London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Supplementary 2 Agenda

Wednesday 13 September 2017
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group
Cllr Ben Coleman, Cabinet Member for Health and Adult Social Care (Chair)
Janet Cree - H&F Clinical Commissioning Group
Councillor Sue Macmillan - Cabinet Member for Children and Education
Steve Miley, Director for Children's Services
Keith Mallinson - Healthwatch Representative
Lisa Redfern, Interim Director of Adult Social Care
Mike Robinson - Shared Services Director of Public Health
Dr Tim Spicer - H&F Clinical Commissioning Group (Vice-Chair)
Ian Lawry – SOBUS (Co-Opted Member)

Nominated Deputy Members:

Councillor Rory Vaughan
Councillor Sharon Holder

CONTACT OFFICER: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 5758
E-mail: bathsheba.mall@lbhf.gov.uk

Reports on the open agenda are available on the Council's website:
http://www.lbhf.gov.uk/Directory/Council_and_Democracy

Members of the public are welcome to attend. A loop system for hearing impairment is provided, along with disabled access to the building.

Date Issued: 13 September 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Supplementary Agenda

13 September 2017

Item		Pages
4.	**DRAFT BETTER CARE FUND**	1 - 91

This report provides the Health and Wellbeing Board with details of the Integration and Better Care Fund Plan for 2017-19 submitted on the 11th September to NHS England.

Note: The documents included in the Supplementary 2 Agenda are appendices to Appendix 1, the Better Care Plan 2017/19.

Appendix 2

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

Agenda Item 4

V01

21 October 2016

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.4bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful. We have listened to the feedback we have received so far from our patients and residents and updated our plan in particular around access to primary care and the delivery of mental health services. We will continue to engage throughout the lifetime of the plan.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group and NW London STP System Leader

Carolyn Downs
Chief Executive of Brent Council

Clare Parker
Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

Contents Page

i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs (e.g. schizophrenia) have a life expectancy up to 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.4bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

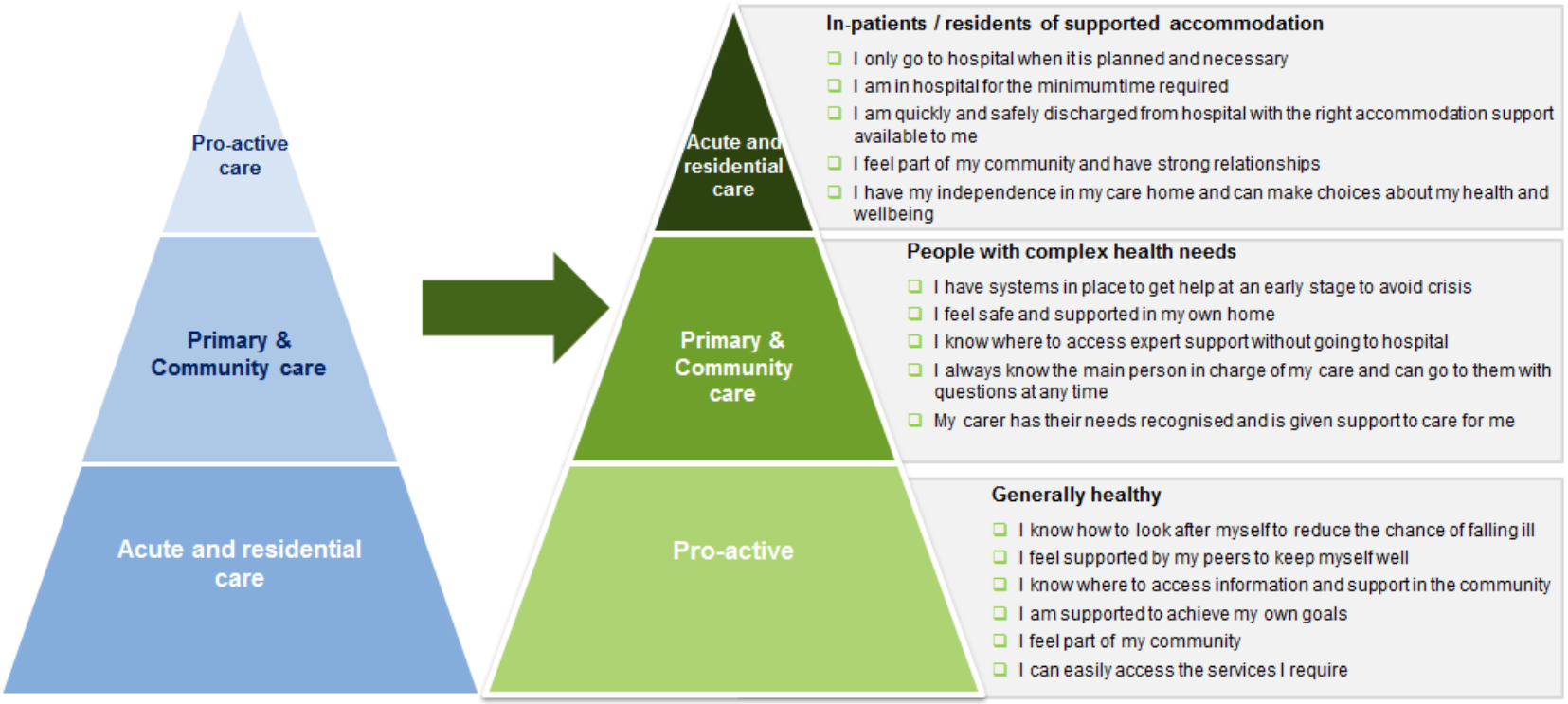
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,000	458,000	26,000	43,300	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	16%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children the get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	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'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care. We will deliver this through primary care operating at scale through networks, federations of practices or super-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves, it benefits from specialisation and innovation. The benefits of senior clinical advice available at most parts of the day are now well documented to improve outcomes as it enables the right treatment to be s delivered to the patient at the right time We know from our London wide work on stroke and major trauma that better outcomes can be achieved by consolidating specialist doctors into a smaller number of units that can deliver consistently high quality, well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our STP sets out how we will meet the needs of our population more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also allow us to deliver primary care to scale with an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs. Due to the on-going uncertainty of the future of Ealing Hospital the vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. As Ealing currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

A joint statement from six boroughs is at Appendix A. Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute services in the two respective boroughs. Both councils remain fully committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

There is a similar vision for Charing Cross Hospital. Here, again, we plan to deliver ambulatory care, primary care to scale and an extensive range of diagnostic services. However at Charing Cross, during this STP period, there are no planned changes to the A&E services currently being provided.

i. Executive Summary:
Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £298m gap in social care, giving a system wide shortfall of £1,410m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the health sector is a £15.1m surplus, and the social care deficit is £35m, giving an overall sector deficit of £19.9m.

Table: North West London Footprint position in 20/21

£'m	CCGs	Acute	Non-Acute	Spec. Comm	Primary Care	STF Investment	Sub-total (Health)	Social Care	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Do Nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	**-**	**(1,112.4)**	**(297.5)**	**(1,409.9)**
Business as usual savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	**108.5**	**680.6**
DA 1-5 - Investment	(118.3)	-	-	-	-	-	**(118.3)**	**-**	**(118.3)**
DA1-5 - Savings	302.9	120.4	23.0	-	-	-	**446.3**	62.5	**508.8**
Additional costs of delivering 5YFV	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	**-**	**1,127.5**	**262.5**	**1,390.0**
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	**-**	**-**	**-**	**15.1**	**(35.0)**	**(19.9)**

Schemes have been identified which support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the areas of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes These schemes, as well as improving patient outcomes, are expected to cost less – requiring £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings.

In addition, the solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, mainly attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for most providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing, once it can be demonstrated that reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.

The remaining deficit is due to London Ambulance Service (NWL only) and Royal Brompton & Harefield, who are within the NWL footprint but primarily commissioned by NHS England.

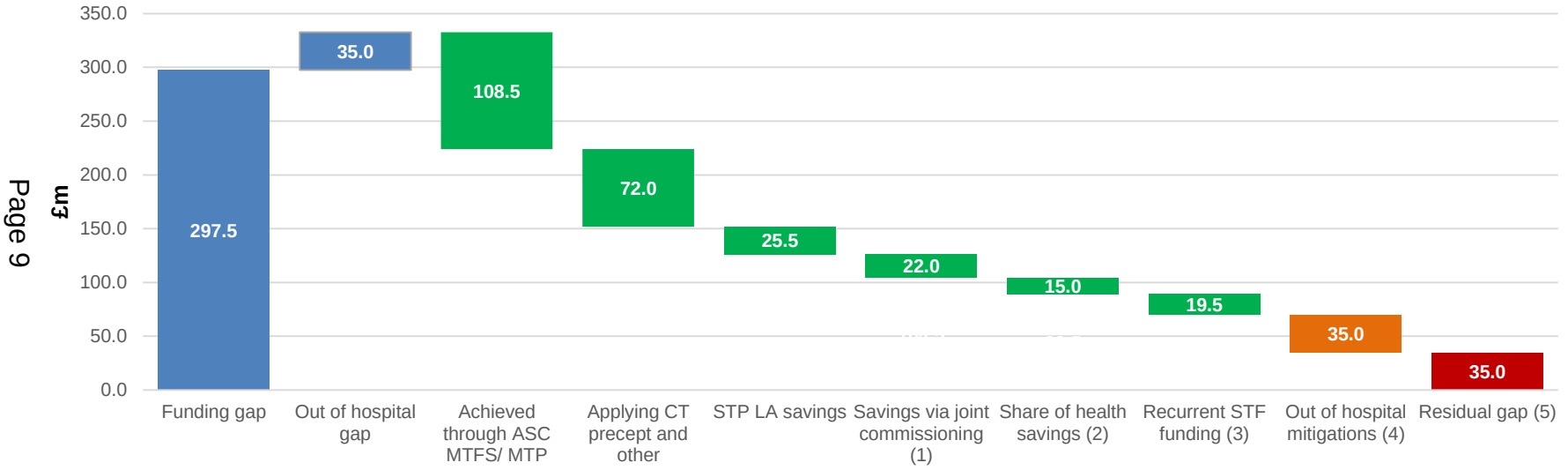
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances (I)

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. In addition to this there continues to be a significant level of service and demographic pressures putting further strain on the service. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The chart below sets out below the projected gap and how this will be addressed. The savings are further broken down on the following slide.



The following assumptions and caveats apply:
The residual gap of £35m by 20/21 will be addressed through further joint working between health and social care. An initial estimated cost pressure of £35m illustrates the likely shift from hospital activity into adult social care, which is to be addressed through a robust business case process. £19.5m is assumed to be funded by STF on a recurrent basis, leaving an unresolved recurrent gap of £35m.

(1) Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3;
(2) The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;
(3) Assumed that £19.5m will be recurrent funding from 2020/21through the STF fund;
(4) Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;
(5) The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.
NB Confirmation of what the final on-going sources of funding will be from 2020/21 is being sought.

i. Executive Summary:
Social Care Finances (2)

The table below sets out how the savings accruing to local authorities from joint work with Health on the Delivery Area business cases will be delivered through the investment of transformation funding:

Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health** (£M)
Public Health & prevention	DA1	**-**	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	**-**	**-**	**-**	**6.1**
Caring for people with complex needs	DA3	**-**	**-**	**-**	**5.1**
Accommodation based care	DA3	**7.7**	**-**	**7.7**	**2.0**
Discharge	DA3	**3.4**	**-**	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	**-**
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	**-**	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:
To deliver the savings requires non-recurrent transformational investment from the NHS Sustainability and Transformation Fund of an estimated £110m over 3 years (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services. The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary:
16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA1	i. Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery ii. Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	i. A shared understanding of public and professional responsibility for use of services ii. Maximising opportunities working jointly to support people with mental health problems, resulting in benefits to the health system and wider local economy
DA2	i. Increased accessibility to primary care through extended hours and via a variety of channels (e.g. digital, phone, face-to-face) ii. Enhanced primary care with focus on providing more proactive and co-ordinated care to patients iii. Comprehensive diabetes performance dashboard at practice and CCG level iv. Delivery of Patient Activation Measure Year 1 targets as part of the self care framework	i. Delivering extended access for Primary Care, 8am – 8pm, 7 days a week, leading to additional appointments available for patients out of hours, every week, as well as a reduction in NELs and A&E attendances ii. Unique, convenient , efficient and better care for patients as well as supporting sustainability and delivering accountable care for patients iii. Improve health and wellbeing of local diabetic population iv. Enable more patients with an LTC to self-manage
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint safer staffing programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.4bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

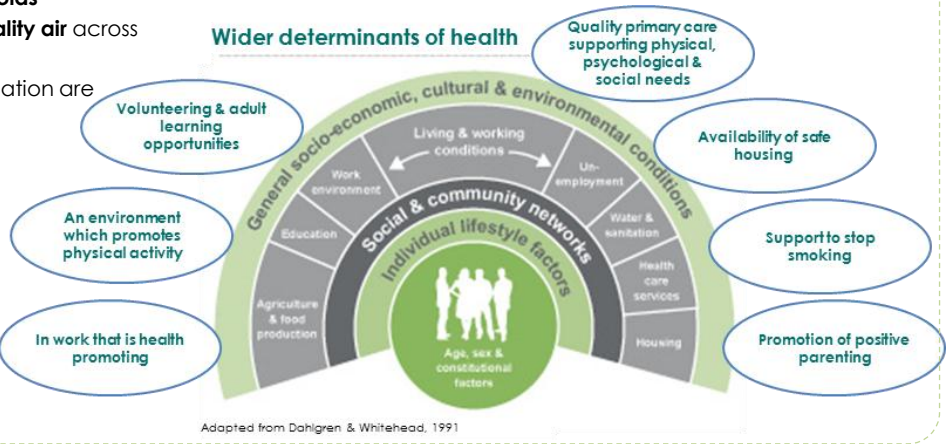
1. Case for Change:
Understanding our population

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- State primary school **children with high levels of obesity**

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Adapted from Dahlgren & Whitehead, 1991

Population Segmentation for NW London 2015–30[3]

Mostly healthy
- 1,216,000 adults in NW London are mostly healthy
- 58% of the total population
- 24% of care spend in NW London

In 2030:
- 4% more adults
- 31% more +65s

One or more long-term conditions
- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030:
- 35% more adults
- 37% more spend in NW London

Cancer
- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4.5% of care spend in NW London

In 2030:
- 53% more adults
- 50% more spend in NW London

Serious and long term mental health needs
- 37,500 adults in NW London have serious and long term mental health needs
- 2% of population
- 7.5% of care spend

In 2030:
- 16% more adults
- 21% more spend in NW London

Learning disability
- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8% of care spend in NW London

In 2030:
- 29% more adults
- 35% more spend in NW London

Severe physical disability
- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults
- 26% more spend in NW London

Advanced dementia / Alzheimer's
- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults
- 44% more spend in NW London

Children
- 438,200 children in NW London
- 21% of the population
- 14% of care spend in NW London

In 2030:
- 6% more children
- 3% more spend in NW London

Socially Excluded Groups
- Westminster has the highest recorded population of rough sleepers of any local authority in the country
- There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

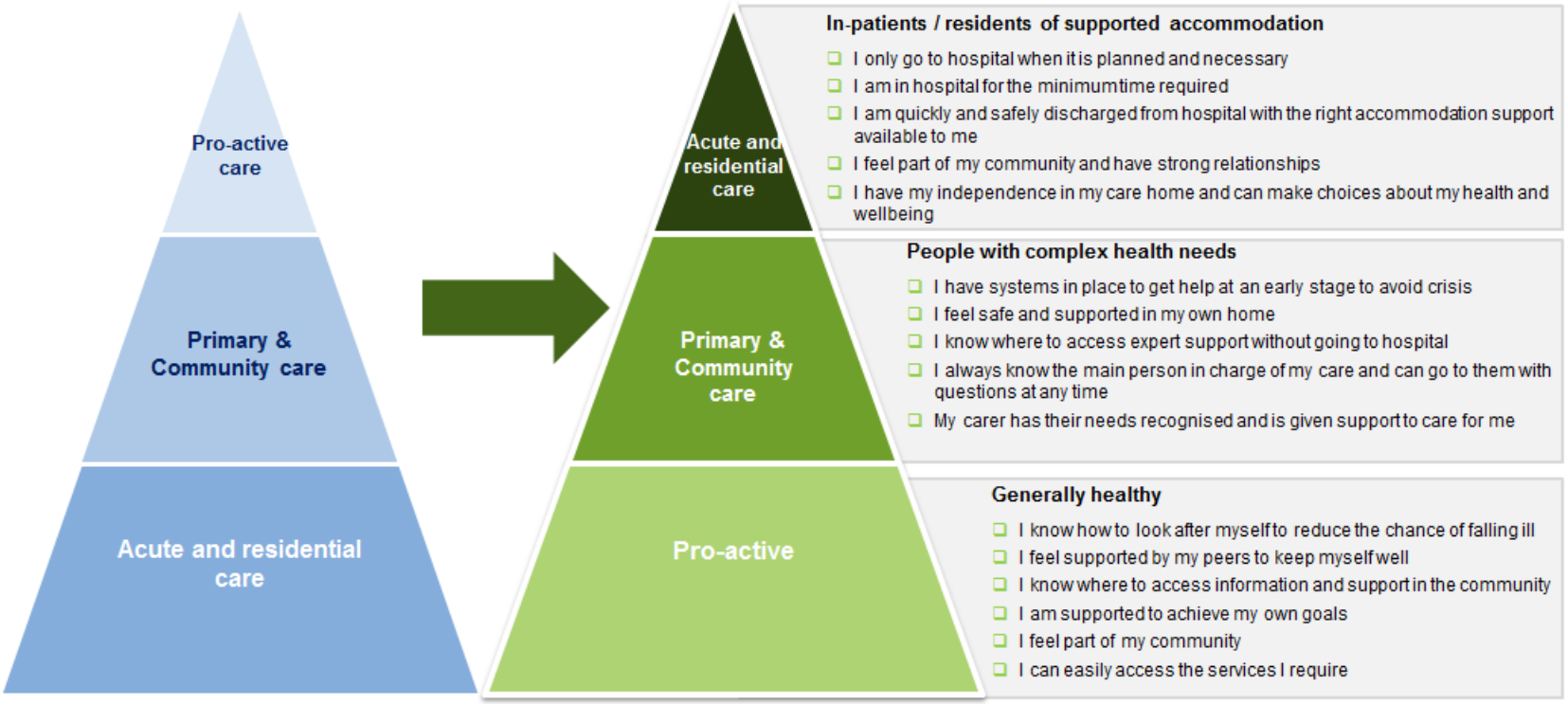
Please note that segment numbers are for adults only with the exception of the children segment

1. Case for Change:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

1. Case for Change:
Understanding people's needs

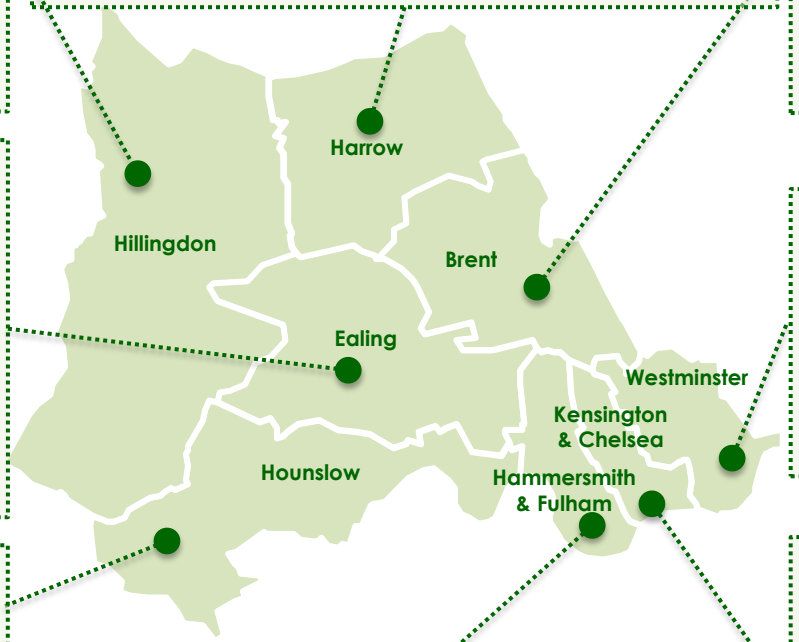
While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6

- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 9.5% rise in the number of people over 75 years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)



- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

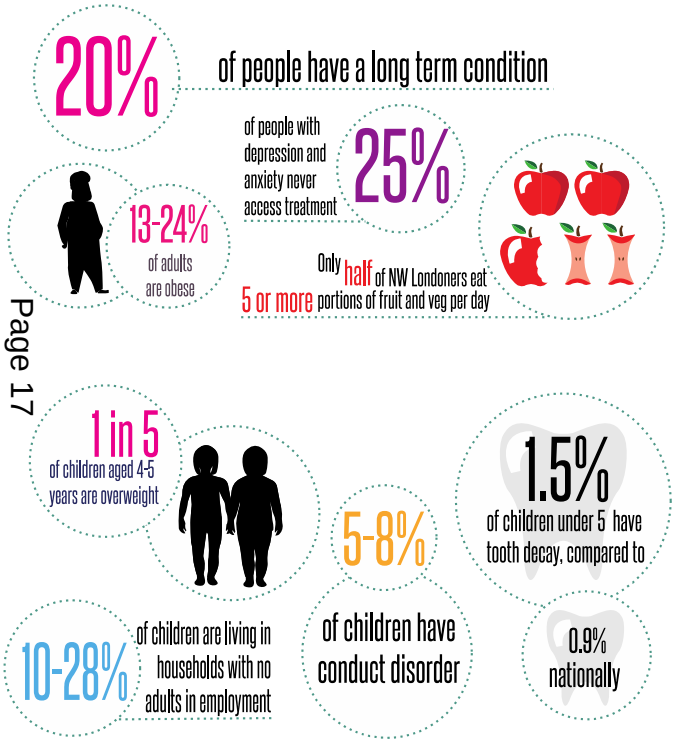
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…



1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

Our Priorities

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Improve children's mental and physical health and well-being
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

"My life is important, I am part of my community and I have opportunity, choice and control"

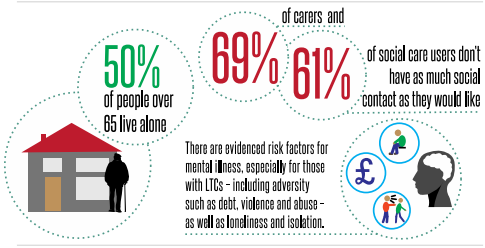
"As soon as I am struggling, appropriate and timely help is available"

"The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me"

"My wellbeing and happiness is valued and I am supported to stay well and thrive"

"I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing"

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health and preventing escalation of mental health needs	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
Over 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy circa 20 years less than the average and the number of people in this group in NW London is double the national average.	People are supported holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

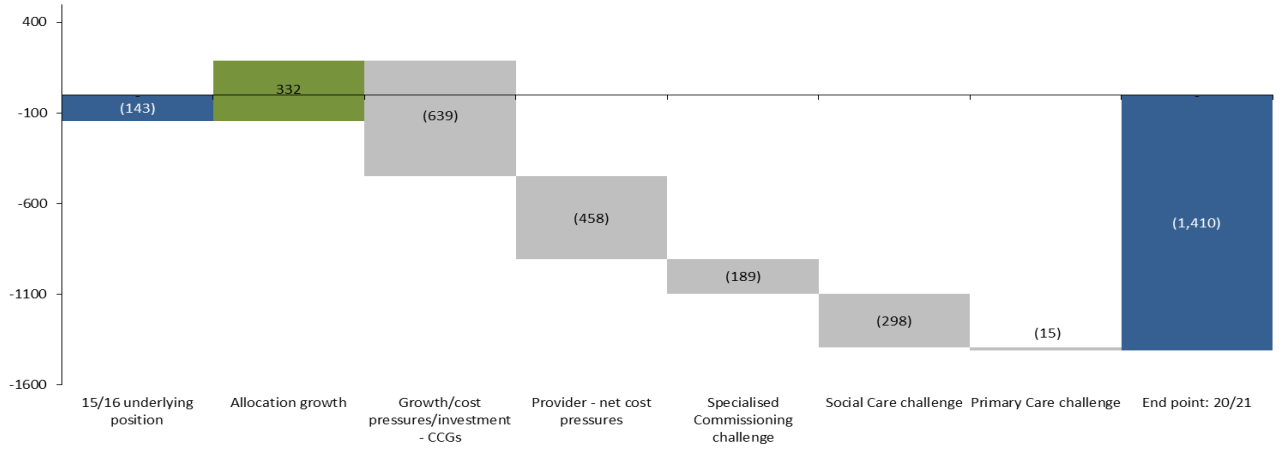
Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £297m gap in social care, giving a system wide shortfall of £1,410m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

Profile of the 'Do nothing' movement in financial position 2015/16 to 2020/21



Profile of the 'Do Nothing' financial challenge by organisation outturn 17/18 to 20/21

Sector	17/18	18/19	19/20	20/21
	£'m	£'m	£'m	£'m
Providers	(403)	(493)	(579)	(661)
CCGs	(77)	(140)	(198)	(248)
Spec Comm	(44)	(90)	(138)	(189)
Primary Care	(1)	(12)	(19)	(15)
Total NHS	**(525)**	**(735)**	**(934)**	**(1,113)**
Social Care	(74)	(148)	(223)	(297)
Total Health & Social Care	**(599)**	**(883)**	**(1,157)**	**(1,410)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children to get the best start in life
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	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'
	4	Reduce social isolation					
Improving care & quality	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	482,700 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Focussed interventions for target populations c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

2020/2021

Target Population:

All adults: 1,641,500
Mostly Healthy Adults at risk of developing a LTC: 121,680
All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is important for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. We will support positive choices through sexual health service transformation. Our residents who have a learning disability are also sometimes not receiving the full support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Developing a number of cross cutting approaches which will amplify the interventions described below and overleaf – embedding Making Every Contact Count and supporting national campaigns being 2 such examples.
- Interventions that are focused on **keeping our whole population well** and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Targeted work with the population who **need mental health support** – the mortality gap is driven largely through unhealthy lifestyles and barriers to accessing the right support. We will work to address the wider determinants of health, such as employment and housing, where there is good evidence of impact. Social isolation, whether older people, single parents, or people how need mental health support affects around 200,000 people in NW London and can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].
- Enabling **children to get the best start in life,** by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A number of cross cutting approaches and new ways of working will support activity in this area and through working across health and social care, with public health leadership will help increase our ability to deliver the interventions and outcomes described below: - **Embedding principles of Making Every Contact Count in all services commissioned across Delivery Areas 1-5** - **Supporting and publicising national campaigns and work such as on cancer prevention, mental health stigma and self care**				
A **Enabling and supporting healthier living – for the population of NWL**	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London • Implement NW London wide programmes for physical activity for adults • Widespread availability of Long Acting Reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss	3.5	9
B **Keeping People Mentally Well and avoiding Social Isolation**	The healthy living programme plans will also cover how Boroughs will address social isolation, building on current local work: In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems	As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda Provide digitally enabled support to people , including Patient Reported Outcome Measures (PROMs), online communities, digital engagement via online and apps (especially for young people), social prescribing and sign posting to relevant support Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities Target smoking cessation activities at people with mental illness to support reducing ill-health as a consequence of tobacco usage.	0.5	6.6
C **Helping children to get the best start in life**	• Implement the prevention priorities within the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services – especially in schools – as part of a wider new model of care • Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough	• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work • Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity	TBC	TBC

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is important for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas. Improving the strength and sustainability of primary care is critical in tackling unwarranted variations and improving LTC management and outcomes. Taking action on the key SCF areas of proactive and co-ordination will equip primary care to do so.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1)[7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].
- Children and young people with special education needs and disabilities are a vulnerable group that can require access to specialist support, often delivered by multi-agency services. Implementing CCG responsibilities for SEND under the Children & Families Act 2014 is therefore a NW London priority.

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A
Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care
	• For Accessible care:
	  • provide extended access specs with quantification of reduced attendances and admissions
	  • Deliver affordable access solutions for the 8-8, 7 day requirements
	  • Create minimum standards for appointment requirements
	  • Achieve accessible read/write patient records
	  • Deliver operational access and a communications programme for patients, key providers and stakeholders
	  • Align extended access provision with urgent care and 111
	• For Co-ordinated care:
	  • define key features for primary and integrated care teams and deliver consistent outcomes for care team models across NW London
	  • Deliver consistent outcomes for care team models across NW London
	  • Agree targeted population within CCG as priority for co-ordinate care management across NWL
	  • Design standard approach to risk stratification and case finding across NWL. Maximise use of WSIC dashboard to monitor patients and case find
	  • Define core intervention for care teams for core population
	  • Define roles that the care team will carry out daily with patients
	• For Proactive care:
	  • finalise key outcome measures for preventive care in LTC
	  • Develop two clinical pathways (including diabetes) and test against provider-models and outcome-measures
	  • Define key outcome measures for needs-based client groups (adults) and explore gap-analysis locally
	  • All eight CCGs supported in implementation of Patient Activation Measure (PAM) programme with target patients receiving PAM assessment and tailored approach to self-care
	• Support CCGs to deliver their GP Access Fund objectives with a consistent and systematic approach, including delivery of the Extended Primary Care Service providing significantly higher levels of access to NW London residents
	• Continue to support the development of federations, enabling the delivery of primary care at scale
	• Host workshops and service-user survey in key geographical areas, building on existing Healthwatch, Patient Participation Group and Lay Partner Advisory Group priorities (e.g. to review I-statements and test outcome measures)
	• Develop two clinical pathways (diabetes, atrial fibrillation) and test against provider-models and outcome-measures
	• Identify four to eight geographical areas to test the draft pathways against the defined outcomes with pilot clinical teams
	• Review of key pressure-points in clinical working day
		• Fully implement the primary care outcomes within the SCF in each of the eight boroughs and across NW London
		• Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working
		• Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers
		• Deliver this range of co-ordinated and population-based care through a system of networked hubs, with facility for both physical and digital access by patients, including services for people with dementia
		• Enable general practices and multi-disciplinary hubs to access and share digital patient records, including crisis care-plans and LTC pathway management
		• Provide access to a spectrum of care, for appropriate population-based interventions for urgent LTC and on-going care needs
		• Ambulatory and emergency care schemes in place
		• Develop relevant LTC clinical pathways in light of co-ordinated and proactive care experience
			18	26.4

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
Improve cancer screening to increase early diagnosis and faster treatment	Our Primary Care Cancer Board will take the learning from Healthy London Partnership's (HLP) Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will: • Share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. • Align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18 to ensure sufficient capacity within NW London. • Roll out improved information regarding patient choice and 2 week wait to support patients referred from primary care with suspected cancer • Implement straight to test endoscopy at Imperial, Ealing, Northwick Park and Hillingdon hospitals. • Begin to work with the voluntary sector to research primary care learning from Significant Event Audits • Work with Trusts to create more effective and efficient inter Trust referrals to support the delivery of national standards.	In partnership with Healthy London Partnership' s Transforming Cancer Programme and the Royal Marsden and Partners Cancer Vanguard, we will develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, These actions will reduce variation in acute care and ensure that patients have effective, high quality cancer care wherever they are treated in NW London.	TBC	TBC
Better outcomes and support for people with common mental health needs (with an initial focus on people with long term physical health conditions)	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC

Reduce variation by focusing on 'Right Care' priority areas	• Three key areas identified to be the largest priority to focus on at sector-wide level: diabetes prevention, atrial fibrillation and reducing hypertension
	• Identified and/or commenced work in 2016/17 in following areas:
	  • Mobilisation of National Diabetes Prevention Programme
	  • Comprehensive diabetes performance dashboard at practice and CCG level
	  • Comprehensive referral process for patients with non-diabetic hyperglycaemia into the National Diabetes Programme
	• Aside from these three deliverables, each CCG will be addressing the issues that cause the most unwarranted variation in care in their locality
	• The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care. Brent and Harrow have are also national 1st wave delivery sites and are focussing on diabetes and MSK.
		• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools
		• Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes
		• Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations
		• Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors
		• Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs
		• Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The 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. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.
			2	12.4

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
Improve self-management and 'patient activation'	• Develop protocols for approved health apps to support self-care in collaboration with Digital Health London • Develop a package of evidence and case studies to support local areas to adopt innovative approaches such as AliveCor, a digital device being rolled out by Hounslow GPs which uses smartphones to detect Atrial Fibrillation in patients Develop best practice approaches to online-management solutions • Host NW London symposium series, commencing with Activating the Workforce in November • Support delivery of IG Governance toolkit L2 compliance within targeted CCG and develop case study for wider support. • Development of Third sector programme framework, supporting development of the voluntary sector infrastructure to support self-care • Patient Activation Measurement (PAM) programme implemented across NW London with target patients receiving assessment and tailored approach to self-care (target 43,920 patients). Self-Care programmes delivered in NW London to be aligned to PAM levels, supporting a tailored approach to self-care and a NW London mental health and wellbeing guidance to PAM levels to be developed.	• Full delivery of Self-Care framework across NW London • NW London workforce supported by embedded self-care training programmes • Technology, including online management solutions, in place to support self-management and health education for people with LTCs • PAM embedded across health and social care supporting tailoring of care for all people with LTC (target 428,700 patients) • Third Sector fully integrated within Accountable Care Partnerships with single point of access and geographically based consortiums • Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from co-ordinated care and continuity with a named clinician to support them with LTCs • Increase availability of, and access to, personal health budgets, taking on integrated personal commissioning approach, including building on good practice from within and outside NW London around the use of brokerage to manage access to such personalised services	3.4	6.2

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

2020/2021

Target Population:

311,500

Contribution to Closing the Financial Gap

£72.1m

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is <u>important</u> for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnerships • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnerships, with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	Upgraded rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible by identifying opportunities and agreeing transformational improvements to NW London models, either locally or NW London-wide • Improve the rate of return on existing services, reducing NEL admissions and reducing length of stay • Enhance integration with other service providers • Establish an older people's reference group to guide this work • Agreed the older person's pathway across community, acute and last phase of life • Agreed areas for standardisation across NW London for IC/RR and acute frailty • Agreed outcomes and standards for intermediate care function and acute frailty	• Use best practice model across all eight boroughs, creating standardisation wherever possible to enable additional capacity to decrease the inappropriate time that a person is cared for in an institutional setting • Operate rapid response and integrated care as part of a fully integrated ACP model	20.2	64.9
D	Create an integrated and consistent transfer of care approach across NW London	• Agree an integrated health and social care model to improve transfer of care • Implement a single needs-based assessment to support appropriate transfer of care via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and transfer of care across NW London	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • Transfer of care correspondence is electronic with the single assessment process built into the shared care records across NW London • Fully integrated health and social care transfer of care process for all patients in NW London	7.4	9.6
E	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

2020/2021

Target Population: 262,000

Contribution to Closing the Financial Gap £11.8m

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is important for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. The NW London STP has mental health threaded throughout our delivery areas – within prevention and within work on long term conditions. But we know that focus is also required as poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact – and the outcomes described in the implementation guidance are reflected in our plans[2].

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially impacted by their condition and **10% will commit suicide**
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before the age of 18 .
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – thresholds to access services can be barriers to access care – and stigma remains a challenge for many people – and in particular within some communities,

Our aim in NW London is to improve outcomes for children and for adults with mental health needs, we will do this by:

- Implementing a new model of care for adults which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing the very specific needs that relate to some of our populations – such as for people with learning disabilities (through the Transforming Care Partnership) and for new mothers
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need – building on current Early Intervention in Psychosis and Liaison Psychiatry services.
- Implementing 'Future in Mind' Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home[3].

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	**Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy**	• More support available in primary care through locally commissioned services – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
		• More support available in primary care through locally commissioned services
			• Full roll out of the new model across NW London providing tailored evidence based support available closer to home to service users and carers, which will include:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			 
				11	16

B	**Focussed interventions for target populations**	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Provide vulnerable individuals and their families with best practice support • Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care	TBC	5

C	**Crisis support services, including delivering the 'Crisis Care Concordat'**	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS), Metropolitan police and other services – meeting access targets
		• Round the clock mental health teams in our A&Es and support on wards, progress towards 'core 24'
		• Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)
			• Ensure care will be available for service users and carers when they most need it through:
			  • Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery
			  • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis
				TBC	TBC

D	**Implementing 'Future in Mind' to improve children's mental health and wellbeing**	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Digital enablement to share information between care settings to support new care models • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

2020/2021

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is <u>important</u> for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Ensure all patients receive prompt treatment in accordance with the national referral to treatment (RTT) standards,
- Consolidate acute services onto five sites (the local government position on proposed acute changes is set out in Appendix A)
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Specialised Commissioning	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	Deliver the 7 day services standards	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C **Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites Fully deliver on the vision for maternity set out in *Better Births* national maternity review – through our 15/16 reconfiguration programme we have already made significant progress delivering this vision for maternity. In 16/17 we will focus on providing continuity of care for women, so that maternity care is provided by a small team of midwives during the antenatal, intrapartum and postnatal period.	Reduce demand for acute services through investment in the pro active out of hospital care model, enabled by investment in the Hubs. Develop the hospital in Ealing and jointly shape the delivery of health and social care provision of services from that site, including: • a network of ambulatory care pathways • a centre of excellence for elderly services including access to appropriate beds • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists. Deliver on the full recommendations set out in *Better Births* national maternity review, in order to achieve joined-up, sustainable continuity of care for women in NW London.	33.6	89.6
D **NW London Productivity Programme**	A Chief Transformation Officer has been appointed to lead a collaborative transformation programme across all NHS Trusts in NW London and a team of interim senior programme directors have been appointed. By the end of 16/17 we will agree and resource a sustainable team to ensure these priorities are delivered. This is a big ticket cost reduction transformation programme within the STP and we should secure investment proportionate to the costs savings. Implement and embed the NW London productivity programme across all provider NHS trusts, focusing on the following four areas: • **Orthopaedics**: mobilise a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT) to reduce unwarranted variation and increase efficiency, thus generating both quality improvements and financial savings. Ensure all Acute Providers in North West London have agreed Best In Sector Performance Metrics and establish a NW London dashboard. Agree priorities and interventions and commence delivery. • **Procurement**: deliver £3m of immediate tactical non-pay savings. Agree plan to reduce unwarranted variation in NHS supplies prices, and make £15.2m savings in non-pay spend. Develop options and agree a NW London operating model, in line with best practice and Carter and identify any structural changes required to the way procurement is currently delivered. , Establish common procurement competencies and staff development plan. Ensure robust plans in place with ownership from Procurement leads, CFOs and clinical lead and identify any investment required. • **Safer Staffing**: Agree a three year delivery plan with trajectory of benefits and any required investment identified. Agree detailed proposal for reduction in agency costs via more effective staff bank, supported by technology. All e-nursing rosters agreed six weeks in advance and plan for medical roster implementation, benchmark and share all data. • **Back Office**: this is **new and additional priority** agreed in September 2016. Deliver additional collaborative productivity opportunities. Agree priorities, geographic clusters and three year delivery plan with trajectory of benefits and any required investment identified. Integrated Procurement and Safer Staffing work within the wider Back Office plans.	Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together to deliver added value. **Rolling programme of pathway redesign and quality improvement initiatives to ensure trusts are consistently in the top quartile of efficiency (Getting It Right First Time principles).** Shared records is a key enabler of all pathway redesign. • **Orthopaedics:** Implement plan agreed in 16/17. Agree a consolidated service model for a NWL collaborative elective Orthopaedic centre, agree a business case and implement subject to investment. • **Identify and implement priorities for rolling programme following Orthopaedics.** • **Procurement:** Implement a pan-NWL procurement operating model which is compliant with the National Interim Future Operating Model, Deliver Carter compliant Procurement Transformation Plans with quantified (and delivered) financial savings which all leads to Collaborative and shared service models in place for NWL procurement operating within a sustainable financial footprint assessed by improving year on year saving: cost ratios. • **Safer Staffing:** build on work from 2016/17 such that rostering is optimised, bank fill rates are maximised and reliance on agency is minimised. (quantified benefits will emerge from 16/17 business case) Developed a workforce plan summarising the total workforce numbers and competencies required across NWL. Collective workforce planning and collaborative resourcing to include recruitment, development and retention with the right balance of permanent and flexible workers . • **Back Office**: Implement priorities as described in business case.	4.1*	143.4

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas	By 2020/21, Enablers will change the landscape for health and social care:		
	Estates will…	**Digital will…**	**Workforce will…**
1. Radically upgrading prevention and wellbeing	• Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality • **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital • **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care • **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care • **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence	• **Target recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers:
Estates

Context

The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.

Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings

Our model requires investment in the development of local hubs to enable the provision of integrated, co-located health care, social care and voluntary support across the eight local authority/CCG areas, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care.

NW London has developed and submitted a joint 'One Public Estate' bid to leverage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.

A joint health and council estates group has been established to oversee the work and minimise gross spend through aligning health and local authority plans for regeneration and seeking innovative financial solutions to provide estate cost-effectively, realising value from surplus assets.

There has been significant local progress towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £614m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs
  - The hub strategy and plans include community Mental Health services, such as IAPT
  - Hubs will support delivery of the GP 5 Year Forward View and are critical in enabling reconfiguration of acute services
  - Hubs will also help deliver the access and coordinated care aspects of the Strategic Commissioning Framework
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local Population
  - Trusts have developed proposals with the resultant capital requirement being presented in the Shaping a Healthier Future business case which is due to go to the NHSE investment committee for approval

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:
- Local services hubs will provide the physical location to support integrated public health, prevention and out-of-hospital care delivered by health , social care and voluntary organisations.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:
Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7 day access to all residents

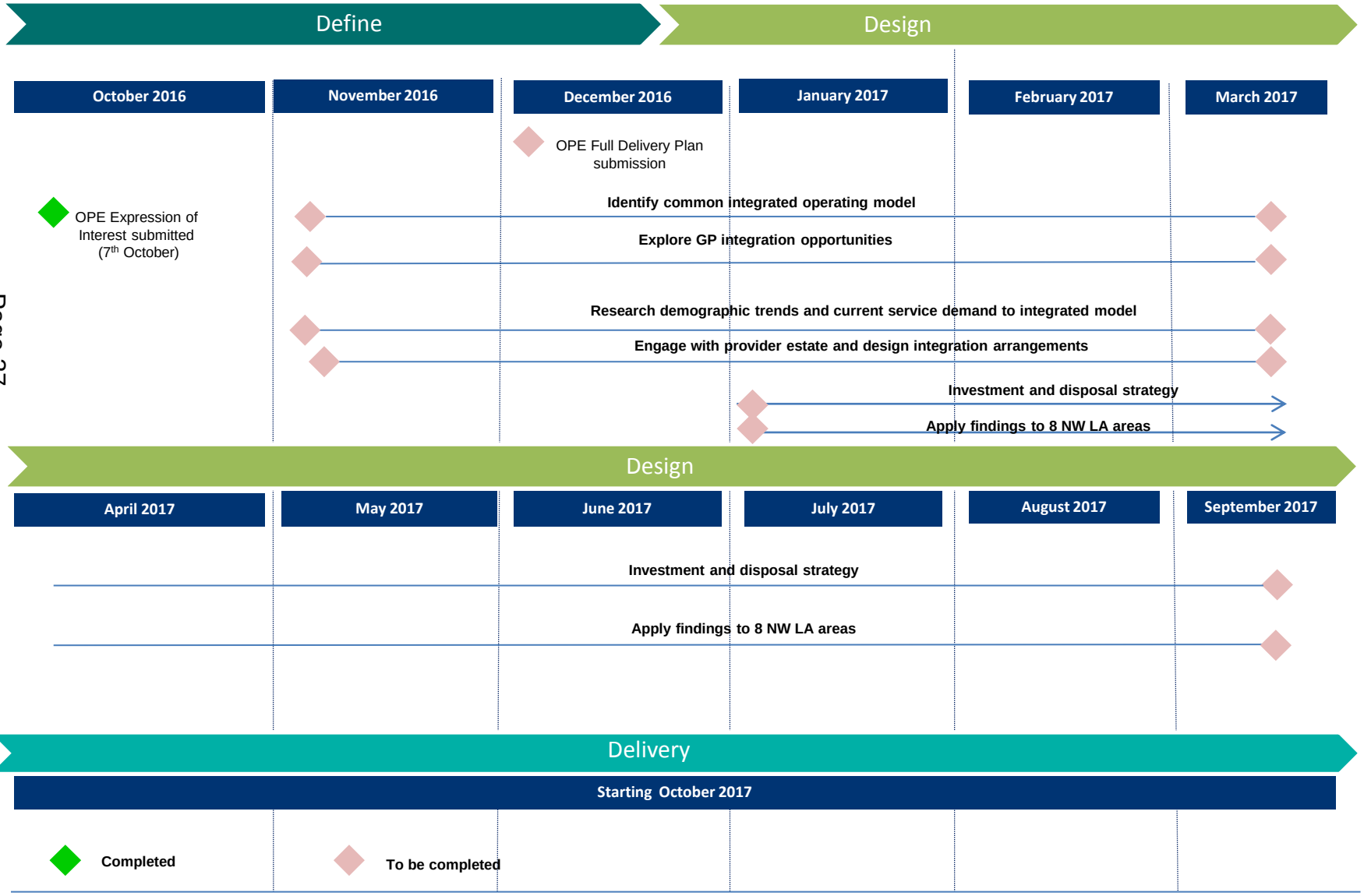
Delivery Area 3 - Outcomes for older people:
- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of appropriate bedded care

Delivery Area 4 - Supporting those with mental health needs:
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

Delivery Area 5 – Providing high quality, sustainable acute services:
- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

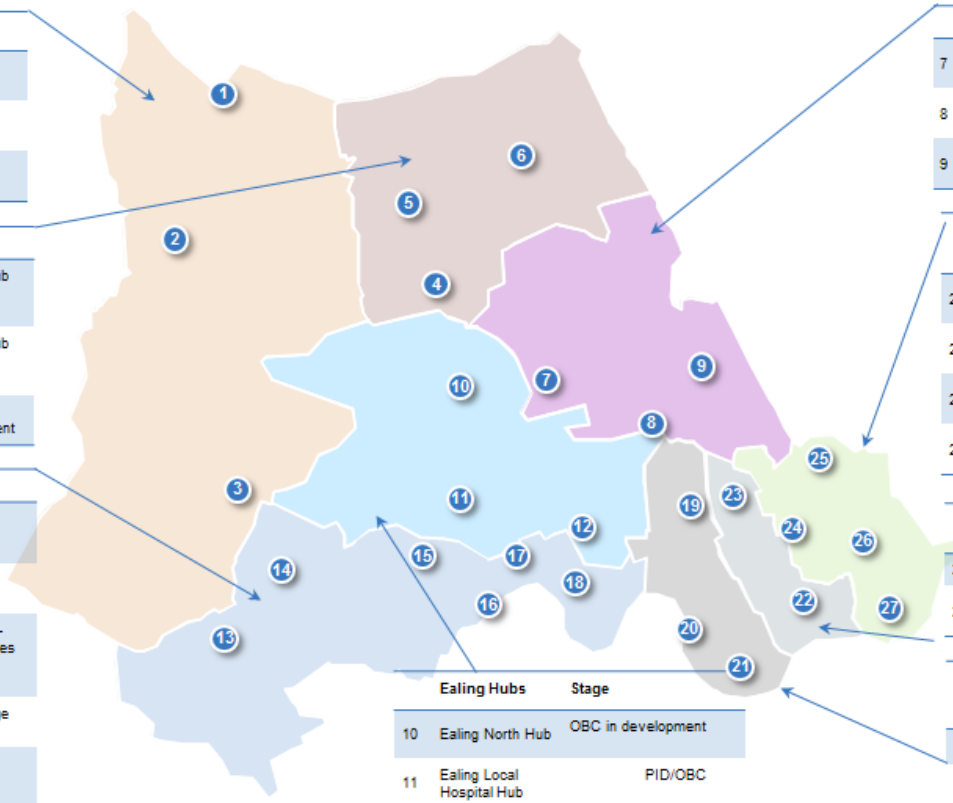
3. Enablers:
Estates

Estates Strategy to deliver Out of Hospital through One Public Estate (OPE) – High level timeline to Oct 2017



3. Enablers:
Estates

Proposed Local Services Hubs map



	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage (pre-PID)
2	Uxbridge and West Drayton Hub	Strategic stage (pre-PID)
3	Hesa Primary Care Centre	Operational

	Harrow Hubs	Stage
4	The Pinn Medical Centre	Existing hub – adding services
5	Alexandra Avenue Health and Social Care Centre	Existing hub – adding services
6	NE Harrow	OBC in development

	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	OBC in development
15	Heart of Hounslow Centre for Health	Existing hub – adding services
16	West Middlesex Hospital Hub	Strategic stage (pre-PID)
17	Brentford Health Centre	Operational
18	Chiswick Health Centre	Operational

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	PID/OBC
12	Ealing East Hub	OBC in development

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	OBC in development
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Strategic stage (pre-PID)

	Central London Hubs	Stage
24	St Mary's Hospital Hub	SOC in development
25	Church Street Hub	OBC in development
26	Central Hub Moxon Street	Strategic stage (pre-PID)
27	South Westminster	Operational

	West London Hubs	Stage
23	St Charles Centre	OBC in development
22	South Locality Hub	OBC in development

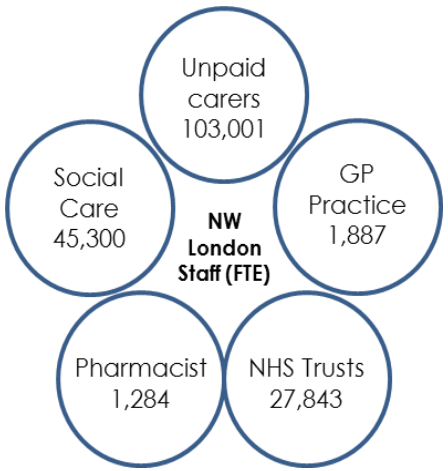
	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	Pre OBC in development
21	Parsons Green	OBC in development

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work. It will also be key to achieving our collective vision of improved quality of care through delivering sustainable new models of care that meet our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly to expand work across social care[1].
- Carers are also a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial to achieving our vision.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Appropriate workforce planning and actively addressing workforce issues will, however, be instrumental in addressing the five delivery areas in the STP.

The NW London workforce



The challenges our workforce strategy will address to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Achievements to date

Workforce planning and addressing workforce shortages

- Developed Infrastructure for workforce planning and analytics
- Established annual workforce planning processes for acute healthcare professionals
- Extended workforce planning to cover primary care including new models of care such as the Cancer Vanguard
- Worked with Skills for Care and engaged with national project work to ensure integrated workforce planning for Social Care
- Invested in a team of 4 workforce planners to support primary care and integration. Work includes the Day of Care Audit designed to improve efficiency in General Practice
- Worked with the Healthy London Partnership to understand the demand and supply of staff in primary care and identified opportunities to close the gaps.
- Led a centralised Pan-London placement management and workforce development programme for paramedics with an investment of over £1.5m, contributing to increasing workforce supply and staff retention
- Utilised health education funding to ensure high quality education for medical trainees is on-going.

Improving recruitment and retention

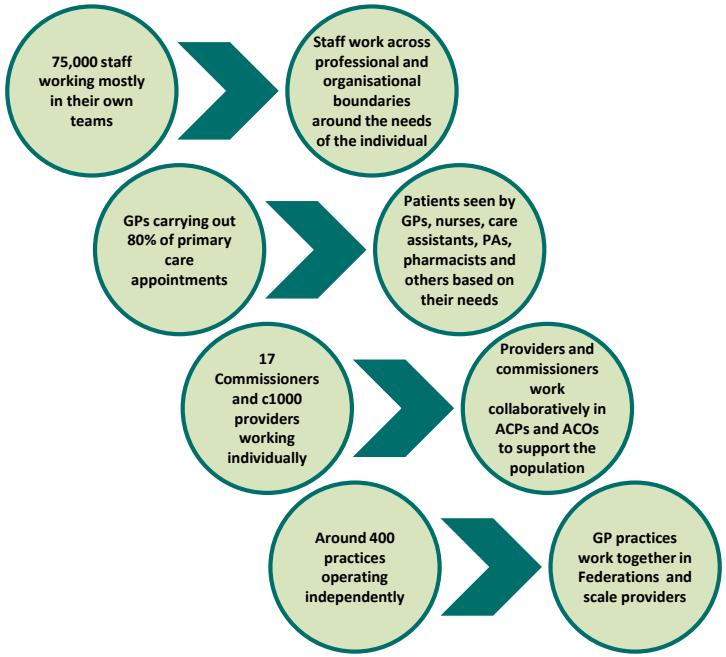
- With Capital Nurse we have started recruitment of 350 newly qualified nurses onto a rotational programme with educational and development support, this covers all NHS trusts in NW London as well as primary care. This investment will demonstrate the benefits of a rotational programme in improving retention rates and developing nurses within NW London to move on from their training to more senior nursing posts.
- We have programmes to improve the recruitment of nurses in general practice including a funded course with placements for nurse from outside of practice nursing to develop skills and experience to move into the sector. In 16/17 we have recruited 26 nurses across NW London.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care. Nine physician associates currently work in NW London, 31started training in September, a further 15 will start in February 2017. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 95 paediatric nurses and 9 consultants paediatricians.

Governance

Governance has been improved to deliver a comprehensive STP workforce strategy. This is supported by a strengthened collaboration between Health Education England and the CCG collaborative, local councils and other stakeholders. A CCG and HEE joint STP workforce team reports to a newly established Board that is co-chaired by the CCG, Social Care and HEE is a **key enabler** to delivery. This approach encompasses critical experience and expertise. It also maximises efficiency and ensures clinically led decision making and input from key stakeholders including health and social care providers, CEPNs (Community Education Providers Network) and the Healthy London Partnership.

A new robust governance structure to deliver the STP workforce strategy

What will be different in 2020[6]?



3. Enablers: Workforce

Current Transformation Plans and Benefits

Workforce planning and addressing workforce shortages

Effective workforce planning is essential for securing our future workforce, it underpins all further interventional activity and investment to support the workforce. We have the infrastructure in place to forecast shortages and develop plans to address them. This includes Primary Care and work is underway to ensure it covers new models of care such as the Cancer Vanguard. Critically this work will also include social care working with Skills for Care and through engagement and national project work.

Improving recruitment and retention

Improving recruitment and retention across health and social care will be critical to closing the financial gap and addressing workforce shortages. Modelling in London and the south east shows £100.7 million could be saved in the next 10 years by retaining new staff for 1 extra year. Recruitment and retention issues lead to high use of agency staff costing £172m.

To reduce spend on agency we will control demand for bank shifts by improving rostering and encourage more staff to work through banks instead of agencies to reduce agency costs.

Delivering the improvements in CAMHS Eating Disorder services will require an increase in numbers of staff with these specialist skills , we know we will face competition for these staff. We will work with our Like Minded programme to make sure NW London is an attractive place to come and work to retain current staff and improve recruitment

Workforce Transformation across health and social care workforce to support integrated care

Care in NW London will be delivered differently in 2021. Building on existing work we will support staff to work in new ways. To deliver the Strategic Commissioning Framework and the 10 point plan for Primary Care we will support workforce to improve productivity and build capacity in general practice and develop the whole care team. We will work with the Time for Care programme at an NW London level and develop local CCG plans based on local priorities and areas where the 10 High Impact Actions will have the greatest effect.

We have established the Change Academy. This is a collaborative programme across NW London to address workforce transformation, organisational development between providers and systems leadership. Through Change Academy High Performing Care programme we will support system change through high performing teams and improvement methodology underpinned by data enabled evidence-based decision-making. The scope of this programme will be multi-organisational change teams charged with delivery of STP on actual delivery issues in real time.

Leadership and Organisational Development to support future services

We understand that effective leadership underpins the transformation we need to achieve in NW London. As part of the Change Academy there are programmes targeted at supporting leaders across health and care:

I. STP/SPG systems leadership

II. Joint commissioning skills development

III. Emerging GP leaders network

IV. Practice manager development programme

This work will support staff and carers across all settings through the changes required by the STP and to develop the right culture to make sure changes are successfully delivered.

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- Using **£1.5m HEE funding** to support new models of care, self-care and LTCs
- Train up to 180 health and care professionals **to support self-care**
- Supporting 24 professionals to become **health coach trainers** to enable patients to take greater responsibility for their health
- Expand the programme in 2017/18 to develop carers as health trainers.
- Embed the NW London **Healthy Workplace Charter** to promote staff health and wellbeing initiatives and ambassadorship

Delivery Area 2 - Reducing variation:

- The seven day services programme is receiving an additional investment of £750K to trial new models of care and to further support the Radiography workforce.
- The Cancer Vanguard is being supported through instigating new project leads to drive evidence based service design

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- Delivery of the SCF and 10-pont plan for Primary Care through workforce transformation
- Consultant outreach into primary care
- CEPNs focused on developing the primary care and community workforce
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

- GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs were supported through an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.
- Using £600k of HEE funding to support the transformation of Serious and long term mental health and children and young people's mental health

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses by improving recruitment and more effective rostering and thereby the cost of service

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London CCGs, with good progress with Information Governance across care settings.
- Each of the eight CCGs has a single IT system across their practices, and six of the eight CCGs are implementing common systems across primary and community care.
- In the acute space, Imperial and Chelsea & Westminster have a strong track record with digital clinical systems and are working together on a common Electronic Patient Record. Imperial (with Chelwest) is expected to be nominated by NHS England as a Global Digital Exemplar and will provide leadership to the rest of the footprint in the provision of improved patient outcomes and enhanced business efficiencies.
- Digital technology will support Primary Care transformation with new models of care that support out of hospital Local Services, through shared records across care settings, including new GP provider networks/hubs and ultimately via Accountable Care Partnerships. Potential funding from the Estates & Technology Transformation Fund (ETTF) will help upskill the primary care workforce and encourage patients to use new digital channels to access care, and use digital tools to become more involved in their own care.
- The footprint has a good track record in delivery of shared records, e.g. the NW London Diagnostic Cloud. The NW London Care Information Exchange is under way, funded by the Imperial College Healthcare charity, to give patients and clinicians a single view of care across providers and platforms, and provide tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne in primary and community care. In the longer term, it is our ambition for the NWL Exchange to interface with the wider London Health and Care Information Exchange.
- There is good support from the NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London information exchange, record locator, and IG register.
- Imperial College Health Partners (ICHP), Academic Health Science Network (AHSN) for NW London, is working closely with local health and care partners to ensure that innovation plays a major part in achieving the goals set out in our STP. One example of this is the roll-out of the Intrapreneur programme which to date has enabled over 100 local executives and frontline clinicians to integrate innovation with their everyday role.

Key Challenges

- There is a significant challenge for digital to transform current delivery models and enable new, integrated models of health and social care, shifting care out of hospitals through shared information between care settings and a reduced emphasis on traditional face-to-face care delivery.
- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access information about the patient[1]. This will be mitigated by sharing care records and converging with other footprints via national and pan-London NHS systems and capabilities (e.g. Summary Care Record, e-Referrals, Co-ordinate My Care, electronic discharges); and in the longer term addressed through the NW London Care Information Exchange and (for the 16% outside the footprint) a pan-London information exchange.
- Due to different services running multiple systems, achieving shared records is dependent on open interfaces, which primary and community IT suppliers have not yet delivered. This will require continued pressure on suppliers to resolve – in particular TPP and EMIS.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is requested from NHSE to define and fund interfaces nationally.
- Clinical transformation projects are invariably costly and time consuming, which needs to be allowed for in the LDR plans
- Some citizens and care professionals have rising expectations for digital healthcare which we cannot deliver; for others, there is a lack of digital awareness and enthusiasm, requiring a greater push for communication around the benefits of digital solutions and education on how best to use them.

Strategic Local Digital Roadmap (LDR) Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper and improving quality
2. **Build a shared care record** across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital
3. **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care
5. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence

Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education.
- **Digital Health** to leverage innovations such as remote monitoring, point of care and self-testing, mobile applications, interoperability of IT systems, big data analytics and AI.

The NW London Digital Programme Board will oversee delivery of the LDR, integrated with the governance of the STP.

3. Enablers: Digital

STP Delivery Area	LDR Work Stream	Key Digital Enablers for Sustainability & Transformation Plan
1. Radically upgrading prevention and wellbeing	• Tools for self-management and self-care • Enable Patient Access • Build a shared care record	**Deliver digital empowerment to enhance self-care and wellbeing:** • Easier access for citizens to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • Innovation programme to find the right **digital tools** to: help people **manage their health and** wellbeing through digital apps of their choice, connected to clinical IT systems; **create online communities** of patients and carers; get children and young people involved in health and wellness • **New digital channels** (e.g. online and video consultations) to help people engage more quickly and easily with primary care **Embed prevention and wellbeing into the 'whole systems' model:** • Support for integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care plans that are shared with patients and carers)
2. Eliminating unwarranted variation and improving LTC management	• Automate clinical workflows and records • Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Deliver digital empowerment by increasing patient engagement to better self-manage their LTCs:** • Delivery of Patient Activation Measures (PAM) tool for every patient with an LTC to develop health literacy and informed patients • Innovation programme to help people **manage their LTCs (conditions and interventions)** through digital apps of their choice, extending clinical systems to involve patients (e.g. SystmOne for diabetes) and potentially telehealth (e.g. wearable technology) **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience • Support for new models of multi-disciplinary care, delivered consistently across localities, through shared care records • **Automation of clinical workflows and records**, particularly in secondary care settings, and support for new pathways and transfers of care through interoperability and development of a shared care record to deliver **integrated health and care records and plans**
3. Achieving better outcomes and experiences for older people	• Enable Patient Access • Build a shared care record • Use dynamic data analytics	**Provide fully integrated service delivery of care for older people** • **Shared clinical information and infrastructure** to support new primary care and wellbeing hubs and ACPs with clinical solutions • Citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange, new digital channels** (e.g. online and video consultations) • Support for a **single transfer of care** approach, and **new models** of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care (NW London and pan-London CIEs) • **Integration of Co-ordinate My Care (CMC) for last phase of life plans** with acute, community and primary care systems; and promote its use in CCGs. through education and training and support care planning and management • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care **dashboards** across 350 GP practices will deliver direct, integrated patient care
4. Improving outcomes for children and adults with mental health needs	• Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Enable people to live full and healthy lives with the help of digital technology** • Innovation programme supported by the AHSN and industry leaders to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities – for example Patient Reported Outcome Measures (PROMs); **create online communities** of patients and carers; get children and young people involved through apps **Implement new models of care and 24/7 services where required** • Support for **new models** for out-of-hours and inter-disciplinary care, such as **24x7 crisis support services** and **shared crisis care plans** to deliver the objectives of the Crisis Care Concordat, through shared care records **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience
5. Ensuring we have safe, high quality, sustainable acute services	• Automate clinical workflows and records • Enable Patient Access • Build a shared care record	**Invest in digital technology in Hospitals** • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Support new models for out-of-hours care through **shared care records and the NWL diagnostic cloud**, such as 24x7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks • Better digital tools to ensure **optimisation of acute resources**, e.g. radiology Clinical Decision Support, referral wizards and decision support tools, greater use of NHS e-Referrals including Advice & Guidance capability • Integrated **discharge planning and management**, and support for **acute-to-acute transfers**. through shared care records • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • **Dynamic analytics** to track consistency and outcomes of out-of-hours care • **Partnership model for informatics delivery** that makes best use of specialist technology skills across organisations

4. Primary Care

Primary Care in the context of out of hospital transformation

The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (FYFV). In NW London, our STP sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans.

Our plans are for the development of integrated out of hospital care – Local Services – that will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be enabled to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. This will improve health and wellbeing and care and quality for patients.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London.

We will transform General Practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all, as set out in the Transforming Primary Care in London: a Strategic Commissioning Framework.

We will implement a substantial up scaling of intermediate care services, available to people locally, offering integrated health and social care teams outside an acute hospital setting.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP. Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

'There is arguably no more important job in modern Britain than that of the family doctor'

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

We are determined that NW London succeeds.

Enhanced Primary Care: Locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care, and co-ordination across key parts of the system against a single shared care-plan

Self-Care: Embedding the self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

Upgrading Rapid Response and Intermediate Care Services: delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

Transfer of Care: implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

4. Primary Care
The local services landscape including primary care

Achieving an effective model of integrated out of hospital services is key to the delivery of the NW London STP. Within NW London, we have a highly diverse population, which is supported within Primary and Community Care by a mix of out of hospital services with varying levels of capacity.

We have achieved much since we began implementing Primary Care transformation across NW London in 2015, and Whole Systems Integrated Care in 2014, but we do not underestimate the remaining challenges. We now have Primary Care operating at-scale across NW London (diagram, bottom right). Our current plans for further transformation are underpinned by national and local policies and initiatives:

- **The 5 Year Forward View (5YFV)**

As part of our Local Services Transformation, we aim to tackle the triple gap identified in the 5YFV: Finance, Sustainability and Quality. All of our initiatives have held these priorities in the forefront of our planning, and are key components of NW London's STP.

- **The General Practice Forward View (GPFV)**

The GPFV sets out a plan, backed by a multi-billion pound investment, to stabilise and transform General Practice. The focus of the plan centres around workforce (incentivisation for recruitment and retention), workload (practice resilience) , infrastructure (estates and technology) and care redesign.

- **The Strategic Commissioning Framework (SCF)**

This is London's agreed approach to supporting the focus on Accessible, Proactive and Co-ordinated Care within Primary Care. Self-care is an integral part of proactive care contributing towards Enhanced Primary Care offer.

- **The GP Access Fund (GPAF)**

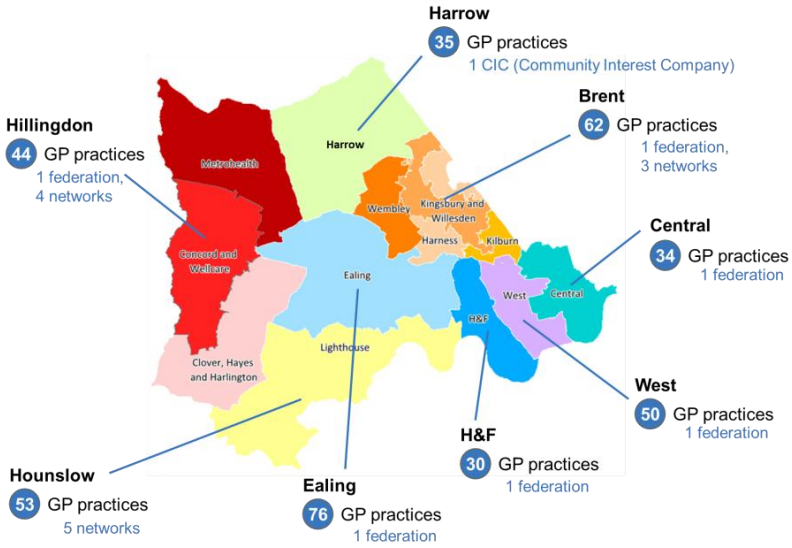
As part of the extended access aspects of Accessible Care, NW London will meet the extended access specifications by the end of Mach 2017, in order to better support our population to access Primary Care services more efficiently, at a time and place that suits them.

- **King's Fund and related reports**

Evidence based, national reports have indicated areas of focus for NW London. We have also utilised local knowledge from reviews and evaluation to assess our current status quo (blue box) and areas for development.

In NW London, we have:

- 1,093 GPs
- 473 practice nurses
- 273 clinical support staff
- Average list size 5,560
- GP and nurse workforce supply is the lowest in London
- 392 GP practices with 31 sites open at weekends
- 17 groups of GP providers
- 388 dental care practices
- 1,284 pharmacists
- Pharmacy and dental practice supply one of the best in London
- 5 different IC/RR services
- Multiple Single Points of Access (SPAs)
- Many care homes, often in disparate locations
- Differing provision of bedded and non-bedded care across NW London



4. Primary Care: CCGs have agreed to support Primary Care providers in delivering a clear set of standards over the next five years, in support of our vision

Proactive care	
Co-design	Work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve health and wellbeing
Developing assets and resources to improve health and wellbeing	Work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected and supported
Conversations focused on individual health goals	Where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	Enable and assist people to access (inc. in schools, community and workplaces) information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing.
Patients not accessing Primary Care services	Design ways to reach people who do not routinely access services and may be at higher risk of ill health.

Accessible care	
Patient choice	Patients have a choice of access (e.g. face-to-face, email, telephone, video)
Contacting the practice	Patients make one call, click, or contact to make an appointment. Primary care teams will actively promote online services to patients (inc. appointment booking, viewing records, prescription ordering and email consultations)
Routine opening hours	Patients can access pre-bookable appointments with a primary health professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	Patients can access a GP or other Primary Care health professional 7days a week, 12 hours per day (8am -8pm or alternative equivalent based on local need), for unscheduled and pre-bookable appointments
Same-day access	Patients can have a consultation (inc. virtually) with a GP or skilled nurse on the same day, in their local network
Urgent and emergency care	Patients can be clinically assessed rapidly. Practices will have systems and skilled staff to ensure patients are properly identified and responded to
Continuity of care	Patients are registered with a named team member, responsible for providing coordination and continuity, with practices offering flexible appointment lengths

Co-ordinated care	
Case finding and review	Practices identify patients, through data analytics, who would benefit from coordinated care and continuity with a named clinician, regularly and proactively reviewing those patients
Named professional	Patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	Each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in care
Patients supported to manage their health and wellbeing	Primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing. including the use of digital tools and education, such as health coaching.
Multi-disciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving. Care will be coordinated via shared electronic care records.

4. Primary Care: A whole population approach to delivering integrated out of hospital care in NW London

We have developed a whole population approach to delivering integrated out of hospital care in NW London.

Majority of activity

Population segments

Service needs	Mostly healthy people	People with complex conditions
Planned	**Prevention measures as per defined protocols** • Lifestyle interventions, health education in schools, smoking cessation, screening • Choice of access options and **centralized scheduling** across multiple channels • Services are available at convenient times (e.g. **evenings and weekends**) • Prevention programs in collaboration with Local Authorities, e.g. walk-in classes	**Care by the same team in core hours** • Support with adhering to a care plan under the guidance of a **care-coordinator** • Tailored advice and support with self-management that includes social interventions and support • Preferred service and a **named clinician** are available for pre-planned appointments • Discharge coordination with hospital services • Infrastructure to support home-monitoring
Unplanned	**Easy access and information sharing** • Walk-in, telephone and tele-consultation options available, including out of hours • Support for self-care (e.g. online advice) • Advanced information sharing between services and professionals exclusively through **Electronic Health Records (EHR), also accessible to the patient**	**Rapid access, preferably to the core team** • **Single telephone line** to direct patients out of hours; otherwise **care coordinator** is main point of contact • Core team keeps sufficient **capacity for unplanned appointments** • All professionals **use EHR;** feed back most important events to the core team

Episodic Care[1]

- Main **emphasis on ease of access**
- Episodic care, overseen **by a qualified GP on duty** during normal and extended hours at a hub / dedicated practice or call centre
- **Patient-self management of limiting illnesses**

Continuous Care[1]

- Main **emphasis on continuity**
- Continuous care provided mainly during core hours by the **same team**, according to **a care plan**
- **Care coordinator** to serve as the first point of contact for the patient, and all other providers

1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)

4. **Primary Care:** Primary care and Intermediate Care transformation is the foundation for Local Services Transformation

The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP.

Our challenges

- **Demand for health and care services is increasing.**
- **There is unwarranted variation in care, quality and outcomes across NW London.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

How Local Services areas of focus fit within STP delivery areas

DA2 — **Improve quality and reducing variation across Primary Care (for LTC management)**

DA3 — **Achieving better outcomes and experiences with a focus on older people**

What are the ways of working

- **Developing sustainable services**
- **Changing how we work together to deliver the transformation required**

Our areas of focus

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

- Joint commissioning and delivery models across CCGs and providers
- Evolving **Primary Care at-scale**
- Managing demand across boundaries through pathway redesign
- **Strengthening care teams** to provide effective care

- Effective **joint governance** able to address difficult issues
- Working **cross-boundary**; across acute and social care
- Collaborating to improve quality and efficiency, e.g., through the Virtual Primary Care Team
- Building upon **Whole Systems Integrated Care**

The impact of our plans

A healthier NW London

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care.

More productive care:

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

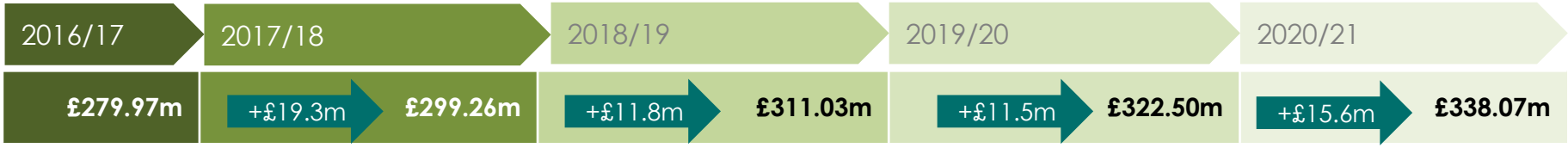
More effective system:

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

4. Primary Care: There will be significant investment in General Practice within NW London

This diagram shows NW London's:

- Efficiency targets
- Increases in primary care medical allocations (blue arrows)
- The planned delivery of the Strategic Commissioning Framework and the Strategy and Transformation Plan



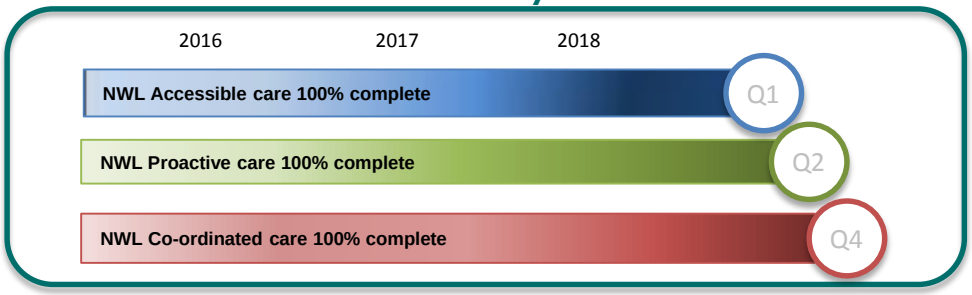
Key

Increases in Primary Care medical allocations

The diagram does not show funding from national programmes (such as the General Practice Access Fund) from which NW London is aiming to access approximately £4.5m in 2016/17 – announced in the GP Forward View.

Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. Transforming general practice in line with the standards set out in the Strategic Commissioning Framework is critical to delivery of the ambitions set out in the STP. The diagram below shows the milestones to full delivery.

Milestones for SCF delivery across NW London



5. Finance:
Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue, with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that overall the footprint including social care has a small deficit of £19.9m.

£'m	CCGs	Acute	Non-Acute	Specialised Commissioning	Primary Care	STF Investment	Sub-total	Social Care	Total	
Do nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	-	**(1,112.4)**	**(297.5)**	**(1,409.9)**	**Note 1**
BAU Savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	108.5	**680.6**	**Note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	**(4.0)**	-	**(4.0)**	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	**15.6**	8.0	**23.6**	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	**(5.4)**	-	**(5.4)**	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	**18.5**	-	**18.5**	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	**(52.3)**	-	**(52.3)**	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	**134.9**	33.1	**168.0**	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	**(11.0)**	-	**(11.0)**	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	**22.8**	6.4	**29.2**	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	**(45.6)**	-	**(45.6)**	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	**254.5**	15.0	**269.5**	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**	**Note 4**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**	**Note 4**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**	
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	-	**1,127.5**	262.5	**1,390.0**	
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	-	-	-	**15.1**	**(35.0)**	**(19.9)**	
				Note 5				**Note 3**		

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since Jun '16 STP due to changes in the underlying position of social care, and inclusion of the Royal Brompton & Harefield and the London Ambulance Service deficit attributable to NWL.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc.

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable).

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated.

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

Note 6: As we have developed our project plans we have more clearly articulated the focus of our delivery areas. This has resulted in 'Delivering the SCF' moving from DA3 to DA2. The individual DA totals have therefore changed although overall investment and saving totals remain constant.

5. Finance:
Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a break even position .

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

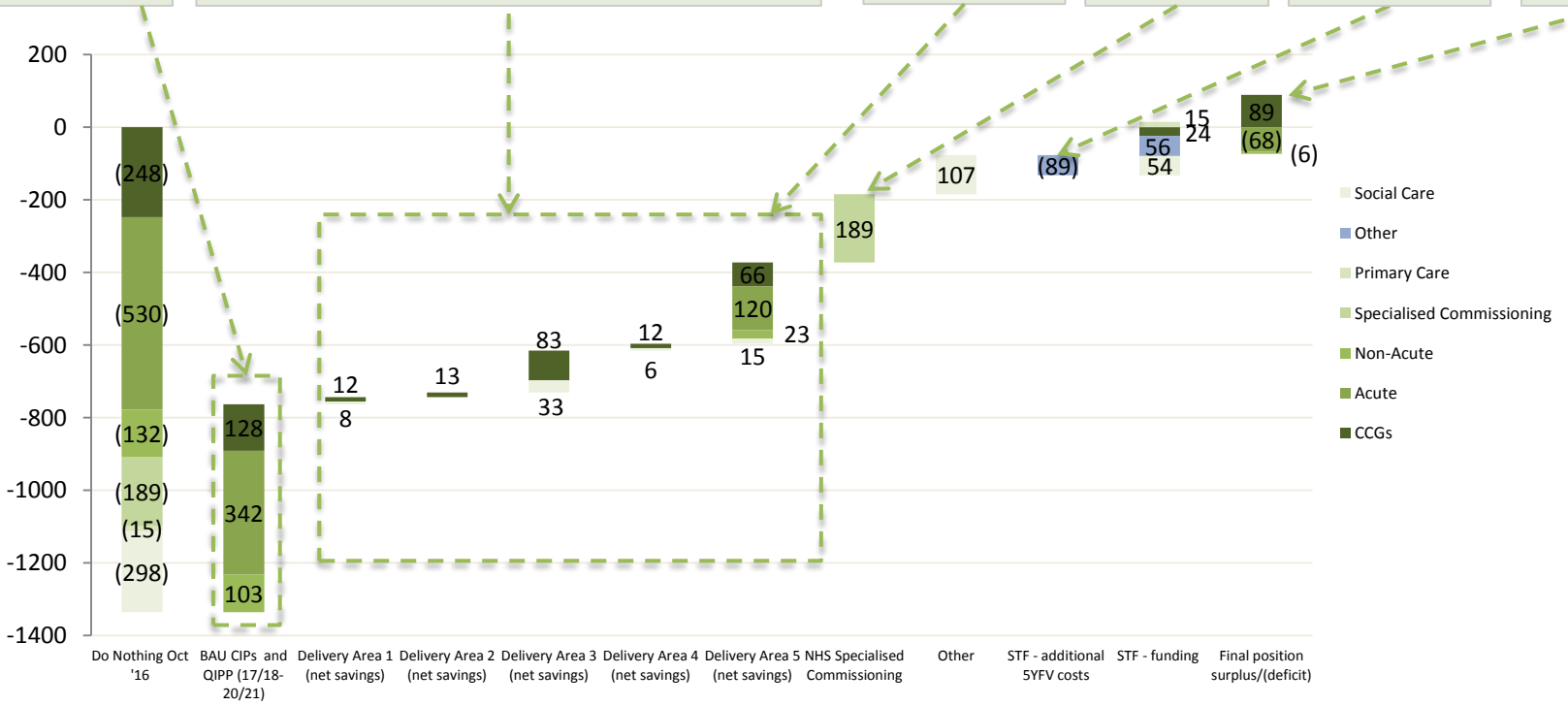
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

Final position CCG Surplus (£89m) Acute deficit (£68m) Non-acute deficit (£6m)



5. Finance:
Next steps

Financial risks to delivery of the STP

There are a number of risks facing NWL commissioners and providers which are inherent in the STP. These are:

- Delivery of business as usual efficiency savings
- Delivery of the service transformations set out in the five delivery areas, and the realisation of the associated savings
- Financial challenges on the provider side that remain at the end of the STP period
- Plans to close the specialist commissioning gap are not yet available
- Deterioration in underlying organisational financial positions since 2016/17 plans were agreed
- Closing the remaining social care funding gap
- Accelerating delivery of transformation plans to enable recently notified NHS financial control totals to be achieved.

The key risk to achieving sector balance is the delivery of the savings, both business as usual efficiency savings and those associated with the service transformations described in the five delivery areas.

There are also particular challenges in relation to:

- The deficit on the Ealing Hospital site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging;
- The deficit at the Royal Brompton and Harefield, which although mostly commissioned by NHSE Specialised Commissioning, is included in the NWL footprint;
- The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution.

The plans to close the Specialised Commissioning gap are not yet available in enough detail to allow an assessment of the level of risk facing the NWL Specialised service providers. This may pose a significant risk to the viability of some providers.

Next steps to address the risks

There are a number of processes in place to quantify and mitigate the risks set out above. These include:

- A robust process of business case development to validate the investments and savings that have been identified so far, and the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered
- A portfolio management approach with clear governance to ensure that project directors are held accountable for delivering agreed savings, with a change control process to close projects and agree new ones as required to deliver the planned patient outcomes and associated savings
- The work through DA5d on productivity will support the development of trust internal infrastructures to support the business as usual efficiency savings
- The acceleration of the changes relating to Ealing hospital, once out of hospital capacity is in place
- Joint pathway planning with specialist commissioning and other CCGs across London to confirm the plans to reduce demand and to quantify the impact on providers
- Quantification of changes in underlying financial positions and differences between the STP financial assumptions and notified control totals, feeding into a sector approach to the 2 year contracting round to ensure that effective risk management processes are in place.

This work will be developed and will continue over the next few months.

5. Finance:
STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. The STF funding being use to support provider deficits has already been notified to Trusts for 17/18 and 18/19, and is not included below. The funding below is being sought **in addition** to provider STF funding.

Sustainability and Transformation funding requirement for North West London

Investment Area	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Investment in Prevention & Social Care	21.0	25.0	30.0	34.0
Social Care funding gap	-	-	-	19.5
Total Social Care and prevention	**21.0**	**25.0**	**30.0**	**53.5**
Seven Day services roll out through to 2019/20	4.0	7.0	12.0	24.0
General Practice Forward View and Extended GP Access	10.0	10.0	5.0	5.0
Increasing capacity in Child and Adolescent mental health services and reducing waiting times in Eating Disorders services	5.0	5.0	8.0	10.0
Implementing recommendations of mental health task force	10.0	10.0	10.0	5.0
Cancer taskforce Strategy	3.0	5.0	10.0	3.0
National Maternity Review	7.0	7.0	2.0	2.0
Local Digital Roadmaps supporting paper free at the point of care and electronic health records	3.0	10.0	10.0	6.7
Total Health	**42.0**	**54.0**	**57.0**	**55.7**
Improvement Resources	2.0	2.0	-	-
Additional Investment in Primary Care services	1.0	12.0	19.0	14.8
System support funding	-	-	-	24.0
Total	**66.0**	**93.0**	**106.0**	**148.0**

5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £978m (funded by £713m from internal resources, £37m from disposals and £228m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

The table below details the 'Do something' capital for the 5 year STP period.

Table : Do Something Capital

Key Capital Schemes	17/18-20/21 £m	Less: disposals £m	Other funding sources £m	Total £m
	Gross Capital			Net capital
Outer NWL (SOC1)[1]	385	(9)		375
Inner NWL (SOC2)[2]	222	(222)		-
IT Digital Roadmap[3]	60			60
CNWL - strategic investments	79	(53)	(26)	-
Royal Brompton	100	(100)		-
Total	**845**	**(384)**	**(26)**	**435**

Note 1 – The Outer NWL business case (SOC1) is modelled on an 'accelerated' approval timeline in order to address the sustainability issue at Ealing Hospital;
Note 2 – The Inner NWL Business Case (SOC2) is funded through the disposal of a charitable asset, thus placing a restriction on the use of the sale proceeds;
Note 3 - IT digital roadmap funding is expected to be funded via the Estates and Technology Transformation Fund (ETTF).

6. Risks and Mitigations:
Strategic Risks

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	• Maintain system attention on importance of delivery over the next five years through focus on Delivery Areas 1, 2 and 3 • Continue to develop delivery plans using learning from vanguards and other areas • Establishment of robust governance process across NW London system focussing on both delivery and assurance • Clear metrics agreed to monitor progress	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	• Support development of GP federations • Early investment in primary care through joint commissioning • Identification and support to vulnerable practices • Digital solutions to reduce primary care workloads	• Support in developing a reliable understanding of sector demand and capacity for primary care
Can't get people to own the responsibility for their own health	Self care and empowerment	• Development of a 'People's Charter' • Closer working with local government to engage residents in the conversation, primarily through DA1	• National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints, and the sustainability issues at Ealing Hospital	Finance and estates	• Submit a business case for capital to NHS England • Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment • Identification of further opportunities through One Public Estate • Submit a business case for capital to NHS England that sets out the clinical and financial rationale for an accelerated timeline	• Support for retention of land receipts for reinvestment, and potential devolution asks • Support for an accelerated timeline for the capital business cases
Information Technology systems are not in place to enable seamless integrated care and a shift towards out of hospital activity.	Information and technology	• Work within new national standards on data sharing to support the delivery of integrated services and systems. • Keep pressure on primary and community IT system providers to deliver open interfaces which will enable record sharing	• NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. • Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality • Continued focus at a national level on open API

6. Risks and Mitigations:
Other Risks

Risks	Category	Proposed mitigations	Support from NHSE
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	• On-going quality surveillance to reduce risk • Contingency plans developed should a service be flagged as *fragile* • Strengthened governance structure with clear joint leadership maintaining focus on delivery and enabling more rapid and effective responses to a situation	
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	• Development of a joint market management strategy lead by the Joint Health and Care Transformation Group • Specific project of work in this area through DA3 • On-going support to homes to address quality issues	
Provider and system sustainability targets result in competing local priorities	Quality and sustainability	• Joint Health and Care Transformation Group provides forum for system wide discussion.	• Alignment of NHS England and NHS Improvement positions on provider sustainability versus system sustainability
We are unable to recruit or retain workforce to support the old model while training and transforming to the new model of care	People and workforce	• Establishment of Workforce Transformation Delivery Board to provide system leadership and focus • Development of cross-sector workforce strategy • Close working with HEENWL	
There is resistance to change from existing staff	People and workforce	• OD support and training for front line staff and system leaders • Wide staff engagement in the design and delivery of new models through project delivery groups.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	• Work closely with partners to understand the implications of 'Brexit' • Provide staff with support to ensure they feel valued and secure.	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	• Developing relationships between health and local authority organisations, supported by joint governance via the Joint Health and Care Transformation Group • Joint statement agreed and areas of commonality identified to enable progress	

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
Case for Change	12-19	[1] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea. [2] NOMIS profiles, data from Office for National Statistics [3] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [4] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs

7. References

Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) Management	23-26	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] Cancer Research UK [3] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf [4] Fund Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund [5] Pan-London Atrial Fibrillation Programme [6] NHS London Health Programmes, NHS Commission Board, JSNA Ealing [7] Kings Fund, 2010 [8] Initial analysis following review of self-care literature [9] http://dvr.sagepub.com/content/13/4/268

7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	27-28	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
Delivery Area 4: Improving outcomes for children and adults with mental health needs	29-30	[1] Tulloch et al., 2008 [2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf [4] Royal College of Psychiatrists, 2012 [5] http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spmin1
Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	31-33	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
Enablers: Estates	35-38	[1] ERIC Returns 2015/16 published 11 October 2016 [2] NHSE London Estate Database Version 5 [3] NW London CCGs condition surveys [4] Oxford University's School of Primary Care Research of general practices across England, published in The Lancet in April 2016 [5] Lord Carter Report: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/http://qna.files.parliament.uk/ws-attachments/450921/original/Operational%20productivity%20and%20performance%20in%20English%20NHS%20acute%20hospitals%20-%20Unwarranted%20variations.pdf

7. References

Section	Slides	References
Enablers: Workforce	39-41	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
Enablers: Digital	42-43	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

Three Borough Integration and BCF plan 17-19
Highlevel Risk and Issues Log V1

Highlight ref	Added (date)	Risk (R) Issue (I)	Description of risk / issue and potential consequence(s)	Action taken to date to mitigate impact of risk / issue	Action still to be taken (planned) to mitigate impact further	Risk / issue owner (initials)	Status	Risk rating	Issue rating
BCF1	01/07/17	Risk	BCF Planning guidance 3 months behind schedule and 2 year plan required	continuous liaison with NHSE for updates	Await further guidance, continue to develop narrative content	All	open	A	
BCF2	15/06/17	Risk	Grenfell Fire tragedy - CCG and RBKC resources redirected from BAU	Ongoing development of BCF plan on reduced resources	monitor ongoing impact	WLCCG	open	A	
BCF3	01/04/17	Risk	Worsening financial position of each organisation	saving while maintaining SC spend of 1.79% uplift for CCG minimum	Turnaround Director continuing to develop final agreed BCF offer	CG/HoFs	open	A	
BCF4	01/07/17	Issue	Change in RBKC Council Leadership and therefore knowledge and experience of previous BCF	WLCCG MD to update and brief new leader	WLCCG MD to update and brief new leader	WLCCG	open		G
BCF5	01/07/17	Risk	Agreement of BCF schemes that will support the delivery of the BCF ambition	small sub group established to continue to discuss full scheme summary in 17-19	Each SRO to develop scheme content	DT/ALL	open	A	
BCF6	01/07/17	Risk	Agreement of the iBCF monies to ensure that grant conditions are met. Need finance and scheme agreement for LA submission in July 17	iBCF 17/18 agreement in principle, now we need the full details that sit behind the expenditure proposal	LA to provide final details of iBCF e.g. how the funding for each agreed area will be delivered	LA	open	A	
BCF7	15/05/17	Issue	Q1 BCF budget and principles agreed and presented at F&P	LA and CCG agreed Q1 position to move forward with BCF	Development of Q2 onwards	LA/CCGs	closed		G
BCF8	01/05/17	Issue	QIPP in 17/18 across 3B health will be £3.2m. This is currently achieved as transactional but in year we need to develop appropriate cash releasing schemes to ensure delivery in 18/19	Transactional QIPP in place for CCGs to achieve while detail of schemes to underpin achievement	Final detail of QIPP schemes to be developed	All	open		A
BCF9	14/08/17	Issue	BCF sign off process. HWBB and F&P prior to 11th Sep deadline	CCGs and LA to work together and agree how sign off can take place before HWBB and F&Ps	LA colleagues will brief chairs. MDs to agree CCG process. Full BCF plan will be presented at meetings in Sep	LA/CCGs	open	A	
BCF10	14/08/17	Issue	Potential differences in content of BCF and also deadline for inclusion to ensure near final draft for circulation by 25th August 2017	Discussed at JET on 14/08/17, agreed approach	Inclusion of MCMW and Primary Care models under OoH section	All	open		A

Managing Transfers of Care (DTOC reduction delivery plan) 2017/18										
Ref	Task Description (8 High Impact Changes)	Organisational Owner	Lead	Intended Outcome	Estimated impact on reducing DTOC	Completion Date	Progress			
							Q1	Q2	Q3	Q4
1	**Early Discharge Planning**									
1.1	Expand the joint discharge policy and procedure to reflect the specific service options available to support discharge in each borough.. **(Include MH colleagues)**	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.2	Develop information for patients.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.3	Establish a consistent approach to the use of an MDT process in advanced discharge planning on all wards.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.4	Develop elective discharge planning across the whole systems pathway with integration with existing pathways e.g. primary care.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.5	Improve understanding and utilisation of the CIS (particularly CIS Liaison role to ensure effective use of resource.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.6	Improve understanding and the impact of the Trusted assessor model on early discharge	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.7	**Mental Health focussed actions:** Scope 72 Hour Formulation Meetings, early stage addressing of barriers to discharge. Senior Managers from inpatient and community enagaged; ongoing input of community teams during admission Consider Discharge Intervention Team – moving community discharge workers to work closer into wards Development of Accommodation Pathway Guidance Explore training for ward managers on Care Act, Ordinary Residence, s117 Scope an “Adult Pathway” review	LBHF & H&F CCG	Shazia Khan	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.10.17				

1.8	**Improving access to MH input** - specific MH Practitioner to support assessment and planning discharge for each hospital site (Chelwest/Charing Cross/Imperial) x 3 MHP (band 7)	LBHF & H&F CCG	Ray Boateng	Reduce length of DTOC for people with Challenging behaviour needs. Effective working with Psychiatric Liaison teams..		31.12.17				
1.9	Check the capacity and functionality for timely Continuing Healthcare screening and assessment within the discharge planning process to meet national standards.. Allocate additional CHC Case Managers/Coordinators capacity (per hospital site)to facilitate CHC assessment and decision making where needed. X 3 CHC Case Coordinators (Band 7)	Hammersmith & Fulham CCG	Ray Boateng	Reduce internal delays associated with CHC process. Identify care pathway for interim care or discharge to assess		31.12.17				
1.9	Explore options for an integrated model of Continuing Healthcare Assessment.and brokerage **(incl MH)**	Hammersmith & Fulham CCG	Ray Boateng	speed up access to care provision		31.12.17				
1.11	Check the timely ordering of community equipment so that it is in place by the date of discharge.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	speed up access to care provision		ongoing				
1.12	Address any contract-related process issues. Eg Deep Cleans.	LBHF	Frank Hamilton	speed up access to care provision		*30.09.17*				
1.13	Check and embed earlier referrals to Hospital Transport.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	speed up access to care provision		31.10.17				
2	**Systems to monitor patient flow**									
2.1	Establish robust process for agreeing SiTReps to ensure full sign off by all partners before submission. To include in guidance (see action 1). Process in place for MH chaired by the DAS in H&F.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	Develop better systems and information for managing DTOC		31.10.17				
2.2	Consider creating a Patient flow coordinator role to establish robust process, accurate information and systems for effective management and progress chasing DTOC	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Develop better systems and information for managing DTOC		31.12.17				

2.3	Development of Discharge Teams is in progress, EDD tracking, support to ward staff responsible for discharges.SAFER bundle implementation through Summer to ensure readiness and efficiency of timely discharges with care plans	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Develop better systems and information for managing DTOC		31.10.17				
2.4	Discharge2Assess Home pilot. Support ward/ social services staff to implement and embed D2AH and Process changes to support effective implementation and 'ramp up' the number if D2A home patients	LBHF	Senel Arkhut	Help plan and faciltitate timely discharge		31.12.17				
2.5	Establish system for daily updates on availability of intermediate care beds (similar to bed state reports)	Hammersmith & Fulham CCG	Lisa Cavanagh	Help plan and faciltitate timely discharge		31.09.17				
3	**Multi-Disciplinary /Multi agency discharge teams including the voluntary and community sector.**									
3.1	Issue Joint statement of Commitment to staff on partnership working, professional behaviour, no blame culture.	Health and Social Care	Joint Executive Team	common process and approach		31.10.17				
3.2	Develop a Standard Operating Process for Joint/Multi-agency discharge teams – standard assessment tool, single approach to managing discharge, and joint budget	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.12.17				
3.3	Develop an integrated model that clarifies and incorporates the third sector input into the 'system' to support patients.	LBHF/ICHT/Chelwest	Senel Arkhut/Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.12.17				
3.4	Geriatrician involvement in the community and hosptial based MD team	LBHF/ICHT/Chelwest	Senel Arkhut/Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function.		31.12.17				
3.5	SW use health data base on wards to state care on discharge, reduce ward staff and discharge planning need to contact SW.	LBHF	Senel Arkhut	Joined up approach towards an integrated		31.12.17				

3.6	Discharge planners able to access to SW office and enable co-location for SW, therapy, and discharge planning..	LBHF	Senel Arkhut	Joined up approach towards an integrated		31.12.17				
4	**Home First Discharge to Assess**									
4.1	Implement lessons from the Home to Assess Pilot (H2A) and roll out across NWL	LBHF	Senel Arkhut	reduce delays associated with assessment and management		31.12.17				
4.2	Discharge home with short term reablement - increase capacity	LBHF	Senel Arkhut	Ensure bridging home care arrangements for people with complex needs as a contingency for winter demand surge period.		31.12.17				
4.3	Include community based programmes in supported discharge:SHSOP,CIS,fals prevention,cognitive impairment/MH.	LBHF & H&F CCG	Senel Arkhut	Check alignment with other actions						
4.4	Pharmacy- patient access to meds before discharge	Acute providers	t.b.c	Check alignment with other actions						
4.5	Explore a bridging short term night care service for people with complex needs	LBHF & H&F CCG	Ray Boateng/ Shazia Khan	Reduce delays associated with lack of support at night		31.10.17				
5	**Seven Day Services**									
5.1	Joint 24/7 services available to support discharge, includes health and front line services and commissioned support services both voluntary and community sector.	West london, Central London & Hammersmith and Fulham CCGs	t.b.c	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		30.11.17				
5.2	Review current social work input at weekends and target it in the most effective areas of the hospitals such as admission avoidance BCF A4	LBHF	Senel Arkhut	Joined up approach towards an integrated discharge function. Reduce delays for		31.12.17				
5.3	Work with care homes to improve access at weekends and out of hours.	West london, Central London & Hammersmith and	Meeta Kathoria	Reduce delays for both health and social care		31.12.17				

5.4	WL Care home project staff to improve liaison with CIS, MCMW and LAS	West london, Central London & Hammersmith and	Meeta Kathoria	Reduce delays for both health and social care		31.12.17				
5.5	Improved involvement and working with third sector (inc. self-care programmes) and primary care to support 7 day working.	West london, Central London & Hammersmith and Fulham CCGs	Primary Care Leads	Reduce delays for both health and social care		ongoing				
6	**Trusted Assessors**									
6.1	Implement plans required to ensure training and competency of Trusted Assessor	CLCH	Ian Jones	Joined up approach towards an integrated discharge function. Reduce delays for		31.10.17				
6.2	Ring-fenced resource for 2 wte dedicated Care Home Nurse Assessors for our Care home providers (especially Care UK and Sanctuary) to enable them to undertake assessments within 24hrs and share assessments with other care providers if unable to accept	Care UK / Santuary Care	Michelle Sampang/ Jane Darani	Reduce delays as a result of nursing homes assessment		30.11.17				
7	**Focus of Choice**									
7.1	Co-produce 'Choice Policy' including standard practice 1-2 residential and nursing home placements, not 3 as currently stands.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	develop common appraoch and process		30.11.17				
7.2	Update/Create one document/ leaflet outlining the offer in line with the Choice Policy produced above	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	develop common appraoch and process		30.11.17				
8	**Enhancing health care in homes (Incl a sustainable market)**									
8.1	N. B work completed in STP work stream on care homes- completed a Baseline Needs Assessment against the national template across NWL.			Ensure that this information is available to leads.						
8.2	Work with the West London Proactive Care Home Project and the H&F Caring for Care homes project to enhance care in care homes	CWHHE CCGs	Meeta Kathoria	reduce avoidable admissions from care homes		ongoing				

8.3	**Improve Accessing of specialist services input into care homes to reduce avoidable admissions**	Hammersmith & Fulham CCG	Louise Maile	reduce avoidable admissions from care homes		31.12.17				
8.4	Aligning Commissioning and Quality Assurance and Contracting for Care Homes across health and social care.	LBHF & H&F CCG	Frank Hamilton							
8.5	Commissioning of 4 dedicated Care Home and Extra Care Advanced Primary Care Nurse Leads - affiliated to Primary Care and GP Federations to provide clinical leadership, service access, quality improvement,workforce devlopment and support service integration. for the care homes community (903 beds) across the three borough CCG areas.	West london, Central London & Hammersmith and Fulham CCGs	Caroline Durrack	Improve quality of care and productivity and reduce avoidable admissions from care homes		31.12.17				
8.6	Explore options for a single team to deliver brokerage, client and service review, contracting and quality assurance function across health and social care	LBHF & H&F CCG	Ben Gladstone & Ray Boateng	Improve quality and productivity in care homes		31.12.17				
8.7	Consider the provision of interim step down/Transitional care beds to enable step down from hospital for people who: • cannot be discharged home immediately and require assessment and planning • This includes interim bed options to carry out Continuing HealthCare Assessments (CHC) outside hospital • Support people with care needs who have temporary accommodation needs Consider case for funding to bolster support current interim step down beds to admit more complex people who are delayed	Hammersmith & Fulham CCG	Ray Boateng	Help plan and faciltitate timely discharge and reduce delays associated with assessment and care provision process		31.12.17				
8.8	Develop care home provision for older people with challenging behaviours, including people with dementia.	CWHHE CCGs	Meeta Kathoria / Ray Boateng	ensure right care in right unit to facilitate discharge and reduce readmission		31.12.17 and ongoing				
8.9	Develop appropriate care setting provision for people of working age with challenging behaviour needs.	CWHHE CCGs	Meeta Kathoria/ Ray Boateng			31.12.17				

8.1	Admission avoidance Hospital SW aligned to A&E and able to switch on short term services within 2-4 hours.	LBHF	Senel Arkhut	Reduce hospital admissions		31.10.17				
8.11	Support for care homes for people with severe mental illness, including dementia.	See Care Homes project	Meeta Kathoria	Improve quality and reduce hospital		ongoing				
8.12	Development of Tele medicine initiative in care homes	West london, Central London & Hammersmith and Fulham CCGs	Toby Hyde	Improve quality and reduce hospital admissions in care homes		ongoing				
8.13	On-going Workforce Development and training to care home staff	CWHHE CCGs	Meeta Kathoria	Improve quality and reduce hospital admissions in care homes		ongoing				

DRAFT

Managing Transfers of Care (DTOC reduction delivery plan) 2017/19

Local Authorities:

Hammersmith & Fulham Council (LBHF)

Royal Borough of Kensington & Chelsea (RBKC)

City of Westminster (WCC)

Clinical Commissioning Groups:

Hammersmith & Fulham Clinical Commissioning Group HFCCG)

Central London Clinical Commissioning Group (CLCCG)

West London Clinical Commissioning Group (WLCCG)

Content:

Action Plan

Intro and background

This draft document supplements the Integration and Better Fund Plan for the three boroughs for 2017-19. It is a plan in development in recognition of the recent challenges, changes, and opportunities to establish a clear and resourced plan to improve our citizens experience of a timely, appropriate, and person centred hospital discharge.

We recognise that a key part of our BCF is the interdependency of our schemes and commissioned services that reduce Delayed Transfers of Care (DToC) and support the principle that quality care is delivered in the right place.

We are committed to implementing the High Impact Change Model and have defined the areas that need input and the timeline of implementation by October 2017. A summary stocktake of our current position against each of the 8 High Impact Changes is attached as appendix 1. The stocktake has informed our action plan.

The High Impact Change Model remains challenging to implement and the three boroughs have therefore agreed to utilise approximately a third of the iBCF monies (£2.3m) to support improvement and change across the DToC pathway.

There is a strong base to build on from the 2016-17 plan which has enabled improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Developed integrated hospital discharge teams and pathways within several hospital wards to provide a common discharge approach across the three boroughs and working on extending this to include three additional boroughs to better manage hospital discharge
- Development of Home First (Discharge Home to Assess) model with enhanced care package, as well as access to Step Up Interim care beds should care breakdown at home
- Increased the provision of interim beds to enable step down from hospital and to allow for full assessments of people's needs to be undertaken in the community. This includes interim bed options to carry out Continuing HealthCare Assessments (CHC) outside hospital as well as support people with care needs who have temporary accommodation needs.
- Development of two Trusted Assessor Nurse posts for Care Homes to speed up assessment and discharge to care homes
- Utilised BCF resources to establish a 7-day hospital social work and therapy services which are due for review in 17-18 to evalaute their impact.
- Modelling and re-commissioning the established Community Independence service to enhance its focus on integrated working with GP's.
- Alignment of organisational Choice policies supported by information for patients, families, and carers on the local options available for community or home based care upon discharge

The draft Managing Transfers of Care Action Plan seeks to extend single Hospital Discharge function across health and social care and scale it up to support achievement of the DTOC targets which have been set for each borough.

Current context, performance, and targets

The stocktake to measure progress in delivering the high impact changes was recently undertaken to include the following;

- Early Discharge planning
- Systems to monitor patient flow
- Multi-disciplinary, multi-agency teams (including vol and community sector)
- Home First Discharge to Assess
- Seven day services
- Trusted Assessors
- Focus of choice
- Enhancing health in care homes

Clear that much good work is underway. For example, the single six borough hospital discharge model. However, it is also clear that there are a range of different project and governance arrangements in place (DA3, WLA, 2 * AE Delivery Boards, Three Borough Hospital Discharge Steering Group); and different challenges with borough hospital discharge performance. These are addressed within the action plan or progress included in this document (eg. Governance).

A copy of the stocktake is embedded here.

DTOC Impact Change 30-8-2017.d

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together.

Through the collaboration of a number of different local authorities in North West London the programme aims to improve outcomes for people being discharged from hospital, including the residents of the three Boroughs. The changes will provide a more consistent transfer of care service in NWL for the residents of all the boroughs, irrelevant of the hospital attended.

The WLA programme naturally progressed from the work undertaken in Hammersmith & Fulham, Royal Borough of Kensington & Chelsea (RBKC) and Westminster City Council (WCC) in 2015/16 to bring together the different hospital teams to act as one single adult social care hospital discharge function. This programme has shown a number of benefits for patients, for each local authority and for the system as a whole.

The benefits to be gained, as shown by the work already completed, can be divided into the following categories:

- Patient outcomes: a more consistent service supporting Hammersmith & Fulham residents
- Staff efficiencies: a more effective and efficient use of Hammersmith & Fulham staff to support service users
- Reduction in delayed transfer of care from hospital (DTOC)

For example, a collaborative service enabled the WCC and K&C social care teams to manage the H&F discharges at these sites, providing an onsite service. This has enabled a more consistent and more effective service for residents of the three boroughs at these sites, improving their outcomes during and after discharge. Not being located on site also caused communication issues with the hospital teams and limited the establishment of successful professional relationships with the trust staff.

The new approach was launched in March 2016 and in the 12 months following this (April 2016 – March 2017) delayed days due to ASC shared service assessments in hospital were 807. For the same period in the previous year (April 2015 – March 2016) the delayed days due to ASC shared services assessment in hospital were 738. Although this shows an increase of 9% this is significantly lower than the national average of 39% for this time period; the higher DTOC levels for 2016/17 can be attributed to the extreme pressure over the winter period compared to a much milder winter in 2015/16.

Furthermore, when focusing on the Imperial sites only (i.e. the sites impacted by this work) DTOC has dropped by 9% and 8 of the 12 months saw zero DTOC days for ASC assessments in this period, compared to 4 of the 12 months in the previous period. This provides clear evidence that the introduction of shared working has particularly reduced delays in Charing Cross and Hammersmith hospitals.

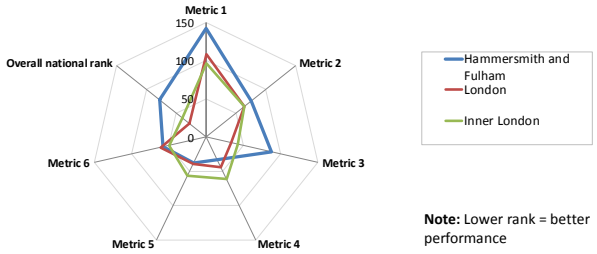
Based on the learning from this work and the evidenced benefits, the programme is looking to expand the arrangement to the London boroughs of Brent and Ealing, which will and provide an even wider level of support to the residents of three boroughs.

The performance dashboards for each borough are as follows

Hammersmith and Fulham

	Hammersmith and Fulham		London average		Inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	31,762	142	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	21	75	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	13.0	88	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /rehabilitation services	89.2%	33	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	4.0%	38	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur at the weekend	20.0%	58	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**78**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



The Spidergram opposite shows performance of the chosen authority (measured as rank within all single and upper tier authorities) for the 6 metrics compared with the average for the authority type and the region relevant to the selected authority. Data is only partially available for the Isle of Scilly. Isle of Scilly and City of London are excluded from the overall national rank (as per the original dashboard published by DH).

Note: Lower rank = better performance

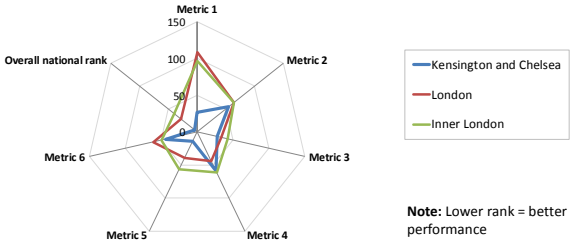
Hammersmith and Fulham vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Hammersmith and Fulham	**31,762**	**21**	**13.0**	**89.2%**	**4.0%**	**20.0%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

Kensington and Chelsea

	Kensington and Chelsea		London average		Inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	21,446	27	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	20	55	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	6.6	28	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	86.4%	59	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive	5.4%	14	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur	20.2%	44	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**4**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



The Spidergram opposite shows performance of the chosen authority (measured as rank within all single and upper tier authorities) for the 6 metrics compared with the average for the authority type and the region relevant to the selected authority. Data is only partially available for the Isle of Scilly. Isle of Scilly and City of London are excluded from the overall national rank (as per the original dashboard published by DH).

Note: Lower rank = better performance

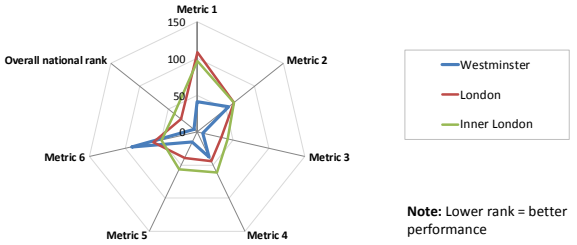
Kensington and Chelsea vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Kensington and Chelsea	**21,446**	**20**	**6.6**	**86.4%**	**5.4%**	**20.2%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

Westminster

	Westminster		London average		inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	22,538	41	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	20	55	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	3.9	8	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	88.6%	38	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	5.2%	15	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur at the weekend	19.5%	91	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**5**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



The Spidergram opposite shows performance of the chosen authority (measured as rank within all single and upper tier authorities) for the 6 metrics compared with the average for the authority type and the region relevant to the selected authority. Data is only partially available for the Isle of Scilly. Isle of Scilly and City of London are excluded from the overall national rank (as per the original dashboard published by DH).

Note: Lower rank = better performance

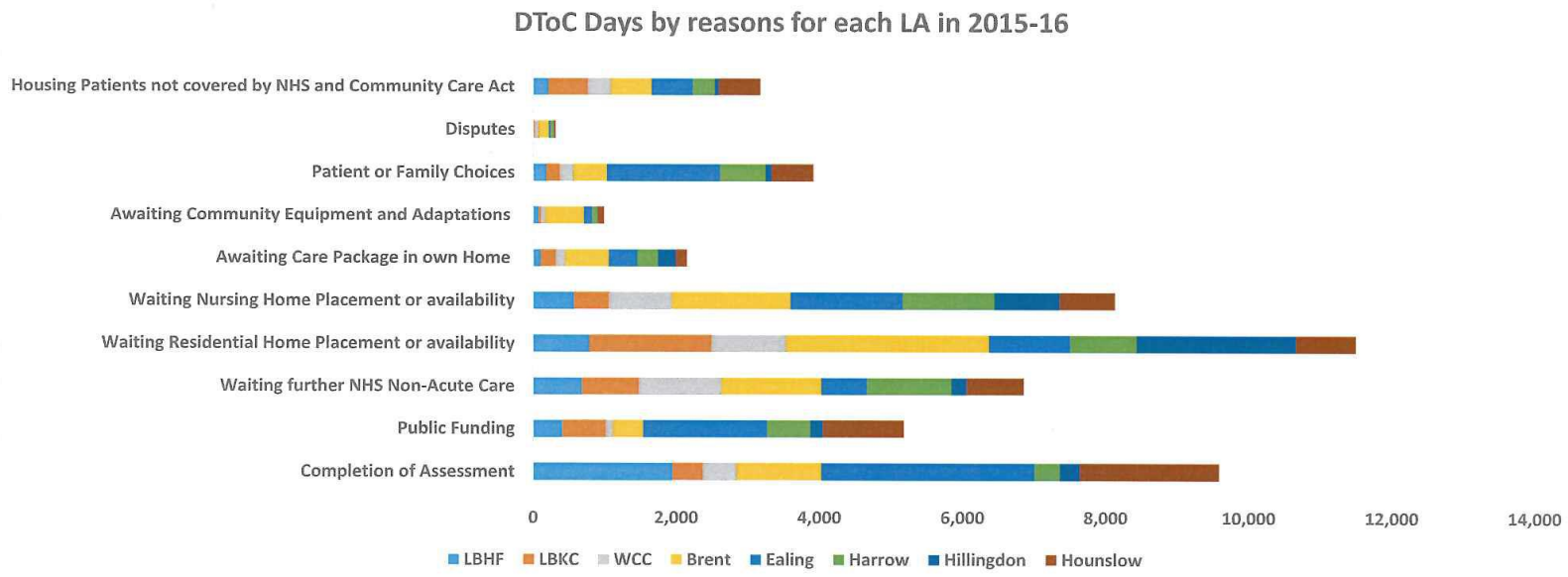
Westminster vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Westminster	**22,538**	**20**	**3.9**	**88.6%**	**5.2%**	**19.5%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

An analysis of the reason for delays for each WLA borough can be seen in the first two tables that follow, and a third table that forecasts the number of DtoC days for 17/18, 18/19, and 19/20.

Source: Adult Social Care Spend and Delayed Transfer of Care (DToC) days between the period from 2012-13 to 2014-15 and forecasts for 2016-17 to 2019-20. This report includes analysis and comparison of Adult Social Care spend by WLA Boroughs LBHF, LBKC, WCC, Brent, Ealing, Harrow, Hillingdon & Hounslow and DToC days by NHS Trust in their area. Information on Adult Social Care Spend for each WLA Borough was provided by Minesh Patel - Head of Finance, Brent Council while data for DToC days was downloaded from www.england.nhs.uk/statistics.

DToC days by reasons for each WLA Local Authority in 2015-16 - Contd..



The Graph above is linked to the Table on page above

Out of 51,831 total DToC days in FY 2015-16, 11,505 DToC days (22%) were due to waiting for Residential Home Placement or availability and Brent had the highest number of DToC days in this category - 2,842 DToC days (25%)

8,138 DToC Days (16%) were due to waiting for Nursing Home Placement or availability and again Brent had the highest number of DToC days in this category - 1,659 DToC days (20%)

3,176 DToC days or 6% were due to Housing Patients not covered by NHS and Community Care Act and Ealing had the highest number of DToC days - 578 days (18%) in this category.

DToC days by reasons for each WLA Local Authority in 2015-16

The Graph on the right and Table below are the analysis of DToC days by reasons for all WLA Local Authorities in year 2015-16

22% of DToC days in year 2015-16 were due to Waiting Residential Home Placements or availability

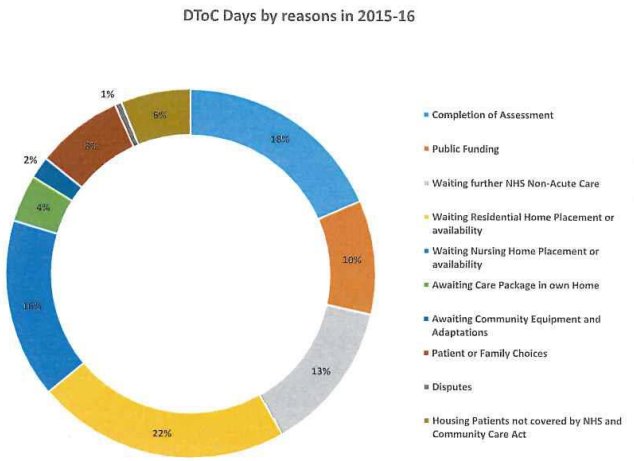
18% were due to Completion of Assessment and 16% were due to Waiting Nursing Home Placements or availability

Under 22% category, Brent had the highest number of DToC days while Hammersmith had the lowest

Under 18% category, Ealing had the highest number of DToC days while Hillingdon had the lowest

Only 2% were due to Awaiting Community Equipment and Adaptations and 4% were due to Awaiting Care Packages in own Home

8% of DToC days in FY 2015-16 were due to Patient or Family Choices and only 1% were due to Disputes.



DToC days by reasons in FY 2015-16

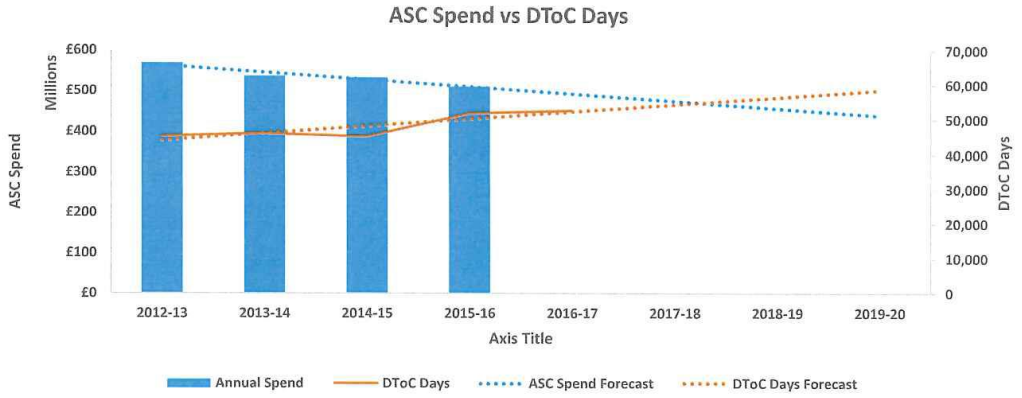
Local Authority	Completion of Assessment	Public Funding	Waiting further NHS Non-Acute Care	Waiting Residential Home Placement or availability	Waiting Nursing Home Placement or availability	Awaiting Care Package in own Home	Awaiting Community Equipment and Adaptations	Patient or Family Choices	Disputes	Housing Patients not covered by NHS and Community Care Act	Total
LBHF	1,950	411	684	789	571	105	80	185	13	217	4,992
LBKC	428	601	794	1,708	492	216	33	193	10	548	5,013
WCC	470	106	1,158	1,041	879	133	63	187	59	327	4,364
Brent	1,185	424	1,399	2,842	1,659	607	538	466	140	565	9,685
Ealing	2,979	1,731	637	1,133	1,570	399	112	1,589	21	578	10,728
Harrow	354	605	1,179	929	1,283	287	80	631	52	308	5,656
Hillingdon	281	173	212	2,226	909	250	3	86	0	56	4,196
Hounslow	1,944	1,133	797	837	775	154	83	584	18	577	6,884
Total	**9,591**	**5,184**	**6,860**	**11,505**	**8,138**	**2,151**	**992**	**3,921**	**313**	**3,176**	**51,831**
% DToC Days	**18%**	**10%**	**13%**	**22%**	**16%**	**4%**	**2%**	**8%**	**1%**	**6%**	

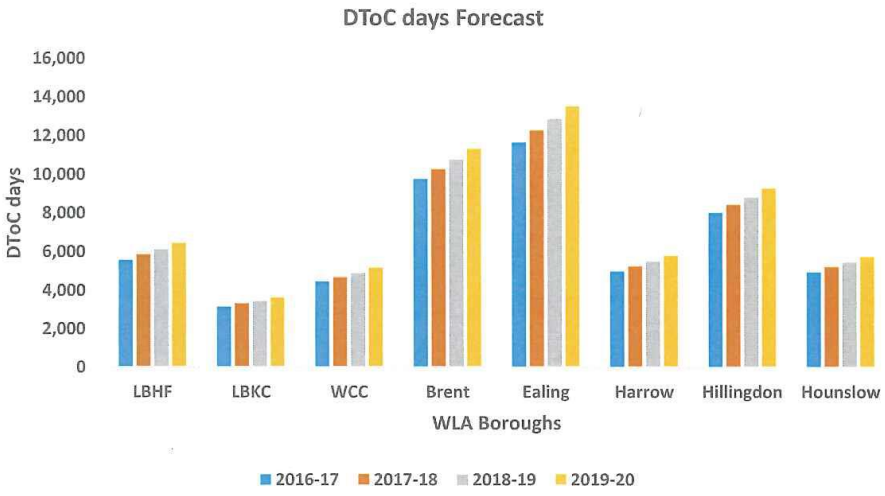
DToC days Forecast for 17/18, 18/19 and 19/20

The Graph on the right and below are the Forecasts of DToC days from FY 2017-18 to 2019-20

Based on past trends, DToC days have been increasing at a rate of 5% per annum and this value is used to forecasts for 2017-18, 2018-19 & 2019-20.

DToC days for FY 2016-17 are expected to increase by 1.5%





DToC days data for 2016-17 is available until Jan 2017 and Moving Averages were used to predict activity levels for the whole year.

Ealing will continue to have the highest number of DToC days based on past trends followed by Brent and Hillingdon.

DToC days Forecast

Local Authority	2016-17	2017-18	2018-19	2018-19
LBHF	5,543	5,820	6,111	6,417
LBKC	3,131	3,288	3,452	3,625
WCC	4,444	4,666	4,900	5,144
Brent	9,772	10,261	10,774	11,312
Ealing	11,677	12,261	12,874	13,518
Harrow	4,995	5,245	5,507	5,782
Hillingdon	8,020	8,421	8,842	9,284
Hounslow	4,965	5,213	5,474	5,748
Total	**52,547**	**55,174**	**57,933**	**60,830**

The table above is based on a past trend of DToC rates rising by 5% per annum. The actions required to achive a reduction in DToC must therefore arrest this trend and achieve the target reduction.

Our agreed trajectories for DToC for 2017/19 are as follows;

*Please note these trajectories may be subject to change

CCG Code	CCG Name	Type	Days (September)	NHS/Social Care Ratio	Baseline Total	Baseline Split	September Position	September Split	March Position	March Split	Phase 1 Step	Phase 2 Step
08C	NHS HAMMERSMITH AND FULHAM CCG	NHS	6.94	55.79%	16.6	9.26	12.45	6.95	8.3	4.63	0.39	0.39
08C	NHS HAMMERSMITH AND FULHAM CCG	Social Care	5.5	44.21%	16.6	7.34	12.45	5.50	8.3	3.67	0.31	0.31
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	NHS	5.49	70.29%	9.76	6.86	7.81	5.49	5.86	4.12	0.23	0.23
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	Social Care	2.32	29.71%	9.76	2.90	7.81	2.32	5.86	1.74	0.10	0.10
08Y	NHS WEST LONDON CCG	NHS	6.72	67.20%	12.5	8.40	10	6.72	7.5	5.04	0.28	0.28
08Y	NHS WEST LONDON CCG	Social Care	3.28	32.80%	12.5	4.10	10	3.28	7.5	2.46	0.14	0.14

Accountability and Governance

Progress on managing transfers of care and achieving the DTOC targets will be managed on a day to day basis by the two A&E/Urgent Care Delivery Boards. Progress will be overseen by the three borough Hospital Discharge Steering Group, which is chaired by a Director of Adult Social Care. Key decisions and current performance will be overseen by a Joint Executive Team meeting and by each Health and Wellbeing Board.

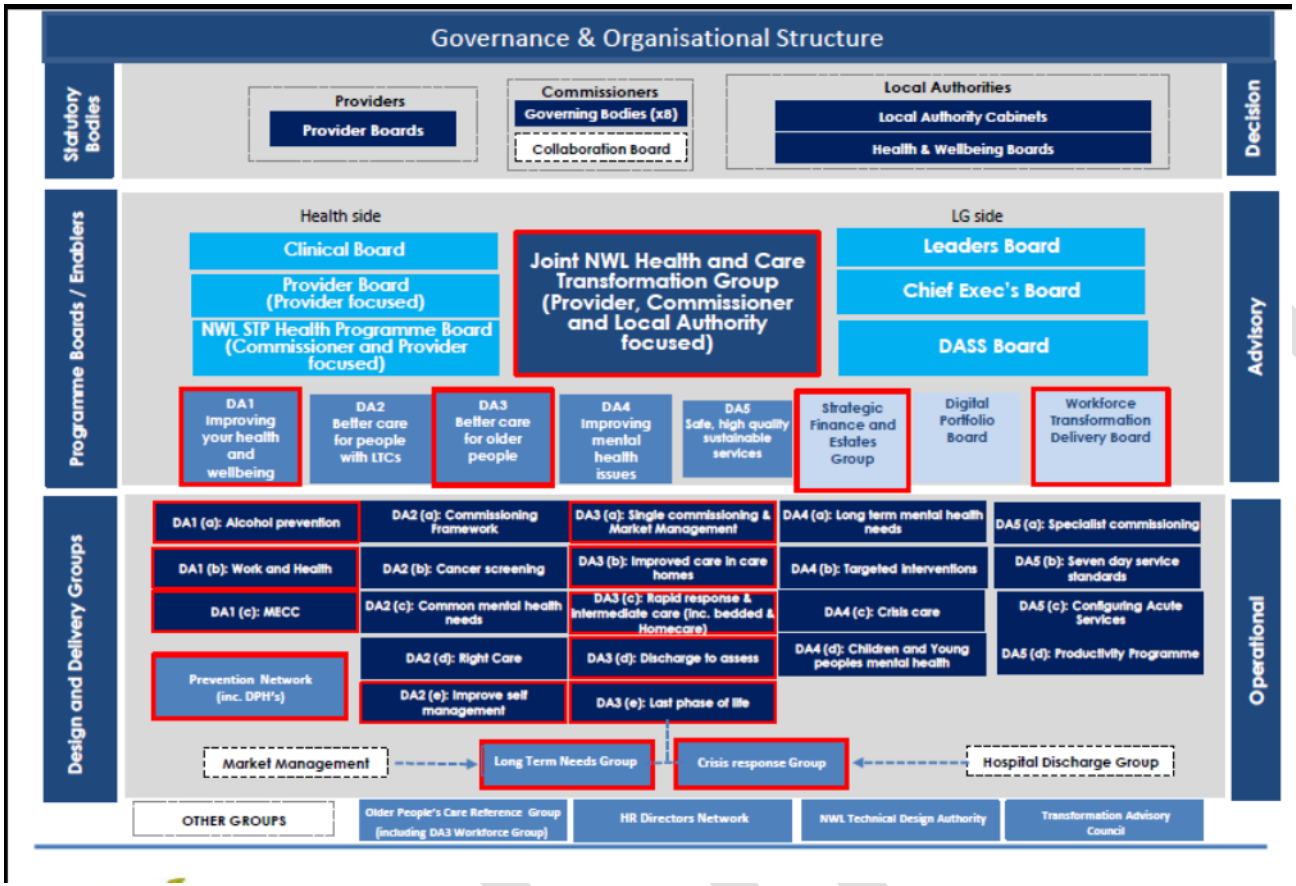
To continue work already underway and respond to the changing landscape a proposed co-ordination and governance structure is outlined below.

A DAS will be the SRO for the three boroughs for this work and will chair the coordination, progress and unblock barriers through the three boroughs Hospital Discharge Steering Group. In Hammersmith & Fulham the DAS chairs a weekly DToC monitoring group on MH delays as non-acute MH delays are a significant contributor to the overall DToC figures for this council and health.

Overall Coordination/Planning	Day to day coordination	3B Hospital Discharge Steering Group	Separate projects/schemes
NWL Health and Social Care Transformation Board DA3 Programme Board JET	2 * A&E Delivery Boards 3* A&E Operational Boards H&F DTOC Team	Early Discharge Planning MDTs Home First 7 Day Services Trusted Assessors Focus on Choice Step Down Beds	Hospital Flow (Acute Lead) Enhancing Care in Care Homes (3B Lead, WLA Support) Community Independence Service (CCG Lead, 3B Support)

An IBCF Transformation Fund has been created to support the delivery of the action plan and will be allocated to assist with improving performance where required. Project briefs, inc resources, costs and expected benefits/outcomes are being developed for new tasks in the action plan and those existing actions being extended further.

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together. The diagram below shows the governance arrangements for the WLA and how the actions in this plan will be designed and delivered, and monitored within this governance and organisational structure.


Governance & Organisational Structure
Statutory Bodies
Providers
Provider Boards
Commissioners
Governing Bodies (x8)
Collaboration Board
Local Authorities
Local Authority Cabinets
Health & Wellbeing Boards
Decision
Programme Boards / Enablers
Health side
Clinical Board
Provider Board (Provider focused)
NWL STP Health Programme Board (Commissioner and Provider focused)
Joint NWL Health and Care Transformation Group (Provider, Commissioner and Local Authority focused)
LG side
Leaders Board
Chief Exec's Board
DASS Board
DA1 Improving your health and wellbeing
DA2 Better care for people with LTCs
DA3 Better care for older people
DA4 Improving mental health issues
DA5 Safe, high quality sustainable services
Strategic Finance and Estates Group
Digital Portfolio Board
Workforce Transformation Delivery Board
Advisory
Design and Delivery Groups
DA1 (a): Alcohol prevention
DA1 (b): Work and Health
DA1 (c): MECC
DA2 (a): Commissioning Framework
DA2 (b): Cancer screening
DA2 (c): Common mental health needs
DA2 (d): Right Care
DA2 (e): Improve self management
DA3 (a): Single commissioning & Market Management
DA3 (b): Improved care in care homes
DA3 (c): Rapid response & intermediate care (inc. bedded & Homecare)
DA3 (d): Discharge to assess
DA3 (e): Last phase of life
DA4 (a): Long term mental health needs
DA4 (b): Targeted interventions
DA4 (c): Crisis care
DA4 (d): Children and Young peoples mental health
DA5 (a): Specialist commissioning
DA5 (b): Seven day service standards
DA5 (c): Configuring Acute Services
DA5 (d): Productivity Programme
Prevention Network (inc. DPH's)
Market Management
Long Term Needs Group
Crisis response Group
Hospital Discharge Group
Operational
OTHER GROUPS
Older People's Care Reference Group (including DA3 Workforce Group)
HR Directors Network
NWL Technical Design Authority
Transformation Advisory Council

Local Capacity

As part of our agreed use of iBCF monies the three boroughs have iIdenitfied the key areas for investment in sustaining the care market, expanding capacity, and using £2.3m to support initiatives to reduce Delayed Transfers of Care.

The full details of how this money will support our shared ambitions will be reported as part of the BCF quarterly submission.

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together.

Through the collaboration of local authorities in North West London the programme aims to improve outcomes for people being discharged from hospital. The changes will provide a more consistent transfer of care service in NWL for the residents of all boroughs, irrespectiveant of the hospital attended.

Action Plan

The attached spreadsheet of actions is a comprehensive list of areas for action under development. Once fully completed, the action plan will provide a clear leadership, accountability and expected outcomes for each action. Wherever possible, it will identifdy the estimated contribution of each action or scheme toward reducing DToC. This plan sits alongside and supports the individual DTOC reduction plans for each provider.

For example, Imperial College Healthcare NHS Trust have identified from health DTOCs by category that for H&F residents, the majority of days lost were due to waiting for non-acute NHS care e.g. a rehabilitation placement or continuing care home placement. The delays in this category are primarily for NHS Continuing Care assessment and access for Care at Home or Placements. This is followed by waits for assessment for interim nursing or permanent placement – particularly Dementia Nursing. It is anticipated that delays for these categories will be reduced through the implementation of Trusted Assessment (see below).

Delays experienced due to community equipment, such as beds, mattresses or hoists, will be improved through the implementation of Integrated Discharge Teams (see below).

37 per cent of delays for Adult Social Care relate to residential and nursing placements. It is anticipated that these delays will be reduced through a combination of Integrated Case Management and Integrated Discharge teams (see below). Capacity and access to assessment for care homes poses a risk to DTOC reduction plans. There are plans to recruit 2 Nursing Home Nurse Assessors as part of the better care plans to support hospital discharges, to facilitate access to nursing home assessment and placements.

The Trust has committed to reducing DTOCs by 50 per cent in H&F as part of an improvement plan to include the following:

- Early discharge planning – discharge planning commenced early in the pathway, with multidisciplinary board rounds, ward allocated Social Workers and assessment of need from admission or pre admission if possible.
- Multi-agency discharge teams – teams that are co-located where possible and include specialist discharge nurses/CHC assessors, British Red Cross, specialist homeless workers and therapy teams. The teams will work together, reducing duplicate assessments and referrals, streamlining processes and handovers of care needs.
- Home First – this is a pathway whereby people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- 7 day service – providing a service for patients and access to clinical review and senior decision making 7 days a week, resulting in access to care requirements and discharge from hospital when they are medically fit to leave. Services provided across the Trust 7 days a week include the specialist discharge team, social services and CIS.
- Trusted assessor roles – delays in patient discharge can be harmful to patients but most can be avoided, particularly if the delay is caused by waiting for a care provider to assess and accept a patient into their service. A trusted assessor carrying out the assessment − someone acting on behalf of and with permission of the provider − is an effective way of dealing with these delays.
- Focus on choice – partnership working to support where feasible choice of care provision and ensuring patients and families are given information on options available. Where first choice options and provision are not available ensuring a joint approach across health and social care to provide alternative care arrangements. Early discharge planning and information will aid the choice discussion and ensure all of the multidisciplinary team understand expectations and limitations.

This is being addressed through three interlinked strategies:

i. Home First (Discharge to Assess)

A Home First pilot commenced in July on four wards across the St Mary's and Charing Cross Hospital sites. This model has demonstrated significant benefit in reducing delays in other areas of North West London, although it has been more challenging than anticipated to identify suitable patients for discharge using this pathway in our hospitals. These challenges are being addressed through dedicated medical and nursing leadership and targeted communications to wards teams.

ii. Trusted Assessor

The Trust now has six trained trusted assessors in place to establish and the process for trusted assessment will be implemented by the newly established Integrated Care Management Team. The team is hosted by the Trust and works across the Imperial College Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust sites. Since its establishment, and in the last two months, the team has supported increased occupancy and reduced length of stay at the Farm Lane bedded community rehabilitation unit thereby freeing up acute capacity.

iii. Integrated Discharge Team

The Integrated Discharge Team includes hospital-based specialist discharge nurses and co-ordinators working collaboratively with hospital-based social workers to address issues of complex social care. A pilot has been running on three wards across the Trust since June with positive feedback received from acute teams. Information technology and governance issues are delaying the reduction in duplicated health and social care assessments. The pilot was extended to include a further three wards from July.

In addition, the Trust is in the process of scoping the potential for establishing a winter ward in a local care home, potentially providing 10 beds for medically optimised patients awaiting placement in residential care. This would be focused on a cohort of patients for whom the Home First model would not be appropriate. The Integrated Care Management Team would be responsible for managing the flow of patients from acute beds to the winter ward. The scoping exercise will be completed and a decision on whether to proceed with this plan taken by the Trust by the end of September.

Appendix 1 Managing Transfers of Care (DTOC reduction delivery plan) 2017/19 for the three boroughs

Appendix 6: Overview of Better Care Fund Plan Funding

	2017-18							2018-19						
	WCC		RBKC		H&F		Three Borough Total	WCC		RBKC		H&F		Three Borough Total
	Target	Plan	Target	Plan	Target	Plan	Plan	Target	Plan	Target	Plan	Target	Plan	Plan
Core BCF	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)	(£,000)
CCG Minimum - Protection Of Social Care	8,086	8,086	5,374	5,374	5,782	5,782	19,242	8,239	8,239	5,476	5,476	5,892	5,892	19,607
CCG Minimum - Out of Hospital Services	5,443	6,285	3,614	5,566	3,787	6,325	18,176	5,546	6,285	3,683	5,566	3,859	6,325	18,176
CCG - Other (Health)	5,624	4,782	3,730	1,778	3,759	1,221	7,781	5,732	4,993	3,801	1,918	3,830	1,364	8,275
Sub-Total - BCF Allocation	***19,153***	***19,153***	***12,718***	***12,718***	***13,328***	***13,328***	***45,199***	***19,517***	***19,517***	***12,960***	***12,960***	***13,581***	***13,581***	***46,058***
Additional CCG Funds														
S75 Commissioned by LA - Add CCG		10,243		10,021		10,014	30,278		9,129		9,547		9,308	27,984
Health Contracts		7,362		8,462		8,119	23,943		6,623		8,250		7,681	22,554
System Resilience		320		315		320	955		320		315		320	955
Sub-total - Additional CCG Funds		***17,925***		***18,798***		***18,453***	***55,176***		***16,072***		***18,112***		***17,309***	***51,493***
Additional Social Care Funds														
IBCF		8,721		3,948		5,128	17,797		12,317		5,329		7,051	24,697
LA Aligned Budgets		28,109		27,268		8,166	63,543		29,007		28,108		8,463	65,578
Sub-total - Social Care Funding		***36,830***		***31,216***		***13,294***	***81,340***		***41,324***		***33,437***		***15,514***	***90,275***
Total		**73,908**		**62,732**		**45,075**	**181,715**		**76,913**		**64,509**		**46,404**	**187,826**

Hammersmith & Fulham HWB

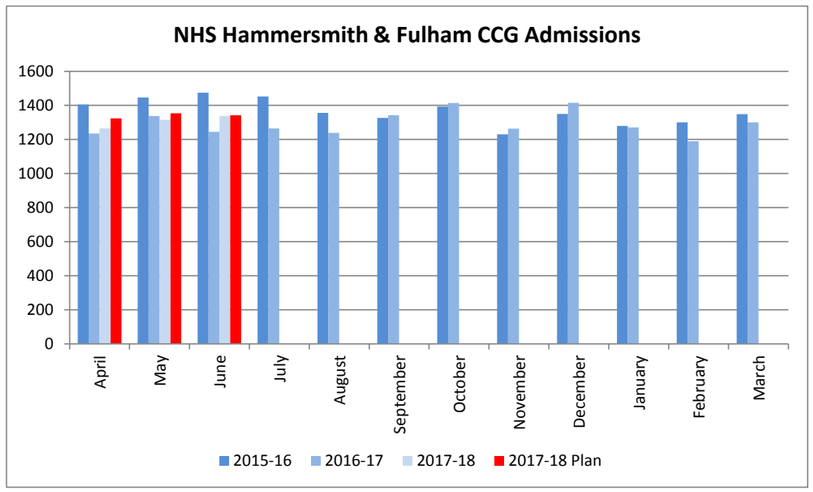
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Hammersmith & Fulham HWB Non-Elective Admission Trajectory for FY 2017/18	1354	1386	1376	1385	1330	1282	1381	1277	1342	1297	1241	1315	15967

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Hammersmith & Fulham HWB Non-Elective Admission Trajectory for FY 2018/19	1326	1358	1349	1359	1304	1255	1301	1197	1264	1218	1162	1238	15331

Percentage Contribution

CCG Name	% HWB from CCG
NHS Brent CCG	0.5%
NHS Central London (Westminster) CCG	2.4%
NHS Ealing CCG	1.2%
NHS Hammersmith and Fulham CCG	87.7%
NHS Hounslow CCG	0.7%
NHS West London (K&C & QPP) CCG	7.2%
Total	99.7%

NHS Hammersmith & Fulham CCG Admissions				
Month	2015-16	2016-17	2017-18	2017-18 Plan
April	1406	1235	1265	1324
May	1446	1338	1315	1353
June	1474	1245	1338	1343
July	1452	1265	0	
August	1356	1239	0	
September	1326	1342	0	
October	1393	1414	0	
November	1230	1263	0	
December	1350	1415	0	
January	1280	1271	0	
February	1301	1189	0	
March	1349	1301	0	
Total	16363	15517	3918	
Growth		-5.17%	2.62%	



Kensington & Chelsea HWB

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Kensington & Chelsea HWB Non-Elective Admission Trajectory for FY 2017/18	955	998	997	1008	965	937	947	900	913	883	851	879	11234

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Kensington & Chelsea HWB Non-Elective Admission Trajectory for FY 2018/19	920	966	967	980	938	912	921	873	889	860	830	860	10916

Percentage Contribution

CCG Name	% HWB from CCG
NHS Brent CCG	0.1%
NHS Central London (Westminster) CCG	5.2%
NHS Hammersmith and Fulham CCG	1.2%
NHS West London (K&C & QPP) CCG	93.1%
Total	99.6%

NHS West London CCG Admissions				
Month	2015-16	2016-17	2017-18	2017-18 Plan
April	1359	1209	1312	1408
May	1479	1326	1337	1476
June	1510	1308	1305	1472
July	1508	1340	0	
August	1408	1268	0	
September	1403	1245	0	
October	1395	1376	0	
November	1344	1329	0	
December	1334	1326	0	
January	1264	1303	0	
February	1328	1265	0	
March	1315	1314	0	

Total	16647	15609	3954
Growth		-6.24%	2.89%