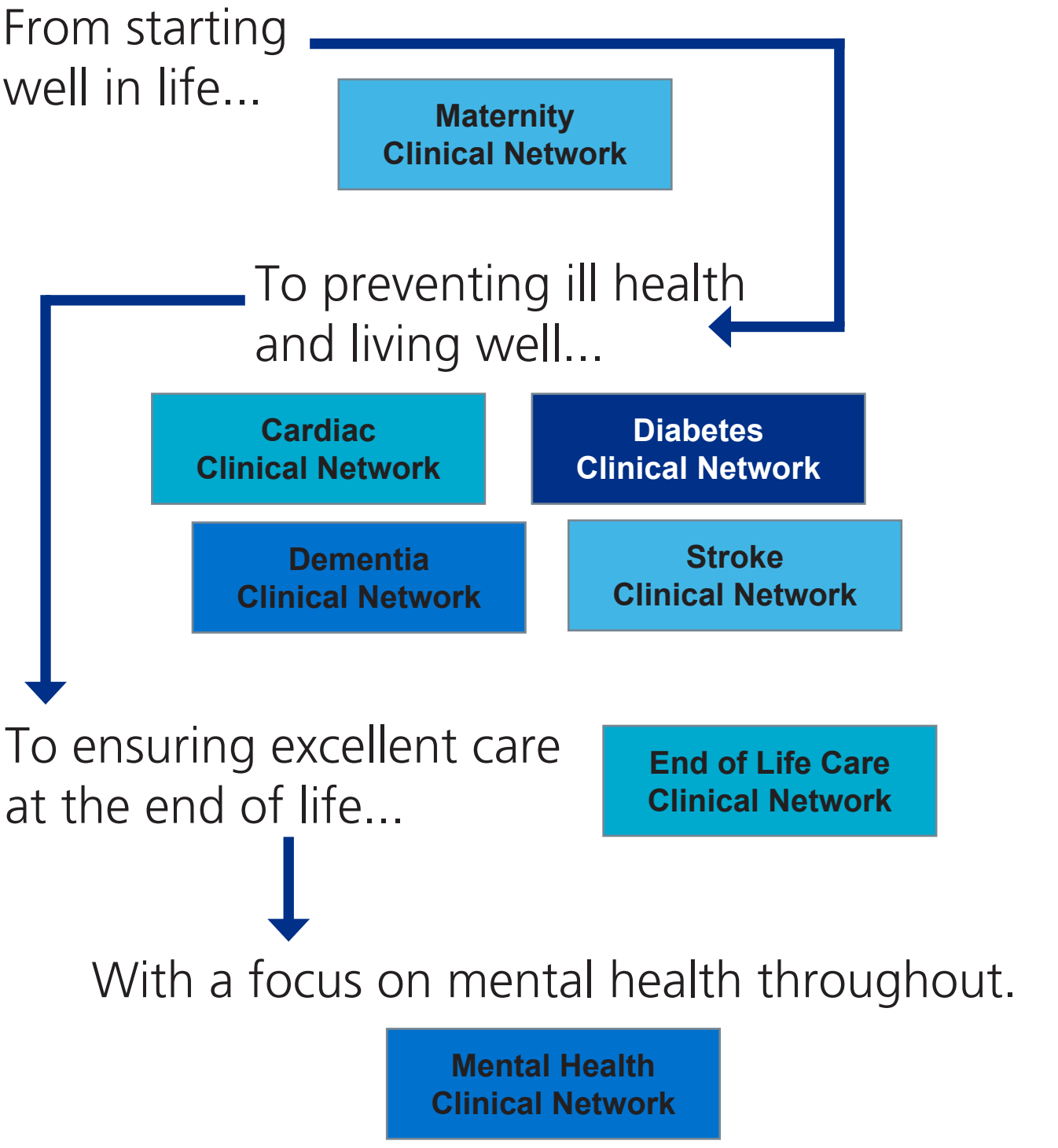
NHS
London
Clinical Networks

London Clinical Networks In focus | 2017/18

About the London Clinical Networks

The London Clinical Networks join together clinical experts, patients and other partners across the capital to improve population health outcomes for Londoners.



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Foreword | Vin Diwakar, Regional Medical Director Malti Varshney, Associate Director, London Clinical Networks

The London Clinical Networks have again proven themselves as a key element towards achieving improvements in the way we provide health and care services in the future.

The networks have made good progress towards achieving our ambitions in 2017/18, but there is still more to be done. Fundamentally, patients need to experience services which are integrated across health and care organisations.

The publication of *Next Steps on the NHS Five Year Forward View* in March 2017 provided us a stocktake of the past three year's achievements, but more importantly, provided us with the details on what we needed to do – and how it would be implemented. This focus on delivery of key priorities ensures that everyone in the NHS is working closely together towards the same goals.

The Clinical Network core team has worked steadily to strengthen relationships across the broad range of partners and service users that they serve. Patients have always been at the heart of the NHS, and the London Clinical Networks ensure that this is core to their work portfolio. They have sought to uncover new opportunities and links across services, organisations and people in London and beyond, both within and external to the NHS. They have made substantial inroads with London sustainability and transformation partnerships (STPs) and clinical commissioning groups (CCGs), and are there to provide clinical leadership and secure clinical engagement in delivering sustainable improvements in outcomes which matter to patients and taxpayers.

The Clinical Networks' work programme has been ambitious yet achievable. The development and continuation of the transformation programmes in mental health, diabetes, and maternity, paired with the broad focus across cardiac, stroke, dementia and end of life care, has resulted in some major wins for the system and, more importantly, the London population. With an eye to the future, the clinical networks are shifting their approach from defining standards and developing guidance to walking alongside frontline staff and leaders, helping them to improve their services, using the NHS Large Scale Change framework as the model of change.

We are delighted to introduce this annual report of the Networks' strong performance, and are confident that the London health and care system will continue to benefit through their continued focus on patients in 2018/19 and beyond. We hope you enjoy reading about the achievements the London Clinical Networks have made over the last 12 months.

Summary

This 2017/18 annual report provides a selection of key achievements by each of the seven London Clinical Networks.

Our networks have built -- and continue to build -- strong relationships and robust partnerships across patients, the public, and every setting of care. These connections are inherent to the way networks function. They unlock opportunities, break barriers and pave the way towards improving health and care at pace and scale for all residents of the capital and beyond.

Through our work...

Maternity

100 *100% of London providers are now carrying out activities to meet all 4 elements of the Maternity Care Bundle:*

- Smoking
- Fetal growth restriction
- Raising awareness
- Fetal monitoring

See page 6

Dementia

London has a dementia diagnosis rate of 70.4% (above the 66.7% national ambition)

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Diabetes

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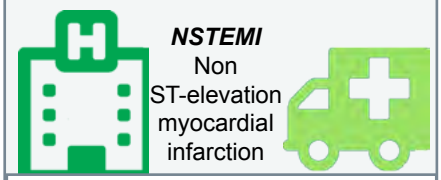
Cardiac

Heart attack centres provide high risk NSTEMI patients with 24/7 access to specialist care



NSTEMI Non ST-elevation myocardial infarction

See page 12

Stroke

Anticoagulation rates across London CCGs have steadily increased

66% to 82% 2015/16 → 69% to 84% 2016/17

See page 14

End of Life Care

All five London STPs now have specific end of life care plans

See page 16

Mental Health

Mental health dashboard use has increased

Users	200	950
Metrics	100	150
Data items	11,000	40,000

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Maternity Clinical Network

The Maternity Clinical Network brings together the voice of the clinical community in London to secure service improvement.

Our work will improve the safety, quality and experience of maternity care for women.

The national maternity review, *Better Births*, outlined the need for maternity services to improve the outcomes for women and their babies by providing safer care and offering greater choice and personalisation. Strong relationships established by the network enabled the climate of transformation to flourish, thus accelerating the development of Local Maternity Systems (LMSs) and their ability to create their own structures for this work.

We continue to work across London to benefit maternity care, aligning our work to the priorities of the LMSs, creating pan London solutions and supporting them on local delivery.

Transformation through clinical expertise plus women's voice and experience

*Challeng*e: Women and their families are experts in their care. Clinical expertise is vital, too. Both enable maternity transformation.

What we did

Guided the development of 5 Local Maternity Systems; 4 of 5 at forefront of national work

Formed the London Maternity Partnership with the Regional Maternity Team

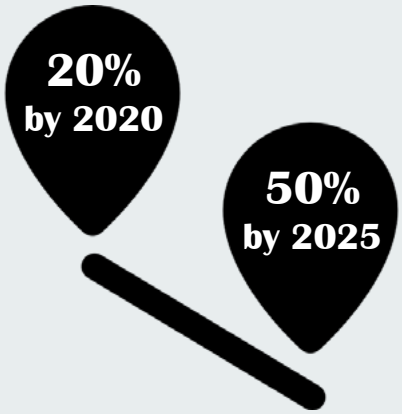
Provided clinical expertise to LMS plans; all ranked **exemplary** or **good** by the national team

Creating consistent metrics and identifying data sources to measure transformation progress

Impact: By bringing together all key partners, we now have strong foundations in place for improving services -- ensuring that women's voices are heard and acted upon, married with clinical expertise.

The ambition

Halve the rate of stillbirths, neonatal and maternal deaths, and brain injuries occurring at birth or soon after in England by 2025 with a 20% reduction by 2020, as set by the government.



Reducing maternal deaths

*Challeng*e: The quality of maternal death investigations was inconsistent across London, and not all learning from these tragic events was widely shared.

Solution: We developed a guide to ensure trusts adopted a consistent approach to investigation, and developed and maintained a database of external panellists to support trusts in meeting the standard to have external input. In 2016 there were 26 maternal deaths in London. The group reviewed all maternal death reports to identify themes and recommendations and disseminated the findings.

Impact: We are sharing the findings with all key stakeholders and are progressing an action plan to address pan London issues, in order to improve safety and care for mothers and their families.

Reducing stillbirths

Challenge: There is around a 25 per cent variation in the stillbirth rates across England[1].

Solution: We collate, analyse, and share the National Stillbirth Care Bundle for trusts across London, signposting to best practice and identifying key themes to be addressed at a pan London level.

Impact: Improvements in compliance with the care bundle should impact on the stillbirth rate.

100 *100% of London providers are now carrying out activities to meet all 4 elements of Care Bundle[2]:*

- Smoking
- Fetal growth restriction
- Raising awareness
- Fetal monitoring

63% of providers are carrying out CO testing for pregnant women and 89% are referring women to stop smoking services

37% of providers ensure that all staff who care for women in labour undertake an annual training and competency assessment on CTG/ intermittent auscultation

68% of providers supply women with information and leaflets on reduced fetal movement

68% of providers use customised growth charts for all pregnant women by clinicians who have gained competence in their use

Nationally validated measure to capture feedback when a baby dies

Challenge: Every day in the UK around 15 babies die before, during or soon after birth[3], which can have profound effects on the wellbeing of women and families. Seeking out feedback can be difficult following bereavement. However, this insight can drive improvements in care.

Solution: We developed and launched a Maternity Bereavement Experience Measure questionnaire and implementation resource to capture these experiences of childbearing loss during pregnancy or shortly after birth.

Impact: The questionnaire — the first nationally validated measure — and accompanying resource provide practical suggestions as to how to collect insight from all cultures, communities and ethnic groups to systematically understand how services can be improved. It is included in the National Bereavement Care Pathway, now in use in 32 trusts across England, with plans for wider roll out. We continue to ensure it is effectively promoted and used.

Embedding women's voices through Maternity Voices Partnerships

Challenge: Previous surveys by the Care Quality Commission have found that women's voices were not represented as strongly as they could be in maternity care and improvements.

Solution: Aligned with the recommendations in *Better Births* to establish Maternity Voices Partnerships (MVPs), we led a development day providing guidance, templates, expert insight and case studies of successful MVPs.

There are now 19 MVPs across London.

Impact: There are now 19 established MVPs across London, mostly aligned to hospital sites, and women's voices have an integral channel of communication into transformation, through the Maternity Transformation Board and Clinical Leadership Group.

Dementia Clinical Network

Timely diagnosis of dementia means that people can access support — as quickly as possible.

The Prime Minister's Challenge on Dementia 2020 set out more than 50 specific commitments that aim to make England the world leader in dementia care, research and awareness by 2020.

An important element of the challenge is that everyone with dementia receives high quality care from diagnosis through to end of life. In line with this, NHS England has set a national ambition that at least two-thirds of people predicted to have dementia receive a formal diagnosis. With a diagnosis, people with dementia can get the most appropriate, high quality support that they need – as quickly as possible.

Improving dementia diagnosis rates

*Challen*ge: Without a dementia diagnosis, people may not receive appropriate care and support to help them live well with the condition, leading to crisis and hospital admissions. Diagnosis rates vary across London CCGs from 60 to 92 per cent[4].

Solution: We provide support to all CCGs with diagnosis rates under 70 per cent, which includes bespoke expert clinical advice, meetings with relevant stakeholders, and action plan development with implementation support by the transformation team and clinical network.

Impact: This year, London has maintained a diagnosis rate of 70.4 per cent, higher than the 66.7 per cent ambition. Twenty-six of the 32 CCGs are above the national ambition, and all others continue to implement their tailored action plans to improve diagnosis rates locally.

Currently

67,000
people are living with dementia in London[5]

with an estimated annual cost of
£2.4 billion[6]

London has maintained a diagnosis rate of
70.4%
(above the national ambition)

Reducing inequalities

*Challen*ge: There is growing evidence that people from black and minority ethnic (BAME) groups access dementia diagnostic and treatment services less often or present later in the condition, which can make them prone to worse outcomes. Added to this, the prevalence of dementia in BAME groups is continuing to increase.

Solution: We reviewed whether referrals to memory services for various BAME groups were proportionate to the percentage of BAME groups in the community, and provided individual feedback to the 19 CCGs which participated in this investigation. London-wide results were anonymised and published in a research paper for Aging and Mental Health, *Parity of access to memory services in London for the BAME population: A cross sectional study*.

Impact: We worked with the Alzheimer's Society to host valuable learning and resources on its website. The information was accessed nearly 1,000 times in the first two months, indicative of its value.

Improve DIAGNOSIS RATES	*for prompt access to* POST DIAGNOSTIC SUPPORT	*to help people* LIVE BETTER WITH DEMENTIA

Streamlining memory service pathways

*Challeng*e: NHS England guidance states that people diagnosed with dementia should start treatment within six weeks of referral to a memory service. Our audit of those services found waiting times varied from 5 to 23 weeks.

Solution: We mapped memory service pathways from referral to diagnosis and published guidance on streamlining these pathways. Beyond that, we worked specifically with the 80 per cent of London memory services that required support for pathway redesign.

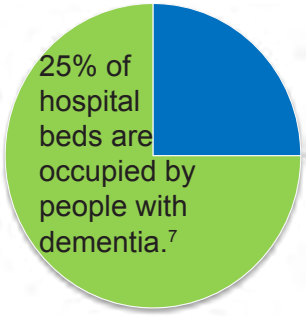
Impact: Memory services have put into place improvement projects such as new administrative processes, changed clinical supervision models and assessment of patients in clinics for better care of people with dementia. We are now working on a formalised ambition for the six-week pathway for London services.

Waiting times to treatment should occur within **6 weeks** of referral to a memory service. Our audit found a variance of

Hospital care for people with dementia

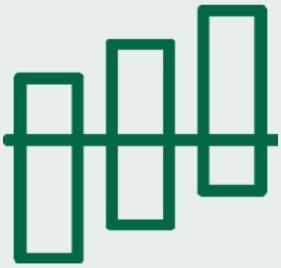
*Challeng*e: Poor care in hospital can have devastating, life changing consequences for someone with dementia. At least 25 per cent of hospital beds are occupied by people with dementia and, on average, people with dementia stay more than twice as long in hospital than other patients over 65 years old.

Solution: We completed peer reviews on nutrition and carer involvement in the first 48 hours of admission, led by directors of nursing across London. Anonymised findings were shared across London and presented at the national Nursing Leadership Forum.



Impact: By implementing new solutions, such as having volunteers in A&E, services will help to improve the care the people with dementia receive in hospital. We will continue this work in 2018/19, focussing on delayed discharges.

The ambition



All CCGs have a diagnosis rate above 70%

85% of people receive a diagnosis and initial treatment plan within 6 weeks of referral to a memory service

Everyone living with dementia has a **named care coordinator**

Everyone has a **care plan** from diagnosis through end of life

Start well	Prevent ill health	Live well	Good end of life

Diabetes Clinical Network

Measuring success

Challenge: Turning data into intelligence is key towards understanding population health needs and the direction of performance from improvement initiatives.

Solution: The National Diabetes Audit (NDA) of primary care and specialist diabetes services covers care processes, treatment targets, complications, and mortality. We closely review several datasets for local performance, including NDA participation, the CCG Improvement and Assurance Framework of metrics, and the national Diabetes Prevention Programme data.

Impact: Within London, 99.7 per cent of GP practices within all CCGs took part in the national diabetes audit.

Reducing inequalities

Challenge: There is wide variation in diabetes care, as well as poor recording and management of the NICE nine key care processes.

Solution: We worked with the Health Innovation Network (HIN) Academic Health Science Network (AHSN) and CCG contacts to create influential strategies that would attract funding to implement the national Treatment and Care (T&C) programme. London STP areas received £7.2 million of funding for 14 programmes across the five London STP areas to implement T&C and improve structured education; achievement of NICE targets; multidisciplinary foot care teams; and diabetes inpatient specialist nurses.

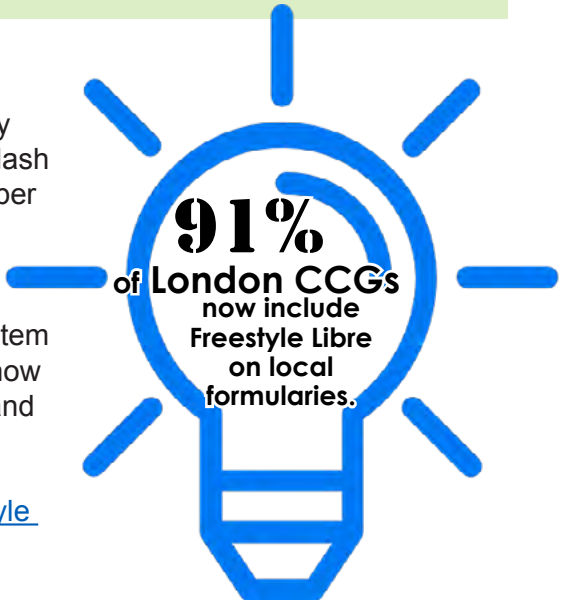
Impact: London, as a region, achieved the 40 per cent national T&C target for HbA1c, cholesterol and blood pressure checks[9].

Consistency in innovation

Challenge: Innovative technologies may benefit patient care, but may be inconsistently applied. One such example is the FreeStyle Libre flash glucose monitoring device, made available on the NHS from November 2017.

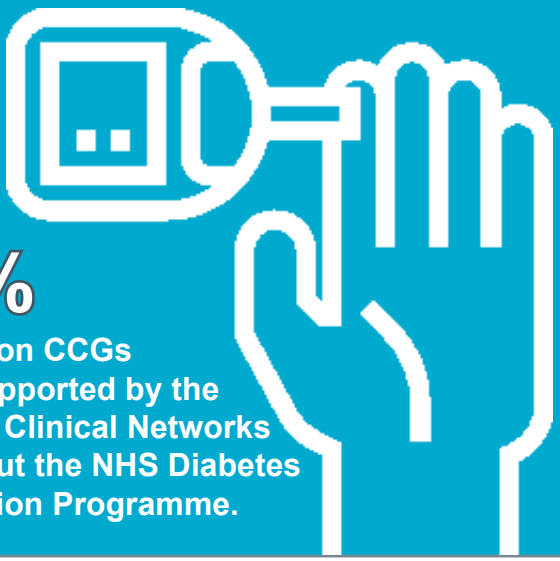
Solution: Our clinical experts developed guidance aimed at area prescribing committees for the implementation of Freestyle Libre system for people with type 1 diabetes. This guidance considers when and how to prescribe this new advancement, along with costing implications and predictive modelling.

Impact: 91 per cent of London CCGs have agreed to include FreeStyle Libre on local formularies, and the remaining CCGs are expected to receive formal sign off in summer 2018.



Working to prevent type 2 diabetes

Challenge: There are currently 3.4 million people with type 2 diabetes in England with around 200,000 new diagnoses every year. While type 1 diabetes cannot be prevented and is not linked to lifestyle, type 2 diabetes is largely preventable through lifestyle changes.



81%

of London CCGs were supported by the London Clinical Networks to roll out the NHS Diabetes Prevention Programme.

Solution: The NHS Diabetes Prevention Programme (NHS DPP) identifies those at high risk and refers them onto a behaviour change programme.

Impact: We worked to roll out the NHS Diabetes Prevention Programme, providing assistance to 81 per cent of London CCGs. We helped to support 26 CCGs to secure additional investment. Because of this work, 11, 508 people were enabled to receive an initial assessment of risk.

We provided assistance to **26** CCGs to secure additional investment beyond the initial national offer for diabetes prevention.

All 32 CCGs will be implementing the NHS Diabetes Prevention Programme from July 2018.

With our implementation support for the NHS Diabetes Prevention Programme,

11,508

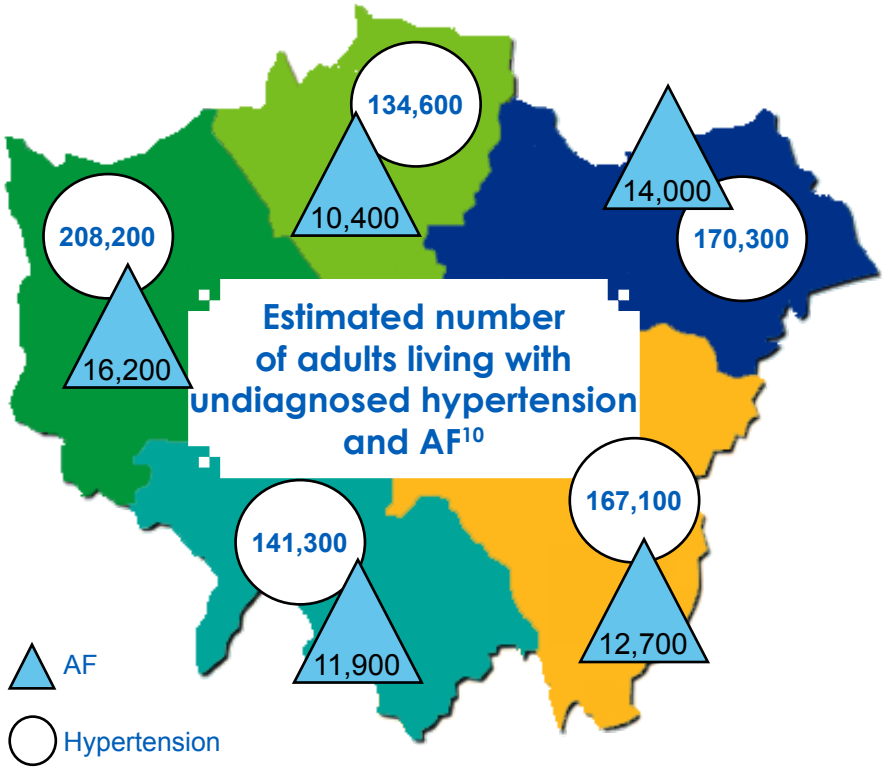
Londoners received an initial assessment of diabetes risk[8].

Cardiac Clinical Network

PREVENTION

CVD prevention across STPs

Challenge: Prevention of cardiovascular disease is a key priority in London. Yet many adults living with certain conditions remain undiagnosed. Without detection and medicine management, these conditions can increase the risk of having a stroke or heart attack, leading to higher mortality rates or greater disability.



Solution: We produced "Improving prevention and care of cardiovascular disease in Greater London", which gives CCGs recommendations to increase diagnosis rates and improve awareness through action plans and a coordinated London approach.

Impact: The outcomes will be worked on in the 2018/19 cardiac network plan, with an overall objective towards reducing cardiovascular mortality and morbidity in London. We will continue working with partners to improve detection, treatment and management of people with atrial fibrillation (AF), hypertension, and familial hypercholesterolaemia (FH) through an agreed pan London vision and work plan to improve CVD prevention.

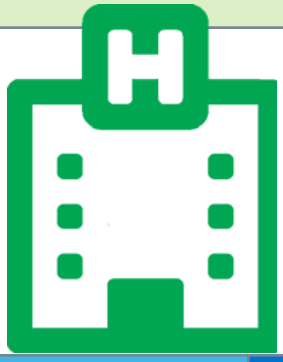
ACUTE CARE

Maintaining high quality cardiac emergency services in London

Challenge: People with acute coronary syndromes may have a poor prognosis without prompt and accurate diagnosis and treatment.

Solution: As per NICE guidance, adults with non ST-elevation myocardial infarction (NSTEMI) or unstable angina who are clinically unstable, should have coronary angiography (with follow on percutaneous coronary intervention [PCI] if indicated) as soon as possible, but within 24 hours of becoming clinically unstable. These patients should be managed at heart attack centres, as per the changed pathway, for 24/7 PCI access.

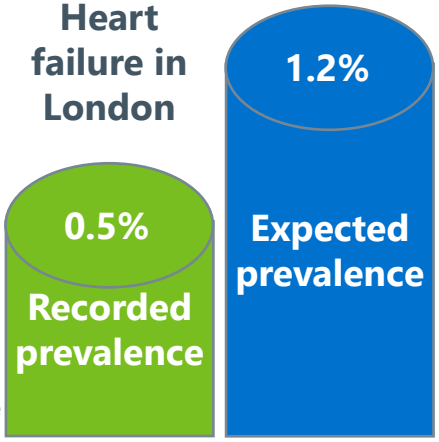
Impact: Recommendations were sent to all heart attack centres, the London Ambulance Service (LAS), and relevant sites, advising them of the change to the NSTEMI pathway. LAS have been trained to identify those who fulfill the high risk NSTEMI criteria.



Heart attack centres provide high risk NSTEMI patients with 24/7 access to specialist care.

LONG TERM CARE

Pan London heart failure pathway published

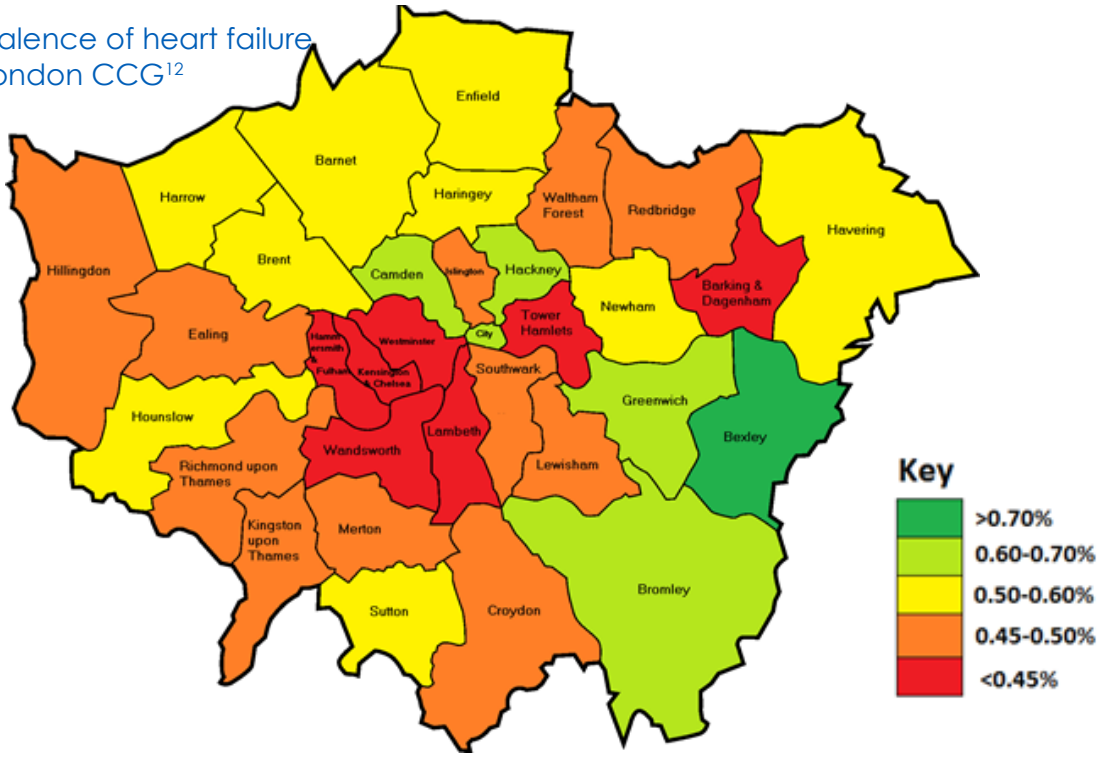


Challenge: Approximately 900,000 people in the United Kingdom have heart failure. Detection of heart failure in primary care is below the expected level. Recorded prevalence for heart failure in London is 0.5 per cent, though expected prevalence is 1.2 per cent and varies across London CCGs[11]. There are also variations in access to specialist care in the acute setting and effective follow up in the community, including cardiac rehabilitation and end of life care.

Solution: We published "Improving heart failure services for people in London", which highlights key areas for improvement across the heart failure pathway. Data from the National Heart Failure Audit was analysed at CCG level to understand gaps and set pan London priorities and recommendations. These focus on improving the diagnostic pathway, standardising the care received by a patient admitted to hospital and improving access to heart failure services in the community.

Impact: A London minimum data set has been agreed for heart failure which will monitor progress against the recommendations and will make up part of the London cardiac and stroke dashboard, which will be piloted in 2018/19. We will also agree a pan London diagnostic pathway and map out community heart failure services, as outlined in the recommendations.

Recorded prevalence of heart failure in 2015/16 by London CCG[12]



Heart failure[13]

900,000
people in the UK have heart failure

accounting for
2% of total NHS expenditure

Heart failure causes or complicates 5% of all hospital admissions.

Stroke Clinical Network

68,000 Londoners are living with undetected AF. Our work will help reduce future risk of stroke.

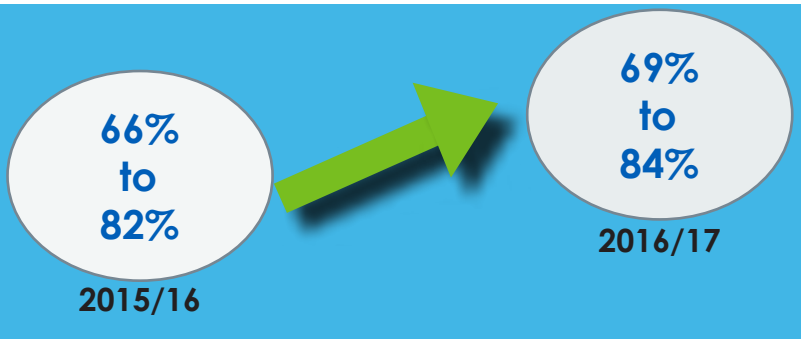
Development and launch of the atrial fibrillation toolkit

Challenge: An estimated 68,000 people in London are living with undetected atrial fibrillation (AF), and are at risk of blood clots, heart failure and other heart related complications beyond the risk of stroke[14]. Of those, approximately 2,000 people get admitted to hospital annually with a stroke due to AF in London[15]. More than half of these people, despite being known to have AF before their stroke, are not receiving anticoagulation of any sort.

Solution: Along with the London AHSNs (the Health Innovation Network, Imperial College Health Partners and UCLPartners) we produced the Atrial fibrillation toolkit for London. Divided into three domains (Detect, Protect and Perfect), it supports commissioners and providers working on AF improvement projects, through practical tools, local data presentations, and examples of innovative practice.

Impact: Through its use, commissioners and clinicians will reduce unwarranted variation in the management of atrial fibrillation and anticoagulation services will not only contribute in stroke prevention, but also contribute in reducing emergency hospital admissions.

Since our work began, the range for anticoagulation rates across London CCGs has steadily increased, indicating more people are receiving anticoagulation as appropriate[16].



Improving the quality of care across the stroke pathway

Challenge: Sentinel Stroke National Audit Programme (SSNAP) data highlighted variation in access to early supported discharge (ESD) and additional inpatient rehabilitation units (level 2b and 3).

Solution: All ESD and level 2b and 3 rehabilitation services in London were reviewed against pan London standards.

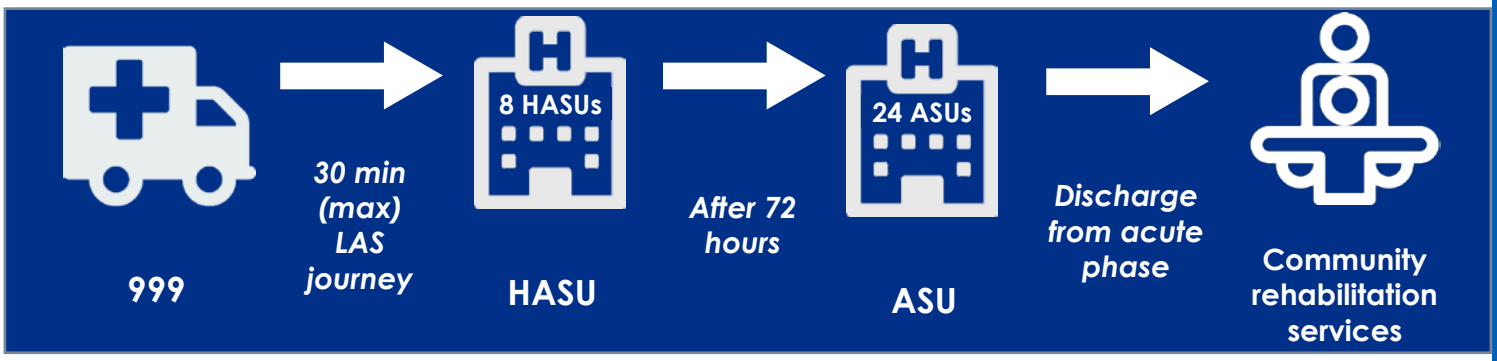
Impact: Commissioners were informed if a service did not meet the London standards and support was given to both the provider and the commissioner to improve the quality of care being delivered.

Maintaining our global exemplar of care: London stroke model

Challenge: The London stroke model has been held as a global exemplar for the high quality of care that it provides. Maintaining its success is vital to providing evidence based, innovative patient care in the capital.

Solution: We support regular peer reviews at all hyper acute stroke units (HASUs) and acute stroke units (ASUs) to ensure we continuously meet the high clinical standards in HASUs and ASUs. Joint CCG and provider action plans are developed and agreed. We also analyse data and produce tailored audit reports for London CCGs based on the national Sentinel Stroke National Audit Programme (SSNAP).

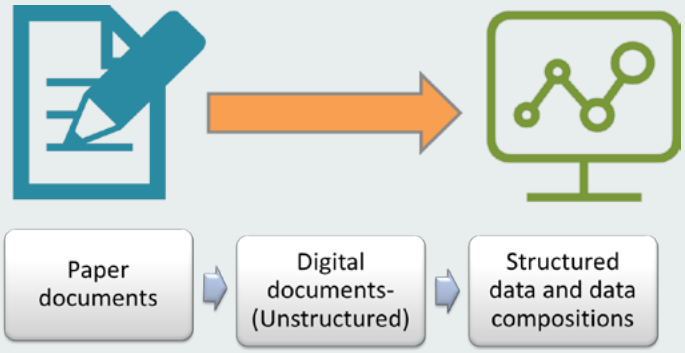
Impact: Peer reviews, tailored audit reports and bespoke network support ensure ongoing improvement, leverages data, processes and outcomes to ensure high standards will continue to be met.



Better patient information, quicker

Challenge: Rapid transfer of accurate patient information is of critical importance as patients travel through the stroke pathway, from HASU to ASU. Upon reviewing data, we found significant variation in the quality and speed of transferred patient information.

Solution: In collaboration with the London Digital Team, we developed the electronic HASU to ASU transfer of information referral form for use in all London acute units.



Impact: This reduces the time taken for clinicians to get high quality information on each patient, improving accuracies and efficiencies. Referrals are automatically received into the ASU and clinicians are immediately notified about them, thereby reducing delay in providing appropriate patient care.

Maximising efficiencies and shared priorities: Local stroke networks

Challenge: Due to pressures across the health system, some patients are still not consistently getting access to established acute stroke services within the agreed time frame. Variation in provision and use of community rehabilitation services resulted in significant blockages in pathway flow.

Solution: We helped to establish local stroke operational networks across each of the five STP areas. Guided by a designated clinical lead, each network provides a more clearly defined process for joint working with commissioners with a better understanding of local quality and pathway issues.

Impact: These local networks will help to improve patient outcomes across the pathway and arguably improve efficiency savings to the system. By sharing best practice across the localities, we can together increase consistency and reduce variation in care.

End of Life Care Clinical Network

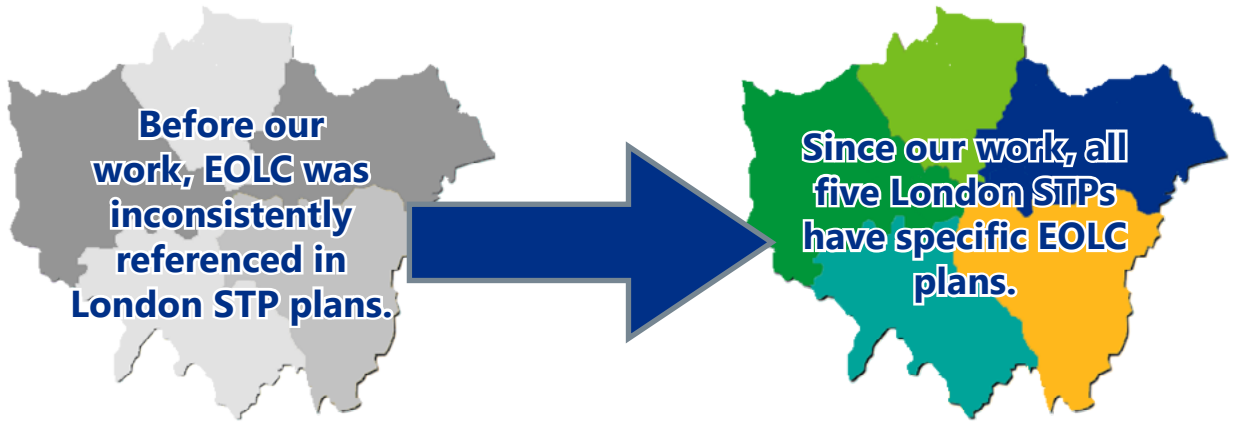
Through our work, end of life care now features in all London STP plans.

Putting a focus on end of life care with STPs

Challenge: There was a lack of focus on end of life care (EOLC) in London STP plans.

Solution: We appointed two clinical leads for end of life care, focussed on the STP footprints, to work on the ground raising the profile of EOLC and supporting the development and implementation of local initiatives.

Impact: All five STPs have specific EOLC plans, and focussed work has commenced in each area with support from the clinical leads.

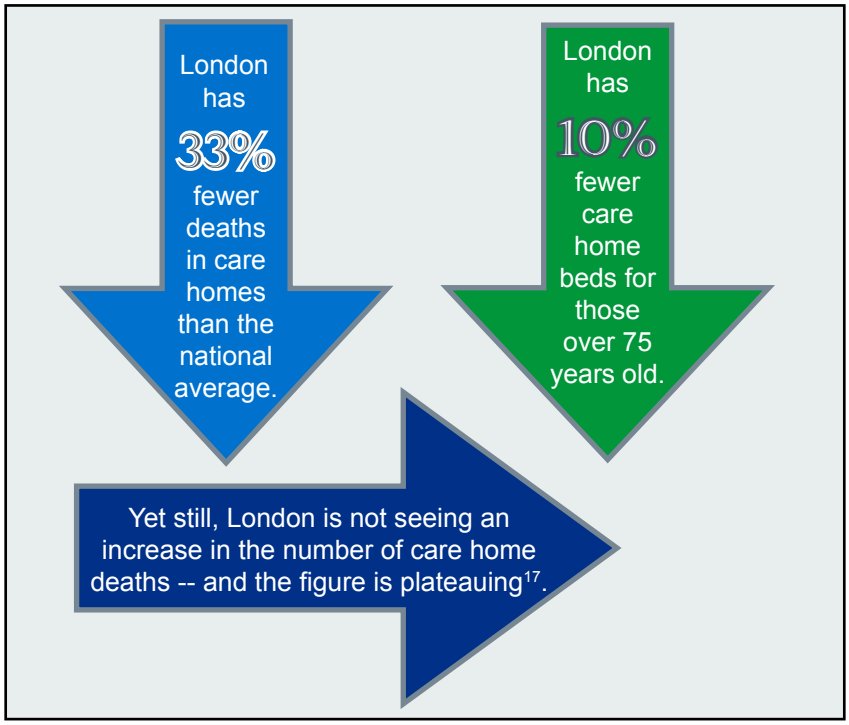


Removing barriers in care homes

Challenge: There are often inappropriate admissions to hospital for people living in care homes.

Solution: We investigated barriers facing care homes in enabling residents to die in care homes, resulting in a comprehensive 3 to 5 year project plan to address these.

Impact: We secured funding for a joint project with the three London Academic Health Science Networks, to embed solutions across London in 2018/19.



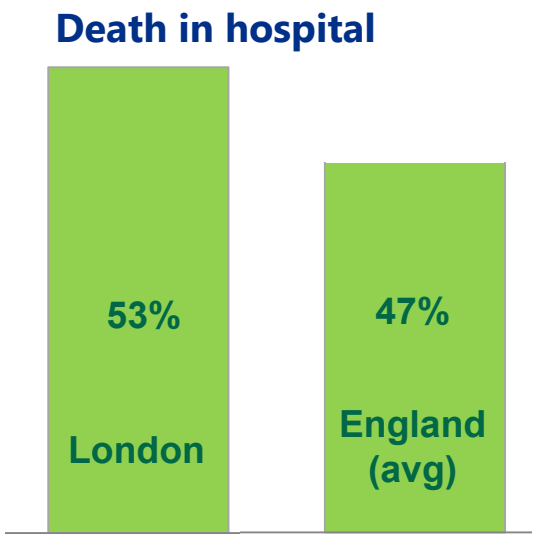
Supporting preferred place to die

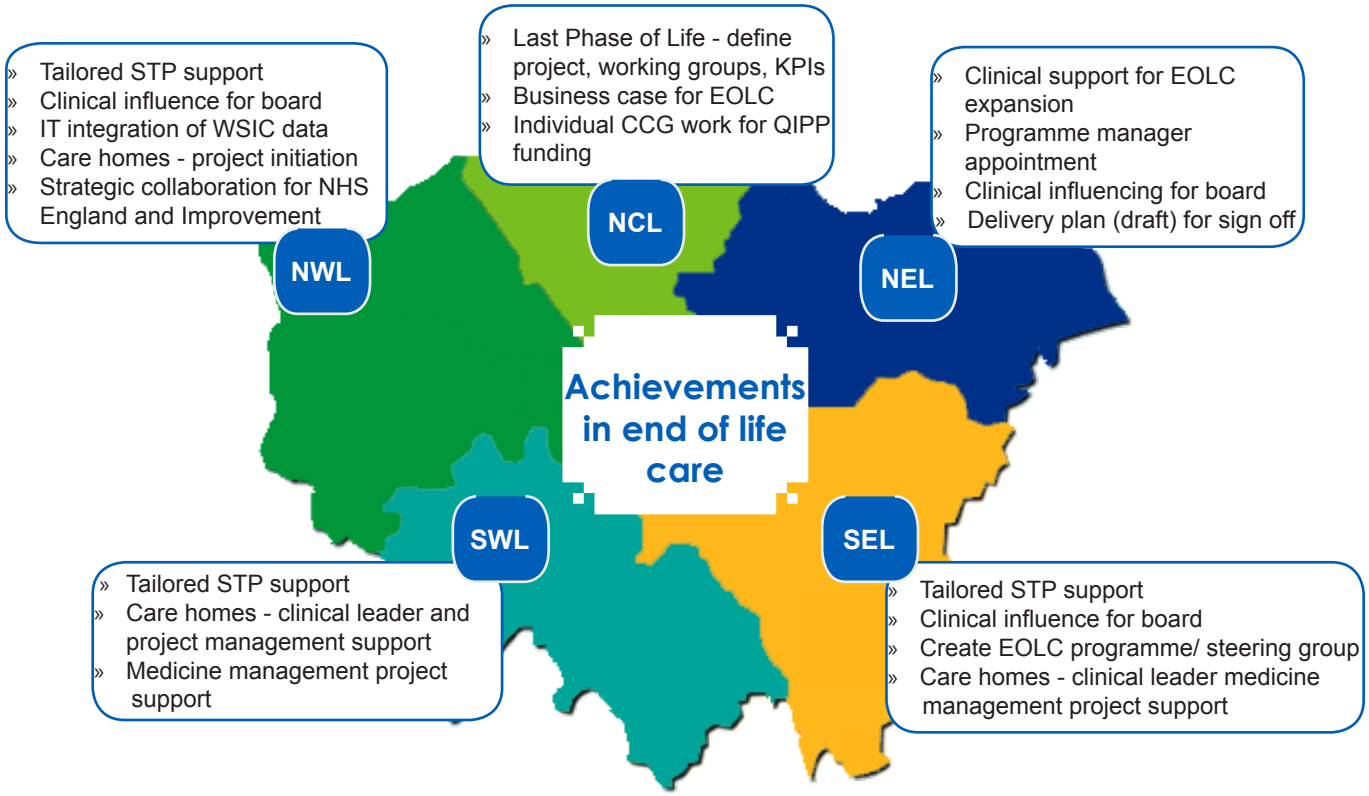
Challenge: Each year approximately 50,000 Londoners will die. Last year, about 53 per cent died in hospital compared with a national average of 47 per cent[18].

Solution: We undertook a comprehensive survey and analysis of services available in each borough of London. Using our EOLC commissioners' checklist as a basis, we identified essential and desirable elements of EOLC service provision. We also worked with RM Partners to understand availability and access of:

» Seven day a week specialist palliative care in all settings;
» Single points of access for EOLC; and
» Enhanced overnight sitting services in each CCG.

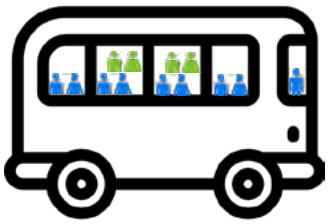
Impact: Our work found that there is no "one size fits all" approach to improve services. Rather, a variety of enablers can be used, based on local need. Commissioners and providers are using our tool to review local data and service provision in order to address inequities.





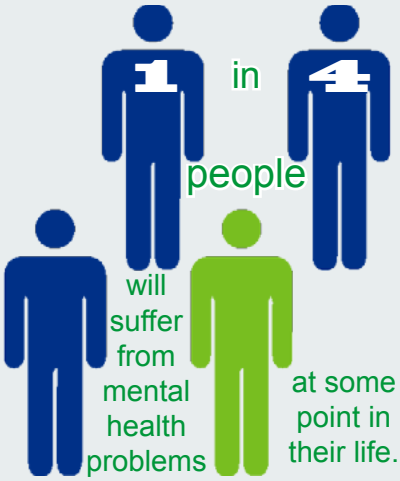
Mental Health Clinical Network

That's 13 people on every bus...



...and more than 100 people on every tube.

Improving access to psychological therapies



One in four people will suffer from mental health problems at some point in their life. This can range from mild conditions such as anxiety to severe depression or complex conditions such as bipolar disorder. Talking therapies can help people work out how to deal with negative thoughts and feelings and make positive changes.

The NHS Five Year Forward View for Mental Health set out a commitment to increase access to psychological therapies for an additional 600,000 people with common mental health problems by 2020/21. This would be achieved by recruiting and training an extra 4,500 clinicians, 3,000 of whom would be based in primary care.

In 2017/18 London Clinical Networks established a clinical reference group to support services to address the key issues identified: funding pressures, variation in performance and integrating IAPT with primary care.

We are providing support for commissioners to implement the targets through the sharing of good practice, learning and experience.

The network has delivered a range of improvement events and an educational programme to improve the understanding of IAPT data and the quality of data submissions. The IAPT network is also working with a number of digital teams to see what opportunities there are to increase access and productivity. Other learning and engagement opportunities with the IAPT sector explored issues around long term health conditions, digital IAPT and payment reform in IAPT with more than 400 attendees across all IAPT events over the year.

Payment and outcomes

We are working to drive standards up through payment reform and measuring outcomes in mental health. The programme has provided regional leadership to help providers and commissioners work collaboratively to improve how mental health treatment is delivered and paid for across London.

We have acted as a regional voice on issues such as HONOS (the designated national clinical rated outcome measure); clustering (the existing mechanism for mental health tariff) and payment reform with bodies such as the Royal College of Psychiatrists and the national teams within NHS England and NHS Improvement.

During 2017 our partners have agreed a common approach to creating a clear mental health outcomes framework for London. We have also undertaken research to gain a baseline understanding of the use of outcomes in mental health services across the capital.

As a result patient care will improve as the programme supports secondary mental health services to embrace the systemic collection of outcomes measures, analysed and used as a way of understanding the impact of mental health services across London. This long term ambition has influenced the way the programme will operate in the upcoming financial year with a view that we will sustainably build and implement a mental health outcomes framework for London.

Improving mental health services in primary care

Providing high quality care in a primary care setting makes a huge difference to people living with mental health conditions.

Receiving mental health care in a GP practice or other primary care setting is perceived as less stigmatising than receiving care in a hospital, and means that both physical and mental health needs can be treated in the same place. We can also improve the efficiency and safety of pathways between primary and acute care, deliver care closer to home, and reduce the pressure on acute services.

In 2017/18 we published a set of guiding principles for CCGs and GPs. They were developed with input from service users, GP clinical leads and Mind to ensure experience is at the heart of what we do. This will help to increase the confidence and capability of professionals working within primary care mental health in London .

These documents included:
» A literature review of primary care mental health models;
» Scoping document to review the current status of model development in London; and
» Commissioning guidance covering key good practice components of a primary care mental health model.

Also included in the guidance was a fidelity tool to enable commissioners and providers to review their model against the guidance.

Improving services for women and families during pregnancy and the first year after giving birth

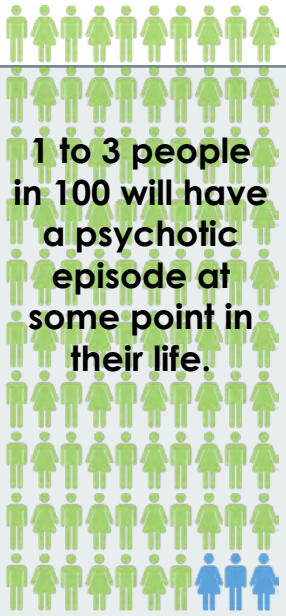
Having a baby should be a joyful time for families. However around 20 per cent (1 in 5) of women in London experience mental ill health during pregnancy or in the first-year post birth. Whole families are affected, and post-natal depression has links with depression in fathers and family breakdown.

Access to specialist perinatal mental health teams across London is variable, as is awareness of the needs of women and their families with health professionals.

To address these issues, London established five Perinatal Clinical Networks for each STP bringing together professionals from maternity, mental health, social care and local commissioners with people with lived experience of perinatal mental health issues, to increase access to specialist services and raise awareness of the issues.

Key achievements in 2017/18 include:
» Successful bidding for £5.4million to establish three new community perinatal mental health teams. After the first six months, the teams are on track to achieve the ambition of providing perinatal services to all prospective patients in their respective population;
» Providing support to STP areas to prepare for Wave 2 national funding bid submissions; all areas have prepared high standard bids for submission in March 2018 and continue to work in improving care;
» Providing face-to-face training to more than 200 professionals and co-producing an online training tool with Health Education England;
» Delivering workshops and workforce modelling tools to trusts, CCGs and STPs to help partners create workforce plans. The tools provided each area with information on the required number of staff and skill mix needed to provide evidence based care and have been used for local STP planning for future service development bids;
» Building capacity in IAPT teams by training and supporting perinatal leads across all 32 London IAPT services. As a result each STP area has a number of perinatal champions within IAPT services that will oversee service improvements that cater to women presenting pre and postnatally;
» Delivering training to designated perinatal champions from a variety of relevant professions. The key role of the champions is to increase awareness of perinatal mental health issues, and to share information with peers and other professional colleagues on how to access support;
» Producing a suite of useful documents for professionals, including a neonatal and tokophobia (fear of child birth) protocol.

Mental Health Clinical Network



Early intervention in psychosis

1 to 3 people in 100 will have a psychotic episode at some point in their life. Psychosis makes people perceive or interpret things differently from those around them.

Treating people as early as possible is important. Research shows early intervention can improve long term outcomes, and reduces people's reliance on emergency and inpatient services. London mental health trusts support approximately 5,500 people experiencing first episodes of psychosis with caseloads expected to increase.

The NHS has agreed that 50 per cent of new referrals of suspected first episode of psychosis or at risk mental state should be assessed within 14 days, and 60 per cent of people will start NICE recommended treatment with a specialist early intervention in psychosis (EIP) service within two weeks of being referred.

This year, a few of our selected achievements include:

» Established an EIP clinical forum that has representation from all 10 mental health trusts. Clinicians have shared good practice and provided operational solutions at a pan London level. This has contributed to all the teams developing and delivering EIP Nice Concordant Care packages, extending services remit to the over 35 age group and achieving EIP waiting times targets;
» Produced and disseminated London EIP workforce capacity and demand modelling reports;
» Held a series of clinically led planning and implementation workshops to support STPs to develop EIP workforce capacity and demand action plans and to share examples of best practice;
» Supported development of training for EIP services in cognitive behavioural therapy, family intervention, and leadership development; and
» Produced London wide materials designed to support families and carers.

Reducing the mortality gap for people with severe mental illness

People with a severe mental illness (SMI), like schizophrenia or psychosis, die 10-20 years younger than people without one – this is known as the 'SMI mortality gap'. In London more than 100,000 people are living with a severe mental illness - nearly 40 per cent of whom are from a black and minority ethnic background. Compared to the general population, individuals living with SMI have double the risk of obesity and diabetes, and three times the risk of smoking and high blood pressure, but often this is not identified or treated. This leads to worse physical health, higher levels of complications from long term conditions, and greater use of emergency and secondary care. In London people with a severe mental illness are over 3 times more likely to die before the age of 75 and over 4 times more likely to die of liver disease or respiratory disease compared to the general population.

Many of the physical health conditions seen in people living with a severe mental illness are associated with preventable risk factors like smoking, physical inactivity, obesity, substance misuse and the side effects of psychiatric medication. While their conditions are mostly preventable and treatable, they are less likely to be diagnosed.

By April 2019 the NHS has agreed that 60,000 people in London with a severe mental illness will have a physical health assessment and a treatment plan. Evidence shows early detection and preventative measures help improve physical and mental health outcomes.

The focus of the partnership's stolen year programme is working to overcome this mortality gap. By working with partners we have developed over the course of this financial year we have developed an online resource which includes tools, recommendations and links to other information and support. This resource was developed to provide support to providers and commissioners seeking to address the mortality gap in their local area. This will help improve consistency of care, detection and treatment.

View the Stolen Years Online Resources.

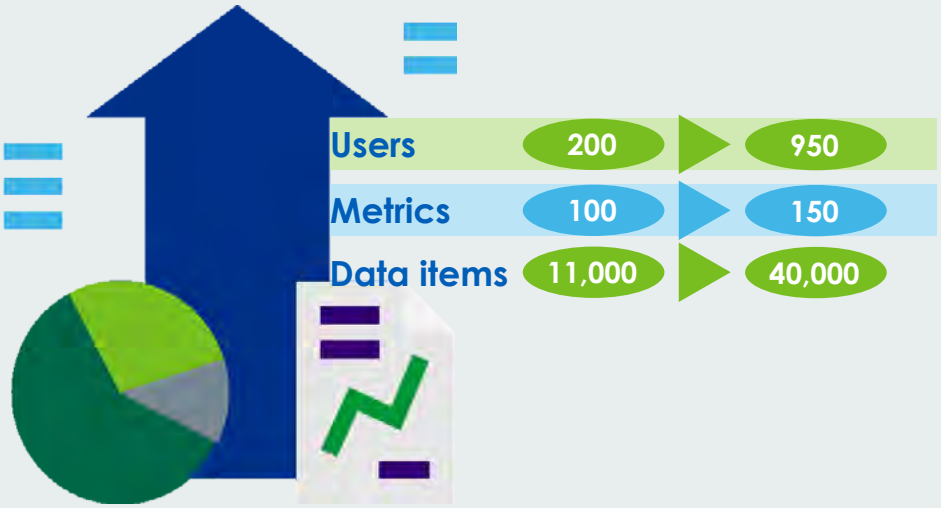
Mental health dashboard

With poor mental health on the rise, there is an urgent need to articulate the contribution services make. Services are commissioned on block contract arrangements, with no unified approach for capturing outcomes to inform patient care.

Mental health clinicians and staff capture a significant amount of information from patients accessing services. However, this information has not historically been easily accessible or presented in a way that supports system transformation or to improve service delivery and outcomes. It has also often been limited in scope. We have worked with NHS Benchmarking, our partners and service users to develop a mental health dashboard.

The mental health dashboard seamlessly brings together a wide range of sources, creating a one-stop data shop. It provides CCGs and trusts with a benchmark of their local and STP system and helps expose variation across London.

Over the past year we have grown the user base of the dashboard from 200 to over 950 users and increased the level of included metrics from 100 to over 150 metrics. The dashboard has become a rich data-source growing from 11,000 to over 40,000 data items. We have also focused on identifying new sources of data that will help shed light on the broader impacts of mental health across public services, alongside including new data feeds from agencies such as the London Ambulance Service.



As a result we will over the next financial year identify how we can provide value and sustainability analytics to the mental health sector. This will involve close working with NHS RightCare and other agencies to move beyond just providing descriptive statistics to providing hypothesis testing functionality to make the dashboard a rich resource for system understanding and transformation.

To help encourage transparency and accountability, the London Mental Health Transformation Board and the Cavendish Square Group have agreed to make the dashboard available to the general public in 2018/19.

A look ahead

The 2018/19 work programme is again ambitious, and prioritises areas of great need which will create the greatest impact to our patient populations.

We are proud of our achievements in 2017/18. However, we must not get complacent. Instead, we must continue to strive for excellence. The challenges that face the NHS are well documented, and maintaining the status quo is not an option. We know a different approach can improve care for patients and create a future sustainable system. As the needs of our patients and the system change so, too, will the clinical networks evolve to meet them.

Futher detail on 2018/19 business plans are available upon request.

Maternity Clinical Network

We are working to improve **SAFETY, CHOICE AND PERSONALISATION** in maternity care as envisaged in Better Births. We are enabling transformation through pan London work; strengthening and collaborating with Maternity Voice Partnerships, and implementing change with Local Maternity Systems (LMSs)

- Support the five Local Maternity Systems in London to deliver on recommendations set out in Better Births.
- Refresh the London clinical quality standards in maternity, and support in its implementations
- Develop a safe and clinically effective in utero transfer pathway, including streamlining the process for locating a neonatal cot in London.
- Update and promote uptake of fetal monitoring resources to support maternity services deliver safer care.

By ensuring the availability of **HIGH QUALITY INFORMATION FOR WOMEN**

- Women will have access to unbiased, tailored information on choice through the My Health London website on local services
- Online digital tool to support accurate and safer postnatal discharge in care of the right team
- Aligning with the national digital programme, develop, pilot, and implement a standardised maternity discharge summary template to ensure faster, more consistent clinical information.

And creating a **CONTINUINOUS LEARNING** culture

- Understand and share learning from perinatal and maternal deaths in London to ensure that, in line with best practice, lessons are learned and safety improved on a system-wide level.
- Promote the Stillbirth Care Bundle, sharing best practice and the national standardised perinatal mortality review tool to support high quality standardised reviews across London.

Dementia Clinical Network

By **IMPROVING DEMENTIA DIAGNOSIS**

- Individual CCG clinical advice and action plans
- GP led diagnosis in care homes
- Streamlined pathways for timely diagnosis
- Effective memory services network
- Integrated assessment for young onset dementia

We can provide a timely, accurate diagnosis of dementia, leading to prompt access to **POST DIAGNOSIS SUPPORT**

- NICE guideline implementation (eg psychoeducation for carers, patient education)
- Appropriate post diagnostic support for young onset dementia
- Implementation guide – named coordinator, annual care plan review
- Support for GPs – digital care plan, education, peer network

Which will enable people to **LIVE WELL WITH DEMENTIA**

- Support safer prescribing of antipsychotic medication
- Improve hospital care and discharge
- Enhance crisis care planning in care homes
- Provide individual care plan
- Improve access to research

Diabetes Clinical Network

We are working to transform diabetes care, delivering the work streams within the National Diabetes Programme, focussed on **PREVENTION**

- Implementation of National Diabetes Prevention Programme (NDPP) in every CCG
- Quarterly data packs and clinical expert interpretation to report and monitor NDPP delivery
- Supporting implementation of best practice across site leads for NDPP
- Assessment, refinement and promotion of reporting tools and analysis to measure programme delivery

And to ensure that people living with diabetes receive optimum **TREATMENT AND CARE**

- Support delivery sites on implementation of local improvements, including standardised data collection and coding systems, for NICE recommended treatment targets
- Metrics, optimum pathway, and guiding principles to ensure the right people, processes and resources are in place for multidisciplinary foot care teams (MDFT)
- Working with providers to implement or enhance a diabetes inpatient specialist nurse service, and the requisite infrastructure
- Increasing access to structured education for people with diabetes

Whilst identifying **NEW INNOVATIONS** and ensuring that **PATIENTS ARE FULLY INVOLVED** in the NHS.

- Analysis of type 1 population needs, increasing patient referrals to structured education, helping commissioners prioritise action, increasing access to specialist care and reducing bottlenecks to innovation
- Extremely strong legacy programme of patient / public engagement, experience and partnership working. Strengthening relationship with voluntary sector around inequalities and access
- Implementation, guidance and training plan for Freestyle Libre glucose monitoring system
- Collaboration with Mental Health CN to improve self management of diabetes for those with severe mental illness

Cardiac Clinical Network

We are working to **PREVENT CARDIOVASCULAR DISEASE**

- Coordinated pan London approach
- Baseline, targets and support for STPs for the detection and management of atrial fibrillation, hypertension, and cholesterol
- Streamlined diagnostic pathway and treatment for familial hypercholesterolaemia (FH), introduction of FH detection tool for GPs

Whilst **IMPROVING URGENT CARE**

- Implementation support for national guidance on out of hospital cardiac arrest (OHCA) STEMI (standardise pathways, raise awareness, identify areas for improvement, apply international best practice)
- Maintain high quality cardiac emergency services in acute coronary syndrome and arrhythmia (review heart attack centre service specifications and pathways, develop CQUIN for patients requiring complex devices)

And **MANAGING LONG TERM CONDITIONS**

- Improve diagnostic heart failure (HF) pathway (audit, pathway design, case for implementation)
- Provide rapid access to high quality HF care in the acute setting
- Increase HF care in the community through better commissioning and utilisation of community HF nurses
- Use data to understand HF service performance
- Standardise quality, access, and outcomes in cardiac rehabilitation

Stroke Clinical Network

We are working to **PREVENT STROKES** through better detection and anticoagulation rates of people with atrial fibrillation (AF) and initiation, self management and adherence in anticoagulant services

- Implementation of pan London AF toolkit
- Map and audit anticoagulation services; develop standards
- Communities of practice for primary care anticoagulation initiation
- Better patient information and upskilled staff to enable increased anticoagulation adherence and self management

Yet **MAINTAINING THE HIGH QUALITY OF ACUTE CARE** in all facets of the global exemplar of the London stroke model

- Hyper acute stroke unit (HASU) / acute stroke unit (ASU) quality reviews
- Data based performance analysis
- Implementation of high quality thrombectomy pathway
- Development of stroke operational networks
- Stroke pathway capacity review
- Accurate, fast digital referrals for HASUs / SUs
- Protocol development for LAS to identify and refer TIA patients directly to specialist clinics
- Revise / agree London stroke tariff with NHS England, providers, CCGs

To ensure optimal support and care to **LIVE WELL AFTER STROKE**

- Develop standards, audit, and improve early supported discharge (ESD) and community stroke rehabilitation (CSR) services
- Implement digital transfer of care information (acute to community)
- Develop, implement and analyse dataset on quality of community services

End of Life Care Clinical Network

We are working to improve the experience and care of Londoners who might be in the last year of life through supporting **BETTER COMMISSIONING**

- Clinical leads working directly with STPs leads to develop high quality EOLC programmes
- Support for CCGs through EOLC commissioners network meetings
- Support the regional recommissioning of EOLC drugs in the community to reduce inequity of availability

Along with **BETTER INFORMATION SHARING**

- Publication of information related to the provision of essential and desirable elements of care important for EOLC, by CCG and by STP
- Support the implementation and use of EPaCCS by working with London Digital Programme and LHCIE teams to develop and optimise work / integration with, and use of CMC and other EPaCCS in all settings

And **SUPPORT FOR PATIENTS, CARERS AND STAFF**

- Working with HLPA and three AHSNs to develop and deliver a project focussed on care homes that will include a regional toolkit for STPs and CCGs on excellent EOLC for care home residents
- Working with London Homeless Health programme to facilitate increased awareness and better care of homeless people approaching EOLC
- Development and publication of a unified resource to support bereaved people

Adult Mental Health Clinical Network jointly with HLP: Improvement Support

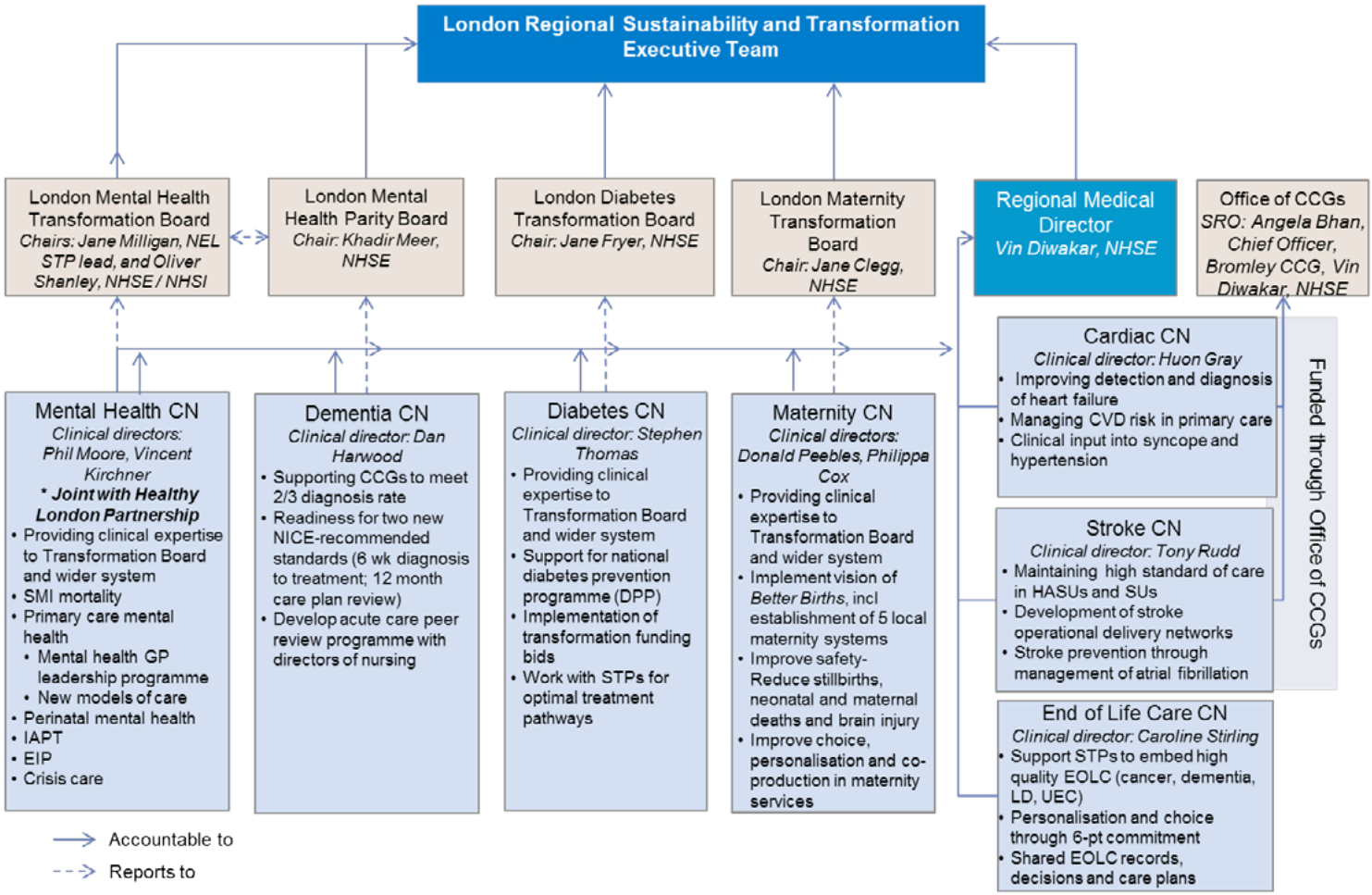
EARLY INTERVENTION IN PSYCHOSIS (EIP)	*People experiencing a first episode of psychosis should have consistent access to specialist mental health care.* » Pan London EIP handbook » Guidance on physical health management in EIP services » Supporting STPs to develop EIP improvements plans based on CCQI 2017 results
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)	*Access and recovery rates and waiting times for IAPT vary – which is a CCG performance metric.* » Peer review visits » Learning sets » Delivery model guidance » Improvement collaborative with STP programmes
PERINATAL MENTAL HEALTH	*Variation exists in access and provision of community perinatal mental heath services, and women and their families' voices may not always be heard.* » Pan London pathway for Specialist Perinatal Community mental health services – using learning from wave one sites » Supporting wave 2 community developments » Perinatal guidance for IAPT services » Supporting STPs to implement the national Perinatal Mental Health Pathways (waiting times AND outcomes)
SERIOUS MENTAL ILLNESS	*There is variation in performance (in both primary care and secondary care) in the delivery of health checks. Physical health checks are a FYFVMH target.* » Improvement collaborative on SMI mortality gap » Summary of written clinical feedback provided to each CCG and STP » Physical Health Leads Network development, with representation from Mental Health Trusts.

Adult Mental Health Clinical Network jointly with HLP: Transformation

DIGITAL IAPT	*Risk mitigation around access and recovery rates and waiting times for IAPT vary – which are CCG performance metrics.* » Develop a London digital offer to improve access to IAPT services alongside Good Thinking » Scope the opportunities for an at scale digital therapeutic offer to be provided by all London IAPT Services.
VALUE IN INTEGRATED SYSTEMS	*The FYFVMH requires expansion in certain MH service areas whilst maintaining sustainability. Leveraging opportunities, we can seek to improve value and unrealised return on investment.* » Support CCGs and STPs for opportunities to identify and articulate value in secondary mental health services » Expand the London mental health dashboard with investment and outcomes » Implementation of a London Mental Health Outcomes Framework.
INCIDENT RESPONSE	*Terrorist incidents can create great need for psycho-social support on a regional level.* » Regional communication campaign » Better share / flow of information by partner agencies » Systemic review and evaluation of response for future learning

Governance

All Clinical Networks work within the following governance framework with ultimate responsibility to the Sustainability and Transformation Executive Team within NHS England (London Region).



Acknowledgements

We are grateful to our clinical directors, the Networks' core team, and all of our partners, without whom the London Clinical Networks would not have been able to achieve this work.

End notes

1 (pg 7) Reducing stillbirths
NHS England Maternity Transformation Programme

2 (pg 7) Care Bundle data
NHS England National Maternity Transformation Programme

3 (pg 7) Nationally validated measure to capture feedback when a baby dies
Office For National Statistics

4 (pg 8) Improving dementia diagnosis rates
NHS Digital

5 (pg 8) Number of people living with dementia
NHS Digital

6 (pg 8) Annual estimated cost of dementia
Alzheimer's Society

7 (pg 9) Hospital care for people with dementia
Alzheimer's Society

8 (pg 10) Initial assessment of diabetes risk
NHS Diabetes Prevention Programme

9 (pg 10) Treatment and Care data
National Diabetes Audit

10 (pg 12) Pan London heart failure pathway published
NHS RightCare

11 (pg 13) Heart failure prevalence
Public Health England Fingertips

12 (pg 13) 2015/16 CCG data
NHS Digital Quality and Outcomes Frameworks

13 (pg 13) Heart failure today
National Heart Failure Audit Annual Report

14 (pg 14) Development and launch of the atrial fibrillation toolkit
NHS Digital Quality and Outcomes Frameworks, National Cardiovascular Intelligence Network

15 (pg 14) Development and launch of the atrial fibrillation toolkit
Sentinel Stroke National Audit Programme

16 (pg 14) Development and launch of the atrial fibrillation toolkit
NHS Digital Quality and Outcomes Frameworks

17 (pg 16) Removing barriers in care homes
Public Health England Fingertips

18 (pg 17) Supporting preferred place to die
Public Health England Fingertips