve outcomes for patients.
2. **Medicines optimisation** – ensure patients with respiratory disease receive and use the right medication, including educating patients on the correct use of inhalers, and improve provision of stop smoking support and uptake of the 'flu vaccine
3. **Rehabilitation** – expand pulmonary rehabilitation services so that more patients have access to them and have the support they need to best self-manage their condition and live as independently as possible
4. **Treatment** – improve the treatment and care of people with pneumonia and pulmonary embolisms aiming to strengthen ambulatory pathways for these conditions.

[6] Baxter 2017; Hopkinson and Baxter 2017
[7] Asthma UK
[8] British Lung Foundation

NCL clinicians are contributing to the London Respiratory Clinical Networks, and we are establishing a new programme of work to deliver the commitments in NCL. This is aligned with our programmes of work on planned care (outpatient transformation and clinical pathway redesign) and the development of Primary Care Networks (PCNs), as well as wider work on prevention, particularly on smoking.

There are examples of good practice across NCL, and the programme of work will look to build on this good practice to reduce variation.

Virtual respiratory case review meetings have been established in Islington since June 2018. These sessions bring together respiratory consultants with GPs, practice nurses and pharmacists to review patient records and optimise the care of adults with long-term respiratory conditions such as COPD and chronic asthma. Proactive searches of patients considered to be of rising risk are run on each practice's COPD or asthma register. So far, this has enabled over 500 respiratory patient records to be reviewed and has identified significant opportunities to correct misdiagnoses and improve management of patients. In addition to improve care plans for patients, there are wider benefits for patients not having to attend unnecessary hospital appointments and knock on benefits in providing upskilling of the primary care team and a chance to strengthen relationships with integrated respiratory services. The project has confirmed the need to improve the quality of diagnostic services, improve accessibility of pulmonary rehab and the need to enhance provision of stop smoking support to these patients.

There is strong evidence from the Camden integrated respiratory service that having a dedicated stop smoking specialist within long term conditions teams significantly improves quit rates and widening access of all patients in NCL to equivalent quality of support is an important aim.

Our priorities in establishing this programme of work will be to review existing best practice across NCL and review initiatives that could improve outcomes and reduce variation in experience for patients with COPD and asthma as part of the next phase of delivery. This will include:

1) Early and accurate diagnosis:

Case finding in the community and in secondary care with subsequent quality-assured diagnostic spirometry. This could include integrated diagnostic hub and spoke models in practices or PCNs and virtual registry reviews with specialist support. This requires an accredited workforce, trained to make an accurate diagnosis of respiratory symptoms. It could also include the development of breathlessness pathways through community integrated diagnostic services

2) Optimal management of airways disease (COPD and asthma):

- Registry reviews/ use of tools such as GRASP-COPD / primary care dashboards to identify patients who may be misdiagnosed or require management and medicine optimisation
- Maximise opportunities for self-management through ensuring timely access to pulmonary rehab and through strategies to improve the quality of annual reviews in primary care. Digital tools may have a role to support self-management in some patients. Offer alternatives to pulmonary rehab such as group consultations, dance/ singing therapy for those not suitable for pulmonary rehabilitation.
- Support development of stop smoking services to meet the needs of this patient group

- Increase uptake of ‘Flu and pneumonia vaccinations

Diabetes

A range of work is happening across NCL to prevent diabetes, improve outcomes and quality of life for people living with diabetes, and to prevent avoidable adverse consequences and complications. The NCL Diabetes Transformation Group was established in 2017 and is overseeing a number of programmes and initiatives focused on transforming diabetes care to improve patients’ experience of care, improve outcomes and prevent avoidable ill health and demand on the health and care system. The three main areas are:

- delivery of programmes of work supported by National Diabetes Transformation Funding (improving diabetes NICE-recommended treatment targets, diabetes inpatient specialist nurses, and multidisciplinary foot teams), following award of funding in 2017
- maintaining an overview of implementation and delivery of the National Diabetes Prevention Programme (DPP)
- work occurring in NCL to address uptake of structured education programmes and psychological support for people with diabetes

The Board and its work programme bring together local DPP leads, Public Health, CCGs, clinicians from secondary and primary care, Diabetes UK and representatives from the London diabetes clinical network.

Diabetes Treatment and Care Targets

The National Diabetes Transformation Funding supports programmes of work that cover three areas of diabetes care across NCL:

Three treatment targets

This area is concerned with improving NCL’s achievement of NICE recommended three treatment targets (3TTs) for diabetes (blood pressure, cholesterol and HbA1c). These treatment targets are recognised evidence-based measures of whether patients with diabetes are being supported to successfully manage their condition. Improved achievement of the 3TTs overall, as well as tackling unwarranted variation in achievement, will lead to improved outcomes for those with diabetes and reduce diabetes-related health inequalities.

Local GP Federations are leading borough level projects that focus on improved achievement of 3TTs for type 2 diabetes patients. The 5 boroughs are working collaboratively, however each has adopted different approaches that best complement and support their established pathways strengths, gaps, resources and processes. Each borough has established a Diabetes Quality Improvement Support Team (D-QIST) to support their work using quality improvement methodologies and drawing on a mix of skills, e.g. GP, nurse, pharmacist and analyst. They identify knowledge and skills gaps in existing primary care teams, deliver training, provide hands-on support to GP practices and give specialist diabetes advice.

The projects have delivered a range of interventions:

Islington	- Practice based pharmacist working to improve performance, with a particular focus on the poorly controlled diabetic patient cohort. Patients have an initial face to face review in the host practice and follow up with a telephone consultation

	- Practice level process mapping to identify areas requiring improvement - Supporting the introduction of group consultations for the target cohort with a view to assess impact on patient experience and outcomes
Barnet	- Holding evening and weekend virtual clinics led by GPs with a Special Interest (GPwSI) in diabetes. The clinics provide advice and guidance to the referring clinician, referral to a face-to-face appointment with a Diabetes Specialist Nurse (DSN) or dietician, and onward referral to secondary care / community service, if necessary. - Delivering primary care education sessions - Working with practices to increase attendance at diabetes annual reviews, review processes and introduce new data recording systems
Camden	- Quality improvement support work in GP practices complementing its established multi-trust Integrated Practice Unit (IPU).
Enfield	- Incentivisation of 3TT achievement via a local incentive scheme (LIS) - Diabetes education session for primary care clinicians - Clinician led quality improvement sessions - Undertaking a deep dive of practices who have demonstrated the greatest improvements and sharing best practice and learning across the borough
Haringey	- Diabetes specialist nurse reviews of poorly controlled patients in primary care - Applying motivational interviewing counselling approach to diabetes treatment and support - Diabetes training/upskilling programme targeting nurses and HCAs, lead practitioners and GPs. Material and delivery tailored to different professional groups' needs - Supporting PCNs to identify areas that require action within practices and devising improvement action plans for those practices. - Incentivising practices to support newly diagnosed patients with extended review appointments

The D-QISTs in all five CCGs are using local data and analysis to target this work to key priority population groups or geographical areas. Local Joint Strategic Needs Assessments (JSNAs), and equity profiles have supported the development of an equity audit approach for the NCL DPP. Learning from this DPP equity audit approach will also support and be embedded in the D-QIST projects to systematically understand and address diabetes related health inequalities going forwards. To date, each borough has demonstrated local improvements in 3TT achievement. GP Federations and CCGs are currently discussing the future sustainability of this work stream and these various projects, ensuring best practice is disseminated and that the most effective elements from each project is continued when the national funding ends in March 2020.

Multidisciplinary Foot Team (MDFT)

The programme has established an acute ambulatory foot service (AAFS) based at the Royal Free. The service acts as a single point of contact for all people with acute diabetic foot conditions in NCL and provides:

- Assessment, treatment and triage of patients to the correct team for ongoing care as an inpatient, outpatient, at another hospital or community clinic
- Ensures urgent, direct admission to the Royal Free MDFT when necessary.

- Collaboration with A&E to reduce wait times for assessment and treatment, and ensure the correct ongoing care

The programme aims to improve A&E waiting times for diabetic foot related attendances, reduce length of stay for diabetic foot related admissions and reduce numbers of major and minor amputations. After one year, the service has treated 660 patients across NCL.

Service outcome and wider system benefits are currently being reviewed with the ambition to be able to continue to commission the service across NCL when the national transformation funding ceases.

Diabetes Inpatient Specialist Nurses (DISN)

Led by the Royal Free, the DISN project involves the recruitment and training of additional DISNs across NCL trusts. Prior to the transformation programme of work, DISN services in NCL existed across the four acute providers; however, National Diabetes Inpatient Audit (NaDIA) data indicated that demand had outstripped supply for each acute provider site. The additional capacity of DISN support in acute trusts aims to reduce the number of diabetes inpatients experiencing medication errors and hypoglycaemic events and improve systems and processes for management of inpatients with diabetes.

Sixteen percent of people occupying all hospital beds have diabetes. The DISNs work proactively to ensure best practice in the management and care of people with diabetes in hospital. They have four broad areas of work: direct care interventions (e.g., monitoring blood glucose), as a conduit for implementing specific interventions (e.g. ensuring hospital compliance with evidence based pathways, improving staff competence in diabetes management), managing the patient journey (e.g. increasing patient self-management and facilitating early discharge), and acting as designer or improver of the system (e.g. introducing new processes, monitoring compliance with evidence based protocols).

London South Bank & Birmingham City University completed a review of the 7 DISNs working in NCL in July 2019. At the time of the research all DISNs were in post for less than six months, new to this area of work and undertaking a period of induction and training. Nevertheless, the research provided encouraging and valuable information on the effectiveness of the role and recommendations for development of the DISN role in NCL. Length of stay reduced by 27% and there was a significant correlation between DISN recruitment and reduced rates of emergency readmissions over 30 days post discharge.

Outcomes data from the DISN project over a longer time period will be analysed and used to support individual NCL trust business cases to ensure continuation of the additional DISN posts when the transformation funding has ended.

Diabetes treatment and care outcomes

The NCL diabetes transformation programme will continue to collectively consider findings from current work streams, reflect on learning and drive improvements in practice. There are examples of innovative ideas, originating from STPs across the country, which NCL can use to generate change locally to improve patient outcomes. This work is strengthened by the creation of an NCL Diabetes Transformation Project Officer post, who meets with counterparts in other London STPs to share learning. The programme will continue to support and encourage partners across the system to participate in various national audits.

Figure1: Adult population size- NCL CCGs

		Total Male population	Total Female population	Type 2 Diabetes prevalence (%) Recorded[3]	Type 2 Diabetes prevalence (%) Estimated[4]	Numbers identified as eligible for NDPP [5]
Barnet CCG	18 - 44	85,199	89,375	6.2%	8.7%	35,771
	45 - 64	48,428	48,928			
	65+	25,580	32,348			
Camden CCG	18 - 44	58,682	62,762	4.0%	6.7%	18,217
	45 - 64	25,819	26,644			
	65+	16,832	13,635			
Enfield CCG[1]	18 - 44	62,861	67,373	7.7%	9.5%	29,270
	45 - 64	41,200	41,475			
	65+	19,439	24,123			
Haringey CCG[2]	18 - 44	69,495	62,752	6.2%	9.5%	25,045
	45 - 64	30,720	31,895			
	65+	12,042	15,148			
Islington CCG[2]	18 - 44	62,370	66,659	5.0%	7.7%	17,443
	45 - 64	22,755	23,173			
	65+	11,525	9,640			

Source: 1 NHS Digital April 2018; 2 ONS Mid-year population estimates 2017,GLA Population Projections (2016 round) for 2018; 3 QOF 16/17; 4 PHE Diabetes Profiles 2017; 5 Modelled figure using PHE prevalence estimate and GLA population.

Provision of emotional and psychological support through diabetes care

Living with diabetes can take an emotional and psychological toll and there are a range of support offers open to NCL residents to help them manage this aspect of their condition. Currently the offers vary depending on the CCG area of residence. A piece of work will be undertaken to map these offers and ensure equity in opportunity to access for all NCL residents.

The support on offer includes: CBT for people with a long-term condition where clinicians have additional training in diabetes and liaison with allied health professionals is encouraged; clinical psychologists embedded within diabetes services; group consultations providing the opportunity for people to share their fears and day-to-day struggles; courses run by experts by experience that explore the emotional and psychological aspects of living with a long-term condition and the connection between physical and mental wellbeing; 1-1 peer coaching for people where their diabetes is impacting on their mental health; and, a range of structured education programmes which have a psychological component that help patients with coping strategies.

Personalised care

The primary care network (PCN) directed enhanced service (DES) will support the delivery of a comprehensive model of personalised care for patients across NCL. Elements of personalised care are already well established in each of the NCL boroughs; shared learning from local areas will facilitate the development of an inclusive personalised care model. For

example, a collaborative care and support planning approach is currently embedded in Islington general practice to support holistic person-centred care planning for patients with long-term conditions; this work is currently supported locally by the long-term conditions locally commissioned service (LTC LCS).

Diabetes Structured Education

We are keen to develop a more coherent, flexible and accessible structured education offer in NCL, subject to capacity and resources, and learning from successful approaches being implemented elsewhere in London and nationally. Within this, we will explore the potential for more digital support for patients, as part of a wider menu tailored to the diverse needs of our residents and communities. NCL is committed to supporting the effective roll out of the HeLP diabetes patient platform, and can draw on local experience of having used a version of this resource previously.

Across all areas of diabetes work, the importance of patient voice and patient co-design of services, at both the local and STP levels of diabetes work in our system is recognised. There are local examples of current patient co-design of structured education programmes which will inform the improvement and development of future services.

Type 2 Diabetes Prevention

National Diabetes Prevention Programme

The NHS National Diabetes Prevention Programme (NDPP) was delivered through two separate waves in NCL – Camden, Islington and Haringey in wave 1, and Barnet and Enfield in wave 2. The new NDPP2 covered the whole of the NCL population of around 1.1m adults, delivered by a single provider ICS Health and Wellbeing with Oviva as their digital partner. The programme delivers behavioural intervention to patients who are referred into the NDPP as a result of being identified as at risk of developing diabetes. A diagnosis of Non-Diabetic Hyperglycaemia (HbA1c of 42-47mmol/mol within the last 12 months) can generate an eligible referral. Significant improvements have been made for the new programme including:

- NDPP2 includes a **digital component** for those ineligible for face to face this is expected to increase access particularly for working age adults
- A more **comprehensive behaviour change programme** to be delivered by ICS as part of NDPP2
    - ICS Health & Wellbeing have developed Healthy Futures, the group-based face-to-face service. Healthy Futures is an enhanced service from NDPP learnings across 21 contracts.
    - Healthy Futures exceeds specification's minimum requirements, providing 25 hours' face-to-face delivery over 14 sessions (excluding separate one-to-one IA). Healthy Futures has been designed with content based on: eating well, moving more and taking charge

The NCL partnership is required to deliver sufficient referrals to ensure 14,829 patients receive the behaviour change intervention delivered by NDPP2 over 3 years (assuming around 40% conversion from referral to intervention we would need 37,072 referrals). NCL has committed to developing local plans to increase equity of access to the programme. An equity audit approach will be undertaken to identify local areas of need and how best to

increase engagement with key population groups, in particular peoples from BAME communities and areas of high deprivation.

NCL's DPP has in place clear referrals pathways, including from NHS health checks, primary care and from other providers. A new referral form is in place on GP systems to facilitate referrals. Some funding may be made available to support mobilisation; options being considered are STP facilitators to work with primary care to identify referrals, text reminders for patients, incentives for GPs, marketing targeting hard to reach communities.

Weight management

Current weight management pathways and provision are being reviewed as part of the STP's prevention work stream, to identify gaps and priorities for potential future investment. Current tier two weight management and exercise on referral provision across NCL is variable.

In April 2020, NCL will launch a low calorie diet initiative for NCL patients with Type 2 diabetes. The initiative will help people achieve significant weight loss through the use of total diet replacement (TDR) products for 12 weeks, along with a 12 month behaviour change support package. The aim is to enable rapid initial weight loss followed by reintroduction of real food, with the overall goal of sustained weight loss and improved nutrition. Funding for the service has been secured from the NHS England diabetes team for 2.5 years.

Diabetes technology – glucose monitoring

An NCL-wide policy has been developed to support the implementation of flash glucose monitoring in clinical practice for eligible type 2 diabetes patients. There is also an ambition to work with local trusts and NCL medicines management teams to review the NCL policy for provision of continuous glucose monitoring (CGM) for pregnant women with type 1 diabetes.

Networked specialist care to improve outcomes and save lives

We know that when people do fall ill and need specialist treatment this is best done when partners work together to provide this. This means people get the lifesaving treatment they need at a specialist centre and are supported to go home as soon as it is safe through rehabilitation and coordinated community care. This is a well-established model for stroke, where a network approach improves outcomes.

We want to continue to collectively work together to improve how our hospitals work together in networks to improve outcomes and experience for our residents. An example of this, is the current review of Adult Elective Orthopaedic Services across NCL that is underway with the view to designing a new consolidated service in partnership with patients, public and clinicians that delivers world class elective orthopaedic services, reduce unwarranted variation and achieve the best outcomes for patients when they do need specialist hospital input.

Working with Specialised Commissioning to join up pathways for long term conditions

We will work closely with the NHS London region to ensure the planning and transformation of specialised services is joined up for patients who may need specialist care with those locally commissioned. The areas we are interested in working closely on as priorities are:

- Cardiovascular disease
- Renal disease
- Mental Health (please see more information in section 8 on improved mental health services)
- Cancer (please see section 7 on improved cancer services)