London Borough of Hammersmith & Fulham

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Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Monday 12 September 2016
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Hannah Barlow Councillor Rory Vaughan (Chair) Councillor Natalia Perez	Councillor Andrew Brown Councillor Joe Carlebach	Patrick McVeigh, Action on Disability, Bryan Naylor, Age UK, Debbie Domb, Disabilities Campaigner

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Date Issued: 01 September 2016

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

12 September 2016

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 9

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on 14 June 2016.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. NW LONDON SUSTAINABILITY AND TRANSFORMATION PLAN 10 - 86

This report gives an overview of the key messages and priorities in the North West London STP submitted to NHS England in June. It updates on emerging governance arrangements that will oversee development and delivery of the STP, consultation and engagement plans and next steps.

5. LIKE MINDED MODEL OF CARE FOR SERIOUS AND LONG TERM MENTAL HEALTH NEEDS 87 - 92

This report sets out the Like Minded North West London Strategy for Mental Health and Wellbeing. Taking a North West London approach is intended to share good practice, avoid duplication and work collaboratively where developing services for a larger population aims to achieve better outcomes.

6. CHILDHOOD IMMUNISATION - PERFORMANCE UPDATE AND PRIORITIES FOR 2016-17 93 - 111

This report provides an update on childhood immunisation performance and details the priorities for both immunisations and flu for 2016/17.

7. WORK PROGRAMME 112 - 113

This report provides an update on the committee's work programme for 2016/17.

8. DATES OF FUTURE MEETINGS

The next meeting of the committee will be held on 2 November 2016.

London Borough of Hammersmith & Fulham

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Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Tuesday 14 June 2016

PRESENT

Committee members: Councillors Hannah Barlow, Andrew Brown, Joe Carlebach, Rory Vaughan (Chair) and Natalia Perez

Co-opted members: Patrick McVeigh (Action on Disability), Bryan Naylor (Age UK) and Debbie Domb (Disabilities Campaigner)

Other Councillors: Sue Fennimore, Sharon Holder and Vivienne Lukey

Officers: Sue Spiller, Head of Community Investment (LBHF), Daphine Aikens, Chief Executive Officer, Hammersmith and Fulham FoodBank, Mick Fisher, Head of Public Affairs, Imperial College Healthcare NHS Trust, Dr William Oldfield, Deputy Medical Director, Imperial College Healthcare NHS Trust.

72. SUE PERRIN - CONDOLENCES AND MINUTES SILENCE

The Chair, Councillor Rory Vaughan, informed Members of the Committee that following a short period of illness, Sue Perrin, Committee Coordinator for this Committee had sadly passed away yesterday evening. Councillor Vaughan said that Sue had supported the work of this Committee for many years, her loyalty, dilegence and effeciency was invaluable, as was her support to him in his role as Chair. Councillors Joe Carlebach, Natalie Perez, Hannah Barlow, and Andrew Brown fully endorsed the comments of the Chair, noting this was not an easy committee to clerk and that Sue had handled this with great strength. Sue had been held in high regard for her

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commitment in serving this Council and the Committee sent their condolences to family, friends and colleagues. There followed a minute's silence for the passing of Sue Perrin.

73. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 18 April 2016 were approved as an accurate record and signed by the Chair Councillor Rory Vaughan.

74. APOLOGIES FOR ABSENCE

Apologies for absence were received from Co-optee Bryan Naylor.

75. DECLARATION OF INTEREST

Councillor Joe Carlebach declared an interest in Item 6, as a Trustee of Hammersmith & Fulham Citizens Advice Bureau, Item 7, a trustee of Arthritis Research UK, which owns property on the Charing Cross site.

76. COMMITTEE MEMBERSHIP 2016/17, APPOINTMENT OF VICE CHAIR AND TERMS OF REFERENCE

The Chair, Councillor Rory Vaughan informed members that he understood the previous concerns of members regarding the appointment of vice-chairs and invited nominations. Councillor Hannah Barlow was nominated by the Chair, seconded by Councillor Natalie Perez:

RESOLVED THAT

Councillor Hannah Barlow be appointed Vice-Chair of the Committee for the municipal year 2016/17

77. APPOINTMENT OF CO-OPTED MEMBERS

RESOLVED THAT:

The following co-opted members be re-appointed for the municipal year 2016/17:

Debbie Domb, Disabilities Campaigner
Patrick McVeigh, Action on disability
Bryan Naylor, Age UK

78. ADDRESSING FOOD POVERTY IN HAMMERSMITH & FULHAM

The Chair welcomed Sue Spiller, Head of Community Investment and Daphine Aikens, Chief Executive Officer of Hammersmith & Fulham Food Bank (HFFB). The Committee had looked at food poverty in the borough on two previous occasions and welcomed the opportunity to receive a update following the opening of the new site at Bloemfontein Road. Sue Spiller reported that whilst it was sadly, a much needed resource the site, named

The Hub@75, was operational. Daphine Aikens explained that it was working fantastically well and heartfelt, positive feedback had been received. There were plans to provide additional funding to extend the service and operate a summer club throughout the long school holiday, making provision for children on free school meals.

Daphine Aiken informed members that the increased funding (from LBHF and The Trussell Trust, until March 2018) to the Hammersmith and Fulham Citizens Advice Bureau (CAB) provided for a second full time advice worker. Work undertaken by them was invaluable, supporting 165 individuals in the past 9 months and securing additional benefits income for them. In addition, three advice sessions provided by Hammersmith & Fulham Law Centre had been held at The Hub@75 and these would hopefully continue once a new housing advice lawyer was in post.

Commenting on the Rose Vouchers scheme, it was explained that HFFB would like to develop this further. The scheme additionally benefits the local market and ensures that eligible families are able to use the vouchers as cash, in exchange for fruit and vegetables with the aim of ensuring a healthy start for young families. Daphine Aikens expressed her disappointment that few of the larger supermarkets were proactive about food disposal and recognised that there was considerable work to be done. FareShare initiated a Tesco pilot scheme which would be reported back on, unused food was collected and disposed of by local charities using FoodCloud.

Councillor Joe Carlebach commented that Wholefoods Market, Kensington be contacted as he was aware that they donate. Daphine Aikens continued, commenting that in June 2010 the aim of HFFB was to alleviate poverty in Hammersmith & Fulham, providing emergency supplies for people in the area. The three sites were fully funded, operating 6 days per week. All referrals were given food of nutritional value, hygiene products, clothing, pots, pans and kitchen utensils. Bulk items, such as beans and pasta were shared out and redistributed with other charities.

With reference to the HFFB annual report, there had been a 22% increase in the past year in the number of people being fed in the past two years. Qualifying some of the data, Daphine Aikens indicated that where low income was the reason for the referral, figures were slightly skewed as it was submitted directly by HFFB branches. The referral arose because the individual had insufficient benefits to survive. The list of Major Voucher Partners is where they saw most of the vouchers being issued and they are vital for identifying need as frontline care providers. In response to a question from Councillor Andrew Brown, Daphine Aikens explained the process, where an individual would approach the CAB and their most pressing need identified, ie, food poverty, and a food voucher issued. The person is welcomed warmly at HFFB and leave with sufficient food covering immediate need. Most are local residents, but some of those who are not have children who go to school in the borough.

Daphine Aikens outlined additional areas of support undertaken, including training courses on meal planning, with those planned for September and

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October already fully booked. Many individuals self-refer such as young people leaving care and other vulnerable groups. The Hub@75 site, being new has gradually established itself. Weekly coffee mornings, use of PC, job searches, CV advice, clothing requests and health and classes are some of the areas of support offered, with a view to extending these to IT classe in the future. Daphine Aikens added that they were also working with with Mitie as part of the local employability scheme.

Councillor Hannah Barlow commended the work of the organisation and enquired about the referral process and how this worked. Councillor Barlow observed that, whilst the service was invaluable, if in the long term the goal was to eliminate it, closer analysis as to why benefit delays were incurred was necessary. Sue Spiller clarified that the delay in benefits from the Department for Works and Pensions (DWP) arose where a review or the overturning of a decision took months. This was a national issue and partly due to the impact of Universal Credit. She confirmed that it was difficult to get an accurate picture of the causes of food poverty and that CAB advice had been quite helpful in terms of establishing the high cost of housing rent locally. Benefits themselves were not always the issue, rather the slow resolution of issues resulting in delayed payment and as such, difficult to unpick. Councillor Barlow commented that a 7 week delay was considerable and caused great impact on vulnerable people.

In a response to a query by Debbie Domb, HAFCAC, Daphine Aikens confirmed that disabled groups were not currently able to join the fuel bank scheme. Sue Spiller added that the CAB, together with national fuel organisations were currently offering this ahead of the winter season. She continued, that funding through local authorities would further mitigate against fuel poverty targeting at risk groups. It was noted that the scheme was currently limited to families with children. Sue Spiller acknowledged this was a concern and stated that once the scheme was established, work would be done to augment it, with options to closely examine the criteria for eligibility in further detail.

Daphine Aikens responded to a comment by Councillor Sue Fennimore, highlighting concerns about the work of job centres in the context of suspending benefits such as Job Seekers Allowance (JSA). She confirmed that she had visited the job centre, which was able to issue vouchers and that the partnership working arrangement with this and other organisations such as the law centre worked well.

Co-optee, Patrick McVeigh, Action on Disability, congratulated them on an excellent report that was both easy to read and understand. He commented on the harshness of the benefit review process where benefits were suspended and then paid in arrears once a decision is reached. Daphine Aikens explained that they dealt with about 90 enquires per week, largely from women and children, and who may visit the site on more than one occasion during a period of benefit sanction extending over 6 weeks or longer.

Councillor Carlebach expressed concern over the lack engagement by hospitals who were absent from the list of voucher partners and encouraged the organisation to approach them, suggesting that it would be useful to establish a central contact point with the local NHS trusts, rather than approaching individual departments, which could be time consuming. Daphine Aikens acknowledged this and a supplementary point from Councillor Carlebach, explaining that they were limited to small scale operations and would find it difficult to manage bulk items from large, local food manufacturers due to storage limitations.

Councillor Perez congratulated Daphine Aikens on the fantastic work being undertaken. In response to a number of points, Daphine Aikens explained that the food parcels were issued on the basis of identified need, establishing the circumstances of each individual, to illustrate access to power, means to cook with and mobility. Demand for the service was increasing and referrals were sometimes received outside partner agencies. Emphasing the level of need, the invidual's access to facilities would be established through discussion and a parcel prepared that they would be happy to take home, to illustrate, "kettle boxes". People gained a sense of self-worth and a degree of control or choice. They were asked for their preference and this was empowering. Daphine Aiken explained that volunteers were trained to be able to provide information, support individuals and be a resource in terms of what they were able to provide.

Self-referrals without vouchers could be checked if previously referred, however, need has to identifiable and we encourage people to apply. However, those in desperate need will not be turned away empty handed. Issues relating to Universal Credit had made it harder to be proactive, clients were likely to visit more frequentely. Some resort to stealing food, debts are further accrued and their situation deteriorates rapidly.

In response to supportive comments from Councillor Sharon Holder, Lead Member for Hospitals and Healthcare, Daphine Aitkens explained that their services were broadly advertised locally utilising free resources such as the LBHF website (also promoted from within the Council) and social media. Local businesses donate either food, cash or support. Additional collection points were being planned but this was balanced against the logistics of dealing with the storage and distribution of 3-4 tons of donated food per week. Replying to Councillor Brown, Daphine Aikens said that issues such as mental health benefit system concerns should be identified early on so that matters do not escalate. Sue Spiller clarified that early prevention through childrens centres was preferable but this was difficult where people were not in touch with or accessible by, service providers. It was noted that whilst many of the clients did not work, there were also those that did not fit the benefit profile, were in work but struggled. Such clients had a myriad of issues to deal with.

The Chair commended Daphine Aikens for the work of the organisation and enquired whether HFFB communicated more widely with other groups working in, for example, White City and if this could be further explored, together with working more closely with the Council on the issue of storage.

Sue Spiller confirmed that this would be helpful in terms of working with food partners, particularly with regard to initiatives such as the summer programme feeding children on free school meals.

ACTION: Sue Spiller

79. DRAFT CLCH'S QUALITY ACCOUNT FOR 2015-16

The Chair welcomed Katie Wilkins, Assistant Head of Quality (Interim), Central London Community Healthcare NHS Trust (CLCH). It was noted that whilst the deadline to respond to the consultation had passed, urgent comments could still be incorporated. Members expressed concern that the version of the document included in the agenda had been further amended.

In response to a question from Patrick McVeigh, Katie Wilkins confirmed that the reviews were conducted by a third party organisation that asked questions about the patients experience, CLCH was not involved in this process and tried to ensure that patients were aware that their comments will not affect the quality of the treatment they receive. Responding to a query from Councillor Andrew Brown, Katie Wilkins acknowledged that figures under Preventing Harm did not present a good picture and assured members that this was taken very seriously. Commenting on the figure for pressure ulcers (212 to 416), target to achieve 50% reduction, was a significant contributor to the overall increase. This had been addressed with a specific pressure ulcer app in order to train staff and improve awareness. Continuing the discussion around the reduction in medication incidents (from 73 to 36 year-end), it was understood that better training awareness was a problem area that had been addressed for example by improving labelling and packing of medicines. Katie Wilkins affirmed that publication of the figures clearly identified areas requiring improvement.

Councillor Hannah Barlow referred to the staff survey results and a quarter of staff (24%) experienced bullying. Katie Wilkins acknowledged that this was a large, national issue and that the Human Resources Team had conducted more in-depth analysis. Each recorded incident was reviewed and protocols established to ensure enhanced supervision and training for not just for an individual, but for that entire team. It was noted that Peter Coles had been recently been appointed Chief Executive (previously interim). Councillor Joe Carlebach commented on the lack of detail for children's health services and expressed concern as to the lack of reference to paediatrics.

ACTION: CLCH

Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care) commented on learning from serious incidents and best practice derived from shared learning. Councillor Lukey noted that there was no mention of safeguarding incidents and asked the extent to which the organisation was outward facing and Kate Wilkins confirmed that it was. Sue Spiller clarified that protocols had developed around sharing good practice with health colleagues. In response to a comment from Councillor Sharon Holder, with reference to the absence of Appendix 1, Complaints Annual Report, from the

draft document, Katie Wilkins confirmed that the report would be attached in the final publication.

ACTION: CLCH

Councillor Natalia Perez identified that there were particular challenges inherent in obtaining accurate feedback and enquired how CLCH captured data from individuals with learning disabilities. Katie Wilkins confirmed that the organisation responsible for this was independent of CLCH and applied appropriate methods and tools to capture the data qualitatively. It was noted that many patients were reluctant to give negative feedback. Councillor Perez was keen to receive further details about the methods deployed for patient engagement to ensure an equitable representation of perspectives.

ACTION: CLCH

With reference to dementia and diabetes, Katie Wilkins responded to a query from Councillor Brown. It was explained that the CQUIN payment framework did not spearhead funding and that there were some difficulties as this was tied to quality improvement targets. Councillor Vaughan noted the signals offered by the traffic lighting of figures and also points regarding funding of training. He recommended that more information be included in the report for 2017/18, particularly children's services and safeguarding. Further detail about pressure ulcers and medicine harm incidents should also be included. He also made further reference to the methods used to capture data through feedback and details on this and patient engagement were important for the Committee to view.

ACTION: CLCH

80. CLINICAL SERVICE IMPROVEMENTS - PROPOSED NEW PATHWAYS FOR ACUTE MEDICINE AND CHEST PAIN PATIENTS

The Chair welcomed Mick Fisher, Head of Public Affairs and Dr William Oldfield, Deputy Medical Director, from Imperial College Healthcare NHS Trust. Dr Oldfield outlined plans to adjust acute medical and chest pain patient pathways. Currently, patients would be admitted and could wait several days before seeing a specialist doctor. With specialisms becoming increasingly hi-tech, the aim was to ensure that delays were reduced and that the patient accesses appropriate treatment more efficiently. To illustrate, following initial assessment a renal patient will be seen by a renal specialist, without the buffering through an acute medical assessment stage, maintaining the same level of intervention but without any delay. Dr Oldfield stressed that the number of beds will remain static. In Hammersmith Hospital, in the cardiology station there would be an additional 15 beds and 8 beds for renal and haematology patients, he confirmed there would no bed closures. Dr Oldfield commented that the hub and spoke model was already operational in terms of cardiology at Hammersmith Hospital. Councillor Joe Carlebach commented that it would be helpful to receive detailed information on bed numbers and allocation indicating the previous position and how this changed.

ACTION: ICH

Debbie Domb, HAFCAC, enquired whether the length of time for treatment would be longer if she were to be admitted on a Saturday. Dr Oldfield confirmed that this was a 24 hours a day, 7 day a week r service and would not impinge on the availability of the service. He reiterated that no beds would be lost. In response to a point raised by Councillor Hannah Barlow, Dr Oldfield replied that staff rotas would become more robust as a result of the changes, removing any delay to specialist treatment will also mean greater long term resilience for service delivery and patient care. Councillor Brown, enquired about stroke services and Dr Oldfield confirmed that this was already operating under this model, the difference being that London Ambulance Service (LAS) would transport an acute stroke patient directly to the nearest hyper acute stroke unit. This will continue to be the case for suspected heart attack patients conveyed by LAS to the heart assessment centre at Hammersmith Hospital whilst the new chest pain pathway establishes itself. Eventually it was hoped LAS will also transport other cardiac-origin chest pain patients directly to the nearest specialist unit.

Responding to a query from Councillor Andrew Brown, Dr Oldfield confirmed that the 10% of patients were referred by GPs (outpatients), and approximately 10-15% were seen by emergency services. Developing this point further, Councillor Holder asked what would happen to a patient that presented themselves (without chest pain) to a hospital and Dr Oldfield explained that they would be transferred to the appropriate site. Councillor Holder requested an assurance that the consultation process would actively engage the public and how this would be managed. Confirming that the consultation had been launched on 13th June, comments would be sought from Healthwatch, staff, CCGs, cardiac and renal patient groups and external stakeholders up to 15th July before a decision was taken at the Trust Board public meeting at the end of the month.

81. WORK PROGRAMME

The Committee noted the Work Programme for the remainder of the municipal year.

82. DATES OF FUTURE MEETINGS

The Chair, Councillor Rory Vaughan informed Members that a suitable replacement date was being sought to replace the meeting currently scheduled for July and that Members would be advised as soon as possible.

Meeting started: 7.00 pm
Meeting ended: 9.40 pm

Chair ....

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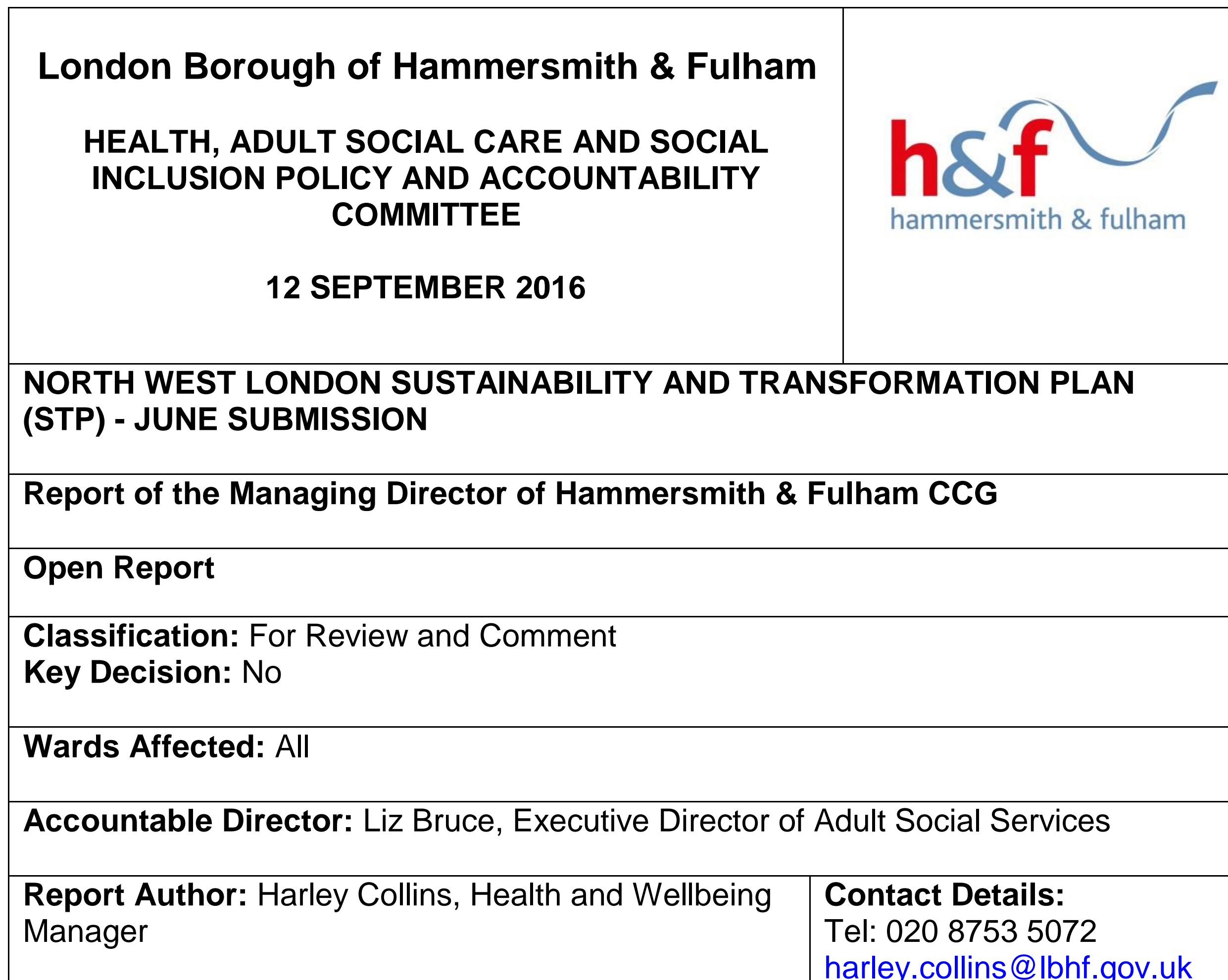
Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.



London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE 12 SEPTEMBER 2016	h&f hammersmith & fulham
NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - JUNE SUBMISSION	
Report of the Managing Director of Hammersmith & Fulham CCG	
Open Report	
Classification: For Review and Comment **Key Decision:** No	
Wards Affected: All	
Accountable Director: Liz Bruce, Executive Director of Adult Social Services	
Report Author: Harley Collins, Health and Wellbeing Manager	**Contact Details:** Tel: 020 8753 5072 harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report gives an overview of the key messages and priorities detailed in the North West London STP submitted to NHS England in June. It updates on emerging governance arrangements that will oversee development and delivery of the STP, consultation and engagement plans and next steps including the deadline for submission of a final plan by 21 October.

2. RECOMMENDATIONS

2.1. The Health, Adult Social Care and Social Inclusion Policy and Accountability Committee is requested to:

- Discuss and provide comment on the June submission of the NW London STP which is included with this paper as Appendix 1. The Committee's comments will be sent for incorporation into the final STP which NW London is required to submit to NHS England on 21st October.
- Once the outcome of October submission is known a further report will be presented to the Committee on the service proposals and funding available in order to address the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in the new plan.

3. REASONS FOR CONSIDERATION

3.1. To ensure ongoing involvement and input from the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee and provide an opportunity for the Committee to comment on the June submission prior to the final submission of the plan to NHS England on 21 October.

4. INTRODUCTION AND BACKGROUND

4.1 Sustainability and transformation plans (STPs) were announced in the NHS planning guidance published in December 2015 as a vehicle to support the delivery of the Five Year Forward View. NHS organisations in different parts of the country have been asked to come together to develop 'place-based plans' for the future of health and care services in their area. The emphasis on 'place' represents a shift in NHS planning policy from one where individual organisations act to secure organisational interests to one where organisations and services collaborate to jointly address challenges and improve the health of the populations they serve.

4.2 STPs are five-year plans covering all areas of NHS spending in England. A total of 44 areas have been identified as the geographical 'footprints' on which the plans will be based. The North West London footprint covers 8 boroughs[1] and 2.1 million residents.

4.3 STPs are local health and care systems' blueprints for accelerating implementation of the Forward View. Guidance from NHS England and other national bodies set out a series of questions for local leaders to consider in their plans, relating to the closure of three 'gaps':

1. Health and wellbeing – preventing people from getting ill and supporting people to stay as healthy as possible
2. Care and quality – consistently high quality services, wherever and whenever they are needed
3. Finances and efficiency – making sure services are operated as effectively as possible

4.4 Leaders have been asked to identify key priorities for their local area to meet these challenges and deliver financial balance. While the guidance focuses on NHS services, STPs also cover better integration with local authority services including public health and social care.

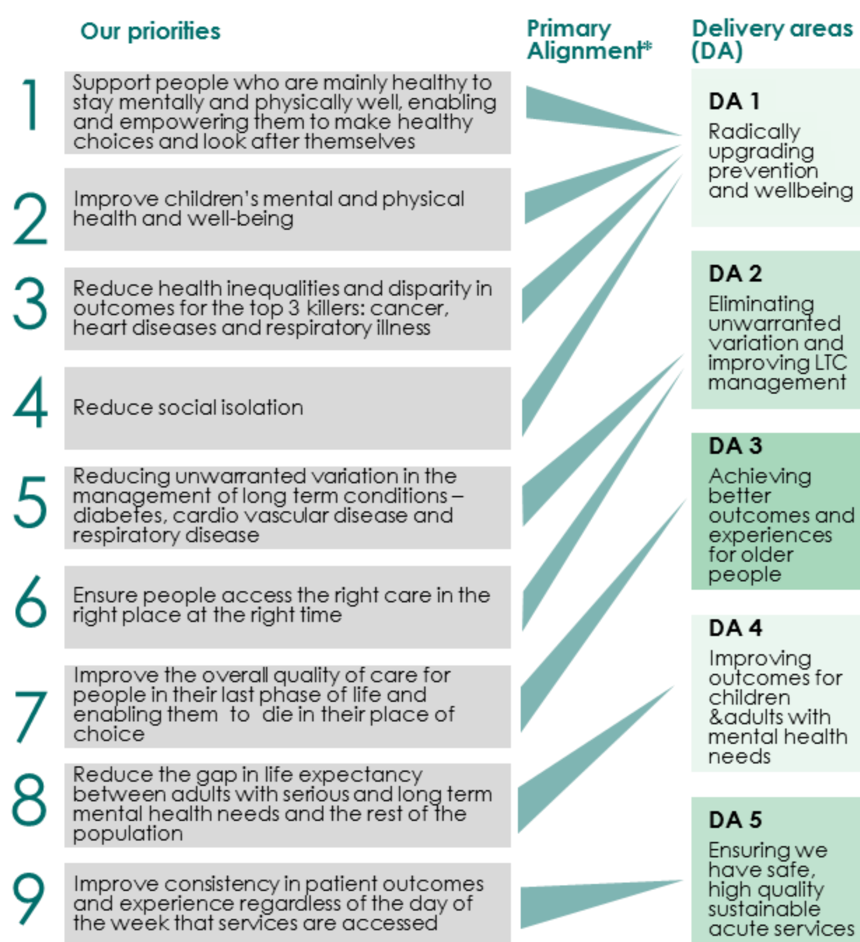
4.5 The NHS and local authorities across NW London have agreed to work together to deliver a better health and care system. Patient groups and other stakeholders have been involved in developing the plan. The NW London STP describes the shared ambition of partners across health and local government to create an integrated health and care system that enables people to live well and be well. A

[1] Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster Councils

draft plan has been developed and was submitted to NHS England on 30 June. The key messages in the June submission were:

- To address the Triple Aim challenges, we must fundamentally transform our system.
- The vision for NW London involves 'flipping' the historic approach to managing care, turning 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.
- We have developed 9 Priorities for NW London which we must address if we are to transform our system.
- From these priorities, we have identified 5 Delivery Areas that we need to focus on to deliver at scale and pace across NW London. Figure 1 below sets out how our Priorities align to the Delivery Areas
- Local areas have created 'Local Executive Summaries' which show how their plans are aligned to NW London priorities. These summaries also reflect local priorities and activities to address specific local challenges.

Fig.1 - Alignment of NW London's Priorities and Delivery Areas



4.6 The STP will determine how much money NW London is awarded from the Sustainability and Transformation Fund (STF). The strongest place-based plans will unlock funding from 2017/18 onwards to support their planned transformation. The STF is a national fund worth £1.8bn and is a major 'one-off' for sustainability, intended to bring NHS providers back to balance. The 44 STP footprints in England are competing for the funding and North West London is the 4th largest. The STF will gradually increase in size, rising to £3.4bn by 2020/21.

5. PROPOSAL AND ISSUES

5.1. In January, CCG and council officers formed a three Borough Integration and Collaboration Working Group (ICWG) to drive forward the three borough element of the North West London STP and align this with the development of the Joint Health and Wellbeing Strategies in the three boroughs.

5.2. An STP 'Base Case' was submitted to NHS England on 15 April setting out: the needs of NW London population, the emerging priorities, governance for implementing the plan and emerging delivery areas. Feedback received from NHS England was that NW London's plan is a good plan with strong patient engagement and a good relationship with local government.

5.3. A further iteration of the plan was submitted on 30 June. The London Boroughs of Ealing and Hammersmith & Fulham were not signatories to the June STP submission due to ongoing concerns around proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in north west London. To move forward, the boroughs have agreed conditions (see Appendix 2 - STP Appendix A) that must be reflected in the STP document. Since submitting the plan NW London partners have met with NHS England to discuss the plans in more detail and are currently awaiting formal feedback.

5.4. The timelines for developing STPs and the process for approving them have been fluid. The original deadline for submitting plans to NHS England and other national bodies was 30 June 2016, but most plans will now be further developed and re-submitted by 21 October. The plans are likely to be assessed and approved in phases, depending on their quality. From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding, with the best plans set to receive funds more quickly.

5.5. Governance

5.6. In order to work together across the system to deliver the transformation set out in the STP, partners need to develop an effective governance approach. Partners are in the process of developing a Joint Health and Care Transformation Group which will have representation from across local government and health, including commissioners, providers and patient representatives. The purpose of this group will be to oversee the development of the STP and its delivery and its first meeting will take place in late September. (A draft overview of governance arrangements and membership is attached as Appendix 3)

5.7. NW London is required by NHS England to re-submit its plan on 21st October (date is provisional at this time). Between now and October the priorities are:

- Completing the plan – incorporating feedback from local governance boards and from public and staff engagement
- Establishing governance arrangements to support the STP delivery
- Mobilising projects outlined in the STP and accelerate delivery
- Measuring and supporting 16/17 delivery and developing a detailed plan for 17/18

6. CONSULTATION

6.1. NW London have collaborated with people, service users and patients at all stages of the commissioning, mobilisation and delivery cycle.

6.2. NW London will be continuing these conversations with people in NW London during the development of the STP, and its implementation. There is joint governance and leadership across the communications and engagement space, with a work stream led by the CCG Director of Communications in partnership with communications leads from providers and local government. This group sets the overall direction for communications and engagement but working in partnership with colleagues from across all sectors involved in the STP.

6.3. North West London partners have followed best practice in their work guided by the principles of discussing early and listening. All work is in partnership with commissioners, providers, local government, Healthwatch, patients groups and residents associations.

6.4. **Having established the delivery areas in the checkpoint submission the purpose of this phase is to engage our partners, staff, patients and residents on whether our focus is right and what more they would like to see**

6.5. **At a local level we have already:**

- Held 22 face to face engagement events across all eight boroughs to help co-design the local plans, on top of regular meetings of the STP planning groups
- These events have included workshops, seminars and public meetings and been very popular with providers, patients, Healthwatch, carers and their families and lay partners
- We have also used Health and Wellbeing Boards along with CCG Governing Body meetings to engage people
- In Brent the Healthy Partners Forum had a turnout of around 100 people with table discussion focussed on the emerging priorities, while in Hillingdon over 100 people attended a STP focussed workshop
- We have promoted these events through our social media platforms to maximise attendance
- These local plans, co-designed with the local community, in turn form the basis for the full North West London STP.
- We have provided feedback to those attending so they can see how their work has fed into the plan

6.6 **At a pan North West London level we have:**

- Identified the key audiences we need to be engaging with over the next few months across the eight boroughs.
- Held joint health and local government meetings across NW London to contribute to the development of the STP.
- Hosted a co-production workshop with lay partners, Healthwatch and providers to help feed into the checkpoint submission and provide an early opportunity to shape the direction of the STP.
- Ideas from that session include the Peoples Health Charter which is an important part of our STP moving forward.
- Hosted a workshop with communications leads from across sectors to help co-design the engagement strategy
- Hosted sessions with clinicians to get their input into the priorities and delivery areas, ensuring our workforce is a driver and owner of change
- Clinicians have been enthused by the process and see the value that comes from the STP
- Created a shared slide deck/core narrative covering our health and social care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – ensuring it is in patient- focused and in accessible language

6.7 **Engagement from summer through to December 2016**

There are four strands to the work we are now doing:

(1) With partners:

- We are designing a programme of more deliberative-style events, looking at bringing together different groups in different ways – e.g. clinicians from across sectors/organisations; all those involved in care for older people – to more directly shape further development and implementation of the STP
- We ran a market stall event for our core partners (20 July) to showcase the range of work which is happening across North West London
- Working with local government partners we will continue to review the assumptions underpinning the changes to acute services and the delivery of local services
- We will hold a second market stall event for a wider audience of partners in the autumn

(2) With staff:

- Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Each of our partners – whether in health or local government – is working up plans for specific staff engagement.
- Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP
- STP updates are already a regular staple of all our internal communications materials and moving into the summer/autumn we will be promoting workshops and updating on progress through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.

- We are also working in tandem with our GP federations to engage primary care providers

(3) And with our patients and residents – through face to face meetings:

- We will set out a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations across the to ensure that we get real input from the local community
- As well as having events in each borough we will also hold pan north west London events, with at least one in the inner boroughs (CWHHE) and one in the outer boroughs (BHH)
- We will exploit the variety of networks available to us from patient representative groups to local authority engagement networks to maximise public involvement
- Feedback form all these events will be made available to help shape the discussion
- These public meetings will be co-hosted by NHS and local councils where possible in each borough in September to discuss the STP. The latest dates are set out below:

Borough	Date
Brent	26 September
Ealing	20 September
Hammersmith and Fulham	21 September (TBC)
Hounslow	27 September
Kensington and Chelsea	14 September

(4) And online:

- We are developing an online engagement tool which will allow us to do targeted audience specific engagement so that we can reach those residents who want to get involved but won't attend face to face events
- We will promote the online engagement programme through our digital media channels – twitter, Facebook etc. – which already exist across both health and local government
- The focus of this engagement phase will be to test the nine priorities and five delivery areas.

7. LEGAL IMPLICATIONS

7.1. *The requirements in respect of the timing and content of Sustainability and Transformation Plans ("STPs") are set out in Delivering the Forward View: NHS Planning Guidance 2016/17. The Guidance was augmented by a Letter dated*

16th February 2016 which included additional information about the purpose of STPs and a timeline for the STP process, including key dates.

7.2. *The STP will cover the period October 2016 to March 2021. Deadline for submission of the final STP is 21st October 2016.*

7.3. *Implications verified / completed by Kevin Beale, Principal Social Care Lawyer, 0208 753 2740.*

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1. *As detailed in the report,* governance arrangements have commenced that will oversee development and delivery of the STP, in preparing the next steps including the deadline for submission of a final plan by 21 October 2016.

8.2. *The West London Alliance (WLA) Finance work stream recently met and has been tasked to review and update the financial modelling which was submitted in the June NW London STP submission. For H&F Adult Social care, the financial pressures estimated of £30.9m over the next 5 years will be updated and incorporated in the October submission.*

8.3. *Once the outcome of October submission is known a further report will be presented to the Committee on the service proposals and funding available in order to address* the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in the new plan.

8.4. *Numbers at this stage are draft and indicative pending completion of work by the finance work stream led by Steven Mair.*

8.5. Implications verified/completed by: (P. Daryanani, Head Of ASC Finance. 0208-753-2523.).

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

- Appendix 1 - NW London Sustainability and Transformation Plan
- Appendix 2 - NW London Sustainability and Transformation Plan Appendices
- Appendix 3 – draft governance arrangements and membership of Joint Health and Care Transformation Group

NW London Sustainability and Transformation Plan

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

V1.0

30 June 2016

DRAFT

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.

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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 £1.3bn 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.

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

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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.

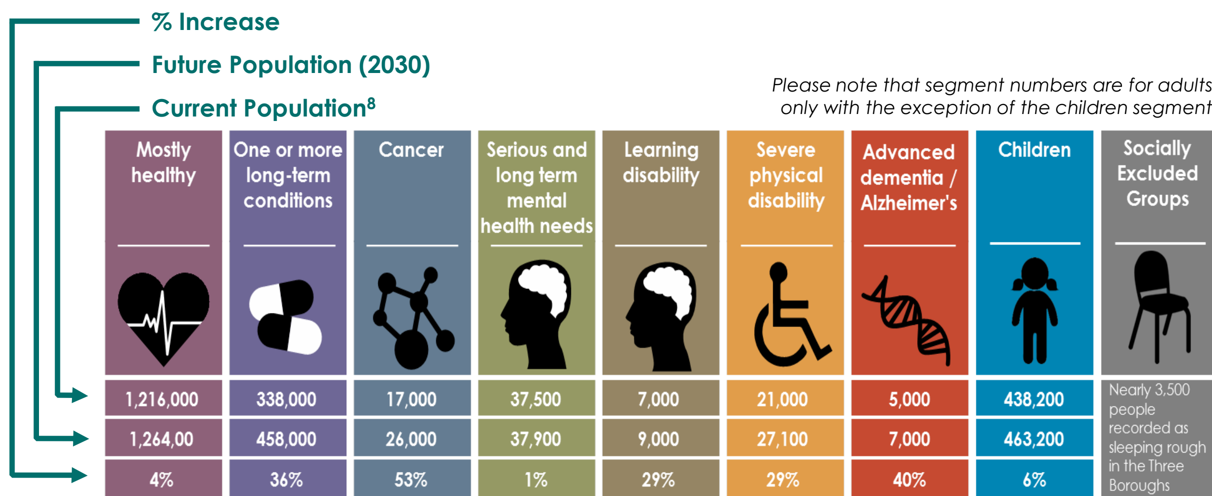
We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

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 have a life expectancy 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 £1.3bn 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.

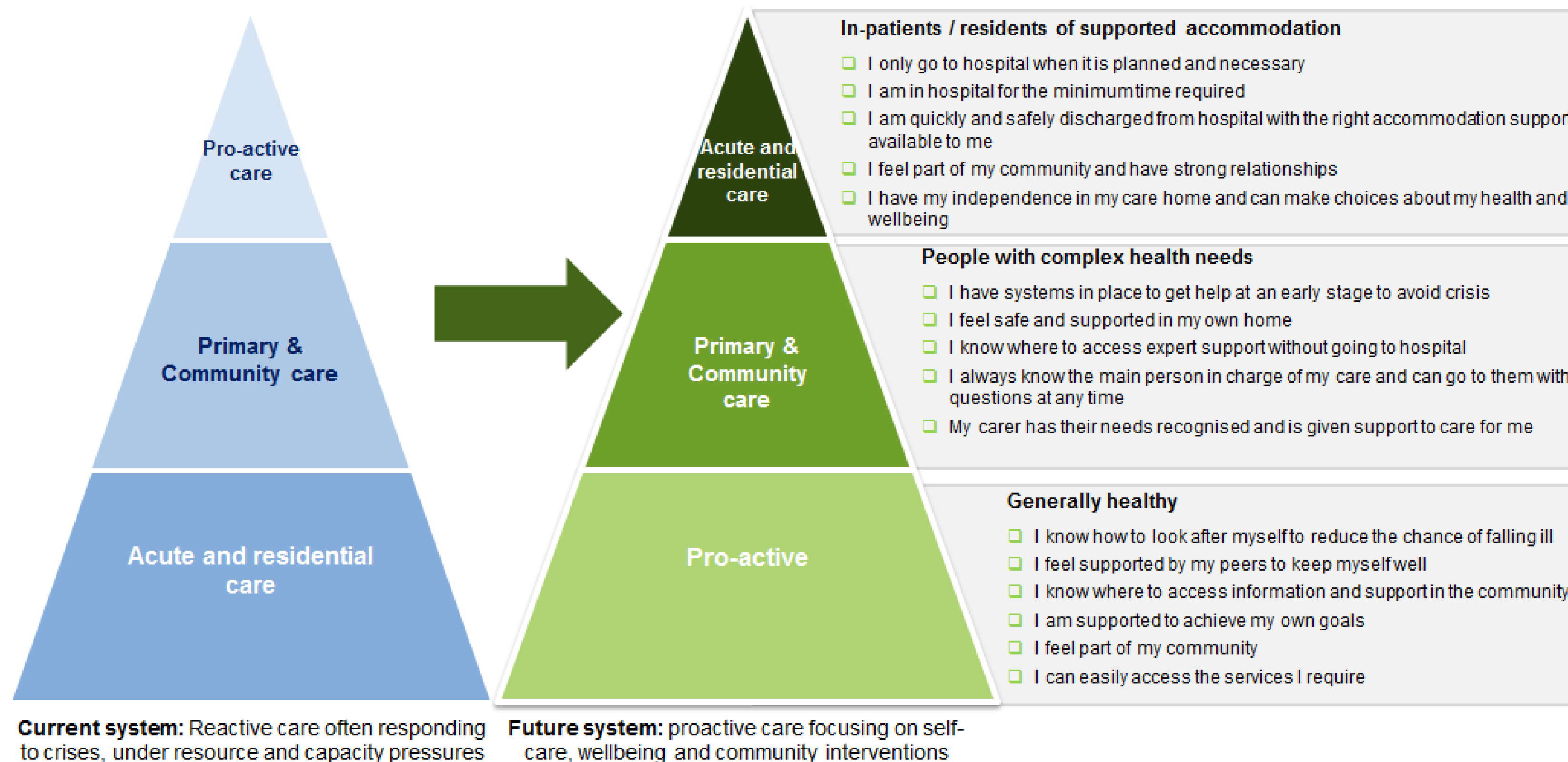


i. Executive Summary:
The NW London Vision – helping people to be well and live well

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



Current system: Reactive care often responding to crises, under resource and capacity pressures

Future system: proactive care focusing on self-care, wellbeing and community interventions

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

- Improving health & wellbeing
- Improving care & quality
- Improving productivity & closing the financial gap

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
4. Reduce social isolation
5. Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
6. Ensure people access the right care in the right place at the right time
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
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

Primary Alignment*

Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
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 b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
DA 2 Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
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. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
DA 4 Improving outcomes for children &adults with mental health needs	262,000 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. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
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 can benefit from specialisation and the benefits of senior clinical advice available at most parts of the day. We know from our London wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that can deliver consistently high quality, consistently 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 acute hospitals are under more strain than ever before. Some of this is due to increasing demand, and our STP sets out how we will manage demand 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. The site 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, meaning that the current clinical model cannot be financially sustainable. 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. 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 and for Charing Cross, 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 host a GP practice and an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs.

The local government position on proposed acute changes is set out in Appendix A.

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 or Hammersmith & Fulham will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

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 £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

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 sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	-	**(1,154.3)**	(145.0)	**(1,299.3)**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7
Delivery Area (1-5) - Investment	(118.3)	-	-	-	-	-	(118.3)	-	(118.3)
Delivery Area (1-5) - Savings	302.9	120.4	23.0	-	-	-	446.3	62.5	508.8
STP additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)
STF funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0
Other	-	-	-	188.3	-	-	188.3	63.0	251.3
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**
Residual Gap (with application of business rules)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**

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.

Additional savings have been assessed across the five STP delivery areas, and require £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings. These schemes 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 area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.

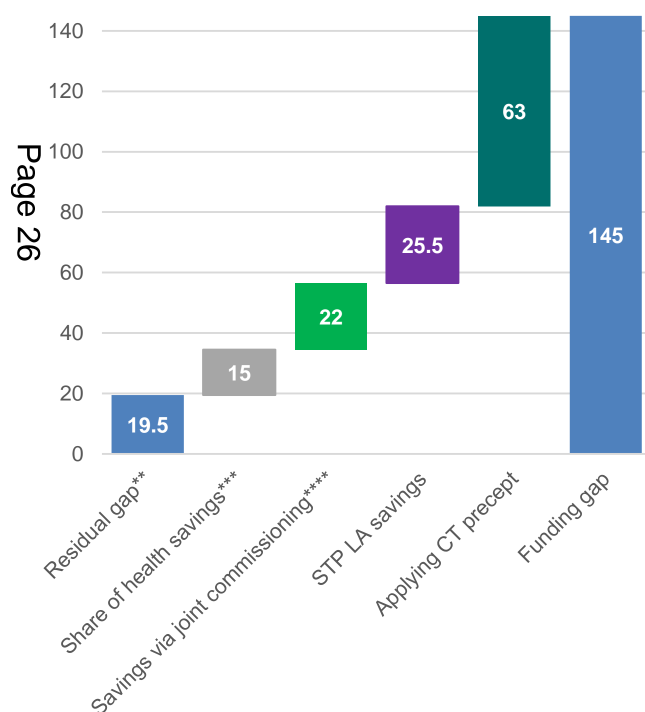
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

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

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. 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 actions set out below describe how the existing gap will be addressed, through 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	-	7.0	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 transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB 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
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9]
	ii. Training and support to care homes to manage people in their last phase of life	ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10]
	iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service	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. Increased accessibility to primary care through extended hours	iv. Aiming to move NW London average of 23mins/1000 people to 30mins/1000 people at pace
	v. All practices will be in a federation, super practice or on a trajectory to MCP	v. Supporting sustainability, reducing unwarranted variation and preparing for Accountable Care Partnerships
	vi. 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	vi. 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)	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11]
	ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint bank and agency programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals
	ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely	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. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	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]

i. Executive Summary:
How we will make it happen?

To deliver change at scale and pace requires the system to work differently, as both providers and commissioners. We are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. Develop a joint NW London implementation plan for each of the five high impact delivery areas

We will establish jointly led NW London programmes for each delivery area, working across the system to agree the most effective model of delivery and accountable to a new model of partnership governance. We will build on previous successful system wide implementations within Health and Local Government to develop our improvement methodology, ensuring an appropriate balance between common standards, programme management, local priorities and implementation challenges. The standard methodology includes a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. We have also developed a common project 'life cycle' with defined gateways. Models of care are developed jointly to create ownership and recognise local differences and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, seven day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

We are reviewing the total improvement resources across all providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around the delivery areas to increase effectiveness and reduce duplication

We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.

We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.

We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

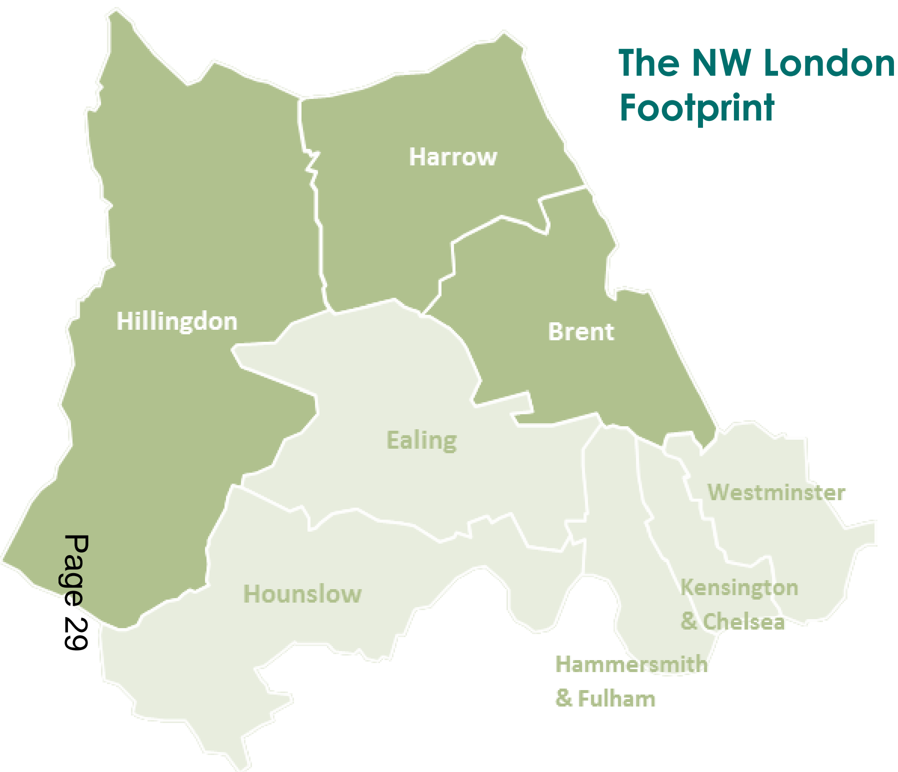
We are moving towards primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system.

By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements.

By 20/21 we will worked jointly across Health and Local Government to implement Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

1. Case for Change:

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



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 £1.3bn 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'.

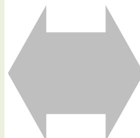
1. Case for Change:
Working together to address a new challenge

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

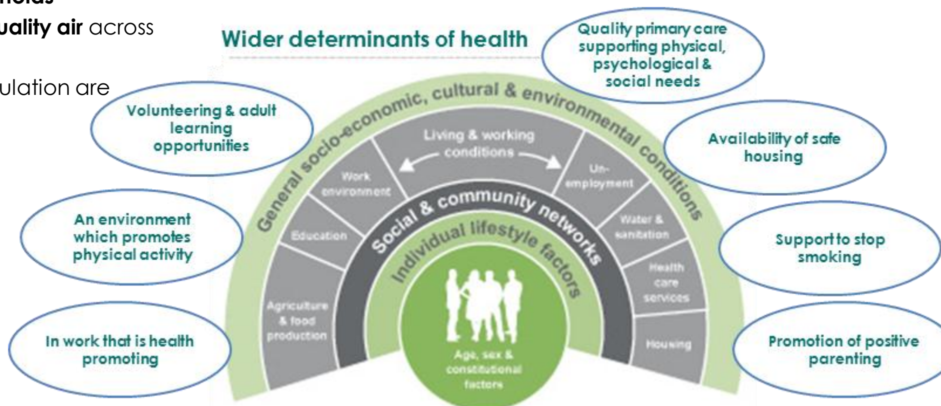
1. Case for Change: Understanding our population

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**



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
- 36% more adults
- 37% more spend in NW London

Cancer
- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4% 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:
- 1% 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.

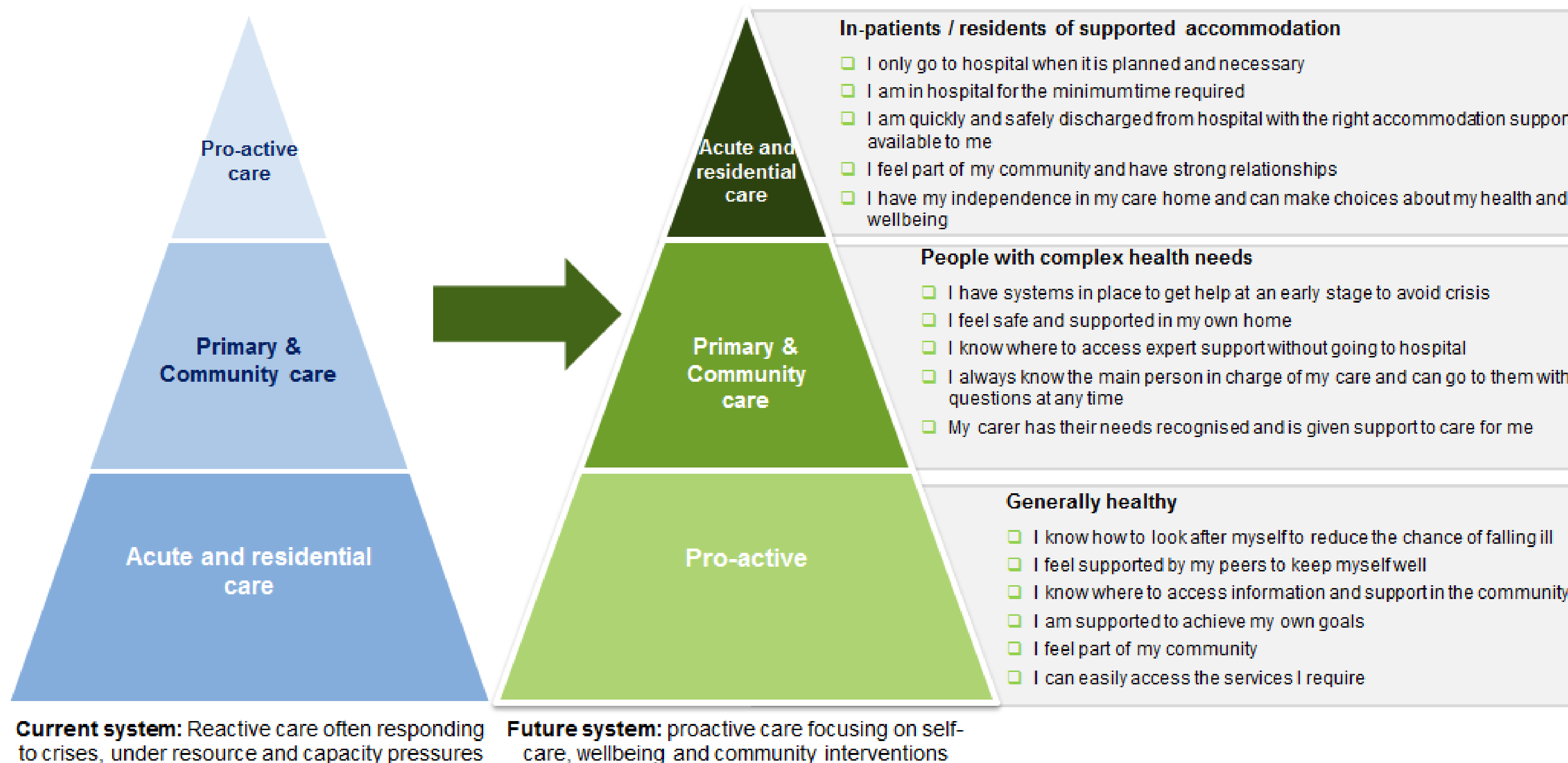
Please note that segment numbers are for adults only with the exception of the children segment

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



Current system: Reactive care often responding to crises, under resource and capacity pressures

Future system: proactive care focusing on self-care, wellbeing and community interventions

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.

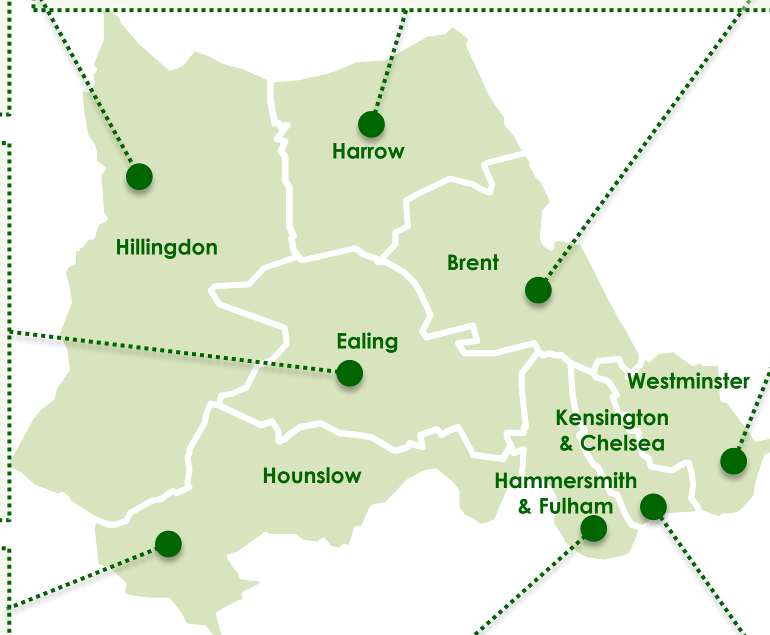
1. Case for Change: Understanding people's needs

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 19.5% rise in the number of people over 65 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)

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- **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

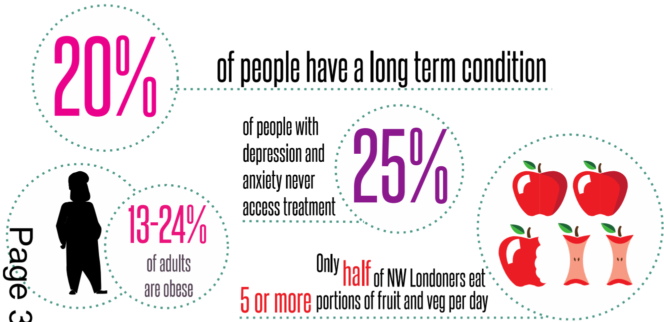
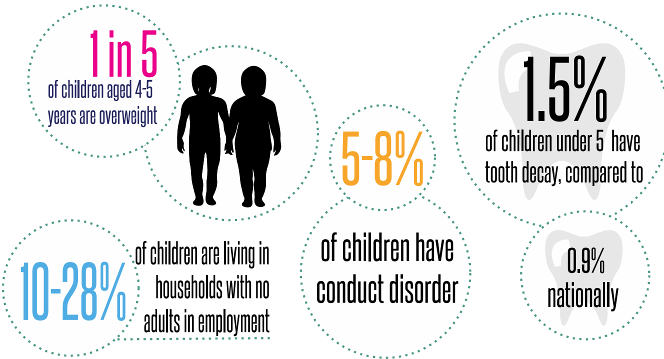
- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due 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…	Our to-be…	Our Priorities
	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	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
	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	2 Improve children's mental and physical health and well-being
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.**	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.	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

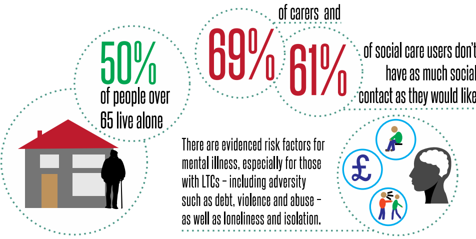
As soon as I am struggling, appropriate and timely help is available

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	**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 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated 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 £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

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.

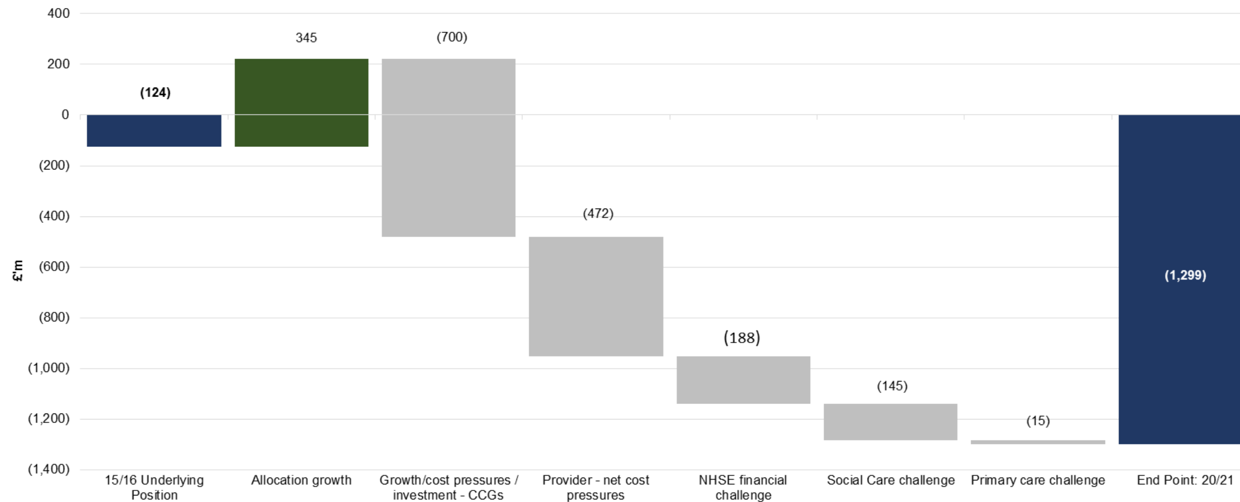


Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

£'m - Residual Gap	15/16	16/17	17/18	18/19	19/20	20/21
Providers	(190)	(304)	(374)	(462)	(544)	(659)
CCGs	60	(4)	(77)	(140)	(198)	(293)
Specialised commissioning	-	-	(44)	(90)	(138)	(188)
Primary care	-	2	(1)	(12)	(19)	(15)
Total NHS	**(130)**	**(306)**	**(496)**	**(704)**	**(899)**	**(1,154)**
Social Care	-	-	(36)	(73)	(109)	(145)
Total NWL Health and social care	**(130)**	**(306)**	**(532)**	**(776)**	**(1,007)**	**(1,299)**

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
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
	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
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
	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
	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

Primary Alignment*

Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
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 b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
DA 2 Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
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. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
DA 4 Improving outcomes for children &adults with mental health needs	262,000 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. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
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. Our residents who have a learning disability are also sometimes not receiving the fully 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:

- Targeting people at risk of developing long term conditions 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 group includes approximately 120,000 people who are currently well but are at risk of developed an LTC over the next five years[11]. 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].
- Working across the system at both NW London and London level to address the wider determinants of health, such as employment, education and housing.
- 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].
- Focusing on social isolation as a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs. Around 200,000 people in NW London are socially isolated and it 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].

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	Enabling and supporting healthier living	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 NW London Primary Care Cancer Board which will look at improving public messaging/advertising around preventing cancers. Launch a NW London communications and signposting campaign to more effectively guide people to support, including voluntary and community, to improve care and reduce demand on services. As part of this we will: • 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: • Training GPs and other staff in Health Coaching and 'making every contact count' to promote healthy lifestyle choices in patients • Delivering an enhanced 111 service driven by a new Directory of Services which will signpost service users to the appropriate service • Rolling out systematic case-finding to identify and support people at risk of diabetes, dementia or heart disease, using our Whole system IT platform • Promoting a community development approach to improve health by identifying local needs and sign-posting through services, such as, information stalls, children's support sessions, health awareness sessions, debt management and maternity drop-ins • Supporting Healthy Living Pharmacies to train Champions and Leaders to deliver interventions, such as smoking cessation • Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda	0.2	2.5
B	Wider determinants of health interventions	The healthy living programme plans will also cover how Boroughs will tackle wider determinants of health. In 16/17, local government already plans to deliver some interventions, such as: • 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 • Bidding for funds from the joint Work and Health Unit to support social prescribing of employment and interventions for those at risk of losing their employment	As part of the healthy living programme, local government, working jointly with health partners, will take the lead on delivering key interventions by 20/21 such as: • Introducing measures reduce alcohol consumption and associated health risks, e.g. licence controls, minimum pricing and promotions bans • 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 • Partner with organisations such as London Fire Brigade to jointly tackle the wider determinants of health such as social isolation and poor quality housing	3.3	6.5
C	Addressing social isolation	The healthy living programme plans will also cover how Boroughs will address social isolation. 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	As part of the healthy living programme, we will implement key interventions such as: • 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 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.	0.5	6.6

D	Helping children to get the best start in life	• NW London will invest part of its PMS premium income in increasing immunisation rates for key areas of need, such as the 5-in-1 Vaccine by 1 Year
		• Implement the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services
		• Collaborate with the vanguard programme and the children's team at NHSE in the development of new care models for children and young people (C&YP)
		• 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
			• Establish a Connecting Care for Children GP hub in the majority of localities where children live, building on 3 Borough work to:
			  • reduce high outpatient and A&E attendance numbers among C&YP
			  • promote healthy eating and obesity screening pathways (e.g. HENRY)
			  • Co-locating dental professionals and deliver dental hygiene training
			• 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.

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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. Unwarranted variation covers all services, from the early detection of cancer, the management of long term conditions, and the length of stay in hospital to the survival rates from cancer and major surgery. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas.
- 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].

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.

DRAFT

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	**Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from HLP's 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. We will 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.	Through the Royal Marsden and Partners Cancer Vanguard, develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, thereby reducing variation in acute care and ensuring patients have effective high quality cancer care wherever they are treated in NW London	TBC	TBC
B	**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
C	**Reduce variation by focusing on 'Right Care' priority areas**	Identified and commenced work in 2016/17 in following areas: • Mobilisation of National Diabetes Prevention Programme (commencing August 2016) • Further development of diabetes mentor/champion role within communities • Extend diabetes dashboards to other LTC, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD, enabling easy navigation through device-drug-dose considerations and supporting professionals and patients in reaching appropriate decisions and achieving adherence to therapy • 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.	• 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
D	**Improve self-management and 'patient activation'**	• Identify opportunities for patient activation in current LTC pathways based on best practice – application for 43,920 Patient Activation Measures (PAM) licences in 2016/17 for people who feel overwhelmed and anxious about managing their health conditions	• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be immediately referred into expert patient training • Technology in place to promote self-management and peer support for people with LTCs • Increase availability of, and access to, personal health budgets, taking an integrated personal commissioning approach • PAM tool available to every patient with an LTC to help them take more control over their own care – planned increase in PAM licences to 428,700 • 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 coordinated care and continuity with a named clinician to support them with LTCs	3.4	6.1

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

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2020/2021

Target Population: 311,500

Contribution to Closing the Financial Gap £82.6m

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 important 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

DRAFT

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 partnership(s) • 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 Partnership(s), 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	Implement new models of local services integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes 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	18	26.3
D	Upgrade 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 • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services 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 discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	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

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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. But we know that 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.

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 handicapped by their condition and **10% will die by their own hand**.
- 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 you are 18.
- The number of people with serious and long term mental health needs in NW London is double the national average
- 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 – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing.

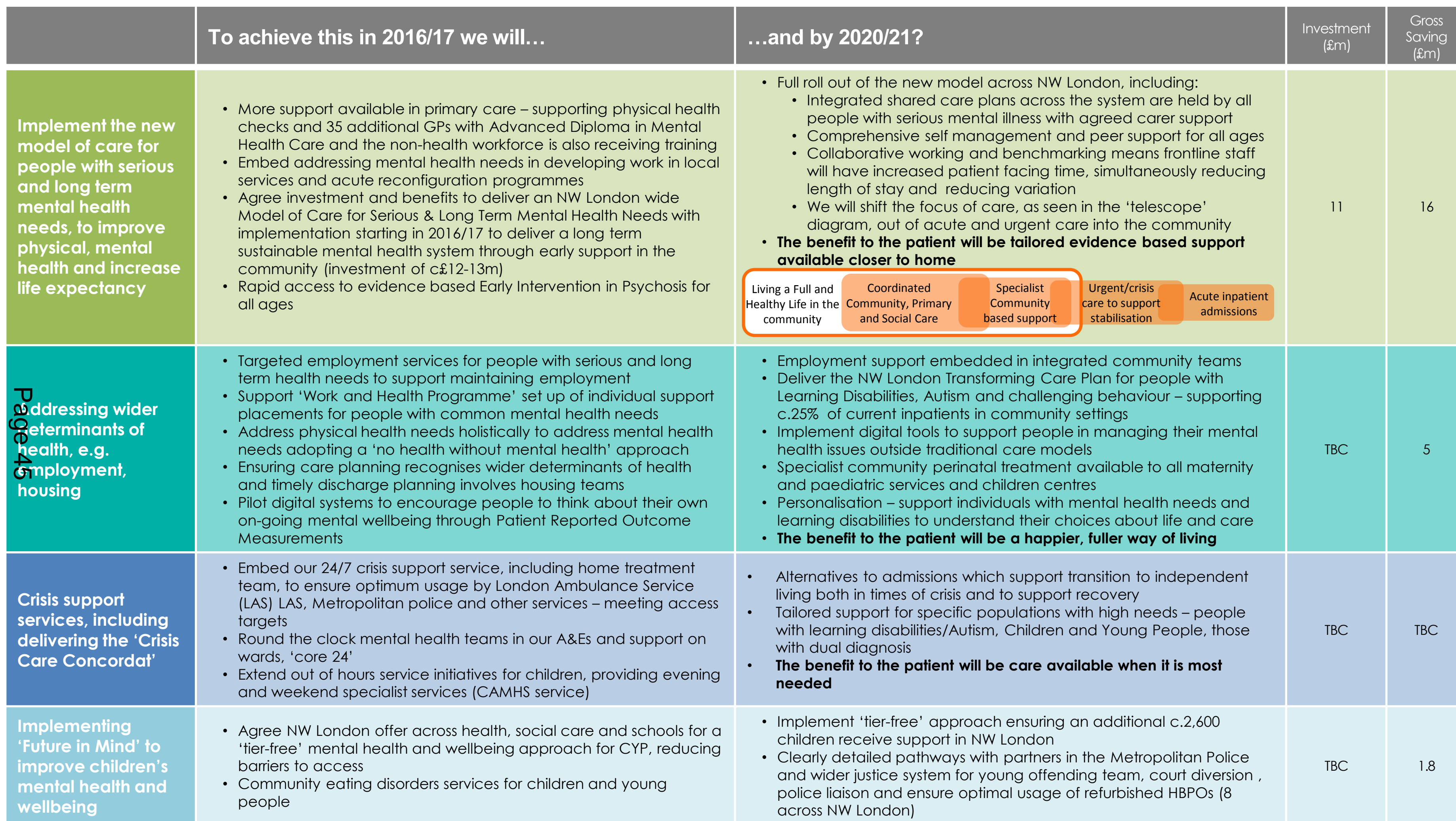
Our aim in NW London is to improve outcomes for children and adults with mental health needs, we will do this by:

- Implementing a new model of care for people with serious and long term mental health needs, 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 wider determinants of health and how they relate to and support recovery for people with mental health needs
- 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
- 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. This includes Future in Mind and Transforming Care Partnerships work.

- 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 – 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 (investment of c£12-13m)
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
			• Full roll out of the new model across NW London, including:
			  • 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
			• **The benefit to the patient will be tailored evidence based support available closer to home**
			Living a Full and Healthy Life in the community → Coordinated Community, Primary and Social Care → Specialist Community based support → Urgent/crisis care to support stabilisation → Acute inpatient admissions
				11	16

B	**Addressing wider determinants of health, e.g. employment, housing**	• 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	• 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 • **The benefit to the patient will be a happier, fuller way of living**	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) LAS, Metropolitan police and other services – meeting access targets • Round the clock mental health teams in our A&Es and support on wards, 'core 24' • Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)	• 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 • **The benefit to the patient will be care available when it is most needed**	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 • 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

2020/2021

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

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 important 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
- Consolidate acute services onto five sites (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham– see Appendix A, condition 5).
- 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

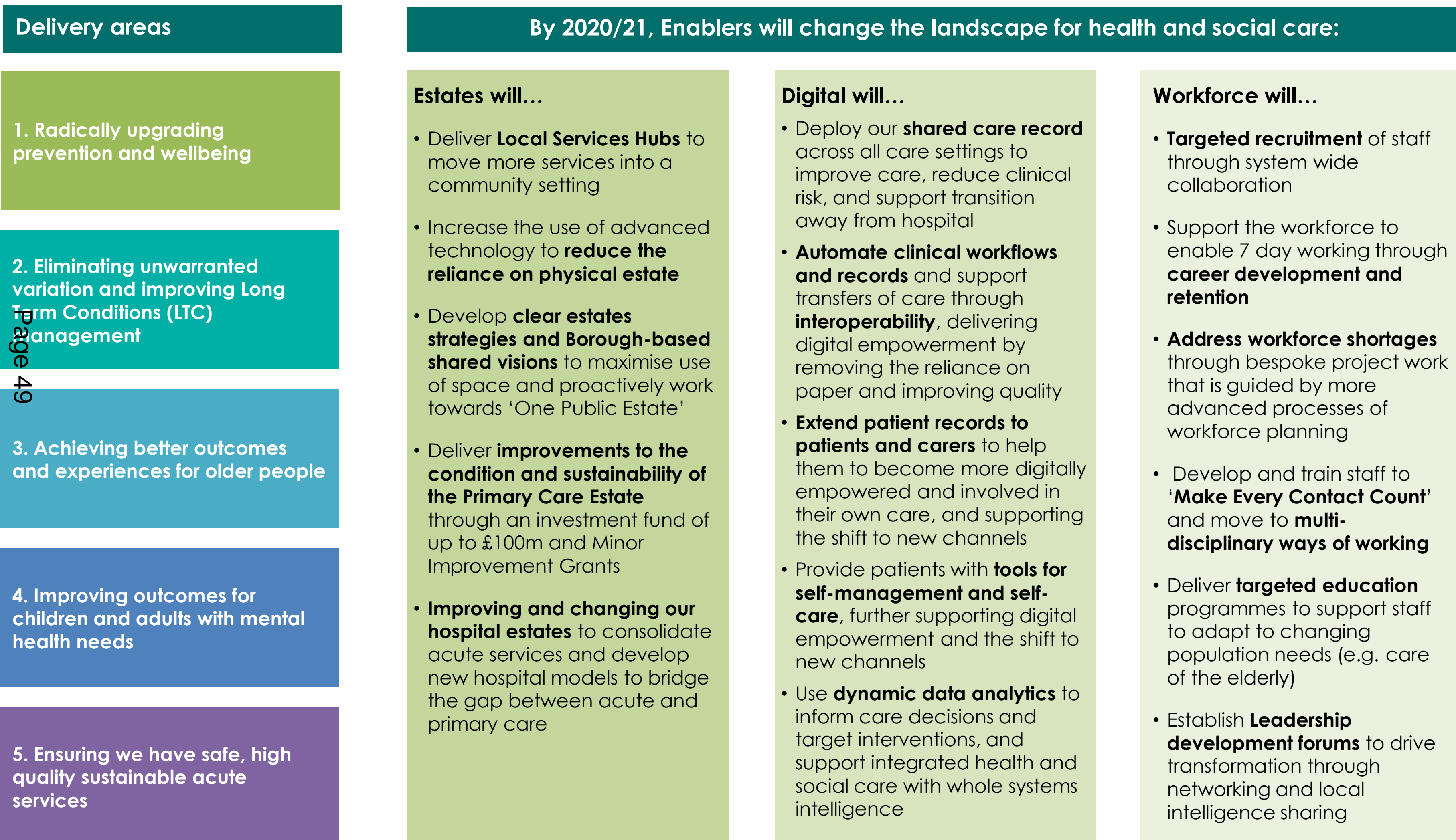
	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C **Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate 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	Reduce demand for acute services through investment in the pro active out of hospital care model. Work jointly with the council at Ealing to develop the hospital in Ealing and jointly shape the delivery of health and social care delivery of services from that site, including: • a network of ambulatory care pathways; • a centre of excellence for elderly services including access to appropriate beds; • a GP practice; and • 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.	33.6	89.6

D **NW London Productivity Programme**	Implement and embed the NW London productivity programme across all provider trusts, focusing on the following four areas:
	• **Patient Flow**: address pressure points in the system that impacts on patient flow, patient experience and performance against key targets (e.g. 4 hour wait and bed occupancy).
	• **Orthopaedics**: mobilise and commence work around establishing 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).
	• **Procurement**: assuming no mandation of the new NHS procurement operating model, establish the necessary enablers for collaboration to take forward sector-wide transformation in procurement and implement the Carter Review recommendations across the STP footprint[8]. These include establishing line of sight of sector-wide savings opportunities through agreed baseline reporting and on-going measurement of the benefits from collaborations, sector-wide visibility of contracts and establishing governance links to enable wider benefit of existing purchasing collaboratives (e.g. Shelford Group).
	• **Bank & Agency**: reduce agency spend across NW London; initiation of a range of workforce activities such as standardised pay and sector-wide recruitment. The sector is expected to reduce agency spend by £46m and deliver net savings of £32m.
		Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together through ACPs to constantly innovate and drive efficiency. Rolling programme of pathway redesign and patient flow initiatives to ensure trusts are consistently in the top quartile of efficiency. 17/18 plans against the initial delivery areas are set out below:
		• **Patient flow:** Implement system level initiatives in areas such as: improving access to GPs, better management of increasing volumes of ambulance attendances, integrated discharge processes from hospital and best practice A&E processing of patients.
		• **Orthopaedics:** Implement orthopaedics best practice based on Getting it Right First Time. Hip and knee replacements initial area of focus with estimated savings in the region of £2.6m to £4.0m across NW London, then roll out in full.
		• **Procurement:** 2016/17 will establish baselines enabling additional quantified benefits from 2017/18 onwards. Early impact areas include utilities, waste management, agency (linked with Bank & Agency workstream) and applying the GIRFT principles to commoditised purchasing for specific clinical areas.
		• **Bank & Agency:** build on work from 2016/17 , linking with South West London to share best practice. Key areas of focus are
		  • Strengthening recruitment to reduce vacancies
		  • Optimising scheduling to reduce demand
		  • Shifting usage from agency to bank to reduce costs
		  • Reducing unit costs for agency by increasing use of framework agencies and reducing rates through volume based contracts
			4.1*	143.4

*This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6

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.



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.
- NW London has the opportunity to work across health and local government, promoting the 'One Public Estate' 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.
- Some progress has been made 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 £623m[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, due by end 2016
  - The hub strategy and plans include community Mental Health services, such as IAPT
- **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 – see Appendix A, condition 5).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local population
  - Trusts are currently developing their site proposals, which will feed into an overall N W London ask for capital from the Treasury, contained in the strategic outline case to be submitted this summer.

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:

- Local services hubs will provide the physical location to support prevention and out-of-hospital care.
- 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 7/7 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 inpatient 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

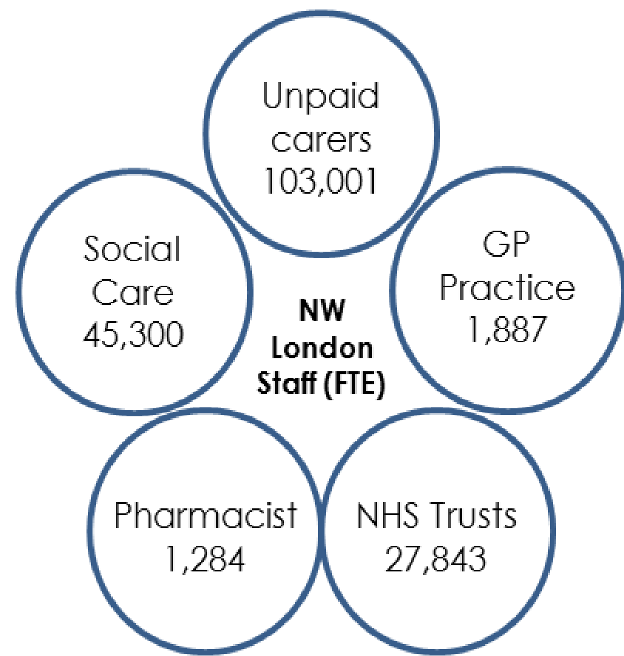
Delivery Area 5 – Providing high quality, sustainable acute services:

- 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: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work and will be key to achieving our collective vision through delivering sustainable new models of care to deliver improved quality of care that meets our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. Carers are 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. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly expand work across social care[1].
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- Appropriate workforce planning and actively addressing workforce issues is instrumental in addressing the five delivery areas in the STP
- 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.
- 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, with 32 commencing training in September. 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, 36 more paediatric nurses (37 more commence in September '16) and 3 consultants paediatricians (6 appointed to start in September '16, with plans to recruit 3 more).
- Building on this track record, **key enablers** will include the collaborative and partnership working between CCGs, Trusts, HEENWL and the CEPNs (Community Education Providers Network) to support workforce planning and development, and the HLP to utilise the established workforce planning infrastructure and expertise, build on strong foundations of on-going strategic workforce investment, and embed the findings outlined in HLP's London Workforce Strategic Framework.



What will be different in 2020[6]?

Our workforce strategy will address the following challenges 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

Current Transformation Plans and Benefits

Addressing workforce shortages

- Through workforce planning and extensive stakeholder engagement NW London is understanding and addressing key workforce issues. For example, NW London is leading a centralised Pan-London placement management and workforce development programme for **paramedics** with an investment of over £1.5m

Improving recruitment and retention

- NW London has plans to step up recruitment. For example, by October 2016, there is planned recruitment of over 100 additional **nursing staff** and 7 additional **children's consultant medical staff** leading to more senior provision of children's care. Further initiatives include:
  - **Scale recruitment drives**; leveraging the benefits of working in NW London.
  - Development of varied and **structured career pathways** and opportunities to **taper retirement**.
  - **Skills exchange** programmes between nurses across different care settings.
- **Promoting careers in primary care** by providing student training placements across professions to introduce this setting as a viable and attractive career option.
- Supporting the **implementation of 7 Day Services** by designing a framework to support career development and retention in radiology. Addressing workforce shortages will also support the development of the Cancer Vanguard.
- A **structured rotation programme** will support 200 nurses to work across primary and secondary care (including key areas such as mental health and care of the elderly).
- NW London's trusts will work collaboratively to **reduce reliance on agency** nurses (current spend: £172m pa on bank/agency[7])

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

- Embedding **new roles** to support the system including: Physician's Associates, Care Navigators, Clinical Pharmacists, Peer Educators (support worker that can share experiences of mental health), and Nurse Associates.
- **Hybrid roles and developing career pathways** across health and social care will be important in the long term.
- Significant investment into Dementia, Community and Neonatal Nursing, Apprentices and the bands 1-4 workforce.
- **Optimising GPs' time** by understanding how we can develop the primary care workforce (including **practice manager development**) to redeploy GP workload where possible and increase the capability to deliver the business requirements of GP networks(Day Of Care Audit).
- **Supporting self-care** through use of patient activation measurements and Health Coaching training to help staff to have motivational conversations with patients, to empower them to set and achieve health goals, take greater responsibility for their health, and grow in confidence to self-manage conditions

Leadership and Organisational Development to support future services

- **Collective, system leadership,** will be key to the success of ACPs. Leadership development will be broader than senior leadership level; empowering MDT frontline practitioners to lead and engage other professionals and take joint accountability across services will be integral to success.
- Leadership and change management programmes will foster innovation, build relationships and trust across multi-disciplinary, cross organisational teams to deliver integrated new ways of working. The **Change Academy** will use an applied learning approach and will be underpinned by improvement methodology (38 leaders supported in phase 1)
- **Commissioning for outcomes** based programmes
- Leadership development forums will include the **GP Emerging Leaders** (providing NW London-wide workshops, mentoring, and sharing of local intelligence and education) and Transformation Network
- More effective ways of working achieved through the **Streamlining London Programme** across Trusts
- Adopting a collaborative approach to embed **health and wellbeing initiatives and ambassadorship** through the Healthy Workplace Charter

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:

- **Health Coaching** training will help staff to have motivational conversations with patients to take greater responsibility for their health, and grow in confidence to self-manage conditions.
- To ensure carers, the largest proportion of our workforce, are supported, we will expand the programme in 2017/18, to build carers' skills around setting achievable health and wellbeing related goals for patients.
- The NW London **Healthy Workplace Charter** will embed staff health and wellbeing initiatives and ambassadorship
- Primary care and specialist community nurse workforce development

Delivery Area 2 - Reducing variation:

The framework to retain staff and support career development in radiology will help address shortages and support **implementation of 7 Day Services** and **Cancer Vanguard**. Growth in primary care and bespoke project work on LTCs prevalent in NW London such as diabetes and heart disease.

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
- **Optimising GPs' time** by developing the primary care workforce (e.g. **practice manager development**) will increase capability to deliver the business requirements of GP networks
- Leadership development forums will join up practitioners, providing NW London-wide workshops, opportunities to network and share local intelligence
- 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 will graduate in June 2016 with an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.

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 and thereby the cost of service
- The **Change Academy**, underpinned by improvement methodology and alignment to achieving productivity gains will support cross-boundary working and support financial sustainability of services.

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London Informatics, and has made good progress with Information Governance across care settings. All of the eight CCGs have a single IT system across their practices and six of the eight CCGs are implementing common systems across primary and community care, and have a good track record in delivery of shared records, for example, through the NW London Diagnostic Cloud.
- The NW London Care Information Exchange is under way, funded by Imperial College Healthcare charity. This technology programme gives individuals a single view of information about their care across providers and platforms, allows sharing of information, and provides 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.
- There is good support from NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London exchange, record locator, and IG register.

Key Challenges

- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access and retain information about the patient[1]. A potential mitigation is to share care records and converge with other Local Digital Roadmaps (LDR) via universal NHS systems.
- Due to different services running multiple systems, there is a dependence on open interfaces to deliver shared records, which primary and community IT suppliers have failed to deliver. This will require continued pressure on suppliers to resolve.
- 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 required from NHSE to define and fund interfaces nationally.
- Clinical transformation projects have in the past been very costly and taken a long time to deliver, which need to be allowed for in the LDR plans
- There is a lack of digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.

Strategic Local Digital Roadmap 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. **Extend patient records to patients and carers,** to help them to become more **digitally empowered** and 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 care, further supporting **digital empowerment** and the shift to new channels of care
5. **Use dynamic data analytics** to inform care decisions, and support integrated health and social care across the system 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**, where much work has already been done
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education

3. Enablers: Digital

STP Delivery Area | **Digital STP Theme** | **Key Impacts on Sustainability & Transformation Planning**

1. Radically upgrading prevention and wellbeing

Digital STP Theme:
- Deliver digital empowerment
- Integrate health & care records

Enhancing self care:
- Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange** to support them to become expert patients
- Innovation programme to find the right **digital tools** to help people **manage their health and wellbeing**; **create online communities** of patients and carers; and to get children and young people involved in health and wellness

Embedding prevention and wellbeing into the 'whole systems' model:
- Support integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care-plans)

2. Eliminating unwarranted variation and improving LTC management

Digital STP Theme:
- Integrate health & care records
- Whole systems intelligence
- Deliver digital empowerment

Improving LTC management
- Deliver Patient Activation Measures (PAM) tool for every patient with an LTC to promote self management and develop health literacy and expert patients
- **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability and development of a share care record to deliver the **integration of health and care records and plans**
- Patient engagement and self-help training for LTCs to help people manage their conditions and interventions

Reducing variation
- Integrated care dashboards and analytics to track consistency of outcomes and patient experience
- Support new models of multi-disciplinary care, delivered consistently across localities, through shared care records

3. Achieving better outcomes and experiences for older people

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Digital STP Theme:
- Deliver digital empowerment
- Integrate health & care records
- Whole systems intelligence

Provision of fully integrated service delivery of care for older people
- Enable citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange**, **remote consultations** (e.g. videoconferencing) and **telehealth**
- Support discharge planning and management, new models of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care
- **Integrate Co-ordinate My Care** (CMC) with acute, community and primary care systems and promote its use in CCGs, where usage is currently low, through education and training and support care planning and management
- **Shared information and infrastructure** to support new primary care and wellbeing hubs with mobile clinical solutions
- **Dynamic analytics** to plan and mobilise appropriate care models
- Whole Systems Integrated Care dashboards have been deployed to 312 GP practices to support co-ordinated and proactive patient care, with a plan to expand to all 400 practices by 2020/21

4. Improving outcomes for people with mental health needs

Digital STP Theme:
- Integrate health & care records
- Whole systems intelligence

Enabling people to live full and healthy lives
- Innovation programme to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities

New model of care
- Support new care delivery models and shared care plans through **shared care records and care plans**

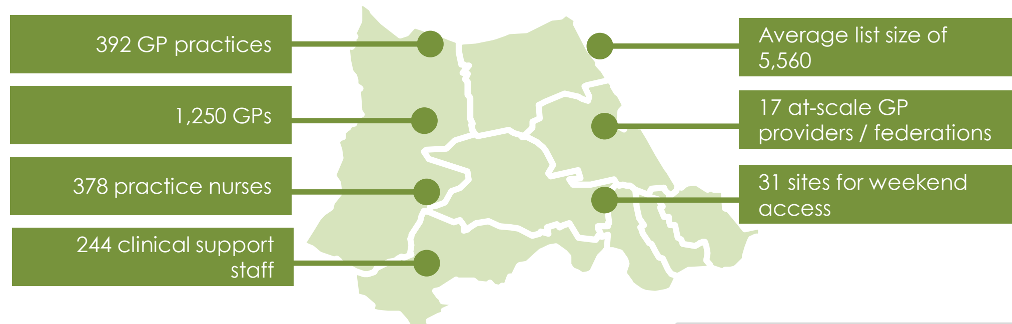
24/7 provision of care
- Support new models for out-of-hours care through **shared care records**, such as **24x7 crisis support services**

5. Ensuring we have safe and sustainable acute services

Digital STP Theme:
- Deliver digital empowerment
- Integrate health & care records

Investing in Hospitals
- Support new models for out-of-hours care through **shared care records and the NW London diagnostic cloud**, such as 24x7 on-call specialist and pan-NW London radiology reporting and interventional radiology networks in acute
- **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care.
- Integrated out-of-hours **discharge planning and management** through shared care records
- **Dynamic analytics** to track consistency and outcomes of out-of-hours care

4. Primary care in NW London



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. GPs are not only the first point of contact for the majority of residents, but also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

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There are, nevertheless, significant challenges. These include:

- dramatic projected increases in the number of older people presenting with multiple and complex conditions, fuelling demand for GP appointments and a greater co-ordinating function within primary care – the number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26;
- 27.1% of the GP and nurse workforce is aged over 55 and 7.4% aged over 65, which represents a significant retirement bubble;
- front-line delivery pressures that are contributing to recruitment and retention challenges, whilst lowering the morale of GPs and their primary care colleagues; and
- inadequate access to primary care, contributing to a patient-reported experience of GP services significantly below the national average.

These and other challenges require fundamental changes to the design and delivery of primary care, within the context of NW London's broader system transformation across health and social care. The NW London CCGs' plan for this is described in this document.

Some other statistics: achievements and challenges

- The NW London CCGs score above the London average for 6 out of 7 facets for co-ordinated care, based largely on the achievements made through the Whole Systems Integrated Care national pioneer programme
- The NW London CCGs score above the London average for 6 out of 13 facets for accessible primary care consultations (including telephone, email, and video consultations)
- 23% of the NW London practices so far inspected by the CQC ratings are performing below the national average
- 60% of people with a long-term condition feel supported to manage their condition – below the national average of 67%.

Some of our achievements so far

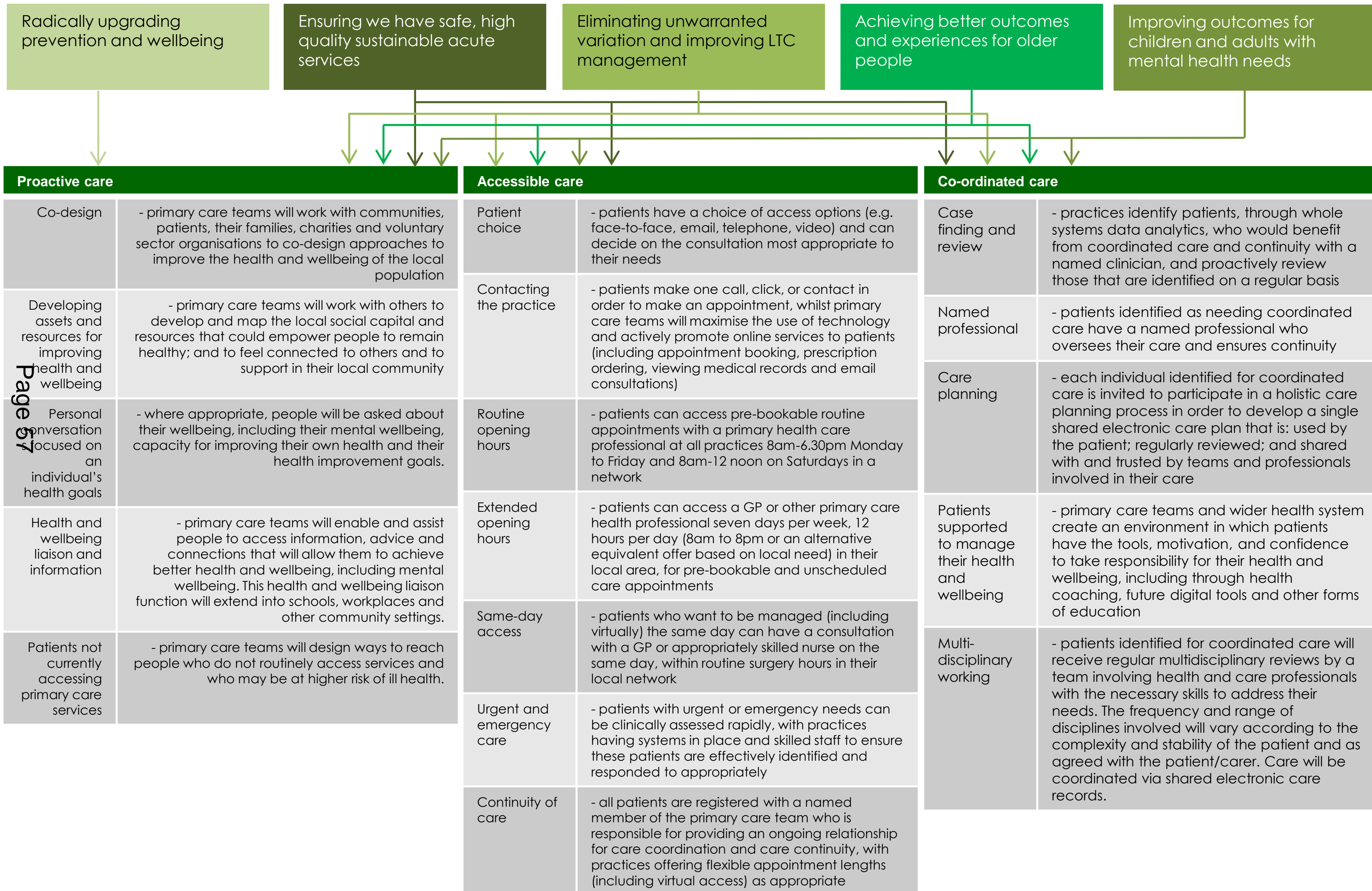
- NW London is the largest national pilot site for the Prime Minister's Challenge Fund, covering 365 practices and 1.9m people. This investment has improved patient access to general practice and supported the development of at-scale organisations in primary care. The CCGs are now working with NHS England to build on this achievement through the new Prime Minister's Access Fund investment announced in the GP Forward View.
- 280,000 patients can access web-based consultations .
- 60,000 patients can access video consultations.
- 97% of practices offer online appointment booking.
- Joint co-commissioning is embedded in NW London . Over recent months each joint committee has agreed its PMS review commissioning intentions, as a first instalment to equalising the patient offer in each CCG, and recommended estates bids to the Estates and Technology Transformation Fund
- Integrated care data dashboards have been piloted in eight practices, with a rollout plan prepared for 350 practices within 12 months. The dashboards link the past two years of patient-level data from acute, primary, community, and mental health, enabling patient journeys through the health system to be tracked and their care to be improved where appropriate.
- Contracts covering 19 services have been let at federation-level across five of the eight CCGs enabling a consistent service offering to the whole population.

Additional work already under way

- CCG self-care leads and lay partners across NW London have co-produced a self-care framework. This includes patient activation measurement that is to be piloted in approximately 200 GP practices by March 2017.
- 180 Healthy Living Pharmacies have been commissioned for 2016/17. They will train Health Champions and Healthy Living Pharmacy Leaders to support local communities with wellbeing interventions such as smoking cessation.
- Hillingdon and Ealing CCGs are providing a Minor Ailments Scheme, allowing patients to self-medicate when appropriate, reducing the impact on primary care. We plan to roll this scheme out across NW London by 2018/19.
- 32 Physician Associates places have been commissioned at Buckinghamshire New University and Brunel University, starting later in 2016.
- The Clinical Pharmacists in General Practice pilot is underway at 23 GP practices in NW London .
- The CCGs plan to make seven collective technology bids to the Estates and Technology Transformation Fund. These will cover areas including digitally-enabled patients, videoconferencing, integrated telecoms and patient management systems, and care home pilots.
- On-going work on local implementation of the 10 Point Plan for workforce includes: a recruitment evening session at Northwick Park Hospital for Foundation Year Doctors, the national thunderclap campaigns organised by HEE, and Joint work with the Foundation School and Medical School to attract new GP Trainers into local training programmes.

4. The future of primary care in NW London

NW London has a clear set of primary care outcomes that the CCGs will support providers to deliver over the next five years. These are shown below, along with how they map onto the five delivery areas to illustrate the crucial role that primary care has in delivering the NW London STP.



Proactive care	
Co-design	- primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
Developing assets and resources for improving health and wellbeing	- primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community
Personal conversation focused on an individual's 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	- primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
Patients not currently accessing primary care services	- primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Accessible care	
Patient choice	- patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs
Contacting the practice	- patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations)
Routine opening hours	- patients can access pre-bookable routine appointments with a primary health care 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 seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
Same-day access	- patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network
Urgent and emergency care	- patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately
Continuity of care	- all patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate

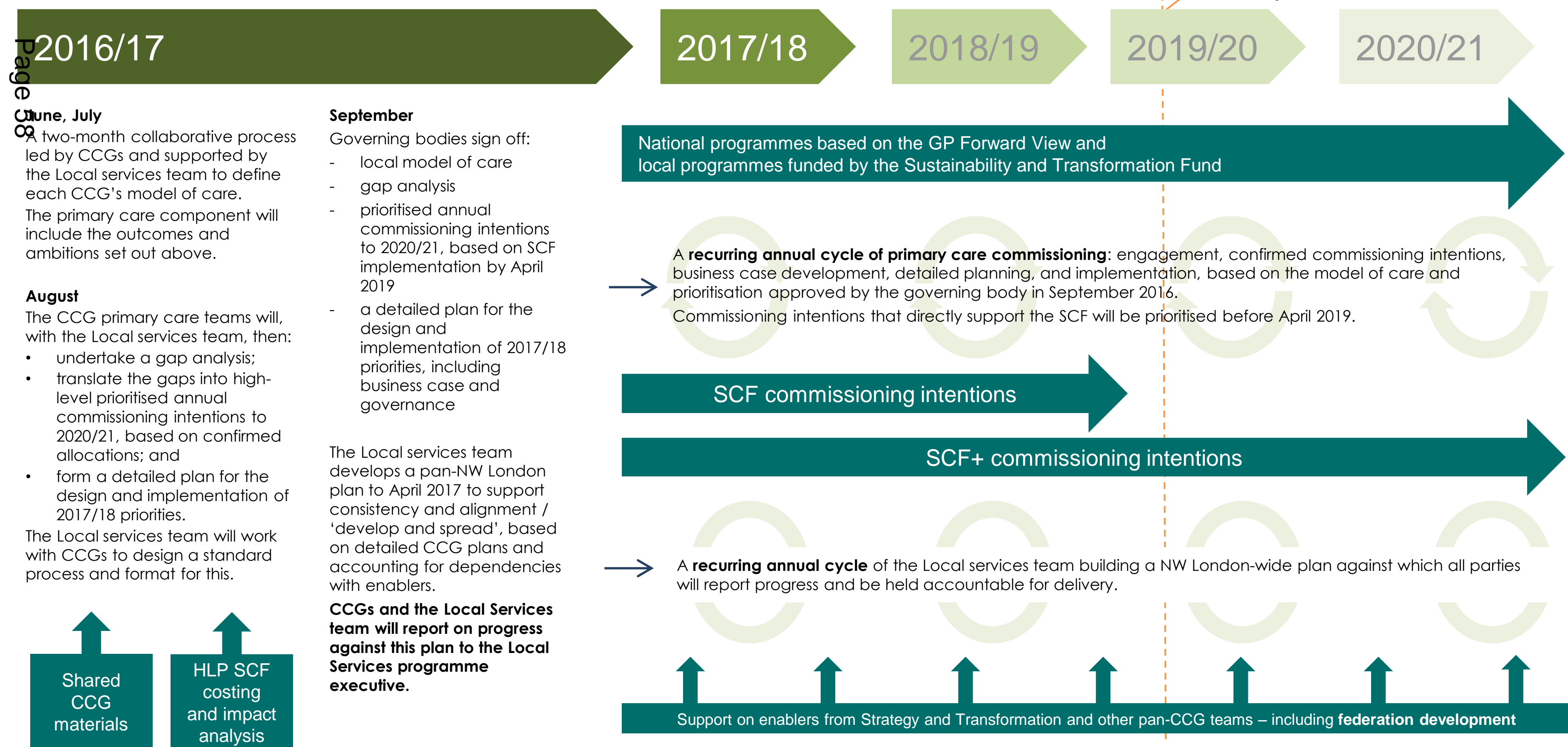
Co-ordinated care	
Case finding and review	- practices identify patients, through whole systems data analytics, who would benefit from coordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis
Named professional	- patients identified as 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 their 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 through health coaching, future digital tools and other forms of education
Multi-disciplinary working	- patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. Care will be coordinated via shared electronic care records.

4. Delivering the ambitions of the primary care strategy

Following the NW London-wide development of ambitions and outcomes for primary care, the CCGs are now working with primary care providers to agree how this will be delivered in each borough in a way that meets the needs of their local populations. The draft process is shown below. This will be the basis of the design and delivery of annual commissioning intentions each year until 2020/21, with delivery of the SCF achieved by the end of 2018/19.

This will ensure that the increases to the NW London primary care medical allocations (shown in the table below) are invested in a way that delivers maximum benefits to patients, alongside the national programmes – such as the Prime Minister's Access Fund, from which NW London might be able to access approximately £12m in 2016/17 – announced in the GP Forward View.

NW London CCGs	2016/17		2017/18		2018/19		2019/20		2020/21
	£279.97m	+£19.3m	£299.26m	+£11.8m	£311.03m	+£11.5m	£322.50m	+£15.6m	£338.07m



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 at an STP level there is a surplus of £50.5m and there is a small, £31m gap to delivering the business rules (i.e. including 1% surpluses).

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care	
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	-	**(1,154.3)**	(145.0)	**(1,299.3)**	**note 1**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7	**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)	(34.0)	(89.7)	**note 4**
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0	**note 4**
Other	-	-	-	188.3	-	-	188.3	63.0	251.3	
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**	
Residual Gap (see note)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**	
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**	
				note 5				**note 3**		

Note: The financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since April '16 STP due to changes in the underlying position of organisations and social care, inclusion of 1% gap requirement on Trusts, NHSE spec comm gap for the Royal Brompton, removal of 16/17 CIP and the inclusion of Primary Care.

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.

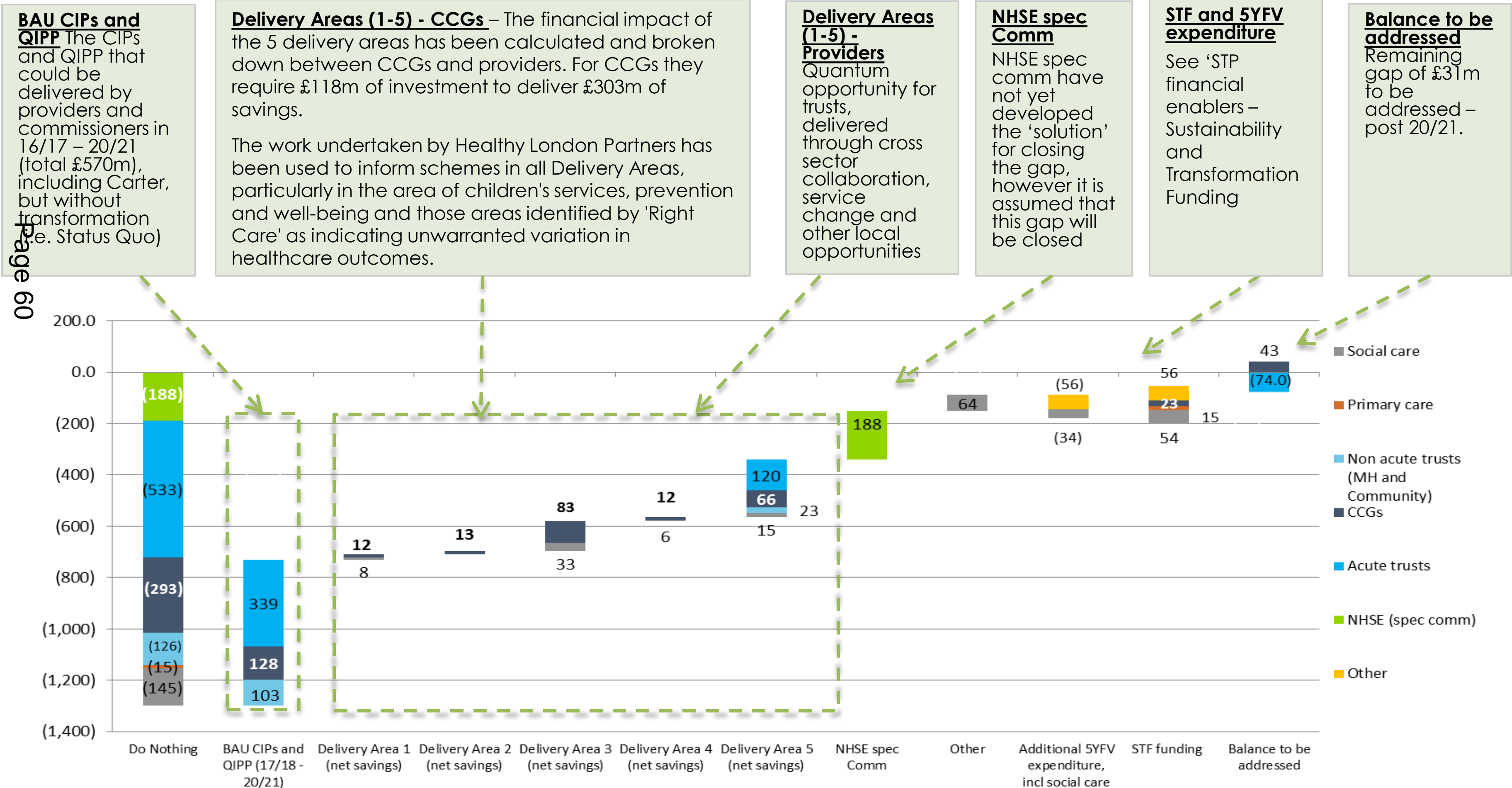
The key financial challenge that remains at 2020/21 is the deficit at the Ealing site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging. This deficit could be eliminated if acute services changes were accelerated, generating a further improvement in the sector position of £62m.

The key risk to achieving sector balance is the delivery of the savings, both business as usual and the delivery areas. There will be a robust process of business case development to validate the figures that have been identified so far and the next section of the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered.

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

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

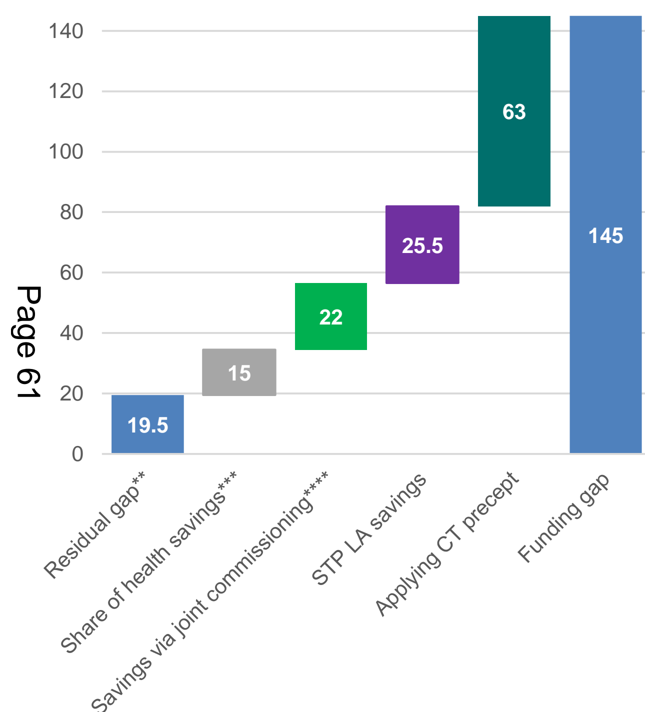
The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a 1% surplus for the NHS.



5. Finance:
Social Care Finances

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. 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 actions set out below describe how the existing gap will be addressed, through 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**	-	**7.0**	**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 transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

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. This is set out below, and shows our expectation of where we expect to invest the funding recurrently from 2020/21.

	16/17	17/18	18/19	19/20	20/21	
	£m	£m	£m	£m	£m	
Sustainability funding	-	112.4	82.3	61.6	0.0	
Investment in prevention and social care	-	21.0	25.0	30.0	34.0	£53.5m
Social care funding gap	-	-	-	-	19.5	
Seven day services	3.0	4.0	7.0	12.0	20.0	£55.7m
Mental health transformation and invetment in services - integrated care models	0.0	10.0	10.0	13.0	20.7	
Federation and primary care development	5.0	10.0	10.0	5.0	0.0	
Support new payment models design and implementation	3.0	10.0	10.0	5.0	0.0	
Digital roadmap	-	3.0	10.0	10.0	15.0	
Improvement resources	2.0	2.0	2.0	0.0	0.0	
Additional investment in primary care services	0.0	1.0	12.0	19.0	14.8	
Uncommitted funding	0.0	0.0	0.0	0.0	23.0	
TOTAL	**13.0**	**172.4**	**156.3**	**136.6**	**147.0**	

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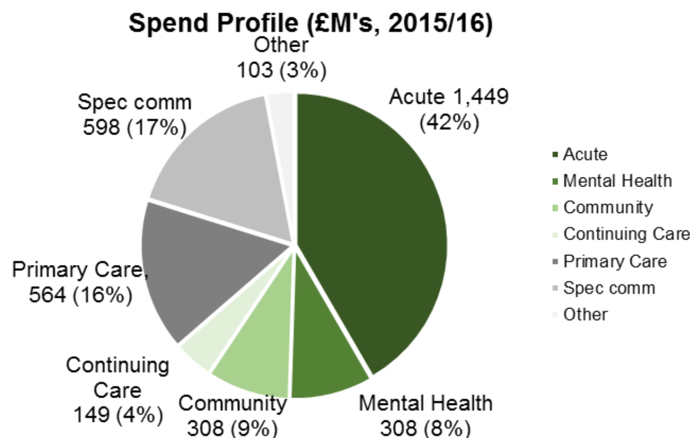
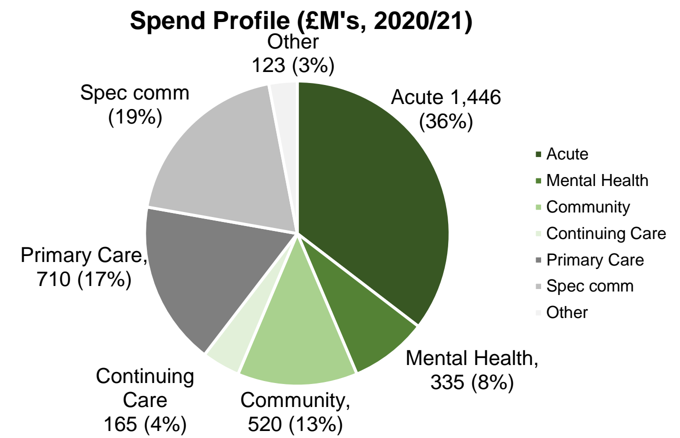
The charts below show how the delivery of the STP will change the commissioner expenditure profile over the next 5 years as we move from a reactive system to a proactive care model. Acute spend by CCGs reduces from 42% to 36% of total spend, while primary and community care spend increases from 25% to 30%. Mental health spend stays the same as a percentage of the total but the expenditure increases and the way in which the money is spent shifts towards community based rather than acute based interventions, enabling increased demand to be managed. Some increased mental health spend is also included within the main primary care and community expenditure totals.





5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £783m (funded by £573m from internal resources, £37m from disposals and £173m 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 and the subsequent five years. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

Table 1: Do Something Capital

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	**747.9**
Disposals and contingency	-	(330.0)	-	-	**(330.0)**
Total Net Capital Requirements	**75.2**	**(82.6)**	**219.2**	**206.1**	**417.9**
Post 20/21					
Gross Capital Expenditure	252.5	1,116.0	4.5	97.1	**1,470.1**
Disposals and contingency	29.0	(681.2)	23.0	-	**(629.2)**
Total Net Capital Requirements	**281.5**	**434.8**	**27.5**	**97.1**	**840.9**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: Projected costs, land sale receipts and affordability, particularly in the second five year period, are indicative and subject to detailed business case processes

Other Additional Capital – there are additional capital cases of £303m made up of: (1) £141m for LNWH for additional investment in NPH and CMH including, ICT and EPR and other IT; (2) £53m for backlog maintenance for THH relating to the tower; (3) £79m for CNWL for strategic developments; and (4) ETTF IT Digital roadmap of £31m.

To address the sustainability challenge at Ealing hospital would require the acceleration of the capital developments and approvals process (within the 'Outer NWL'. If that were achieved the capital profile would change, with the estimated position shown below :

Table 2: Accelerated timeline

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Total Net Capital Requirements	**249.9**	**(82.6)**	**219.2**	**206.1**	**592.6**
Post 20/21					
Total Net Capital Requirements	**106.8**	**434.8**	**27.5**	**97.1**	**666.1**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: The table shows the re-phasing without any assumed inflation saving (estimated to be c. £30m)

The funding for above capital ask will be a mixture of loans and PDC, which will modelled within individual business cases.

6. How we will deliver our plan: Our NW London Delivery Architecture

To deliver this change at scale and pace will require the system, us, to work differently, as both providers and commissioners. At its heart, this requires shared commitment to an agreed vision, a credible set of plans and the right resources aligned to those plans. We know this both from the literature but more critically through our own experiences and track record of delivery change. Therefore we are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. **Agree a joint NW London implementation plan for each of the 5 high impact delivery areas**
2. **Shift funding and resources to the implementation of the five delivery areas, recognising funding pressures across the system and ensure we use all our assets**
3. **Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities**
4. **Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital**

1. Develop a joint NW London implementation plan for each of the 5 high impact delivery areas

We will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We have built upon previous successful system wide implementations to develop our standard NW London improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges. This has been codified in the common project lifecycle, described below, with common steps and defined gateways:

Critical success factors of the standard methodology include a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. Models of care are developed jointly to create ownership and recognise local differences, and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, 7 day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures and complementary skills across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

- We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
- We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
- We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

To further support the alignment of resources we are mapping and reviewing the total improvement resources across all providers and commissioners, including the AHSN, to realign them around the delivery areas to increase effectiveness and reduce duplication. The diagram on the next page also indicates where the various delivery areas are being supported:

NW London Collaboration of CCGs Strategy & Transformation Team *Commissioner* ~ 80-100 staff	**West London Alliance Local Government** Work in progress to allocate key L G staff	**Academic Health Sciences Network (Imperial College Health Partners)** AHSN ~ 8 staff	**Provider Transformation/ Productivity (CIP)/ Integration Teams** *Providers* ~ 90 staff
DA1 a) Enabling and supporting healthier living			Business as usual CIP
	DA1 b) Wider determinants of health interventions		DA2 c) Delivering 'Right Care' priorities
	DA1 c) Helping children get the best start in life		DA4 c) Crisis support and Crisis Concordat
DA1 d) Addressing social isolation			DA5 a) Specialised Commissioning
DA2 a) Improving cancer screening			DA2 a) Improving cancer screening
DA2 b) Better outcomes and support for people with common MH			DA5 b) Delivering the '7 day standards'
DA2 d) Improving self management and patient activation			DA5 c) Configuring acute services
DA3 a) Improving market management and whole systems approach			DA5 d) NW London provider productivity programme
DA3 b) Implementing Accountable Care Partnerships (ACPs) by 2018/19			
DA3 c) Implement new models of local services			
DA3 d) Upgrade rapid response/IC services			
DA3 e) Creating a single discharge process			
			DA3 f) Improving last phase of life
DA4 a) New model of care for people with serious and long term mental health needs			
DA4 b) Addressing wider determinants of health			
DA4 d) Implement Future in Mind			
DA5 b) Delivering the '7 day standards'			
DA5 c) Configuring acute services			

Over time, we are seeking further alignment and integration between these teams, to avoid duplication and align the relevant people and skills to the most appropriate programmes of work

6. How we will deliver our plan:
Our NW London Delivery Architecture

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities
NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.
We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.
Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

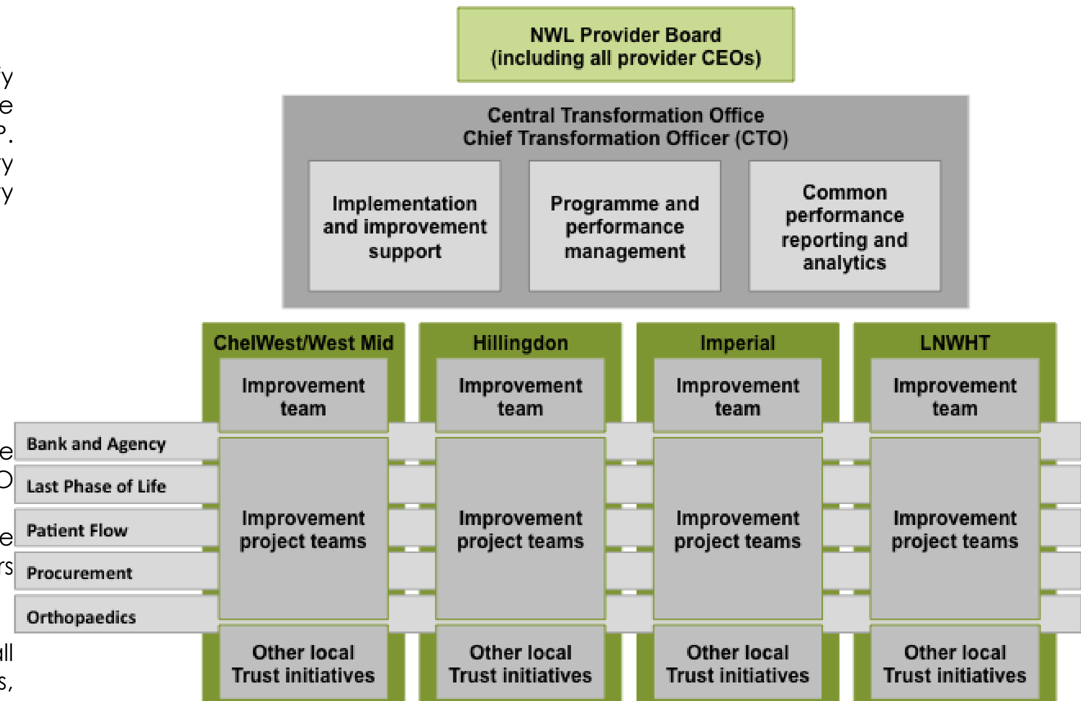
4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital
- We are moving towards federated primary care primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system
- By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements
- By 20/21 we will have implemented Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

Latest progress with the provider productivity programme

Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review. These opportunities are detailed in the STP. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery the priority projects of:
- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.
To achieve this providers are working together to:
- Recruit a sector transformation director to lead the programme, with analytics funded by CCGs and PMO provided by ICHP.
- Programme directors are now in place for all but one programmes, programme directors and project managers funded by acute trusts.

As a result savings are expected in year from procurement, all trusts expecting to deliver their bank and agency targets, planning for a pan NW London bank by the end of the year.



6. How we will deliver our plan:

Risks and actions to take in the short term

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	Development of a dashboard and trajectory, and regular monitoring of progress through joint governance Adoption of learning from vanguard and other areas	Access to learning from vanguards and other STPs
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	On-going quality surveillance to reduce risk	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	Support development of federations Early investment in primary care through joint commissioning Identification and support to vulnerable practices Digital solutions to reduce primary care workloads	Clarity about future of and funding for GMS and PMS core contracts
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 joint market management strategy On-going support to homes to address quality issues	
Can't get people to own their responsibilities for their own health	Self care and empowerment	Development of a 'People's Charter' Work with local government to engage residents in the conversation	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	Finance and estates	Submit a business case for capital in summer 2016 Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment.	Support for retention of land receipts for reinvestment, and potential devolution asks.
We are unable to access the capital required to increase capacity at the receiving hospitals quickly enough to address the sustainability issues at Ealing hospital	Finance and estates	Submit a business case for capital in summer 2016 that sets out the clinical and financial rationale to accelerate the timeline	Support for an accelerated timeline for the capital business cases
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	Development of workforce strategy, close working with HEENWL	

6. How we will deliver our plan:
Risks and actions to take in the short term

Risks	Category	Proposed mitigations	Support from NHSE
There is resistance to change from existing staff	People and workforce	OD support and training for front line staff Wide staff engagement in development of new models to secure buy in	
Providers are unable to deliver the level of CIPs required to balance their financial positions	Finance and sustainability	Establishment of new sector wide improvement approach to support the delivery of savings	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	Establishing a new political relationship and reflecting this in enhanced joint governance, taking a 'whole systems view' to investment and market management	
BI systems aren't in place to enable shifts of activity through integrated care	Information and technology	Work within new national standards on data sharing to support the delivery of integrated services and systems.	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
Lack of interoperability in our primary and community IT systems, EMIS and SystmOne, which prevents shared care records which support integrated care	Information and technology	Keep pressure up on supplier to deliver open interfaces.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	Work closely with partners to understand the 'Brexit' implications and provide staff with support to ensure they feel valued and secure.	Early clarity of impact Political messaging to staff

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	23-24	[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

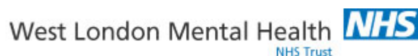
7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	25-26	[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	27-28	[1] Tulloch et al., 2008 [2] Royal College of Psychiatrists, 2012 [3] 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	29-31	[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	33-34	[1] ERIC Returns 2014/15 [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	35-36	[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	37-38	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint



Imperial College Healthcare
NHS Trust

NW London Sustainability and Transformation Plan

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

APPENDICES – v1.0 20160630

List of appendices

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Appendix A: Joint Statement on Health and Care Collaboration in NW London from Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster Councils

These six boroughs in NW London welcome the opportunity to improve the outcomes for local people and communities

- Local Government and Health partners in North West London (NWL) are committed to working together to design a sustainable health and care system that improves outcomes for our communities.
- We recognise the huge financial and demographic challenges facing public services over the next five years and acknowledge our duty to work together as system leaders to create a sustainable health and care system, whilst retaining our rights as sovereign organisations to help our communities get the outcomes they need.
- We support person-centred health and care that enables increased numbers of older people and those with disabilities to access clinical and social care in community settings whenever appropriate.
- We welcome joint working with the NHS to prevent health problems occurring and to improve the wellbeing of local people. We are committed to working together to deliver integrated health and social care systems that provide the highest quality out-of-hospital services for residents.
- The councils covering North West London will work closely with NHS partners to implement work in these areas, building on our strong track record of partnership delivery.

In order to deliver the ambitions of the STP, our six boroughs also agree that the following conditions must be reflected in the STP document itself:

1. Explicit reference to how the NHS will help to close the £145m social care funding gap, through investment in prevention and integration services
2. Explicit reference to the need to map and 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
3. Explicit reference to plans to significantly expand pooled budgets and joint commissioning for delivery of integrated and out of hospital care, especially for older peoples services, to support the development of the local and NW London market
4. Explicit reference to a devolution proposition around local retention of capital receipts from estates and joint commissioning of all out of hospital care, with resources allocated to deliver it. This in no way infers any assumptions about acute reconfiguration.
5. There will be no substantive changes to A&E in Ealing or Hammersmith & Fulham until after of a review process, based on criteria to be agreed, led jointly by the six local authority partners and communities. All partners will work to significantly improve out of hospital provision to enable patient demand to be met.
6. A commitment from NHS partners to review with local authority partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes
7. A commitment to work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures

Any changes to this agreement will be subject to joint review based on agreed criteria with the six local authority partners and their communities.

Concerns still remain around the government's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in north west London or downgrade the status of Ealing or Charing Cross hospitals, including A&E services.

We recognise that there is significant work still to do to develop a genuinely joint approach and reach agreement on any hospital changes in these areas. At the same time, the six boroughs recognise the significant opportunity to work together to invest in better care for local residents.

To move forward, our boroughs ask that NHS partners commit to work jointly to:

- develop an agreed approach to the delivery of the commitments , following the 30 June checkpoint
- develop an acceptable set of review criteria for any changes
- strengthen the supporting data and evidence base, and understand the financial risks and benefits and overall business case across health and care by October 2016
- agree a 'review point' in 2018 to review the agreed criteria
- co-produce the final plan with leaders, clinicians and the public from June through to October 2016

Appendix B: Leadership and governance

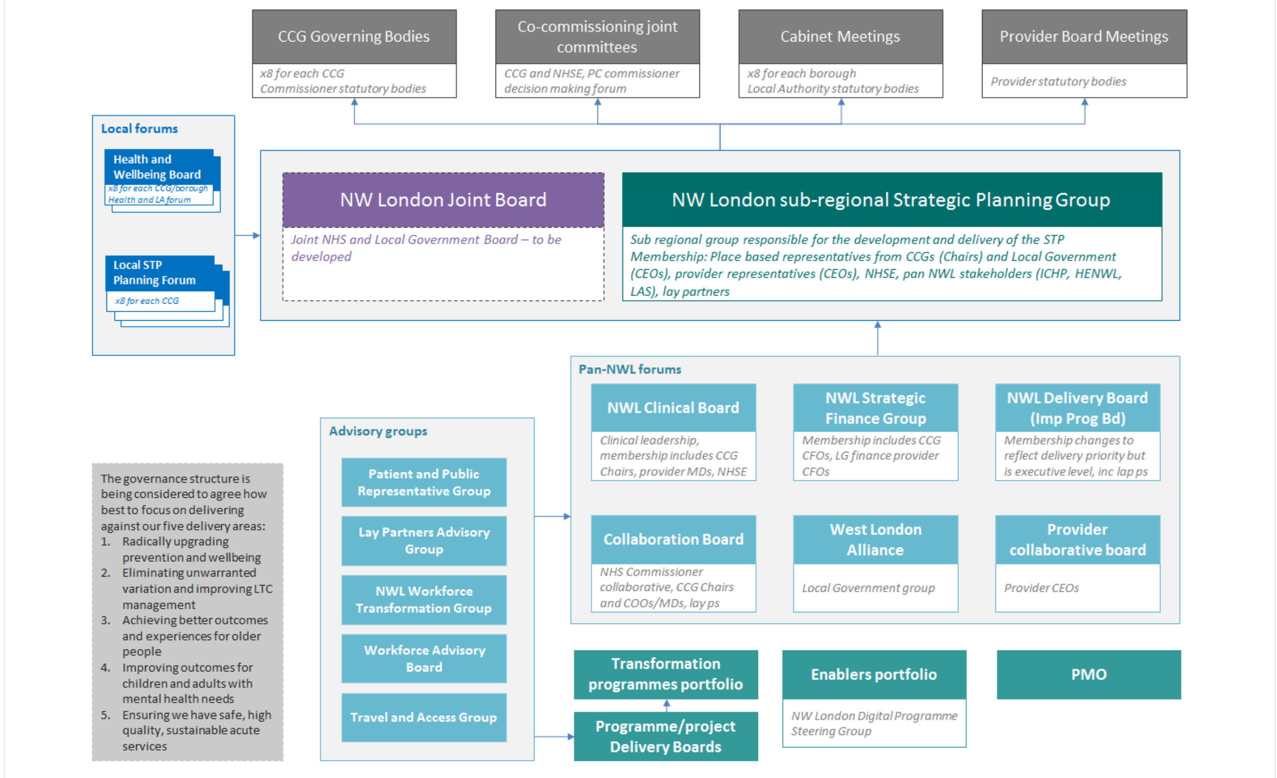
NW London has meaningful leadership and robust governance to drive transformational change

There is a history of collaboration at a sub-regional level in NW London across both health and local authorities. To help us work most effectively we have in place a robust governance structure and leadership arrangements.

NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership.

With the development of the STP, we have strengthened our ways of working. NHS and Local Government partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy. We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government STP partners for each of the five delivery areas and three enablers. Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

Incorporating the individual's voice, clinical expertise and our managerial functions, we are operating in the following structure to develop and implement the STP:



STP Leadership Team

The STP is led by the appointed STP System Leadership Team, which meets weekly and includes representation from all of the key stakeholder groups in our system:

Dr Mohini Parmar *System Leader*
(Ealing CCG Chair)

Dr Tracey Batten *Provider Lead*
(Chief Executive, Imperial College Healthcare Trust)

Carolyn Downs *Local Authority Lead*
(Chief Executive, Brent Council)

Rob Larkman *Joint NHS Commissioner SRO*
(Chief Officer BHH CCGs)

Clare Parker *Joint NHS Commissioner SRO*
(Chief Officer CWHHE CCGs)

Matt Hannant *STP Programme Director*
(CCG Director of Strategy & Transformation)

Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
1. How are you going to prevent ill health and moderate demand for healthcare?	**Priority 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	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-22	• 5 of the 8 boroughs in NW London are part of the Diabetes Prevention Programme Pilot • PMS review - move to equitable provision of preventive screening and immunisation, targeting prevalence across CCGs potentially depending upon commissioning intentions • 6 of 19 primary care hubs up and running in NW London • Model of care work and federations - based on principle of commissioning for the whole population in order to address health inequalities • Risk stratification enabling care planning for high risk individuals • Patient activation measurement tool rolled out across NW London
2. How are you engaging people, communities and NHS staff?	**Priority 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 **Priority 4:** Reduce social isolation	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-11 **Enabler:** Workforce (Pages 35-36) **Enabler:** Digital (Pages 37-38) **Appendix C:** Co-production, communications and engagement with service users, partners and staff (Pages 5-6)	• Embedding co-production throughout our transformation, supported by the Lay Partner Advisory Group • Expert Patient Programmes in some CCGs • Federation commitment to engaging people and communities e.g. all practices have a Patient Participation Group • All CCGs signed up to healthy workplace charter • Change Academy has supported 4 multi-disciplinary teams to date as part of Phase 1 • Mental Health engagement events in collaboration with West London Collaborative
3. How will you support, invest in and improve general practice?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA3:** Achieving better outcomes and experiences for older people **DA5:** Ensuring we have safe, high quality sustainable acute services	**DA3:** Pages 25-26 **DA5:** Pages 29-31	• Established federations to increase GP accessibility • Improvements to maternity and children's care across NW London by consolidating inpatient and emergency services onto 5 sites • 1.9m people have access to weekend primary care appointments • NW London CCGs score above London average for accessible and coordinated care dimensions • Primary care is working at scale – all eight CCGs have federation population coverage of above 75%
4. How will you implement new care models that address local challenges?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 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 **Priority 5**: Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**DA3:** Achieving better outcomes and experiences for older people **DA2:** Eliminating unwarranted variation and improving Long Term Condition management	**DA3:** Pages 25-26 **DA2:** Pages 23-24	• Joint commissioning of services (in particular rapid response) across health and social care • Whole Systems approach developed and in practice to segment the population and develop tailored services • Development of local models of care for urgent care, including 111 • There are urgent care centres at all A&Es in NW London • As part of the reconfiguration of paediatric services, a new model of care and paediatric assessment units have been developed
5. How will you achieve and maintain performance against core standards?	**Priority 3:** Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Performance is managed through a range of forums between providers and commissioners including quality meetings which feed into CCGs, Finance and Performance meetings and Contract meetings

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Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
6. How will you achieve our 2020 ambitions on key clinical priorities?	**Priority 2:** Improve children's mental and physical health and well-being **Priority 8:** Reduce the gap in life expectancy between adults with severe and long-term mental illness and the rest of the population **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA1:** Radically upgrading prevention and wellbeing **DA4:** Improving outcomes for children &adults with mental health needs **DA5:** Ensuring we have safe, high quality sustainable acute service	**DA1:** Pages 21-22 **DA4:** Pages 27-28 **DA5:** Pages 29-31	• Single point of access' and rapid response home treatment teams for urgent mental health needs launched across all 8 Boroughs Urgent care centres across NW London all operate to the same specification • Maternity – after the transition of maternity services at Ealing, there has been an improvement in: - midwife to birth ratio from 1:31 to 1:30 - midwife vacancy level from 8.1% to 7.2% - consultant ward presence from 108 hours to 122 hours • Signed up all North West London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of their staff. • launch of young people's eating disorder services. Providing quicker access for this vulnerable population
7. How will you improve quality and safety?	**Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Launched seven day services programme • Implemented single discharge process • Psychiatric liaison in all A&Es and Urgent Care Centres (UCCs) in NW London • Maternity & Paediatrics – agreed quality standards which are tracked monthly across NW London • Mental health Crisis Care Concordat signed • Agreed clarifications on 7 Day Services standards on radiology
8. How will you deploy technology to accelerate change?	Underpins all priorities		**Enabler:** Digital (Pages 37-38)	• NW London Diagnostic cloud • Roll out of Electronic Prescribing Service (EPS2), Summary Care Record • Patient Online functionality available at all practices • Integrated Care data dashboards being piloted • In primary care 280,000 patients have access to web-based consultations and 60,000 patients have access to video consultations
9. How will you develop the workforce you need to deliver?	Underpins all priorities		**Enabler:** Workforce (Pages 35-36)	• Joint working with Health Education England (HEE NW London) • Care Coordinator and Care Navigator role developed, trained and in post (increasing numbers in the existing workforce) • Health and Social Care Coordinator role development (enhanced clinical skills) • CEPNs established across NW London which are improving ways of working across different parts of health and social care • PA programme in Hillingdon mobilised
10. How will you achieve and maintain financial balance?	Underpins all priorities		**Finance** (Pages 42-47)	• NW London financial strategy being implemented for the past few years • The Shaping a Healthier Future programme, by creating new unified clinical pathways and providing higher quality care across the system

Appendix D: Further information about our Mental Health and Wellbeing Transformation

Appendix D: The current picture

In North West London we have had a shared whole systems mental health programme (across health and social care) since 2012 reflecting a commitment to improving mental health and wellbeing for the 2 million residents of North West London. Since 2015 we have been working under the banner of Like Minded – with a Case for Change endorsed across all Health and Wellbeing Boards, and CCGs setting out our challenges and common ambition for change.

The programme coproduced the following 3 statements to articulate the overall vision our population. These statements are supported by a number of principles. Critically the Strategy, vision and principles describe the outcomes and experience we want to change – rather than focus on services.

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

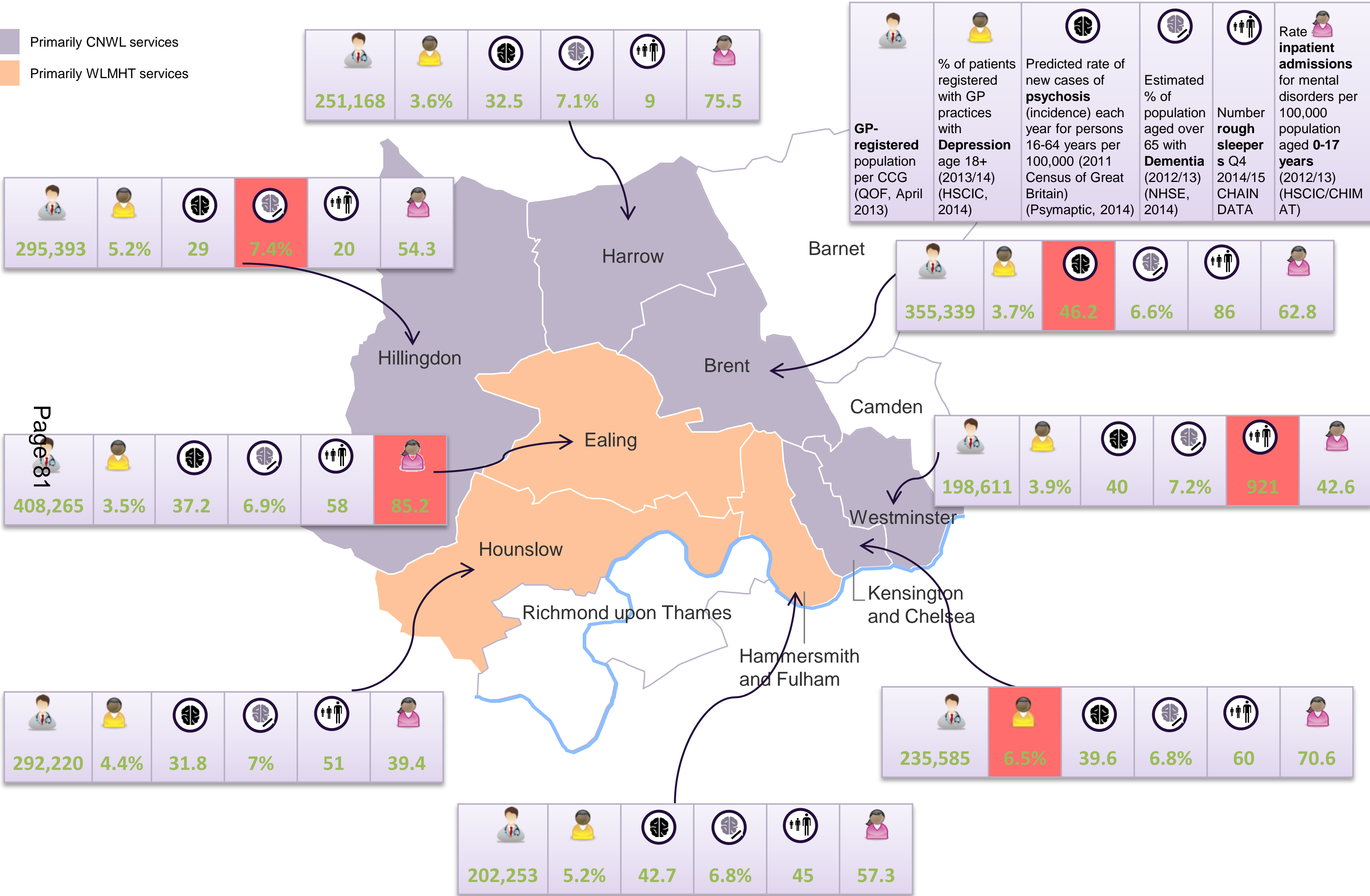
As soon as I am struggling, appropriate and timely help is available

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

Core principles

- 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 for the whole of my life

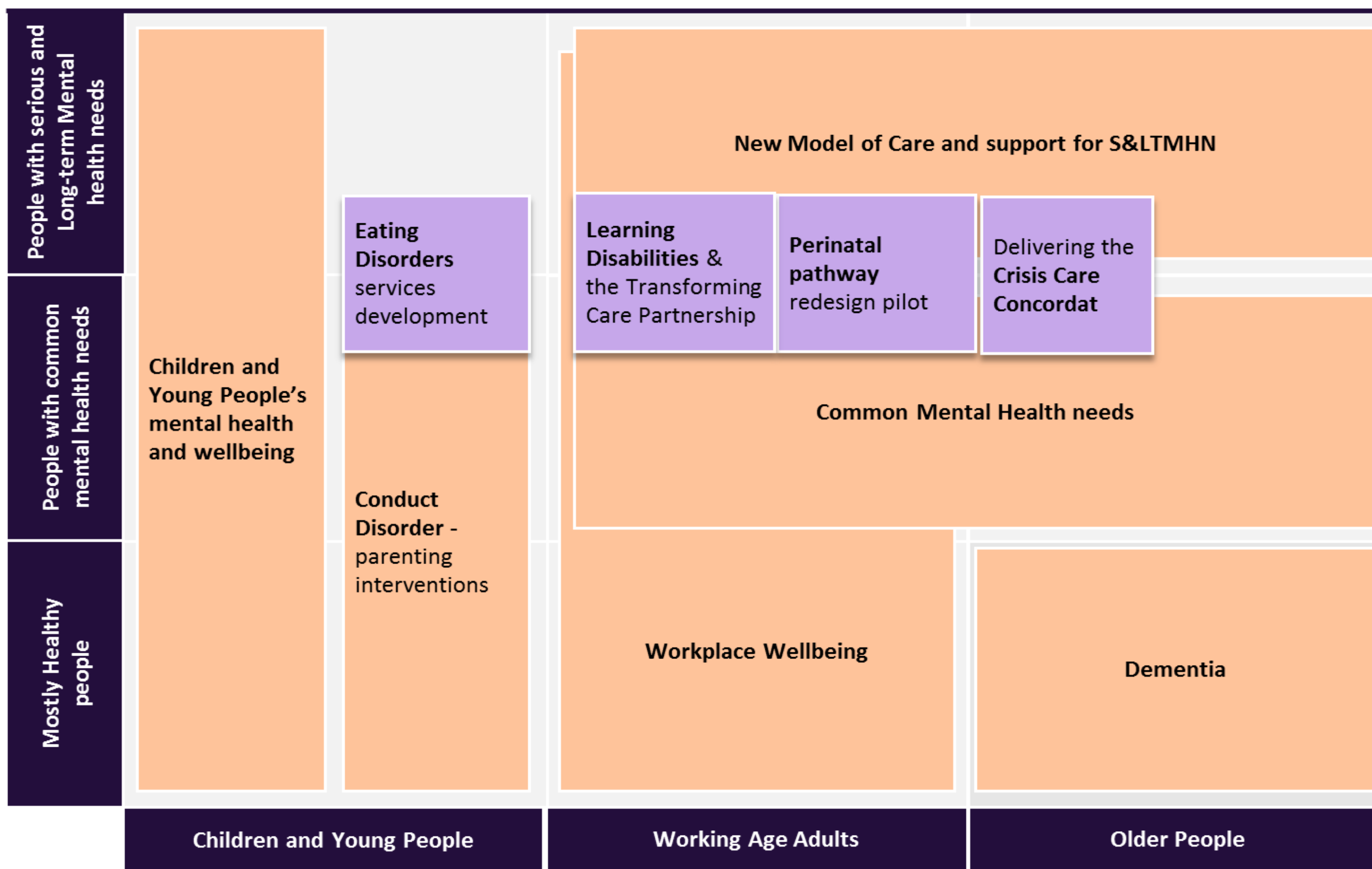
Appendix D: Case for change: there is still much we can do to improve outcomes and reduce variation



Appendix D: We use an approach across the life course, aiming to reducing mental health inequalities

In approaching mental health transformation in North West London we have considered an approach across the life course aimed at reducing mental health inequalities. Whilst we know that people are not defined by their diagnosis (we acknowledge that comorbidity is the norm) or demographics, this is a useful framework to prioritise and focus within an area of vast need.

We recognise that learning disabilities and mental health needs are not the same thing – but our work since 14/15 to address needs of our population who have both learning disabilities and mental health needs provided a spring board for wider work on learning disabilities under the Transforming Care Partnership Programme.



Appendix D: As a transformation programme with a wide remit we embed in NW London the sense that mental health is everyone's business

The Like Minded Strategy is a 'whole systems', all ages strategy. Throughout the programme we recognise the critical role that services and initiatives across the system have in supporting mental health and wellbeing. Our combined work across NWL naturally builds on the local transformation and co-production work within each Borough, and on work led by local mental health providers – CNWL and WLMHT. As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business – through supporting our own workforce to remain healthy, as much as focusing on supporting the mental wellbeing and recovery of our service users, carers and wider population.

As we have approached mental health transformation in North West London one key commitment has been to co-production – not just with service users and carers, but through a cross-system leadership approach in health, social care and the voluntary and community sector. Our work to date lends itself to a 'place based approach' - with no health without mental health we have to work with a wide range of partners and recognise the impact of mental illness on all statutory services and broader societal outcomes, such as employment and educational attainment.

The whole programme is focused on delivering the ambitions for Parity of Esteem, all transformation work rooted in a holistic approach to meeting the needs of the public.

We work closely with service users and carers, clinicians, professionals and experts across the system in health, social care, voluntary sector and public health and have held workshop events in specific areas, including children & young people, socially excluded groups, and mental ill health prevention.

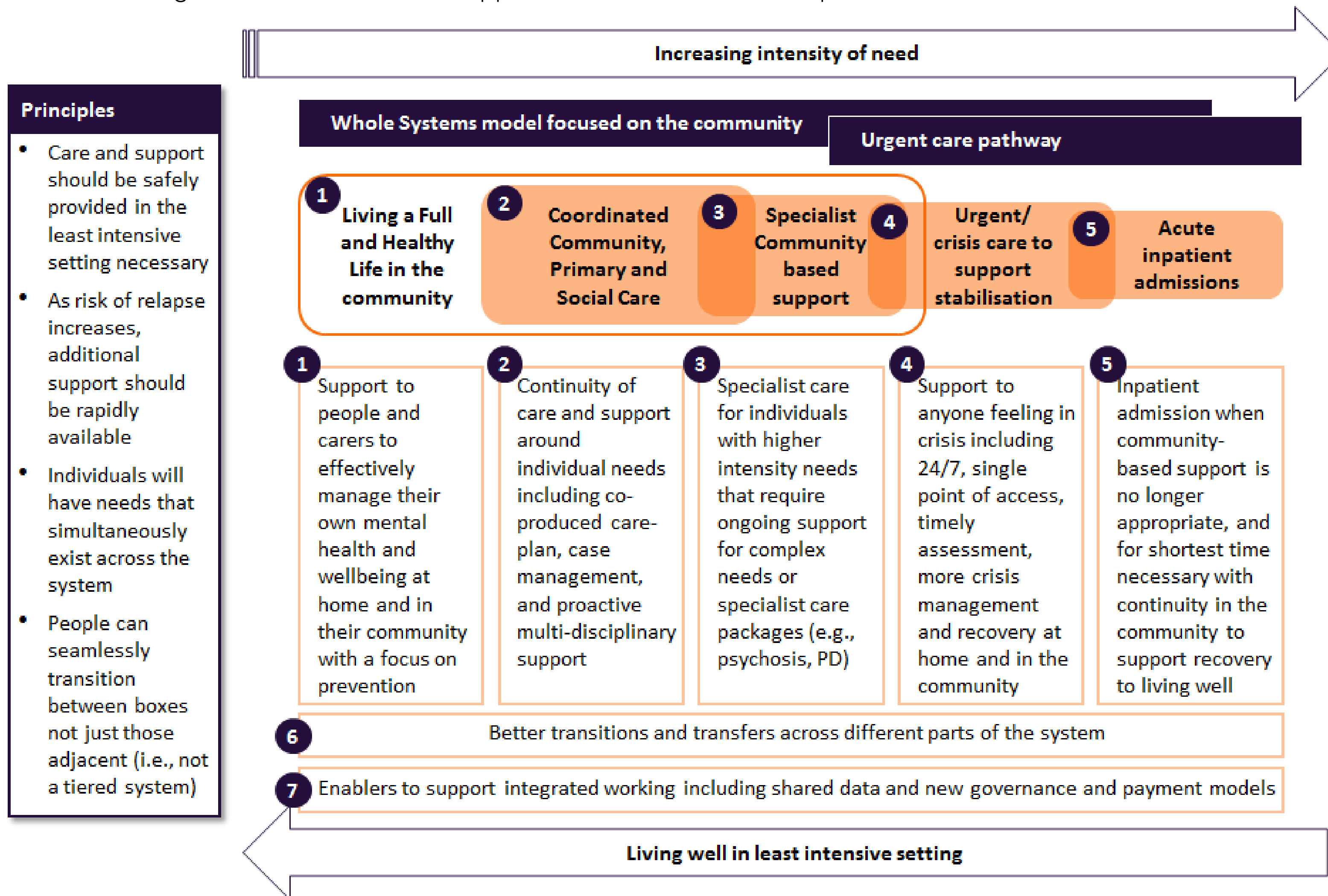
We are not starting from scratch – our 24/7 urgent care pathway has been the critical development over the last year and unlocks the gateway to wider services for adults with serious and long term needs:

Appendix D: Like Minded new Model of Care and Support for people with Serious and Long Term Mental Health Needs (SLTMHN)

Like Minded has put much focus on the development of a model of care and support for people living with and experiencing SLTMHNs, as shown below. This model of care has been developed in conjunction with service users, CCGs, Trusts, and local authorities.

The model of care is designed to ensure care and support takes place in the least intensive setting possible, maximising independence and wellbeing.

Local business cases for the implementation of the model are still in development with the intention of these being agreed by governing bodies in September 2016.



DRAFT

Joint NW London Health and Care Transformation Group

Joint NWL health and care transformation group

DA1: Radically upgrading prevention and wellbeing

Chair: Michael Lockwood

DA 2 Eliminating unwarranted variation and improving LTC management

Co-Chairs: Carolyn Downs, Rob Larkman

DA 3: Achieving better outcomes and experiences for older people

DA 4: Improving outcomes for children &adults with mental health needs

Chair: Fiona Butler

DA 5: Ensuring we have safe, high quality sustainable acute services

Co-Chairs: Clare Parker / Tracey Batten

'Joint transformation group', principles and planning assumptions

- **Initial role:**
  - Oversight of STP development and recommendation to statutory orgs
  - Design and oversight of allocation of STF (driven through individual CCGs)
  - Oversight of STP delivery
- No delegated decision-making authority (at this stage)
- Subsidiarity applies
- Annual review of leadership and membership arrangements
- Terms of Reference to be determined
- Members of the Group only represent one role/function, i.e. either a place, type of organisation, population group, or a DA, not multiple roles

	Membership		
	Role	Name	Governance Link
1	Co Chair (NHS)	Mohini Parmar	NHS/comm
2	Co Chair (LG)	Cllr Shah	LG
3	NHS Rep 2	Clare Parker	NHS/comm
4	NHS Rep 3	Rob Larkman	NHS/comm
5	NHS Rep 4	Tracey Batten	NHS/comm
6	NHS Rep 5	TBC	NHS/provider
7	NHS Rep 6	TBC	NHS/provider
8	Community/MH Trust Rep	Claire Murdoch	NHS/provider
9	Acute Trust Rep	Lesley Watts	NHS/provider
10	LG Rep 2 (Elected Member)	Cllr Curran	LG
11	LG Rep 3 (Elected Member)	Cllr Robathan	LG
12	LG Rep 4 (Elected Member)	Cllr Corthorne	LG
13	LG Rep 5 (Officer)	Carolyn Downs	LG
14	LG Rep 6 (Officer)	Michael Lockwood	LG
15	LG Rep 7 (Officer)	Liz Bruce	LG
16	Lay Partner Rep 1	Julian Maw	Citizen/patient
17	Lay Partner Rep 2	TBC	Citizen/patient
18	Finance & Estates Enabler	Charlie Parker / Keith Edmunds	NHS/LG

NHS members	LG members	Lay Partner	Finance Rep	**Total**
8	7	2	1	**18**

DRAFT

Mapping of SROs, CROs, and leadership resources to STP delivery areas and programmes

Delivery Area	Description	LG SRO	NHS SRO	CRO	Project	Project Sponsors	PD
DA 1	**Radically upgrading prevention and wellbeing**	Michael Lockwood (Chair)	Ethie Kong	Fiona Butler, Jan Norman, LG?	a. Enabling and supporting healthier living		
					b. Wider determinants of health interventions	Michael Lockwood	Penny Emerson
					c. Helping children to get the best start in life	Jan Norman	Jane Wheeler
					d. Address social isolation	Matt Hannant	Jane Wheeler
DA 2	**Eliminating unwarranted variation and improving LTC management**	Carolyn Downs (Co Chair)	Rob Larkman (Co Chair)	Fiona Butler, Jonathan Webster, Mohini Parmar LG?	a. Improve cancer screening to increase early diagnosis and faster treatment		Lizzy Bovill
					b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions	Matt Hannant	Jane Wheeler
					c. Reducing variation by focusing on Right Care priority areas		Penny Emerson
					d. Improve self-management and 'patient activation'	Rob Larkman	Penny Emerson
DA3	**Achieving better outcomes and experiences for older people**			Nicola Burbidge, Neville Purssell, Susan LaBrooy, Tim Spicer, Mohini Parmar, LG?	a. Improve market management and take a whole systems approach to commissioning	Phil Porter	
					b. Implement accountable care partnerships	Clare Parker/Liz Bruce	David Freeman
					c. Implement new models of local services integrated care to consistent outcomes and standards	Rob Larkman	Penny Emerson
					d. Upgraded rapid response and intermediate care services	Rob Larkman	Penny Emerson
					e. Create a single discharge approach and process across NW London	Rob Larkman	Penny Emerson
					f. Improve care in the last phase of life	Lesley Watts	Alison Kingston
DA 4	**Improving outcomes for children & adults with mental health needs**		Fiona Butler (Chair)	Fiona Butler, Sarah Basham, LG?	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	Matt Hannant	Jane Wheeler
					b. Addressing wider determinants of health		
					c. Crisis support services, including delivering the 'Crisis Care Concordat'		Jane Wheeler
					d. Implementing 'Future in Mind' to improve children's mental health and wellbeing		Jane Wheeler
DA 5	**Ensuring we have safe, high quality sustainable acute services**		Clare Parker (Co-Chair) Tracey Batten (Co Chair)	Susan LaBrooy, Tim Spicer, Mark Spencer, Mohini Parmar, LG ?	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services	Tracey Batten	Hazel Fisher
					b. Deliver the 7 day services standards	Clare Parker	Simon Cook
					c. Reconfiguring acute services	Clare Parker	Simon Cook
					d. NW London Productivity Programme	Shane Degaris	Merav Dover
Enabling workstream		**LG SRO**	**NHS SRO**		**Project**	**Project Lead**	**PD**
Workforce			Ethie Kong		Workforce	Ethie Kong	Delvir Mehet
Digital			Ian Goodman		Digital	Ian Goodman	Sonia Patel
Finance & Estates		Charlie Parker	Keith Edmunds		Finance and Estates		Sue Hardy

Missing Name | >1 SRO | Key

London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE 12 September 2016	h&f hammersmith & fulham
Like Minded Model of Care for Serious and Long Term Mental Health Needs	
Report of the Executive Director for Adult Social Care and Health - Liz Bruce	
Open Report	
Classification: For Policy and Accountability review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Director: Liz Bruce – Executive Director for Adult Social Care and Health	
Report Origin: NW London NHS Trust	**Contact Details:** Tel: 020 8753 5758 bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The attached report has been prepared by NW London NHS Trust and sets out the *Like Minded* North West London Strategy for Mental Health and Wellbeing. Taking a North West London approach is intended to share good practice, avoid duplication and work collaboratively where developing services for a larger population aims to achieve better outcomes.

2. RECOMMENDATIONS

The Committee is invited to submit any formal comments on the report.

3. REASONS FOR DECISION

3.1. Not applicable.

4. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

Like Minded Model of Care for Serious and Long Term Mental Health Needs

Update and discussion on progress and next steps with Hammersmith and Fulham OSC – 12 September 2016

1. Introduction

Like Minded is the North West London Strategy for Mental Health and Wellbeing. Taking a North West London approach means we can share good practice, avoid duplication and work collaboratively where developing services for a larger population means we can deliver better outcomes.

Like Minded's vision is for NW London to be a place where people say:

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

Hammersmith and Fulham has a long standing commitment to mental health as a priority for the local population – and good examples of development of innovative services that support particular local needs.

Like Minded aims to set the overall strategic direction, the framework of outcomes and ambition – and then naturally as we implement in Hammersmith and Fulham there will be variation – due to specific population needs and existing services.

This paper provides an update on the work stream looking at the needs of adults with Serious and Long Term Mental Health Needs (SLTMHN). It reflects the joint work that is taking place between Like Minded, Hammersmith and Fulham CCG, Hammersmith and Fulham Local Authority, CNWL and others. We are keen to have the opportunity to discuss progress and next steps before all plans are finalised.

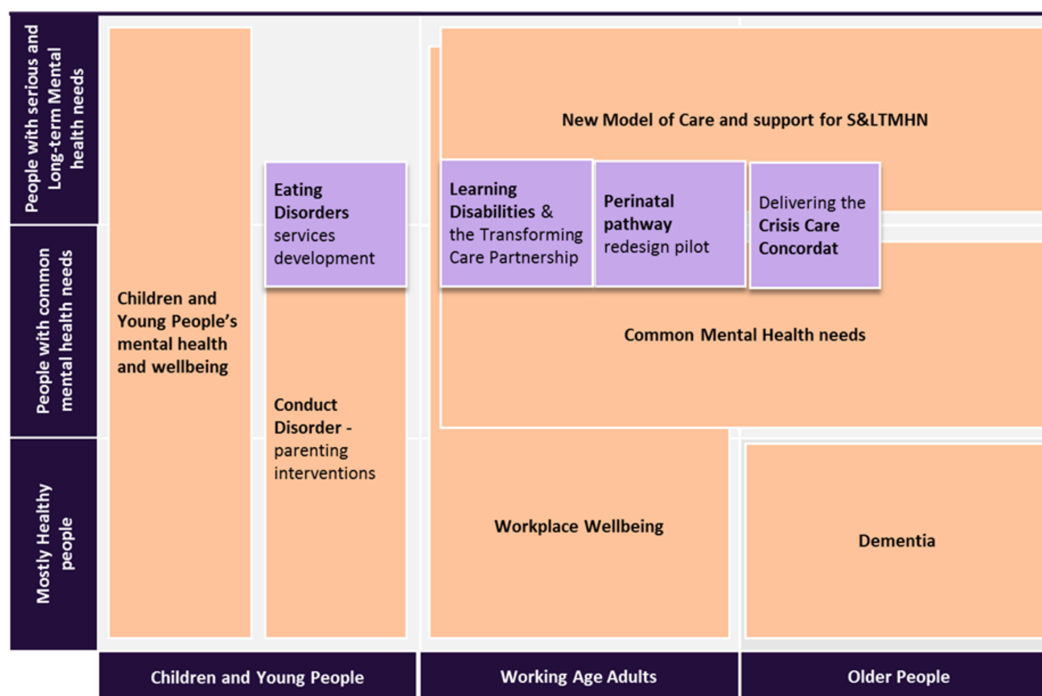
We are asking today for the chance for discussion and guidance ahead of formal decisions being required. We are keen to have clarity from you on the key questions you will need to have answered when we are next in front of you looking at formal decision making stages.

The Overview and Scrutiny Committee is being asked to note this paper, discuss and comment.

2. Background

Like Minded's goal is to promote wellbeing and to improve the mental health care and support we receive if we need it. Like Minded's Case for Change has identified eight major issues that we currently face in NW London and the ambitions that we must all sign up to if we are to improve things.

Like Minded addresses mental health needs for people of all ages and levels of need; whilst we know that people do not exist in a single box this is a useful framework to prioritise and focus within an area of vast need.



Like Minded takes account of work already happening locally in order to deliver on our vision. We have particularly valued taking a co-productive approach to developing plans – and delivering service change. This has included engaging widely with the population and supporting and enjoying the formal membership of the 'Making a Difference Alliance' of Service Users and Carers on our Boards and steering groups.

The Case for Change was endorsed by the NHS NW London Collaboration Board, the Governing Bodies of all eight CCGs and all eight Health and Wellbeing Boards in Autumn 2015. The Like Minded programme is addressing the identified issues through transformation programmes on Children and Young People, Common Mental Health Needs, Wellbeing and Prevention, Perinatal, Learning Disabilities and Serious and Long Term Mental Health Needs. This paper focusses on the SLTMHN work stream aims and objectives, the model of care and support, progress and next steps.

3. Serious and Long Term Mental Health Needs (SLTMHN)

3.1 Aims and objectives of SLTMHN work stream

We need to improve the quality of care for those with serious and long term mental health needs, where illness can have a devastating impact on lives from relationships, jobs and friends. Compared to the rest of London[1],Hammersmith and Fulham have a higher than average burden of Severe and Enduring Mental Illness (SMI) and is likely to have a similar burden of common mental illness. People with severe and common mental illness in Hammersmith and Fulham suffer from significant co-morbidities, and their healthcare costs

[1]A Mental Health Strategy for Hammersmith (Draft 4) May 2016.

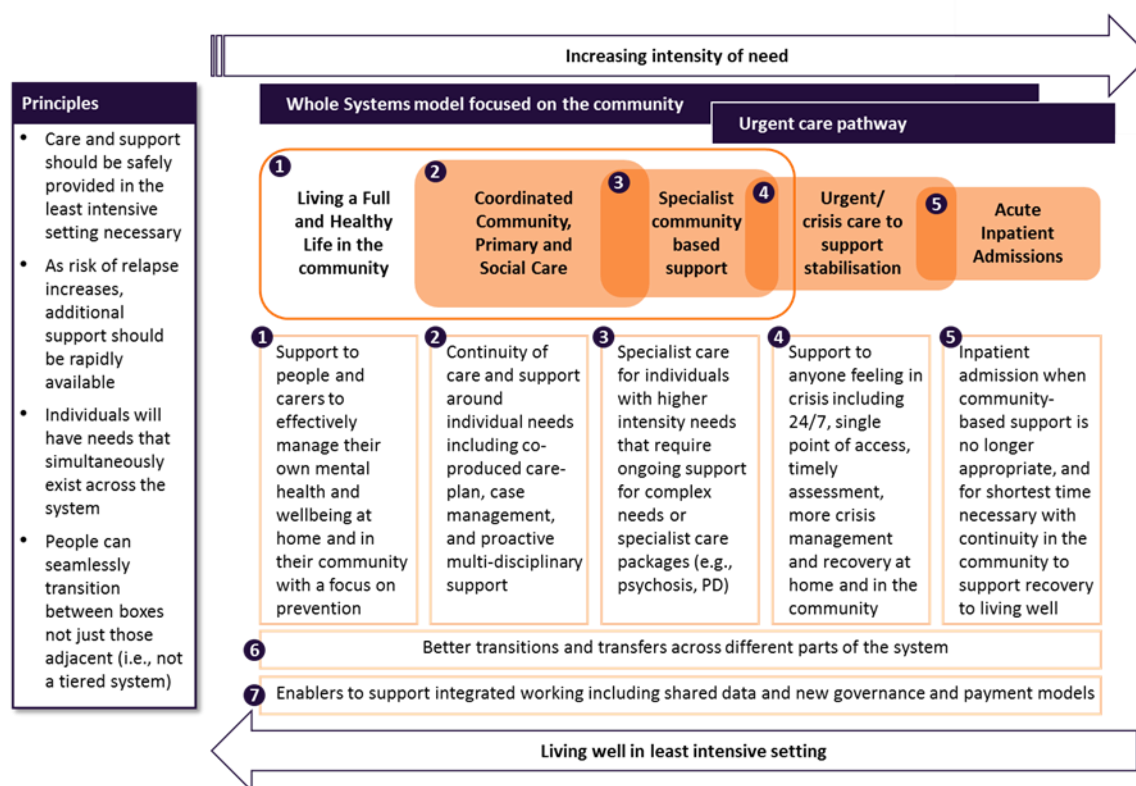
are higher than average[2]. Locally, mental health is the most common reason for long term sickness absence and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons[3]

Our ambition is that for people with serious and long-term mental health needs we will:

- Make their care journey simpler and easy to understand
- Develop new, high-quality, services in the community
- Focus care on community based multi-disciplinary support rather than just in-patient care so people can stay closer to home

3.2 Model of Care and Support for people with SLTMHN

Our Model of Care and Support for people with Serious and Long Term Mental Health Needs was endorsed at the Mental Health and Wellbeing Transformation Board in October 2015 which is attended by CCG teams, representatives from Local Government, service users and carers and other key stakeholders.



Our aim is integrated transformation across health and social care and there are twelve separate initiatives which help define how the Model is to be delivered.

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[2] A Mental Health Strategy for Hammersmith (Draft 4) May 2016.
[3] Hammersmith and Fulham Joint Strategic Needs Assessment Highlights. Report 2013-14

Model	Component	Description	
Whole systems community based model	Living a full and healthy life in the community	**Community mapping and navigation service** – develop and maintain an active database of community services and assets; make this information available to people, carers and care providers; work with community to reduce stigma and build better community based support	
	Coordinated community, primary and social care	**Whole Systems model, likely (but not necessarily) in primary care with model defined locally on how to provide; example described and costed**	Longer **GP appointments** (or alternative) to assist with more intensive care planning and case management
			Increased **PCMH Resources (e.g., social workers, OTs, nurses)** to ensure that **all Boroughs can provide primary care based MH care and support**
			Case Management (by case manager or appropriate alternative) to work with service users to support with case management, care planning and coordination
			Working in **Multidisciplinary Teams** to support better care planning and coordination
	Specialist community based support	**Community Based Packages** – implementing evidence based (i.e., NICE guidelines) specialist care and treatment packages in the community	
		Technological Advancement – e.g. software to centrally schedule community team visits and minimise the time spent on non-face-to-face activities; install hard/software infrastructure to allow for video conferencing	
Urgent care pathway to living well	Urgent/crisis care in the community	**Crisis Response & Home Treatment teams** – Expanded resourcing and role of CRHT teams, so that they can provide as much intensive home-based care and treatment as possible to minimise the need for admission	
		Crisis/recovery houses – Alternative safe places in the community and step up/step down facilities in the community, to provide preferred alternative options for users	
	Inpatient admissions	**Supported accommodation** – More accommodation (or more appropriate provision) to receive people who no longer need an acute inpatient bed but also cannot be safely discharged to their home	
		Discharge planning - Greater collaboration on discharge planning between inpatient teams and ongoing-care teams	
		Closer **post discharge follow-up**	

4.3 Work to date in Hammersmith and Fulham

The mental health team, Hammersmith and Fulham CCG, West London Mental Health Trust and the Local Authority are working closely together to define what will be required to implement the model of care. For example, work is taking place to:

- Define how Hammersmith and Fulham will meet the ambitions in the model for a primary care mental health team, building on services already in place
- Define the resources required to meet an increase in community-based care and ensure pragmatic areas of support such as housing, employment, financial and peer support are included
- Understand the impacts of the model of care on social care services and resolve or identify issues to be addressed as part of service design
- Begin to define the 'alternatives' that will help avoid unnecessary acute admission and get people out of hospital when they don't need to be there
- Define how existing developments are taken forward, such as the 24/7 Single Point of Access already live for the Hammersmith and Fulham population.

We are drafting a North West London business case of shared ambition, with CCG chapters related to specific local need, services and pace of change. The local business case for Hammersmith and Fulham is developed in parallel with Hammersmith and Fulham Council to ensure we quantify and address the impacts of the business case for the Council.

Locally, the model defines a shift in activity away from in-patient beds towards alternative forms of community-based support which are to be developed in Hammersmith and Fulham.

4.4 Integrating the Model of Care and Support in Hammersmith and Fulham

The Business case will bring together the impact of work already underway, describe any additional work required – and critically address how working as a whole system with the right multi-disciplinary support at all stages of the patient experience (including a greater focus on early intervention and prevention) is required. The overall outcome will be a description of outcomes and benefits that we as a system can then hold ourselves to jointly deliver.

Our ambition is to achieve endorsement of the model as *'the right thing to do'* with Hammersmith and Fulham Council and CCG in parallel.

Questions posed by local teams in Hammersmith and Fulham Clinical Commissioning Group and the London Borough of Hammersmith and Fulham so far are helping us to shape the local Model of Care and Support. These questions include:

- Which service users will benefit from any additional supported accommodation?
- What sort of additional supported accommodation (or equivalent) will be needed (e.g. crisis avoidance, step-down)?
- Do the increased resources/roles for community-based support in the model 'fit'? Are there any gaps?
- What ways of working together will be important from the Local Authority and Clinical Commissioning Group perspective a) during design and implementation b) delivering the service?
- What other changes will be needed to achieve the shifts in activity in the model (e.g. improved processes for admission avoidance, discharge, delayed transfers of care, trusted assessment, joint multi-disciplinary team working?)

4.5 Next steps and timeline

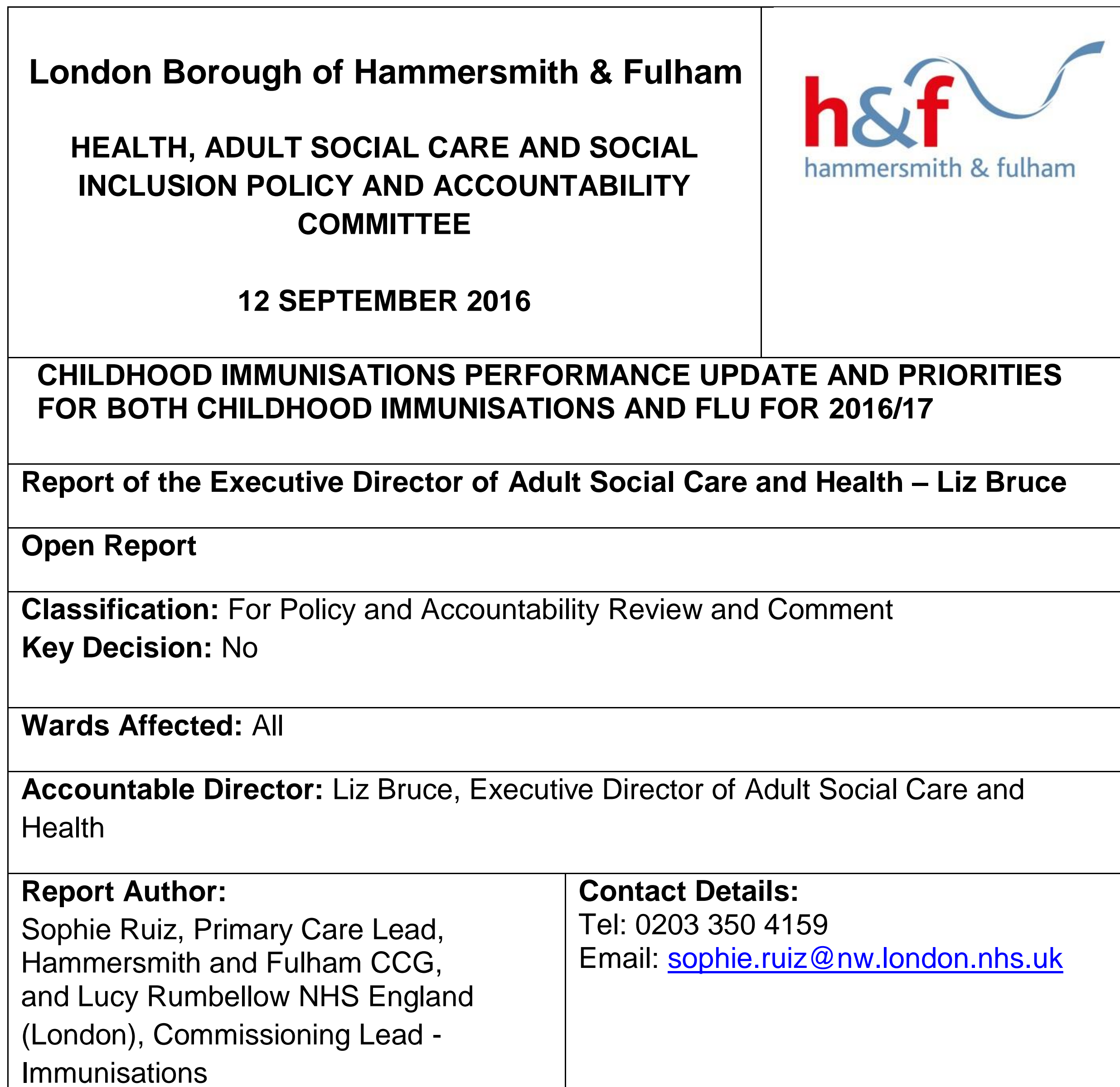
The timeline for the next stage of work is to develop and approve the local business case by Autumn 2016.

5. Recommendations

The OSC is asked to comment on the following questions:

1. What other questions should we be asking to help shape the SLTMHN Model of Care and Support on a local or North West London level?
2. What other elements will be important to explain or demonstrate to members in order for the SLTMHN Model of Care and Support to receive endorsement from Hammersmith and Fulham Council and the CCG?
3. What forums would be helpful to attend to further inform relevant stakeholders?

Agenda Item 6



London Borough of Hammersmith & Fulham

HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE

12 SEPTEMBER 2016

h&f hammersmith & fulham

CHILDHOOD IMMUNISATIONS PERFORMANCE UPDATE AND PRIORITIES FOR BOTH CHILDHOOD IMMUNISATIONS AND FLU FOR 2016/17

Report of the Executive Director of Adult Social Care and Health – Liz Bruce

Open Report

Classification: For Policy and Accountability Review and Comment
Key Decision: No

Wards Affected: All

Accountable Director: Liz Bruce, Executive Director of Adult Social Care and Health

Report Author:	**Contact Details:**
Sophie Ruiz, Primary Care Lead, Hammersmith and Fulham CCG, and Lucy Rumbellow NHS England (London), Commissioning Lead - Immunisations	Tel: 0203 350 4159 Email: sophie.ruiz@nw.london.nhs.uk

NOTE: A Glossary of all abbreviations used in this report can be found in Appendix 1.

1. Background

Childhood Immunisations – NHS England responsibilities

NHS England commission practices to deliver Immunisations and Vaccinations, as part of an Enhanced Service which is commissioned nationally. A summary of the immunisations given between birth and five years old, taken from the Summer 2016 version of the routine immunisation schedule, is shown below.

When to immunise	What vaccine is given	How it is given
Two months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Pneumococcal conjugate (PCV) Rotavirus Meningococcal B	One injection One injection One oral application One injection

Three months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Rotavirus	One injection One oral application
Four months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Pneumococcal conjugate (PCV) Meningococcal B	One injection One injection One injection
Between 12 and 13 months of age	Pneumococcal conjugate (PCV) Measles, mumps and rubella (MMR) Meningococcal B Hib and Men C	One injection One injection One injection One injection
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio (DTaP/IPV or dTaP/IPV) Measles, mumps and rubella (MMR)	One injection One injection

Childhood Immunisation data

Data around immunisations is recorded on the GP clinical system. Data from this is analysed by Health Intelligence and then extracted and cleansed by the Child Health Informatics Service (CHIS) who then report the data to Public Health England on a quarterly basis. Current published data is up to the end of Quarter 4 for 2015/16 (January to March 2016).

NHS England assures delivery of vaccinations by its providers through:

- Policy and management of vaccine incidents
- Audit and review of contract deliverables
- Quality Improvement Initiatives
- Cost Management
- Monitoring of KPI's
- Increasing provision e.g. Open access SLA, Maternity SLA and delivery of flu and PPV (pneumococcal polysaccharide vaccine) by pharmacies
- Continual utilisation of the CHIS SOP and COVER SOP to ensure better accuracy and reliability in reporting quarterly rates.
- CHIS procurement
- Promotion of dovetailing vaccinations e.g. giving child flu vaccine, MMR2 and preschool booster together.

Childhood Immunisations – Hammersmith and Fulham CCG responsibilities – work undertaken to improve immunisation rates

Hammersmith and Fulham CCG has a statutory duty to improve the health and wellbeing of all residents in Hammersmith and Fulham – which includes immunisations. In 13/14 and in 15/16, the CCG had a specific focus on improving immunisation rates for MMR Dose 1 and MMR Dose 2 respectively.

<u>13/14 MMR 1st Dose</u>

In 13/14, the CCG had a quality premium target of 87% to improve immunisation rates for MMR Dose 1. In order to support delivery of this target, the CCG enabled Practices to access real time reports to identify children eligible to receive MMR immunisation as well as developing and sharing MMR 'good practice' guidance for

practices. A community nurse working across the tri borough CCGs was also recruited for 6 weeks to focus on contacting and encouraging immunisation for those hard-to-reach families and parents who had booked but not attended the practice for their child to be immunised.

Whilst the CCG did not achieve the target that was set (end of year performance was 85.54%), there was a 1.5% improvement in immunisation rates from 2012/13.

15/16 – MMR 2nd Dose

In order to support the CCGs quality premium target in achieving 77.58%, MMR2 targets for practices in Hammersmith and Fulham were included as an element of the Network Plan 15/16, a local incentive scheme that all practices are contracted to deliver. Measures to increase MMR2 immunisation uptakes by Practices included starting recall 6 months before the quarter that children were due, telephoning and booking convenient appointments, scrutinising reports by health intelligence and calling-in parents (non-attendees) proactively via recall systems. In addition, sharing of best practice during network meetings and the distribution of look ahead reports by the CCG also supported practices to hit their targets.

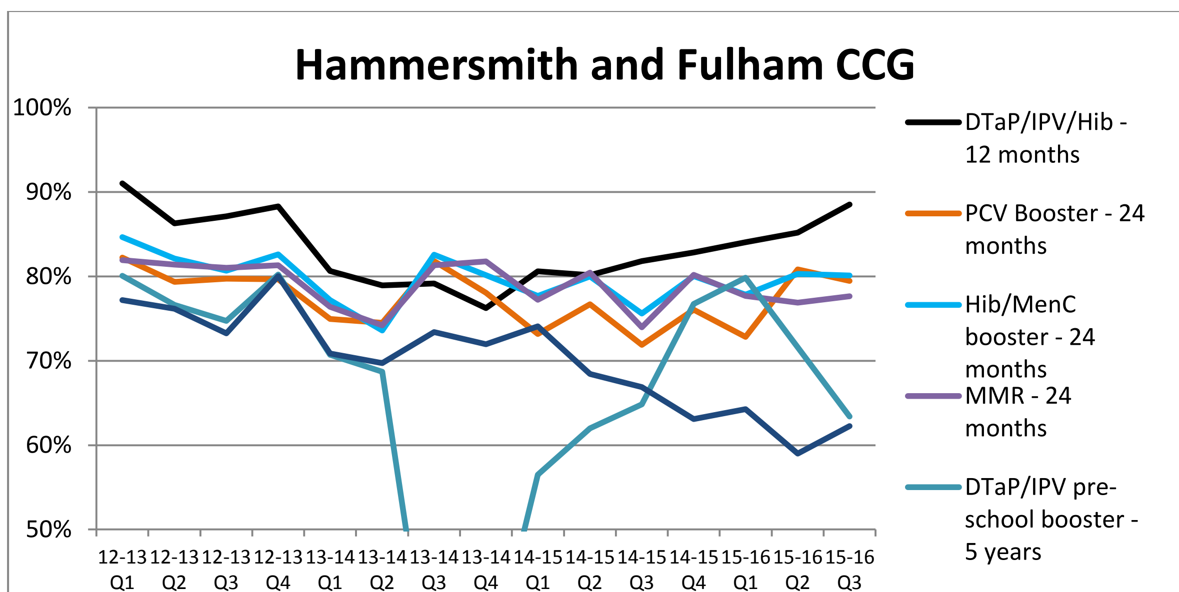
As a result of including MMR2 in the Network Plan, the CCG successfully met its target and achieved 78.1% in 2015/16.

Collaborative working to improve immunisation performance in Hammersmith and Fulham

The Hammersmith and Fulham systems immunisations group has been meeting throughout the 2015/16 flu season with the aim of improving the uptake of the flu immunisation in Hammersmith and Fulham. Membership of the group includes Local Authority Public Health, Hammersmith and Fulham CCG, Children's Services, NHS England and CNWL NHS Trust who are the commissioned provider for the school based programme. The remit of this group has now been extended to focus on improving childhood immunisations jointly.

2. Childhood Immunisation performance - 2012 – 2015/16

The chart shown below gives and overview of the performance of all primary immunisations in Hammersmith and Fulham in the past five years:



The tables below show the performance data for all primary immunisations for England, London and the three boroughs compared. London performs below average in all primary immunisations. Hammersmith and Fulham perform higher than the other two borough areas for all primary immunisations but is still below the London and England figures. The aim is for all primary immunisations to be delivered at 95% to ensure herd immunity.

DTaP/IPV/Hib - 12 months			**2012/13**	**2013/14**	**2014/15**	**2015/16 (provisional)**
England	DTaP/IPV/Hib	12Month	94.7%	94.3%	94.2%	93.5%
London	DTaP/IPV/Hib	12Month	91.1%	89.8%	90.6%	89.6%
Hammersmith and Fulham	DTaP/IPV/Hib	12Month	89.8%	81.2%	82.8%	79%
Kensington and Chelsea	DTaP/IPV/Hib	12Month	82.8%	80.7%	76.9%	70.9%
Westminster	DTaP/IPV/Hib	12Month	79%	79%	75.1%	71.3%

PCV Booster - 24 months			**2012/13**	**2013/14**	**2014/15**	**2015/16 (provisional)**
England	PCV Booster	24Month	92.5%	92.4%	92.2%	91.8%
London	PCV Booster	24Month	86.6%	86.3%	86.4%	85.7%
Hammersmith and Fulham	PCV Booster	24Month	82.2%	78.7%	76.8%	70.4%
Kensington and Chelsea	PCV Booster	24Month	76.9%	76.4%	71%	69.7%
Westminster	PCV Booster	24Month	75.1%	76.9%	72%	66.6%

Hib/MenC booster - 24 months			2012/13	2013/14	2014/15	2015/16 (provisional)
England	Hib/MenC Booster	24Month	92.7%	92.5%	92.1%	91.8%
London	Hib/MenC Booster	24Month	87.3%	86.8%	86.8%	85.8%
Hammersmith and Fulham	Hib/MenC Booster	24Month	84.6%	80.5%	80.5%	72.8%
Kensington and Chelsea	Hib/MenC Booster	24Month	78.8%	76.6%	74.7%	67.4%
Westminster	Hib/MenC Booster	24Month	77%	77.5%	72.1%	66.7%

MMR - 24 months			2012/13	2013/14	2014/15	2015/16 (provisional)
England	MMR	24Month	92.3%	92.7%	92.3%	91.6%
London	MMR	24Month	87.1%	87.5%	87.3%	85.8%
Hammersmith and Fulham	MMR	24Month	83.7%	82.7%	80.8%	73.4%
Kensington and Chelsea	MMR	24Month	81.3%	80.4%	75.1%	56.3%
Westminster	MMR	24Month	77.4%	79.5%	73.8%	52.2%

DTaP/IPV pre-school booster - 5 years			2012/13	2013/14	2014/15	2015/16 (provisional)
England	DTaP/IPV Booster	5Year	88.9%	88.8%	88.5%	87.4%
London	DTaP/IPV Booster	5Year	79.9%	79.3%	79.5%	78%
Hammersmith and Fulham	DTaP/IPV Booster	5Year	82.7%	(No data available)	78.6%	65%
Kensington and Chelsea	DTaP/IPV Booster	5Year	73.6%	63.9%	83.4%	56.3%
Westminster	DTaP/IPV Booster	5Year	76.6%	65.2%	77%	52.2%

MMR2 - 5 years			2012/13	2013/14	2014/15	2015/16 (provisional)
England	MMR 2nd Dose	5Year	87.7%	88.3%	88.6%	88.1%
London	MMR 2nd Dose	5Year	80.8%	80.7%	81.1%	79.7%

Hammersmith and Fulham	MMR 2nd Dose	5Year	81.4%	73.4%	70.8%	64.1%
Kensington and Chelsea	MMR 2nd Dose	5Year	72.9%	63.8%	66.6%	56.1%
Westminster	MMR 2nd Dose	5Year	75.4%	64.2%	64%	53.3%

Performance by GP Practice for Childhood Immunisations

Top 5

- Brook Green Medical Centre
- Lilyville Surgery
- Sterndale Surgery
- The Hammersmith Surgery
- Drs Uppal and Partners

Bottom 5

- Fulham Cross Medical Centre
- Lillie Road Surgery
- Palace Surgery
- Salisbury Surgery
- Shepherds Bush Medical Centre

Protocol for ensuring that "*Looked after Children*" receive immunisations

The immunisations protocol addressing all the immunisations and Flu vaccinations for looked after children is as follows:

1. The doctor or health professional who completes the health assessment for the looked after child (IHA or RHA) reviews the immunisation status of each child by checking the child's red book , Systmone and Imperial record.
2. The health professional completes a health care plan after each health assessment.
3. The health care plan is shared with the social worker, the foster carer, the GP, the health visitor and school nurse on consent.
4. If the immunisation status of the child is up to date, this will be entered in the health care plan.
5. If the immunisation status is not up to date, an entry is made in the health care plan identifying what immunisation(s) is (are) due.
6. The health professional writes to the GP to ask the GP to immunise accordingly regardless of where the child lives.
7. The immunisations status is checked at the next health assessment.
8. Social workers, foster carers and personal advisors are reminded to read the health care plan and follow up actions.

3. Development of Childhood and Flu immunisation improvement Project plans

Childhood and Flu immunisation project plans have been developed which have been informed by learnings from the 15/16 flu campaign. These plans can be found in *Appendices 2 and 3*, and have been divided into specific themes and owned by named individuals and organisations with clear time scales.

Childhood Immunisation improvement focus for 16/17

Given the number of immunisation areas and on analysis of GP Practice performance over the last 5 years, the Immunisations and Vaccinations Group, recommended that focus should be given to the following two immunisation areas:

- **MMR 1st Dose (2 years)**
- **Pre School Boosters (At 5 years)**

As a group we have decided to target these two immunisations as following the initial course of immunisations, these are the most likely to be missed by parents.

Flu Immunisation improvement focus for 16/17

NHS Evaluation of Flu update in 2015/16

NHS England has undertaken an evaluation of the 15/16 flu season identifying the cohorts of patients that have had the lowest uptake and have proposed recommendations on making improvements in these specific areas. These actions have been incorporated into the flu project plan appended at Appendix 2 with an assigned owner and clear timescale.

Focus on improving Child Flu Immunisation in 16/17

For 16/17, there is a London wide / National focus on improving child flu immunisation rates (2,3,4 year olds). The target for immunising these groups have been set between 40 - 60%, as the pilots have shown this is sufficient to reduce the spread of disease to the wider population.

By improving rates of uptake among children, pilot areas have seen a 94% drop in children presenting at GP practices with influenza like symptoms, 74% drop at A&E for respiratory illnesses, and a 93% drop in hospital admissions for confirmed influenza cases. GPs in the pilot area also saw a drop of 59% in adult consultations for influenza like illness symptoms.

For the 2016/17 flu season, the vaccination has been extended to include children in Year 3 (7/8 year olds) in addition to children in Year 1 and Year 2. NHS England has commissioned CNWL to provide flu vaccinations within the school setting. CNWL

have confirmed that contact has been made with both public and independent schools to set dates starting in October for sessions to deliver the flu vaccination. Some of these sessions have been booked already.

NHSE have developed a new monitoring tool for community providers to complete weekly to monitor child flu uptake. This will be used to ensure that providers are immunising against plan and targets. The commissioner will evaluate this on a weekly basis so that any issues in performance will be quickly identified. The provider will be required to offer assurance that any issues are quickly rectified.

Joint GP practice visits to address low GP Practice performers

Hammersmith and Fulham CCG and NHS England will be jointly visiting practices that are the lowest performers in childhood flu vaccinations (i.e. those achieving below 10% for two or more of the cohorts).

For Hammersmith and Fulham there are three practices to visit. Their names and the relevant uptakes for 2, 3 and 4 year olds are:

Borough	GP Practices	2 y/o Uptake <10%	3 y/o Uptake <15%	4 y/o Uptake <15%
NHS HAMMERSMITH AND FULHAM CCG	THE SURGERY, 13 WESTWAY, SHEPHERDS BUSH, LONDON, W12 0PT (DASGUPTA S)	11.4	3.7	3.2
	DR DANDAPAT & PARTNERS, PARKVIEW CENTRE FOR HEALTH & WELLBEING, CRANSTON COURT, 56 BLOEMFONTEIN ROAD	12.5	9.1	9.8
	322 LILLIE ROAD, FULHAM, LONDON, SW6 7PP (HUSSAIN Z)	9.1	0.0	0.0

At each visit, practices will be examined against an audit of best practice for improving uptake of influenza immunisations. A copy of this audit form is shown in Appendix 4. It will cover:

- Uptake from 2015/16
- Contracts
- Data extraction
- Call/recall systems
- Generating the eligible population list
- Failsafes in place e.g. following up DNA's
- Staffing levels
- Training

Each practice will be given an action plan to personalise and will be closely monitored during the season.

In addition, action plans are being sent to all practices achieving below 15% which highlights the best practice that they should be following. The practices achieving below 15% in two or more cohorts are shown below:

Borough	GP Practices	2 y/o Uptake <15%	3 y/o Uptake <15%	4 y/o Uptake <15%
NHS HAMMERSMITH AND FULHAM CCG	510 FULHAM PALACE ROAD, FULHAM, LONDON, SW6 6JD (MANGWANA B)	10	15.8	9
	336 UXBRIDGE ROAD, SHEPHERDS BUSH, LONDON, W12 7LS (BADAT AA)	0	13.3	13.3
	THE SURGERY, 178 DAWES ROAD, FULHAM, LONDON, SW6 7HS (MUTHIAH RN)	14.3	8.3	16.7
	HAMMERSMITH & FULHAM CENTRES FOR HEALTH,HAMMERSMITH HOSPITAL,DU CANE ROAD,HAMMERSMITH,LONDON,W12 0H	15.6	16.1	8.8
	THE PRACTICE CANBERRA, PARK VIEW CENTRE FOR HEALTH AND WELLBEING, CRANSTON COURT,56 BLOEMFONTEIN ROA	14.8	22.7	9.1

In addition, all practices in the borough will be sent a checklist to maintain and adhere to throughout the season which reminds the practices of the following:

1) Has the practice registered with Immform?
2) Who is the Influenza lead for the practice?
3) Has a register been developed to identify all 2, 3 and 4 year olds (on the 31st August 2016) in your practice?
4) Has the practice ordered enough nasal spray vaccine to achieve the 40% ambition uptake rate?
5) Are all practice staff aware of the agreed proactive reminders method for inviting their 2, 3 and 4 year olds for the seasonal Influenza vaccination (letter, email, text, phone call).
6) Are there publicity materials displayed within the practice for the Child Influenza Programme?

By implementing the above steps in all practices, which are mapped against the research around best practice of the highest performing practices, uptake should be higher in all surgeries across the borough in 2016/17.

Service Level Agreement (SLA) – Imperial and Chelwest Hospital Trusts

NHS England has been working closely with Chelsea and Westminster Trust and Imperial Trust to agree the SLA on their maternity units delivering flu vaccinations for pregnant women. Chelsea and Westminster have been issued with a letter of intent by NHSE who are currently awaiting the return of the signed copy. Imperial initially refused to sign this due to a change in staffing within their maternity unit; however, the CCG have escalated this through the clinical quality group (CQG) and negotiations are continuing with them with the aim to have it agreed before September.

Multi Agency Project Plan for improving flu immunisations

In addition to the immunisation project plan, a flu project plan has also been developed to ensure that uptake rates improve and the 75% target is achieved for patients over 65 and patients under 65 at risk. A named lead has been assigned to each of the actions within the plan with a clear timescale to monitor progress.

Both project plans for the flu and childhood immunisations incorporate the main themes addressed at the PAC and Hammersmith and Fulham Immunisation meetings. The actions within the plans are collaborative and capture actions at a multi-agency level.

NOTE: A copy of both action plans can be found in Appendix 2 and 3

Appendix 1

Glossary of abbreviations used in this report

CHIS – Child Health Informatics Service

CNWL – Central and North West London Foundation Trust

CQG – Clinical Quality Group

DTaP – A vaccine that protects against Diphtheria, Tetanus and Pertussis

Hib – Haemophilus influenzae type b bacteria

IPV – A vaccine that protects against polio

KPIs – Key performance indicators

MenC – Meningococcal C conjugate

MMR – Measles, Mumps and Rubella

PCV – Pneumococcal conjugate

SLA – Service Level Agreement

SOP – Standard Operating Procedure

COVER – The Cover of Vaccination Evaluated Rapidly Programme

LBHF Systems Leadership Project Plan for Flu

Appendix 2

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
1	**Engaging with School Networks in Hammersmith and Fulham to raise awareness of current immunisation status**		**Milestone 1: Improve the uptake of Flu for School Children (Years 1,2 and 3) to try and achieve a minimum of 40% uptake**												
1.1	Start school engagement before the end of the summer term	Jonathan Freedman (CNWL)	All primary schools in H&F have been emailed regarding nasal flu sessions starting in October. Some schools have already committed to a date for the session to take place.		31-Jul										
1.2	Write to each school headteacher and Chairman of the Governors emphasising the importance of engagement with the programme	Ike Anya (Public Health)	Letter has been written and sent out to headteachers and chairs from local public health team in H&F. In addition, this coincides with the national public health letter that also went out at a similar time.	30-Jun											
1.3	Ask for one designated and accountable person per school who will oversee arrangements for the flu immunisation clinic.	Jonathan Freedman (CNWL)	This has been included in the flu engagement letter that has been sent to schools.	30-Jun											
1.4	Explore ways of engaging independent schools	Jonathan Freedman (CNWL)	CNWL have made contact with the independent schools in the borough to set up flu clinics from October onwards	30-Jun											
1.5	Work further with school nurses to ensure they are promoting the flu vaccine. School nursing is currently being reprocured and the service specification requires that the service works to increase vaccination coverage	(PH)/ Sarah Bright (PH AND Childrens Services)	The commissioner for school nursing has confirmed that promotion of ALL immunisations (childhood imms & flu vac) is part of the 'core service' which is delivered by school nurses. The new school health service specification requires the provider to: • Work with NHS England and immunisation providers to achieve 90% coverage for vaccination programmes in all schools. • Work with NHS England and immunisation providers to implement recovery plans in schools where this is not achieved. • Promote uptake of immunisations with the immunisation team in secondary schools. • Review immunisation status and signpost as necessary. • Identify and reduce barriers to 90% coverage for all childhood immunisations in order to prevent serious communicable disease, particularly targeted at vulnerable groups. The commissioner has suggested (if this has not already happened) that CNWL immunisation service liaise and provide the school nursing service with oversight of the up and coming flu vaccination plan, to ensure a co-ordinated approach is taken and enable school nurses to promote the flu vaccinations in a timely manner.			31-Aug									
1.6	NHSE to request that CNWL provides specific plans and timelines for performing immunisations in schools	Lucy Rumbellow (NHSE)	The new school health service specification requires the provider to: · 1)Promote uptake of immunisations with the immunisation team in secondary schools, · 2)Review immunisation status and signpost as necessary. · 3) Identify and reduce barriers to 90% coverage for all childhood immunisations in order to prevent serious communicable disease, particularly targeted at vulnerable groups. The commissioner has suggested (if this has not already happened) that CNWL immunisation service liaise and provide the school nursing service with oversight of the up and coming flu vaccination plan, to ensure a co-ordinated approach is taken and enable school nurses to promote the flu vaccinations in a timely manner.	30-Jun											
1.7	Attend Integrated Head Teachers meeting in Hammersmith and Fulham once date has been set	LA/NHSE		ASAP											
1.8	Work to identify schools with nurseries attached and work with CNWL to see whether SLA could be extended to cover 2,3,4 year olds	Lucy Rumbellow (NHSE)			31-Jul										

LBHF Systems Leadership Project Plan for Flu

Appendix 2

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
1.9	Ensure that each nursery receives enough information leaflets for each child to take home	Ike and Sarah Bright					30-Sep								
1.9.1	Include the flu immunisation in the information given by the health visitor during the 2 year review.	Ike Anya (Public Health)													31-May
2	**Practice Engagement**	**CCG / NHS England**	**Milestone 1: Increase uptake for over 65s by 5% Milestone 2: Increase Flu uptake of under 65 at risk by 5% Milestone 3: Increase Flu uptake of 2,3,4 year olds by 5%**												
2.1	Send an update to practices with performance at a practice level every 2 weeks. This should include numbers of immunisations needed to reach 75% target.	Sophie Ruiz /Hannah Hanfy (CCG)	This is to commence during the flu season Oct-Jan					Throughout the flu season							
2.2	Further promotion of the housebound flu immunisation SLA to general practices,which will again be offered next season.	Lucy Rumbellow (NHSE) AND Sophie Ruiz (CCG)	This is to commence during the flu season Oct-Jan					Throughout the flu season							
2.4	Continue to send regular bulletins to surgeries with updates and best practice information	Lucy Rumbellow (NHSE) AND Sophie Ruiz (CCG)	This is to commence during the flu season Oct-Jan via CCG				Throughout the flu season								
2.5	Immunisation Log to be developed in SystmOne for practices to identify why patients are declining the flu vaccination	Sophie Ruiz /Hannah Hanfy (CCG)	investigating to see if a surverymonkey questionnaire can be added to the declined read code to understand reasons why patients have declined.			31-Aug									
2.5	Advertise flu sessions at hubs early in 16/17 flu season and develop mechanism to allow patients to walk in	CCG/ Weekend Plus Providers						31-Oct							
2.6	Visits to practices with uptake below 10% in two or more of the cohorts (2,3,4 y/o's)	Lucy Rumbellow (NHSE)	This will be arranged by Hannah Hanfy (CCG) over the next month - 3 practices have been identified so far				30-Sep								

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
3	**Other stakeholder engagement**		**Milestone 1: Increase uptake for over 65s by 5% Milestone 2: Increase Flu uptake of under 65 at risk by 5%**												

	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
3.1	Work further with adult social care and voluntary organisations to raise the profile of the flu immunisation.	Ike Anya					30-Sep								
3.2	Identify events where pharmacies could attend to administer flu vaccines, and create a list of local pharmacies who would be willing to attend.	All: CCG, LA, NHSE					30-Sep								
3.4	Immunisations, including flu, to be placed as a standing item for H&F CCG and NHSE co-commissioning meetings.	Sophie	This will commence in September in preparation of the start of the flu season				Mid-Sep								
3.5	Include the flu immunisation in the information given by the health visitor during the 2 year review.	Ike	Annabel Burkimsher is ensuring this happens and will update once this is in the 2 year review guidelines												31-May
3.6	Strengthen local authority arrangements for delivering the vaccine to frontline social care workers.	Public Health	A meeting to be arranged in August with occupational health to secure arrangements for the forthcoming flu campaign			31-Aug									
3.7	PAC asked to consider making representation to the Department of Health on behalf of residents to consider changing its policy and allow pharmacies to administer the flu immunisation to children.	PAC		30-Jun											
4	**Secondary Care Engagement**		**Milestone 1: Increase Flu uptake in pregnant women by 5%**												
4.1	Work further with hospitals to ensure that they promote the flu vaccine to eligible patients.	Sophie Ruiz/Janet Cree / Ike Anya and Amy Wilson (CCG and Public Health)	to receive outcomes of discussions around this at next CQG 25/08/16				30-Sep								
4.2	Work with the maternity providers to ensure that obstacles are overcome, and they sign up to the NHSE SLA to provide flu immunisations.	Janet Cree(CCG)	ChelWest to sign the SLA for maternity patients. This was taken to Imperial's CQG and remains under negotiation. A teleconference will take place to discuss further with NHSE and Imperial to agree whether the SLA is workable.		31-Jul										
4.3	Ask local NHS providers to submit a short report on their staff immunisation plan, including their plans to promote the flu immunisation to patients, to the local Clinical Quality Group.	Janet Cree(CCG)	This request was taken to the CQG on 28/07/16 and will be submitted to the CCG by 25/08/16			31-Aug									

LBHF Systems Leadership Project Plan for Flu

Appendix 2

Item	Project / Tasks	Description of schemes	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
5	**Engaging with hard to reach groups**		**Milestone 1: To improve uptake rates of patients who are normally considered hard to reach**												
5.1	Explore the possibility of developing flu champions in local communities	Sophie Ruiz to engage with Community Champions(CCG)				31-Aug									
5.2	Engage mosques and local groups early in the flu season	Ike Anya/ Vanessa Andreae(Public Health and CCG)	Currently exploring if Thrive Tribe (a PH provider service) can provide some assistance with mosque engagement. One of their health advisors is a Muslim man who undertakes all their work with mosques (working on smoking and shisha) and has strong links with local community groups. PH are asking if thrive tribe can make an approach about the flu vaccination when they do their own work in mosques or to assist us in an introduction so that we can engage directly.			31-Aug									
5.3	Identify local health professionals of the Muslim faith who would be willing to act as 'flu champions' and undertake peer engagement.	Sophie Ruiz /Hannah Hanfy(CCG)	A local health professional identify that is of the Muslim faith. Sophie and Hannah will be engaging with him directly to see what can be done to promote flu vaccinations. - 23/06/16		31-Jul										
5.4	Use existing networks, such as schools, to promote the vaccine among local faith communities	Ike Anya and Sarah Bright(Public Health and Childrens services)	PH are approaching the Community Champions Service (a PH provider service). They have been told that the service comprises of quite a few female Muslim champions who have strong relationships with their communities and neighbourhoods. The Champions deliver health projects in different areas of the borough and target the most deprived wards. The plan is to work with the Champions to ensure the vaccine is promoted locally amongst faith communities. PH are also approaching the local BME forum to explore how the forum can assist us in promoting the vaccine to voluntary sector groups and specifically to faith groups. We are also approaching the local BME forum to explore how the forum can assist us in promoting the vaccine to voluntary sector groups and specifically to faith groups.			Ongoing									

Item	Project / Tasks	Description of schemes	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
6	**Flu Promotion**		**Milestone 4: To better promote the flu vaccination in advance of the flu season and throughout the flu season**												
6.1	Develop bespoke flyers for distribution at Open Age & Age UK by direct mail to the membership	Central Comms CCG					30-Sep								
6.2	Place A1 and A2 posters on local authority owned billboards across H&F and Kensington	Central Comms CCG					30-Sep								
6.3	Produce roller banners and free standing display boards for pharmacies and GP Surgeries	Central Comms CCG					30-Sep								
6.4	Promote flu vaccinations on twitter and social media	Bethany Goulding - CCG					30-Sep								
6.5	Distribute children's flu leaflets, posters, and 28 page healthcare booklets to GP surgeries, children's centres, health visitors, district nurses, and libraries around CWHHE	Bethany Goulding - CCG					30-Sep								
6.6	Community engagement to be undertaken in various venues within the borough, for example at an Age UK forum, housing association venues, and community champions' events.	LA/PH					30-Sep								

6.7	Voluntary organisations to be contacted and asked to promote immunisations to their members on social media, websites and in newsletters	Bethany Goulding - CCG					30-Sep								
6.8	Flu immunisations promoted on the backs of 258,000 Argos till receipts at Fulham , Shepherds Bush and Hammersmith branches	Central Comms CCG						Throughout the flu season							
6.9	Text messaging flu reminders delivered to target cohort by selected flu practices across H&F	CCG working with practices	on screens at practices reminding of flu					Throughout the flu season							
6.9.1	Flu included in stay well healthcare directory mailed to every residential household in the borough	Central Comms CCG						Throughout the flu season							
6.9.2	Flu promoted as part of community outreach projects in the borough	Bethany Goulding - CCG					30-Sep								

LBHF Systems Leadership Project Plan for Immunisations

Appendix 3

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
1	**Engaging with School Networks in Hammersmith and Fulham to raise awareness of current immunisation status**		**Milestone 1: Primary School admissions process to include pre-school boosters as a pre-requisite for entry**												
1.2	Liaise with education colleagues to see whether the admissions process could include one form where parents must confirm the immunisation status of their child	Sarah Bright/ Laibun Nessa-O' Sullivan (Childrens Services)	This action is still ongoing . Sarah Bright to provide an update on this.		31-Jul										

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
2	**Practice Engagement**		**Milestone 2: Improvement in MMR Year 1 and Pre-School Boosters**												
2.1	Circulation of current immunisation rates to practices and to confirm what herd immunity is	Lucy Rumbellow (NHSE) AND Sophie Ruiz (CCG)			15-Jul										
2.2	Send an update to practices with performance at a practice level every month. This should include numbers of immunisations needed to reach 95% target.(Herd immunity)	Sophie Ruiz /Hannah Hanfy (CCG)		Throughout the year											
2.3	Continue to send regular bulletins to surgeries with updates and best practice information	Lucy Rumbellow (NHSE) AND Sophie Ruiz (CCG)	all comms to practices via CCG	Throughout the year											
2.4	Immunisation Log to be developed in SystmOne for practices to update to identify why parents are not having their children immunised	Sophie Ruiz /Hannah Hanfy (CCG)	Working closely with the informatics team to set this up on SystmOne		31-Jul										
2.5	Scrutinise immunisation specific arrangements for local practices with the lowest imms uptake	Lucy Rumbellow (NHSE) AND Sophie Ruiz (CCG)	This will need to be carried forward beyond August. Practices have been identified and Lucy is working with Laura Su from public health to target and visit these at the moment. Laura is working on a SOP for childhood imms and flu for all practices to use.			31-Aug									

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
3	**Other Stakeholder Engagement**		**Milestone 2: Improvement in MMR Year 1 and Pre-School Boosters**												
3.1	Immunisations, including flu, to be placed as a standing item for H&F CCG and NHSE co-commissioning meetings.	Sophie Ruiz /Hannah Hanfy (CCG)					30-Sep								

LBHF Systems Leadership Project Plan for Immunisations

Appendix 3

3.2	Work with Health Visitors to ensure that they provide information on MMR1 through their interactions with parents.	Ike Anya (Public Health)	The Commissioner for Health Visiting has reported following a meeting with the Heads of Health Visiting that promotion of ALL childhood immunisations and MMR1 is undertaken routinely by health visitors. The following actions are undertaken: • All imms are discussed at the new birth visit. • A leaflet on imms is given to each parents. • Information on imms is detailed in the new e-red book. • All imms are promoted and messages are reinforced at the 1 yr visit. A review is undertaken, which includes a check list that covers imms. • A letter is sent to parents regarding the BCG • All early years nurseries ask new registrations if they are immunisation. • All early years staff are required to be immunised. PH have requested that copies of the information given out by the Health Visitors is sent to them so that they can have oversight of all promotional activities.		31-Jul			31st Oct			31st Jan				
3.3	Immunisation schedule to be shared with all children centre staff	Sarah Bright (Children's Services)			31-Jul										

Item	Project / Tasks	Description of schemes	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
4	**Engaging with hard to reach groups**		**Milestone 3: To improve uptake rates of patients who are normally considered hard to reach**												
4.1	Working with 'hard to reach' communities that refuse these vaccinations.	Vanessa Andreae (CCG)	Attending Somali TV base in Park Royal in order to raise MMR awareness			to see an improvement by 31 Oct 16									
4.2	Identify local health professionals of the Muslim faith who would be willing to act as 'champions' and undertake peer engagement.	Sophie Ruiz /Hannah Hanfy (CCG)	A local health professional identified that is of the Muslim faith. Sophie and Hannah will be engaging with him directly to see what can be done to promote MMR immunisations.		31-Jul										
4.3	Use existing networks, such as schools, to promote the vaccine among local faith communities	Ike Anya (Public Health) and Sarah Bright(Children's Services)	PH are approaching the Community Champions Service (a PH provider service). They have been told that the service comprises of quite a few female Muslim champions who have strong relationships with their communities and neighbourhoods. The Champions deliver health projects in different areas of the borough and target the most deprived wards. The plan is to work with the Champions to ensure the vaccine is promoted locally amongst faith communities. PH are also approaching the local BME forum to explore how the forum can assist us in promoting the vaccine to voluntary sector groups and specifically to faith groups.		Ongoing										

Item	Project / Tasks	Action/Owner	Key outcome/s of project	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
6	**Childhood Immunisation Promotion**		**Milestone 4: To better promote the childhood immunisations**												
6.3	Produced roller banners and free standing display boards for GP Surgeries	Central Comms CCG / NHSE					30-Sep								
6.4	Promote childhood immunisations on twitter and social media	Central Comms CCG / NHSE					30-Sep								
6.5	Distribute 28 page healthcare booklets to GP surgeries, children's centres, health visitors, district nurses, and libraries around CWHHE	Central Comms CCG / NHSE					30-Sep								
6.6	Community engagement to be undertaken in various venues within the borough, for example at community champions' events.	Central Comms CCG / NHSE					30-Sep								
6.7	Voluntary organisations to be contacted and asked to promote immunisations to their members on social media, websites and in newsletters	Central Comms CCG / NHSE					30-Sep								

NHS England

Appendix 4 - London Child Flu GP practice visit audit form

Date of form completion:	Click to enter date	**CCG:**	Click to choose your CCG
Practice 'E' code:	e.g. E12345	**Practice name:**	Click here to enter text
Practice Manager name:	Click here to enter text	**Phone number:**	Click here to enter text
Practice Manager email address:	Click here to enter text**@nhs.net**		

	GP payment Systems		
Q1	**Uptake 2015/16 for 2, 3 and 4 year olds**		*Comments / discussion*
a	Why do you think you were unable to achieve the recommended 40% uptake of child flu vaccine for 2, 3 and 4 year olds last year?		
Q2	**Contract**		
a	Has your practice signed up to the 2016/17 national DES?	☐	
b	Will your practice be delivering influenza vaccinations to your 2, 3 and 4 year olds this coming influenza season?	☐	
Q2	**Data extraction**		
a	Did the Immform data extraction tool automatically upload your practice influenza uptake data last season?	☐	
b	If no, did you enter the data manually onto Immform?		
c	Do you know how to contact Immform for support?		
d	Which IT system does the practice use?		
	GP performance		
Q3	**For Influenza vaccinations does your practice: *(select all that apply)***		
a	Have a call and recall process for 2, 3 and 4 year olds?	☐	
b	Follow up DNAs	☐	
c	Calculate cohorts for vaccinating using the latest demographic data from HSCIC (i.e. use a "look ahead" report)?	☐	
e	Have allocated immunisation clinic times?	☐	
f	Have ad-hoc immunisation appointments?	☐	
g	Have extra clinics at the weekend (Saturday pm and/or Sunday)?	☐	
h	Have extra clinics in the evening?	☐	
i	Have an up to date cold chain policy and when was it last reviewed	☐	
Q4	**How many influenza immunisation staff:**		
a	Work at your practice (WTE)?	Number	
b	Do you feel this is adequate for all the vaccines that the practice has to deliver over the winter season?		
c	Have received immunisation training in the past year?	Number	
Q5	**Are these immunisation staff *(select all that apply)*:**		
a	Fully trained and updated on the local cold chain policy?	☐	
b	Using an up to date, complete PGD and know where to access updates	☐	
Q6	**Action plan**		
a	We will require your practice to complete an action plan and submit to us within two weeks of this visit. We will provide you with a template		
	Thank you for your cooperation		

NHS England use only	Actions:	Click here to enter text
	Additional comments:	Click here to enter text

Appendix 1

London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE 12 SEPTEMBER 2016	h&f hammersmith & fulham
WORK PROGRAMME 2016-17	
Report of the Chair	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Kim Dero, Director of Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2016/17.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:
Appendix 1 – Work Programme 2016-17

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
20th October 2016		
Chelsea and Westminster Hospital NHS Foundation Trust: Integration with West Middlesex Hospital	ChelWest and West Middx NHS Trust	
Listening To and Supporting Carers	TBC	
JOHSC Update	Governance and Scrutiny	
2 November 2016		
Digital Inclusion Strategy	Policy / Housing	
End of Life Care: JSNA and CLCH to Update on Action Plan		
12 December 2016		
West London Mental Health Trust: Update	WLMHT	
Community Independence Service		

Items for future agenda planning:

- Meal Agenda
- Impact of devolution on Local Health Services
- Commissioning Strategy: Providers
- Community Champions
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- H&F Foodbank
- Immunisation: Report from the HWB Task and Finish Group
- Integration of Healthcare, Social Care and Public Health
- Listening To and Supporting Carers
- Public Health Report
- Self-directed Support: Progress Update
- Antibiotic prescriptions