Annex A: Ealing and Hounslow Integration Health and Care Experience Profile

Integration Health and Care Experience Profile 5

What are the characteristics of this health and care experience profile?
A woman with multiple health conditions, including recent experience of care for a cardiovascular condition(s).

Rationale
This health and care experience profile:

- Demonstrates the complexity of living with multiple health conditions – and therefore service users who benefit significantly from well-integrated care and support.
- Provides the opportunity to explore both integration between the different health services involved and integration with other relevant services and organisations including any relevant community support, social prescribing and/or social care services.
- Provides the opportunity to explore women's experiences of having a cardiovascular condition, which have been typically (and incorrectly) considered to be "men's conditions".[1]
- Reflects a key commitment of the NHS Long Term Plan – better care for major health conditions.[2]

What kind of care should this health and care experience profile be able to expect?

NICE Quality Standards[3] highlight the need for all NHS patients to receive coordinated care with clear and accurate information exchange between relevant health and social care professionals.

> "For many people care is not about a single visit to a single service… Health and care services may provide high-quality care individually but, may fail people moving between services if they are not working well together with other services.

[1] British Heart Foundation, Women and heart attacks (accessed 17/11/2020)

[2] NHS England (2019) NHS Long Term Plan

[3] NICE (2019) Quality standards: Patient experience in adult NHS services [QS15]

Information needs to be exchanged effectively between services so that care can be coordinated across specialties and between providers."

Further NICE guidance on care for people with two or more long-term health conditions[4], and older people with social care needs and multiple long-term conditions[5] establish that the approach to care for people with multiple conditions should:

- Focus on how the person's health conditions, and their treatments interact, and how this affects their quality of life.
- Focus on improving the coordination of their care across services – including seamless referrals between practitioners and appropriate information sharing.

According to the NICE Quality Standards[6] relating to Cardiovascular risk assessment, adults under 85 years who have been identified as at increased risk of Cardiovascular disease (CVD), should be offered a full formal risk assessment for the primary prevention of CVD in primary care.[7] This assessment involves calculating the 10-year risk of CVD by evaluating demographics (e.g., gender, age) and health and lifestyle (e.g. smoking status, diabetes status, kidney disease, mental illness).

NHS England's CVD Prevention Programme[8] and Public Health England's guidance[9] on prevention of CVD aim to develop targeted interventions to optimize care by maximizing diagnosis and treatment to minimize both individual risk factors and population risk. This will be achieved by:

- Co-ordinating action to tackle the secondary prevention of CVD.
- Improving the effectiveness of NHS Health checks to rapidly treat those at high-risk.
- Supporting pharmacists and nurses in Primary Care Networks to find and treat people with high-risk conditions and offer treatment in a timely manner.
- Expanding access to genetic testing, enabling diagnosis and treatment for those at genetic risk of sudden cardiac death.

In particular, NICE guidance[10] has been published relating to the increased risk of cardiovascular disease and smoking. Adults who are disadvantaged (e.g., who smoke), need to be:

[4] NICE (2016) Multimorbidity: clinical assessment and management [NG56]

[5] NICE (2015) Older people with social care needs and multiple long-term conditions [NG22]

[6] NICE (2015) Cardiovascular risk assessment and lipid modification [QS100]

[7] NICE (2016) Cardiovascular disease: risk assessment and reduction, including lipid modification [CG181]

[8] NHS England Cardiovascular disease prevention (accessed 27/11/2020)

[9] Public Health England (2019) Health matters: preventing cardiovascular disease

[10] NICE (2008) Cardiovascular disease: identifying and supporting people most at risk of dying early [PH15]

- Provided with flexible, coordinated services that meet their needs, such as drop-in or community-based services, outreach, out-of-hours services, advice and help in the workplace and single-sex sessions.
- Offered services that are sensitive to culture, gender and age, such as providing multi-lingual literature in culturally acceptable styles; promote services using culturally relevant national and local media with representatives of different ethnic groups.

NICE published guidance[11] referring to acute, maternity and mental health service use, for women with cardiovascular or respiratory disease and who smoke. The guidance states that:

- A robust system is put in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care.

Downing et al.[12] demonstrated that a community-based cardiovascular service intervention can be effective in reducing hospital admissions. The Knowsley CVD service provides integrated elements of care: a consultant-led clinic, diagnostic service, community heart failure clinic, community stroke rehabilitation service and cardiovascular rehabilitation service. This service provides community care, but also can provide in-home care when needed. Additionally, education and exercise classes can be provided in one-to-one or group settings, which demonstrates how integrated care is being used to base the service around the needs of individual patients. The integrated model allows GPs to refer patients to all the required parts of the service in a single referral, simplifying the process and reducing the likelihood of a patient not being referred to an element of the service that would have been beneficial.

There is a range of care services provided for women who suffer from long term health conditions. The level of care they receive is based on the individual's eligibility. The three levels of care include NHS provided care packages, self-care, and interactive tools.

NHS continued healthcare and NHS funded nursing care are packages of care arranged by the NHS for individuals outside of hospital. Continued healthcare is based on a checklist tool and a multidisciplinary team is used to complete a decision support tool which covers 11 different type of needs. In urgent cases a fast-track tool is used. Funded nursing care is provided to those who are not eligible for continued care and care home residents.

The NHS also offers a health check for those aged between 40-74. This looks at risks of developing and methods of controlling heart and circulatory disease. It is designed to spot early signs of stroke, heart disease, type 2 diabetes or dementia. These checks are available for those who do not have pre-existing conditions such as heart disease. The free check-up will tell individuals if they're at risk of heart disease and during the check-up they will be informed of how to reduce the risk of heart disease and other conditions.

[11] NICE (2013) Smoking: acute, maternity and mental health services [PH48]

[12] Downing, J. et al (2019). Impact of a community-based cardiovascular disease service intervention in a highly deprived area. *British Medical Journal*. Health care delivery, economics and global health care

Both the British heart foundation and the NHS offer interactive tools for this health and care experience profile. The NHS change4life provided nutrition and fitness support on their website. The British heart foundation my life check is a tool which ranks your heart score out of 10 and provides suggestions for improvements.

The NHS offers a range of apps that provide health tracking and pharmacy services. Such as the Echo pharmacy, Changing health and Chat Health. These digital tools are assessed by the NHS for use and allow individuals to access mental health support, lifestyle programmes and repeat prescription ordering.

What kind of care should this health and care experience profile expect in Ealing and Hounslow?

The literature indicates that Ealing and Hounslow share many similarities in the care pathways available for women with multiple health conditions including a heart condition. This is due in part to both boroughs following the NICE guidance in supporting those with heart conditions and those with multimorbidity. In addition, at city level, both Ealing and Hounslow also share the strategic frameworks of London's collective health and social care policies and aims. For example, The London Primary Care Strategic Framework[13] highlights the need for primary care to deliver a framework that is a specification for general practice and sets out a new patient offer for integrated care, arranged around three aspects of care that matter most to patients:

- Proactive care – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy;
- Accessible care – providing a personalised, responsive, timely and accessible service;
- Coordinated care – providing patient centred, coordinated care and GP/patient continuity.

More locally, Ealing and Hounslow's proximity, the similarities shared in population characteristics, in addition to both boroughs falling under the North West London (NWL) region's Integrated Care Partnership and the NWL Health and Care Partnership, the two boroughs have a similar set of delivery areas that pertain to this health and care experience profile. The NWL Strategic Transformation Plan[14] outlines 5 key delivery areas with all five applicable to this health and care experience profile:

[13] London Primary Care Transformation Board and Primary Care Transformation Clinical Board (2015). Transforming Primary Care in London: A Strategic Commissioning Framework

[14] North West London Collaboration of Clinical Commissioning Groups (V01, 2016). NW London Sustainability and Transformation Plan

- DA1 - Radically upgrading prevention and wellbeing.
- DA2 - Eliminating unwarranted variation and improving LTC management.
- DA3 - Achieving better outcomes and experiences for older people.
- DA4 - Improving outcomes for children & adults with mental health needs.
- DA5 - Ensuring we have safe, high quality sustainable acute services.

Delivery Area 2 consists of five planned areas for improvement which are likely to have a more or less direct impact:

a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care.

b. Improve cancer screening to increase early diagnosis and faster treatment.

c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions

d. Reducing variation by focusing on Right Care priority areas.

e. Improve self-management and 'patient activation'.

The Sustainability and Transformation Plan prioritises a return on investment for health and wellbeing conditions, such as CVD, to be achieved through several key areas including, regular health checks, early diagnosis and prevention, the integration of services to support self-management, holistic care to support individuals with long-term conditions and quick and efficient discharge back home and into primary/ community care settings when appropriate. One of the integral pieces that make up the practical framework that is required to reach this ambition is the migration and utilisation of an 'integrated care toolkit'.

In 2013, eight CCGs in North West London announced plans to reform into one jointly commissioned CCG (commencing April 2021). The Whole Systems Integrated Care (WSIC) programme was an IT toolkit devised to guide the NWL delivery of the organisation's integrated care.[15] The utilisation of this centralised patient database system was proposed as the technological system required to facilitate a more collaborative clinician network and adapt a new, person-centred model of care. The WSIC programme allows for collaboration on individual patient care monitoring as well as being an analysis tool that enables health professionals to gain granular insight into the behaviours and outcomes of specified cohorts. More data is available to support GP decision-making, including activity and quality dashboards for practices and networks to help them track, compare and improve patient outcomes and interventions for urgent care and patients with long-term conditions. The

[15] Bailey, C., & Paice, E. (2016). North West London Whole Systems Integrated Care: a case study

adoption and utilisation of the WSIC programme by Ealing and Hounslow CCG theoretically supports each borough's approach to meeting the NWL STP delivery areas.

The NWL Five Year Strategic Plan[16] states that the NW London cardiovascular disease (CVD) programme is being developed in partnership with the London Clinical Networks, the London CVD Prevention Partnership and specialised commissioning. The aims of the programme are to improve care in four main project areas: CVD prevention, heart attack, stroke and heart failure. The importance of delivering on the aims of this plan is demonstrated by the fact that in the context of NWL, approximately 338,000 individuals are living with one or more LTC with 1500 people under 75 dying each year from Cancer, Heart Disease and Respiratory Illness. Of note, an estimated 1460,000 of individuals with an LTC also have a mental health problem, whether diagnosed or not; 512 strokes per year could be avoided in NWL by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart; and only around 40% (198,691) of individuals with hypertension have been diagnosed and controlled.

Indirectly, the success of the work around Diabetes in NWL also highlights the support and care for this particular experience profile. This includes an overall reduction in people being diagnosed with diabetes for the first time since 2005, due to the Diabetes Prevention Programme. Over 8000 patients have benefited from the Diabetes Prevention Programme since April 2018. The growth in hospital admissions for diabetes-related complications has been almost halved to 4.9% in 2018/19 from 8.3% in 2017-18 and spells out a continued reduction of heart related complications, in theory.

These ambitions and aims at city and regional level are essential to shaping the actions taken at local level. The following sections explore how these aims around Cardiovascular Disease and Multiple LTCs have been translated into borough policy and care pathways. To illustrate the support for individuals that fit the experience profile, the following sections - Identification & Referral, Intermediate Services & Chronic Care and Other Community Care - detail what support is available in Ealing and Hounslow, at each stage of care.

IDENTIFICIATION AND REFERRAL

Primary Care

The Ealing Standard[17] and Hounslow CCG Primary Care overview[18] outline, in detail, how primary care within each borough will meet the London Primary Care Strategic Framework's three aspects of care, thereby supporting the identification and referral process for this experience profile. First, primary prevention begins with the NHS Health Checks service. Everyone between the age of 40-74

[16] The North West London Health and Care Partnership (2019). North West London Primary Care Strategy 2019/20 plans and outline proposal to 2023/24. *Initial Draft submitted to NHSE on 01/04/2019*

[17] Ealing CCG (2017). The Ealing Standard, Quality Framework for Primary Care 2017/18 - 2020/21

[18] Hounslow CCG, Hounslow CCG Primary Care 2019/20 (2019)

who has not already been diagnosed with heart disease, stroke, diabetes, kidney disease and dementia are invited to an NHS health check in Ealing once every five years. The implementation of these health checks is a proactive approach by Ealing and Hounslow Primary Care to identify those at a high risk of developing Atrial Fibrillation or Hypertension and add them to a related register for health monitoring and prescribed anticoagulants, in line with NICE guidance. In mild cases, these Health Checks provide Ealing residents with the opportunity to seek out advice on lifestyle changes they can make to improve their CVD risk 'score', while in more moderate to severe cases in which individuals score high or show signs of Heart Failure, patients must be referred either to the Community Heart Failure Service or onward to CVD risk reduction therapy, respectively. These Health Checks also offer an opportunity for the health service to identify other long-term health needs of individuals and is something of a gateway to prevention of any future long-term health conditions through the identification of risk factors, in this case pertaining to CVD.

As part of the work toward delivering on both the Hounslow[19] and Ealing Local Plan[20] areas related to this experience profile, Ealing CCG has begun working with NHSE and the Local Authority to support uptake of NHS screening through primary care and successfully completed a borough-wide move onto the SystemOne data programme. This programme, alongside the WSIC programme, ensures that clinicians within primary care and social workers have access to patients' primary care record, regardless of where the patient presents and that in appropriate cases the care is jointly managed by the care coordination team. This coordination of patient information provides the foundation that the NHS Health Checks need to be effective in the prevention and management of any long-term health conditions that an individual may be suffering from.

The aims of the NWL STPs workplan around CVD is to improve the Primary and Secondary Care offering in the region through the speed and quality of clinical diagnoses, provide good follow-up care and enable the promotion of self-help advice. Work includes offering access to expert patient programmes to those newly diagnosed with an LTC, use of the Patient Activation Measures (PAM) to help patients control their own care, recognise the link between physical and mental LTCs and ensuring IAPT is accessible when needed; and using Right Care data to identify unwarranted variation across the region. Atrial Fibrillation (AF) and hypertension dashboards have been created to help better understand the needs of the local population. Heart failure lounges at West Middlesex and Ealing hospitals have been established with the aim to reduce hospital admissions and prevent people from deteriorating.

At borough level, the Ealing Local Plan outlines two deliverables related to this health and care experience profile:

- 3. Clarity in outcomes for the 3 killers, cancer, heart disease and respiratory illness

Proposed methods of delivering on this included: working with NHSE and the Local Authority to support uptake of screening through primary care; ongoing support to the newly implemented

[19] Hounslow Council (2018), Hounslow Joint Health and Wellbeing Strategy 2018-2022

[20] Ealing CCG (2016, working document). Ealing Local Plans

cardiology service; mobilisation of Ealing Local Improvement scheme focused on improving prevention and prevalence of hypertension and AF treatment and diagnosis.

- 5. Reduce unwarranted variation in the management of LTCs

Proposed methods of delivering on this included: movement to outcomes-based commissioning contracts with providers; benchmarking the right activity (and using right care data) for priority disease pathways from preventative care through primary, secondary and specialist care; a focus on understanding the local Ealing disease burden and understanding of current local interventions that are achieving best value at present; ensuring borough-wide move onto SystemOne data programme; ensuring that clinicians within primary care and social workers have access to patients' primary care record, regardless of where the patient presents and that in appropriate cases the care is jointly managed by the care coordination team.

This paper and these deliverables are expanded on in the Ealing Health and Wellbeing Strategy[21] which highlights 12 key actions with 6 directly relating to improving the health and wellbeing of the health and care experience profile (Key Action 3,4,7,10,11 and 12) and a further 5 indirectly supporting the health of our experience profile (Key Action 1,2,6,8 and 9). These key - actions decided on by key stakeholders within the borough - are designed to meet the local strategic priorities as well as the regional and national policies (e.g. the NHS Five Year Forward view, The NWL Health and Care Partnership Strategic Delivery Plan for the NHS Long Term Plan).

Diabetes

At sector-wide level, the Ealing Corporate Plan[22] identified three key Right Care areas to focus on: Diabetes, Atrial Fibrillation and Hypertension with the Hounslow Health and Wellbeing Strategy highlighting similar areas of focus.[23] Due to the association between diabetes and CVD, it is estimated that a significant increase in the number of diabetic and pre-diabetic patients would further increase CVD prevalence in both boroughs. Consequently, in the JSNA[24], Ealing partners agreed to follow the NICE guidance on Preventing Excess Weight Gain (NG7)[25]. From 2016/17 work commenced across NWL on the mobilisation and implementation of the National Diabetes Prevention Programme, the use of a comprehensive diabetes performance dashboard for Practices and CCGs and the roll out of a comprehensive process for non-diabetic patients with hyper-glycemia (a diabetic precursor) into the National Programme. In Ealing, the prevention of Diabetes remains a priority alongside supporting those that already have it by teaching them the tools they need to manage their own condition. The Ealing Corporate Plan also states that prioritisation must be given to improving the identification of people with diabetes who may also be suffering from depression and anxiety and increase their access to IAPT. Adults with diabetes are also entitled to use the Care Coordination Programme (see below) and those with Type II Diabetes can be referred to the Ealing Community Partners Right Start Diabetes Programme. Similarly, Hounslow CCG produced a clear care pathway for their Community Diabetes Service, that outlines the 9 checks that are required to

[21] Ealing Health and Wellbeing Board (2016). Ealing Health and Wellbeing Strategy 2016-2021
[22] Ealing Council (2017). Ealing Corporate Plan Update 2017/18

[23] Hounslow Council (2018), Hounslow Joint Health and Wellbeing Strategy 2018-2022

[24] Ealing Council (2014). Ealing JSNA. Chapter 7: Strengthen the Role & Impact of Ill Health Prevention, Lifestyle-related Morbidities, Obesity

[25] NICE (2015). Preventing Excess Weight Gain

make decisions about future care, the ways in which one can manage their own condition and the services that are available to support individuals.

This new level of access to diabetic care across NWL will reduce the numbers of pre-diabetic progression, reduce diabetes related CVD outcomes (CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations) and enable joint working with the public health team to address wider determinants of health that will support clinicians to refer patients to services that help address social factors. Over 2,000 patients have accessed a digital diabetes type 2 structured education course. Over 7,000 patients received self-management support for diabetes since April 2018 and over 8000 patients benefited from the Diabetes Prevention Programme since April 2018[26].

Obesity

Regarding levels of obesity in each borough, Ealing[27] and Hounslow CCG's objectives outlined in their Health and Wellbeing Strategies are linked with the NWL Sustainability and Transformation Plan.[28] This includes empowering people and their families to direct their care with GPs at the centre of organising a coordinated and integrated pathway, tackling conditions related to obesity by making it easier for residents to make healthy choices such as the promotion of walking and cycling programmes and initiatives, infrastructure to support this physical activity, discouraging car journeys for short distances and continuing to support those with drug or alcohol addiction. This is of particular pertinence to tackling the health inequalities seen in both boroughs. Findings from the Health Survey for England[29] found that the link between socioeconomic status and obesity was most pronounced in women, with 39% of women in the most deprived areas being obese. Given that 10 of Ealing's wards and 8 of Hounslow's wards are in the 20% of the most deprived areas in England, it is evident that these inequalities will have a significant impact on each borough's population. Further still, inactivity inequalities are also concerning as a previous iteration of the Health Survey for England found that the lowest rates of physical activity were found in southern Asian women with only 11 per cent of Bangladeshi and 14 percent of Pakistani women reporting to have done the recommended amounts of physical activity, compared with 25 per cent in the general population – itself a modest score.

Social Prescribing

In addition, to the direct work of GPs in identifying risk factors and long-term health condition needs, each PCN in Ealing have recently been assigned two (one for each Hounslow PCN) Social Prescribers - often referred to as a Community Link Workers - to support Primary Care delivery. Patients can either speak to Social Prescribers directly at surgeries or individual patients can be

[26] The North West London Health and Care Partnership (2019). North West London Primary Care Strategy 2019/20 plans and outline proposal to 2023/24. *Initial Draft submitted to NHSE on 01/04/2019*

[27] Ealing Health and Wellbeing Board (2016). Ealing Health and Wellbeing Strategy 2016-2021
[28] North West London Collaboration of Clinical Commissioning Groups (V01, 2016). NW London Sustainability and Transformation Plan

[29] NHS (2020). Health Survey for England

referred on to Social Prescribers by Ealing Local Authority to provide support in connecting the patient to the appropriate community groups and statuary services they need in relation to their health and wellbeing as well as broader socioeconomic issues such as finance, housing, work and legal issues.

ACUTE CARE

As is often the case, the other way that undiagnosed individuals in need are identified, treated and referred onto the appropriate longer-term care is via acute care services. Under the London North West University NHS Trust, Ealing residents suffering from a cardiac event can be taken to Central Middlesex, Ealing, Northwick Park or St Marks Hospitals, depending on the specific type of acute care required.

In most cases, Hounslow residents suffering from a cardiac event will be taken to the Cardiac Care Unit at West Middlesex University Hospital provided by the Chelsea and Westminster Hospital NHS Foundation Trust or at Hillingdon Hospital provided by the Hillingdon Hospitals NHS Foundation Trust. Like the services at Ealing Hospital, both West Middlesex and Hillingdon Hospital's Cardiac Care Unit is led by a team of interventional, imaging, heart failure and device consultants and are fully equipped to provide a complete range of services for the diagnosis and treatment of heart conditions. Full investigations are provided by a team of highly qualified cardiac surgeons and physicians. The teams work alongside two consultant cardiologists providing full investigations and treatment in the management of heart patients. They work closely with the cardiac rehabilitation team, heart failure specialist nurse and senior cardiology nurse. Coordination is also required between the Hillingdon Hospital and other nearby cardiovascular services including Central Middlesex, Northwick Park and St Marks Hospitals if other facilities are required. If an individual presents to their GP with signs of Angina, the Hounslow Rapid Access Chest Pain Clinic (RACPC) will provide a specialist assessment.

Whether an individual is identified by Primary or Secondary care services as at risk of or currently suffering from any type of heart condition, each pathway facilitates the referral of a patient onto community based, care management services.

INTERMEDIATE SERVICES AND CHRONIC CARE

After the appropriate treatment and discharge by acute teams or assessment by Primary Care, Hounslow residents with cardiovascular conditions are commonly referred on to the Cardiac Care Unit at West Middlesex University Hospital. This Unit provides both acute and chronic care in addition to the cardiac team utilising the referral route to specialist cardiac support at The Royal Brompton and Hammersmith Hospitals, if required. They also have a cardiac prevention and rehabilitation service to help people return to health after treatment and if an individual receiving intermediate services or chronic care displays any symptoms of Angina they will once again be supported by the boroughs, RACPC.

Ealing residents with cardiovascular conditions are referred on to the Imperial Healthcare NHS Trusts, Ealing Cardiovascular Health and Rehabilitation Service at Hanwell Health Centre[i]. This rehabilitation service is supported by the British Heart Foundation's National Audit of Cardiac Rehabilitation (NACR), a programme led by the University of York in partnership with NHS digital. This audit is in place to:

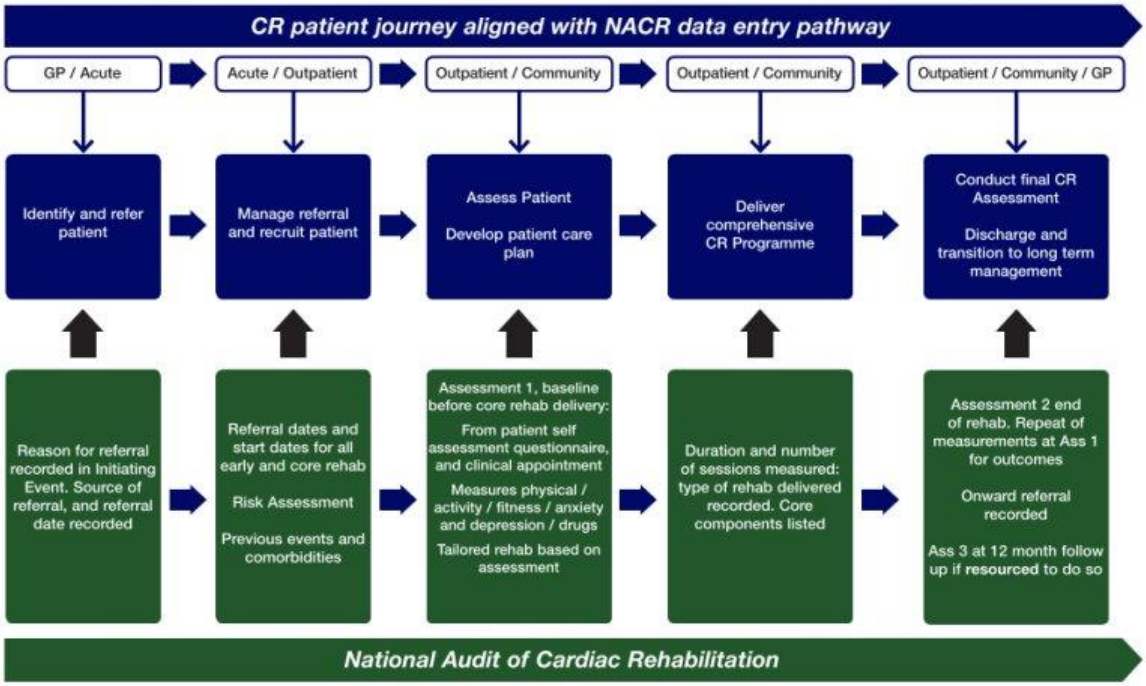
- Monitor and Support Cardiovascular rehabilitation teams to deliver high-quality services to evidence-based standard for all eligible patients
- Map the extent of provision in order to highlight inequalities and insufficiencies in the delivery of care
- Conduct research to determine the effectiveness of CR services on patient agreed outcomes, CVD risk profiles and health and social care utilisation
- Use audit and research data to inform: NICE clinical guidance, Clinical practice standards, NHS healthcare commissioning processes and decision making, and public and cardiac patient group about how their local services are performing.

The NACR produced a Cardiac Rehabilitation Pathway (see Attachment 4 of the report) that illustrates how the journey of the patient through Cardiac Rehabilitation aligns with the consistent entry of data to inform the NACR's objectives.

The Cardiac Rehabilitation website outlines the necessary information for patients detailing what Cardiac Rehabilitation is and its benefits to the individual as well as the practical matter of accessing one of these programme and what makes individuals eligible for them (different programmes may offer rehab to different patient populations but, for the most part, this is offered to those who have had a heart failure, coronary angioplasty, heart surgery, angina, heart failure or if one has had an ICD). The website also provides links to BHF Cardiac Rehab Resources, providing people with more information on what to expect and includes the Information on Patient and Public Participation in Commissioning Health and Care[30] , outlining how staff can include patients and the public in their work in a meaningful way to improve services, including giving clear advice on the legal duty to involve.

[30] NHS England (2017). Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England

The NACR offers both the CR programme and the supplementary British Association for Cardiovascular Prevention and Rehabilitation Phase 4 exercise programme in NWL with CR programmes being delivered via Imperial Healthcare NHS Trust at the Hanwell Health Centre as the borough's Cardiac Community Service (with exercise programmes delivered in various locations across each borough). Generally, each Cardiac team consists of cardiac specialist nurses, dieticians, exercise specialists, clinical psychologists and a Consultant Cardiologist. The team will devise a plan at how best to help patients with their on-going care and treatment. After an initial two-hour appointment with a cardiac nurse, physical activity specialist and dietitian, the team explores other lifestyle factors that may be impacting patient's health before being invited to attend a cardiac class once every week for 6-8 weeks. These classes included an individually tailored exercise programme and different health talks each week. Upon completion the patient is assessed once again in the clinic to monitor progress and have another discussion about what they need to do to maintain health going forward. Further information on the management of cardiovascular conditions can be found on the Hanwell Health Centre website.



Care coordination and Care planning

In addition to receiving Cardiac Rehabilitation, women who also have other long-term health conditions should expect to be supported by some form of care coordination and planning. The Ealing Care Coordination Service (CCS) is an Ealing Community Partners (ECP) service provided by the West London NHS Trust and aims to ensure that an integrated health and social care system keeps patients well at home. The service provides cost-effective, evidence based and timely care in the right place appropriate to individual's needs. This service is offered to those over 18 years old who need help to find their way around different health and social care services because of having one or more long term conditions (e.g., diabetes, asthma, COPD, coronary vascular disease, Alzheimer's disease, Dementia). An individual is assigned a Care Coordinator who works closely with the individual's GP, carers and family to ensure they receive the best possible care. They help the individual navigate the health and social care system, ensure that the care they receive is tailored to their health and social needs, bring together the different services involved in their care where

needed and help the individual communicate effectively with Health and Social care professionals involved in their care. The Care Coordination Service works across GP locations in Ealing's 8 Primary Care Networks. One care coordinator is allocated to each Primary Care Networks (PCN) within the borough.

Standard 7 of The Ealing Standard,[31] outlines the requirements and ambitions for a care planning and coordination service delivered by Primary Care. The service is designed to both reduce the risk of unplanned care while simultaneously empowering individuals and their carers (formal or informal) through coproduction and transparency. Mainly for those of a certain age that exhibit frailty, service providers are expected to create a register of those who need a coordinated care plan. This is through tools such as the Electronic Frailty Index as well as GP knowledge and awareness of the needs of their patients. A personalised and individually tailored care plan is coproduced between a trained healthcare professional and the individual, family and/or carer. Goals are set for the individual within the plan and self-management of conditions is championed throughout the plan. In instances where the needs of the patient stretch beyond that of self-management, clear contact points must be provided. A final important point of the care plan is that the needs of the patients' carers should be considered and integrated into the care plan. An agreed case-management plan usually takes the form of a 4-6 month review with patients. However, if a non-elective hospital admission occurs and/or intermediate services are required, a review of the care plan will commence. Individuals are provided with their own copy of the plan and the care coordination team will arrange MDTs with the relevant stakeholders such as Intermediate Care Service, Community Cardiology etc., to provide targeted interventions.

In Hounslow, care should be coordinated through an individual's GP. Individuals are also encouraged to use the Coordinate My Care tool to proactively organise their own care.

Other Rehabilitation Programmes

Upon discharge from Hospital for any conditions, residents from both boroughs should be assessed for reablement services provided by each respective Council. This includes a needs assessment, nursing support and the coordination of any physiotherapy services required.

For those that are suffering from multiple long-term health conditions, other rehabilitation services in Ealing and Hounslow are available. Such services require a similar referral process as the Cardiac care pathway outlined above – via acute or primary care teams. Examples include, the Community Neuro Stroke Service Specification Pathway for Adults (Annex L of the accompanying report) provided by the West London NHS trust and the NWL Diabetes Guidelines for patients[32]. The Neuro Stroke Pathway outlines the provision of a specialist multi-disciplinary team comprising of physiotherapy, occupational therapy, speech & language therapy, counselling, specialist nursing and clinical psychology. To provide coordinated community care for patients with neurological conditions (progressive & acquired), including stroke. The NWL Diabetes Guidelines provides a comprehensive illustration of how the specific needs of an individual with Type I or II Diabetes can be met by health and social care services in the region. At this stage, there is no such pathway for

[31] Ealing CCG (2017). The Ealing Standard, Quality Framework for Primary Care 2017/18 - 2020/21

[32] The North West London Health and Care Partnership (2019). North West London Diabetes Guidelines

the cardiac specification service or guidelines for how to prevent and manage cardiovascular conditions.

The current literature indicates that plans remain underway for the full integration of care pathways for long-term health conditions in Ealing and Hounslow. Although some services such as NHS Health Checks serve to prevent or manage a range of health conditions, rehabilitation services are still largely operating as individual entities in a fragmented approach to care.

However, current services provided by the West London Trust indicate the establishment of a more integrated and coordinated level of health and social care across Ealing and Hounslow. The Trust provides treatment for children, adults and older people living in the London boroughs of Ealing, Hammersmith & Fulham and Hounslow, delivering services in the community (at home, in GP surgeries, care homes), hospital specialist clinics and forensic (secure) units. Of relevance to women with multiple long-term health conditions including a cardiovascular condition, the Trust provides a range of mental health services including IAPT (Improving Access to Psychological Therapies), Primary Care Plus, the Hounslow Wellbeing Network, and Integrated Care Services through Ealing Community Partners.

The range of health and care services that Ealing Community Partners provides, from Nursing for people in their own homes and community clinics to Care for people with long term conditions, such as diabetes, pressure ulcers and continence needs, as well as psychological and psychiatric care represents the level of coordination that the region is beginning to develop. In addition, the ECP provides Ealing with a single point of access community referral hub which combines and co-locates multiple existing referral routes in planned and unplanned care teams[33].

Lastly, for Ealing, the Trust provides the Intermediate Care Service, provided by the ECP at Ealing Hospital that includes Rapid Response and Home First teams. Individuals are referred to this service through their GP or Hospital staff if they have suffered from a severe or sudden illness, or when they have been discharged from a general hospital, so they can return home quickly and recover in a more comfortable and familiar environment with the necessary care coordinated for them upon return.

For Hounslow residents who require intermediate support, the Hounslow and Richmond Community Healthcare NHS Trust provides the Integrated Community Response Service (ICRS) and the Hounslow Community Recovery Service (CRS). The ICRS aims to prevent patients from being admitted to hospital if they don't need to be through a team of GPs, nurses, occupational therapists, physiotherapists, support staff, social workers, pharmacist and a handyman. This team coordinates a comprehensive assessment which takes a holistic approach to reviewing an individual's needs, including their health, social needs and mental health needs. The team can be involved with a patient for up to 7 days, during which plans will be collaboratively made to ensure all ongoing needs are supported by working with and referring to other community services (community nursing and therapies, GP, social services). The CRS then provides integrated health and social care services for adults identified with uni- and multi-disciplinary recovery needs. Much like the services provided in Ealing, one of the main aims of these services is to prevent any possible physical and psychological and social deterioration that can happen during hospital-based rehabilitation and reablement and ensure a timely return to the home setting with the required provisions in place.

[33] Ealing Community Partners (2020), Integrated care services, Ealing Community Partners - Six month update

To further support self-care, Hounslow and Richmond Community Healthcare NHS Trust offer the Expert Patient Programme a self-care programme for free for those people and carers living with long term health conditions including heart disease. These programmes are run across Hounslow and led by those living with the long-term conditions, therefore providing real life experience. It aims to increase confidence; help manage the individual's condition and reduce time spent with the health professionals.

OTHER COMMUNITY SUPPORT

Alongside advice from GPs and other healthcare professionals, other community interventions in Ealing are summarised in the Ealing Healthy Weight Healthy Lives Strategy[34] including; the Ealing Walks programme delivered by Southall Community Alliance, Active Health Workplace interventions for Ealing Council Staff in which Health Trainers provide 1:1 support on behaviour change and health promotion, the Ealing Health Champion programme is in place providing training to frontline staff and individuals from ECVS to support them in delivering consistent health and wellbeing messages, Active Travel Projects within the Healthy Borough Programme including Active Travel Routes (Healthy Environment), Active Travel Plans (Healthy Organisations) to deliver overall increase in walking and cycling.

Several community-based programmes were commissioned by the local authority to support the reduction of diabetes and cardiovascular related factors in Ealing. However, funding cuts resulted in the services being discontinued. Examples of this include the Ealing Healthy Lifestyle Programme (EHLP), OneYou Ealing and SmokeFree Ealing and GPs have since shifted any advice for those at risk of these condition to more reliable and sustainable National Health initiatives that are promoted by Ealing Council. Smoking cessation remains a priority in reducing the overall prevalence of CVD and a self-care programme for those with CVD must be maintained and developed to help individuals effectively manage and live with their condition.

In Hounslow, the One You Hounslow service is still operating, offering lifestyle information support for residents such as how to eat well, moving more, drinking less and stopping smoking. They also promote both physical and mental wellbeing. They offer a range of resources on their website which translate to Gujrati, Hindi, Polish, Punjabi, Tamil and Urdu.

What does the evidence tell us about experiences of integrated care for this health and care experience profile?

People with multiple conditions are significant users of both primary and secondary care services, including urgent care services, and so are more likely to report care coordination issues. However, there is a lack of research into experiences of community health and social care for those with multiple conditions.

People living with multiple long-term conditions are seven times more likely to be prescribed polypharmacy than those without any long-term conditions. This risk is further increased when the patient is female.[15] Case study research[16] has shown that some people experience adverse side effects when medications for different conditions interact, without careful consideration from

[34] Ealing Council (2016), Healthy Weight Health Lives Strategy 2016-2019

health professionals. Further complications arise when multiple medications are prescribed with little comprehension and differing adherence. Additionally, people have reported that the cumulative effect of multiple health conditions has an impact on mental wellbeing. However, mental wellbeing was not often discussed or reflected on by health or social care professionals.

The Richmond Group of Charities have stated people living with multimorbidity experience challenges to care coordination including:

- Standardized care plans that do not match patients' needs.
- Different care plans that conflict with each other or are too complex.
- Healthcare professionals who simply focus on their own clinical specialty rather than their patient's holistic situation.
- Healthcare professionals who do not communicate with each other, between services and sectors.
- Inconsistent information from different health care providers.

In 2019, as part of the NWL strategic delivery plan, Healthwatch carried out research with thousands of people from across England living with a range of health conditions, including heart conditions. This work focused on understanding how people felt the NHS could better support their health and wellbeing. Some of the key findings included:

- Those with heart disease reported better experiences of health and social care support than people with other conditions, which related to timeliness of diagnosis and treatment, access to rehabilitation and support courses, complementary wellbeing therapy, and annual check-up. However, those with multiple long-term conditions felt that similar levels of support were not always in place for them when compared to cardiovascular care.
- People were frustrated by the fact that they had to repeat themselves to different professionals involved in their care; they wanted information sharing between services to be simpler, so they could focus on getting the support they need.

The National Audit of Cardiac Rehabilitation in 2019[35] reported lower female participation in Cardiac Rehabilitation programmes, with this proportion staying the same in 2020 (29%). However, there is significant variation in attendance of women between programmes in England. This may be owing to differing infrastructure and funding models between neighboring services.

The British Heart Foundation[36] found that women suffering from heart attacks receive poorer standards of care across diagnosis, treatment and aftercare, compared to men. In addition, many risk factors for heart disease are more deadly for women (e.g. smoking, high blood pressure and type 2 diabetes). This highlights the need for a more cohesive approach to prevention and support in the community, diagnosis in primary care and treatment in primary and secondary care.

Although, heart failure teams are multidisciplinary, there is no current evaluation of the specialist teams and infrastructure provided.

[35] The National Institute for Cardiovascular Outcomes Research (2019). National Cardiac Audit Programme 2019 Annual Report.
[36] Lee, K. et al (2019). Sex-Specific Thresholds of High-Sensitivity Troponin in Patients With Suspected Acute Coronary Syndrome. J Am Coll Cardiol. 74 (16) 2032–2043.

What does the evidence tell us about experiences of integrated care for this health and care experience profile in Ealing and Hounslow?

The data shows that this relatively small cohort from each borough generate a sizeable amount of emergency and planned visits, using a significant amount of NHS resources as a result. The evidence also suggests that there are clear similarities and differences in the experience of Ealing and Hounslow residents who share similarities with this health and care experience profile.

The data highlights several inequalities within this population sample that require further exploration. First, the significant proportion of A&E visits from individuals living in the most deprived areas in Hounslow seems to suggest that women living in these areas require a great deal more support from health and social care services to both manage any long-term health conditions they have and prevent any further ones from developing. Furthermore, a significant percentage of Ealing residents who fit this Profile were of a BAME ethnicity, making up the majority of those living in the most deprived areas in the borough. Further still, in both boroughs, there were more women of BAME ethnicity than White British women suffering from 5 or more long-term health conditions, including a cardiovascular condition. In conjunction with the finding that women of BAME ethnicities in both boroughs had a significantly higher incidence of CHD and Hypertension, these findings highlight clear disparities between the health of those of a BAME ethnicity and a White British ethnicity, particularly those living in deprived areas.

Overall, the data reinforces the previous literature on women in NWL with multiple LTCs, indicating that a lack of - or underdeveloped - holistic approach to care in Ealing and Hounslow may, in part, be responsible for the significant use of NHS resources by this cohort of women. In particular, the significant number of BAME women in this cohort with Hypertension may suggest that there is a delay in the health and social care support that these women are receiving. By introducing more coordinated and integrated care pathways that provided primary care prevention and management for those that need it most, there is a strong argument that individuals would rely less on acute care for their health and wellbeing.

Hounslow Patient Experiences

The engagement with women in Hounslow who shared similarities with this experience profile uncovered several key themes relating to their care that further reinforced the data findings. Communication between professionals and with patients were both consistently referred to as unsatisfactory and identified by women as one of the main catalysts for service fragmentation and, paradoxically, feeling disconnected from their own care while at the same time feeling that the responsibility of progressing any treatment fell largely on their own shoulders. Women from Hounslow largely agreed that they had experienced no form of holistic care pathway with many being restricted to talking about just one or two conditions at their GP appointments, either due to a lack of time or explicitly instructed by their GP. Viewed together with the data findings, the lack of coordination and communication experienced by these women could partially explain why these women require such a high level of care from secondary services.

A lack of continuity in care was also highlighted by Hounslow residents. One patient had experienced continuity and integration within her care after being referred onto the Cardiac team at University

College London Hospital. However, other patients stated that they had to regularly repeat their medical history to new healthcare professionals with this issue being cited in both health and social care services. This will have undoubtably contributed to the distress that patients felt when interacting with professionals with one patient stating that 'no one acknowledges you as a human being' and another suggesting that she tries her best to stay healthy as she is concerned about the standard of care she would receive.

A final interesting theme to come out of the discussions with Hounslow residents was the lack of recognition and support for family members and informal carers of patients within this experience profile criteria. One patient who herself suffered from an LTC indicated the care that she was required to provide for her husband caused significant friction in their relationship. This sentiment was echoed by two daughters who had to care for their mother after she suffered a Stroke and hadn't received any social care for over a year. The level of care required to support their mother had a significant impact on one daughter's education, causing further stress for the family.

Hounslow Stakeholder Engagement

Agnes Kaba (AK) – Clinical Nurse Specialist, Rapid Access Chest Pain (RACP) Services Lead at West Middlesex University Hospital - said there is capacity for 66 slots for patients to attend this service. However, during the pandemic the slots were reduced to half. AK will determine if they have heart disease and Cas Shotter Weetman (CS) – Lead Specialist Nurse Cardiology at West Middlesex University Hospital - is 'at the end of the investigation' once patients have been diagnosed with heart disease. If patients come through A&E, then they are referred to RACP Clinic. Once patients have received treatment, they will then be seen by a Cardiac Rehabilitation Nurse Specialist to discuss their recovery process and treatment plan. They will then be treated by the cardiac rehabilitation team who work in the community.

CS stated that during the pandemic, they did not see many patients. There were several reasons, including patients being afraid to come to the hospital. However, they have noticed patients are attending clinics and it has become busy and that wards are returning to normality.

Patients are referred through several routes to the RACP clinic. Patients can be referred via their GP, Ambulatory Emergency Care and A&E. CS said many of the patients who come through the RACP clinics have multiple risk factors e.g., diabetes, hypertension. CS said hypertension is 'not very well managed' in the community and is referred to as the 'silent killer' as it may not show any symptoms. CS and AK both recognised that there is a misconception about men being more likely to use the service. They stated that they are seeing almost an equal number of men and women coming through the service. They are seeing a pattern in ethnicity as well. There has been an increase in women from a South Asian background using the services. Patients have access to 'Patient Knows Best' and the resource library.

CS and AK mentioned that they are heavily involved in empowering patients and CS said there needs to be more coordinated and integrated work between and within primary care and secondary care services, utilising the skills and experiences of those who have ideas on how to improve health outcomes and inequalities and orchestrate a borough wide focus on detailing care pathways and reorganising prevention strategies. Both CS and AK highlighted the importance of prevention. They have initiated several prevention initiatives, especially focusing on health promotion on cardiac care

and that they are currently working in partnership with Hounslow and Richmond Community Healthcare Trust to deliver 'Right Lifestyle' Roadshows to help improve resident's health and lifestyle.

Ealing Patient Experience

Although there were some similarities shared between the views and experiences of Ealing women with multiple long-term health conditions and a cardiovascular condition compared to those living in Hounslow, more striking were the reported differences in the level of care integration.

Most Ealing women who were interviewed spoke positively of the level of communication both from and between healthcare professionals with praise for several proactive GPs. In contrast to the experiences shared by Hounslow residents, there were only a few instances of poor communication referenced by Ealing residents. One patient experienced a lack of coordination between a GP and Nurse in relation to whether she needed a blood test or not and two patients indicating that they had to chase respective healthcare professionals to find out about their own appointment.

On the other hand, involvement of patients and their families in their own care plans was inconsistent and while some patients indicated that they were experiencing a holistic approach to their care others experienced difficulties. One example of this came from a patient who wanted to change GPs due to inadequate care but felt 'over a barrel' as they were the only GP within her area that spoke her first language of Punjabi.

Lastly, a unique theme to Ealing was the identification of inadequate physiotherapy and reablement services. While several patients indicated that this may well be due to the pandemic, other patients stated that inadequacies within these services were apparent prior to it. Reviewed in conjunction with the fact that some Hounslow patients a lack of social care altogether suggests that this is an area of concern that must be rectified in both boroughs.

Ealing Stakeholder Engagement

Dr. Fragoyannis highlighted the integration of IT systems within Ealing as one of the reasons for a robust and coordinated cardiovascular service in the borough. The use of SystemOne and WSIC across NWL CCGs as centralised databases allows for patient's health records to be reviewed and updated by any healthcare professional and as a result led to more coordinated and efficient individual care pathway monitoring.

Ealing was the first NHS CCG in England to successfully develop and launch their Community Cardiology Service. The service was created by leading senior cardiac clinicians in the borough with all healthcare professionals involved in the service receiving regular training - part of the concerted

efforts within Ealing and throughout the NWL CCGs to educate GPs on cardiology. Instead of patients being referred to a hospital in Ealing they go to Hanwell health centre. The shared system, departmental administration teams and email referral process allows for less duplication in work, more efficient and personalised follow-ups from the relevant cardiology department and ability for healthcare professionals involved in an individual's care (GPs, Clinicians, etc.) to access the same data for a quicker progression of an individual's treatment and care. Further efficiencies within the service pathway comes from conducting any pre-diagnostic interviews prior to preliminary testing via telephone or video before employing a 'one-stop shop' style of testing, enabling Echo scans, ECGs, Blood tests etc all to be carried out during one appointment. After preliminary tests, consultants triage all referrals using the same database and email system. Finally, GPs only refer patients that truly need the support of the community cardiology service to prevent overwhelming the service, utilising specialist's care efficiently and utilise other services in circumstances where patients need less support such as medication prescriptions or community group support for self-management of conditions.

Zoe Sargant indicated that the Cardiac care pathway referral process can take between 2hrs to 6-weeks depending on the severity and urgency of the issue. Dr. Fragoyannis mentioned that the service has become a template for all other NWL CCGs and is one of the most common pathway driven areas of healthcare that the NWL CCGs have alongside Diabetes. However, Ms. Sargent alluded to the fact that while there are services specification pathways for other conditions, such as the Community Neuro Stroke Rehabilitation Pathway [Annex L], there is no documented pathway for Cardiac conditions.

Dr. Fragoyannis did recognise that, although the Cardiology service is well-regarded, there remains a degree of variation that can occur for women with heart conditions across the NWL region due to the inequalities in access and information between and within boroughs and the level of specialisation of services in the region. For example, boroughs that do not have this level of specialised community services are likely to have extended waiting times for patients which again, can contribute to this inequity in care from one borough to the next. Dr. Fragoyannis mentioned that Hounslow does not have a similar community cardiology service but does work well with Hospital Trusts for efficient referrals and coordinated care at West Middlesex Hospital.

Another area that requires improvement was highlighted by Dr. Ip who outlined the most prevalent mental health issues in those with cardiac conditions (depression, anxiety and post-traumatic stress). Dr Ip indicated that cardiac rehabilitation services and other rehabilitation services too, must understand how psychological support can be integrated into their respective programmes. Ms. Sargent indicated that this was not just exclusive to psychological therapies. Physical rehabilitation services are equally fragmented and the coordination of physical rehabilitation with psychological and social care in order to provide a more holistic approach to individual care is still required.

Lastly, Dr. Chauhan stated that the cuts to borough funding have led to a diminished pre- and post-infarction offering which has undoubtedly affected the identification of 'at-risk' individuals as well as effective prevention and management strategies for cardiovascular conditions and other related long-term health conditions. Dr. Chauhan stated that NHSE must have sustainable social and community-based programmes like the former Ealing Healthy Lifestyle Programme that provides tangible output and outcomes that also target individuals emotional and mental wellbeing as a holistic lifestyle improvement programme. This would align with the NHS 10-year CVD plan that focuses more on prevention as well as answering the question of 'how do we motivate a high-risk group of individuals?'.

Summary

The data and the views of local healthcare professionals suggest that individual Cardiac Care Services are well-structured and that any significant gender discrepancies may be caused by contributory factors that impact the accessibility of these services for women who share this experience profile. Stakeholders also recognised that, in some instances, the current fragmented approach to care may not best serve those who have more than one LTC and that holistic care is still in a process of development, not helped by the impact of the COVID-19 pandemic. Once again this is clear from the data which outlines the amount of secondary care that this population of women requires.

The views and experiences shared by patients reinforced these findings. Patients from both boroughs indicated that there was an absence of holistic care at from primary and chronic care services and that the level of coordination between services did often lead to inefficient health and social care. However, while communication both between professionals and with patients seemed to be largely satisfactory in Ealing, this was a consistent area of concern for Hounslow residents that arguably led to this frequent breakdown in coordination between services, resulting in patient's receiving unsatisfactory treatment and care. On the other hand, in several instances, Primary Care in Ealing was recognised as proactive in its care and coordination and Hounslow residents more frequently referred to issues with feeling disconnected from their own care while at the same time feeling that the responsibility of progressing any treatment fell to them. Although there are areas for concern in both boroughs, particularly in terms of access to required services, stakeholders in Hounslow should look to prioritise patient involvement in their own care planning as this will lead to patients feeling respected and supported through greater communication and transparency of services.

Work in progress and future projects to ensure integrated care

Continued efforts at borough level will enforce the key delivery areas of the NHS Long Term Plan[37] at local level including; increased medical training to ensure a better balance between specialists and general doctors and reducing the occurrence of smoking by creating cessation pathways for expectant mothers and those with mental health issues. In addition, Local Authorities and Health Care Partners have a number of areas of work that will be developed in the short term to develop a more integrated level of care.

Ealing and Hounslow CCG, fall under the new North West London collaborative CCG. The Case for Change[38] cited several benefits of expanding into a regional commissioning group, which puts integration at the center of development. The merger will theoretically support the move to a regional Integrated Care System as of April, 2021 through pooling resources to reduce inequalities across the region, reducing duplication, investing more in out of hospital care and ensuring local residents can influence the decision-making through the EPIC (Engage-Participate-Involve-Collaborate) programme in partnership with local Healthwatch.

The NWL Five-year strategic plan[39] also sets out its vision and strategy for improving the health and wellbeing of the region's population as we move into this Integrated Care System. A borough level Integrated Care Partnership has been instated to ensure this vision is implemented at local level. In particular, the partnerships will; Ensure that access to and proactivity of care is improved; Ensure high intensity users of urgent and emergency care services all have personalised multi-disciplinary care plans to help them manage their complex health and social care needs; Ensure patients with LTCs will be supported proactively by a care team and provided with motivational and educational resources; Further scale a range of schemes to increase the use of alternate care pathways for ambulance crews; and tailor self-care and service to individual patient needs - through the Patient Activation Measurement.[40] Additionally, to ensure no variation across the care for individuals, increase access to technology and testing for earlier diagnosis of heart conditions - The Right Care Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. Lastly, a strong focus on tackling Childhood Obesity, which in the long-term will have a positive impact on reducing the number of those suffering from cardiovascular conditions.

These sentiments are echoed in the Hounslow Health and Wellbeing Strategy which also outlines the need for a new set of recommendations on how to continue the success of the National Diabetes Prevention Programme, a remodelling of community social work implementation and a review of care coordination among patients with a known risk of going into hospital. Further still, the Hounslow ICP outlined a workstream for the 2021/22 financial year that includes priority work on

[37] NHS (2019), The NHS Long Term Plan

[38] NHS NW London Collaboration of CCGs (2020), The case for change for a single NW London CCG - August 2020

[39] https://www.hounslowccg.nhs.uk/about-us/our-plans.aspx

[40] The North West London Health and Care Partnership (2020). NWL Journey to ICS: draft paper, VO2

the development Community Heart Failure and Diabetes services and the implementation of Primary Care Patient Coordinators.[41]

Support will also be provided by the London Cardiac and Stroke Clinical Network including pilot schemes in 2020/21 and 2021/22 to increase access to echocardiography and improve the investigation of those with breathlessness and the early detection of heart failure and valve disease.[42] From 2022/23 funding for wider roll out will be included in fair shares allocations to systems, improving efficiency of stroke care by coordinating hospital stroke services with community-based stroke rehabilitation.

Ealing's Health and Wellbeing Strategy has as one of its key actions, to continue to develop a joint approach to service integration and prevention for people with complex needs. The aim would be to provide holistic, person-centred care to other priority groups, where there is added value in collaboration across services and potential to achieve better outcomes for individuals. In relation to this experience profile, Ealing aims to provide ongoing support to the community cardiology service as part of the policy outlined in the Ealing Local plan to deliver on Clarity in Outcomes for the three killers and reduce unwarranted variation in the management of LTCs by moving to outcomes-based commissioning contracts with providers benchmarking the right activity (using Right Care data) for priority disease pathways from preventative care through primary, secondary and specialist care. Additionally, further focus on understanding the local Ealing disease burden and understanding of current local interventions that are achieving best value at present.

Practical steps in both boroughs are due to recommence after the pandemic and resulting efforts in the vaccination rollout.

In addition, Dr. Ip suggested that the resources within the community needed to be improved as well as the knowledge amongst healthcare professionals of what is available in the community. And other gaps remain - Dr. Chauhan highlighted the lack of timely diagnosis for heart and CVD-related long-term health conditions. For instance, Diabetes is notoriously undiagnosed and is often only identified once a serious cardiac event, such as a Myocardial Infarction occurs. Dr. Chauhan went on to say that the lack of diagnosis, lack of an efficient and signposted care pathway, and a lack of pre- and post-infarction support services combined to undermine the effective management of long-term health conditions, particularly those related to cardiovascular health.

Dr. Fragoyannis stated that work to further build on the efficiency and effectiveness of the Community Cardiac Service continues while it is also being used as a service template for the other boroughs, within the region. Concurrently, Ms. Sargent suggested that as the impact of COVID begins to ease, Ealing Community Partners can start to turn their attention back to the integration of treatment and rehabilitation services into a more holistic pathway. This has already begun in certain

[41] Hounslow CCG (2019), Hounslow Integrated Care Partnership Roadmap

[42] London Cardiac Clinical Network (2017). Improving Heart Failure Services for People in London.

areas of work. Ealing Community Partner's update on Integrated Community Services[43] indicated that it has reached several milestones in the move toward a more coordinated approach to care across Ealing and Hounslow. First, Home First supported discharge activity continues to grow while the appointments of a number of key coordination roles including, Community Matrons, District Nurse Team Managers and Care Coordinators in each PCN have been confirmed and continue to be refined. Most notably, other new clinical health psychology activity has commenced with further work planned to integrate the IAPT-LTC[44] offer within rehabilitation services to provide psychological support for individuals who are managing long term health conditions. IAPT-LTC services will target the needs of people with depression and anxiety disorders who also have LTCs. This service is recognised as a crucial step toward recognising the impact that a physical long-term health condition has on an individual's mental wellbeing, a key aim of the NWL STP for 2020/21.

Further work in this area was outlined by Dr. IP. A coproduction group of professionals and service users has been formed to address how pain management and psychological services need to be integrated into rehabilitation services for physical conditions and a psychologist has now been appointed within the Pain Management service in Musculoskeletal team with the hiring process currently underway for the same position in the Diabetes and Cardiology teams as well. Furthermore, Ms. Sargent and Dr. Ip outlined a holistic service that individuals could be referred to for the breadth of their health and wellbeing issues representing a tri-aspect care service that would provide individuals with access to support for their mental and physical wellbeing as well as involving PCN Social Prescribers to provide support for other contributory health and lifestyle factors. Both Ms. Sargant and Dr. Ip indicated that the utilisation of other care services within a stepped approach; including IAPT, community sector organisations and Social Prescribers, would be crucial to ensuring that patient's needs are met while ensuring that the pressures on primary secondary care services are more reasonably distributed. However, as Dr. Chauhan pointed out this would require support for community organisations to offer such services and a strong knowledge base for GPs to improve the local referral process.

[i] Although Hounslow and Richmond Cardiovascular Rehabilitation Service at Whitton Corner Health and Social Care Centre is referenced on the NACR website, there was no indication in the literature or from borough healthcare professionals that this was an operational service.

[43] Ealing Community Partners (2020), Integrated care services, Ealing Community Partners - Six month update

[44] National Collaborating Centre for Mental Health (2018), The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms. Full implementation guidance. London: National Collaborating Centre for Mental Health.