Appendix 2

CCG Narrative Template to Support Operational Planning, 2015/16

Version 1.2

Context

Supplementary information for commissioner planning, 2015/16 asks that a full narrative detail of commissioners' operating plans must be available locally to be shared with partners and stakeholders including NHS England.

The key elements of CCG operating plans to be covered in a full narrative are set out in the following template. **The template asks that you outline any recovery or action plans where performance is not in line with trajectory. When detailing these, please provide specific actions, measureable ambitions and timeframes for delivery.**

The template should be completed and submitted **in draft by Tuesday 7th April.** The narrative will be reviewed alongside CCG activity data, financial planning data and UNIFY submissions.

CCG:	**Hammersmith & Fulham CCG**
Date:	**14th May-15**
CO signature:	**Clare Parker**

1. Delivery across the five domains and seven outcome measures

	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
Securing additional years of life for your local population	E.A.1 (annual) - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	The CCG has delivered reductions in 2012 and 2013 above the mandated 3.2% reduction, and therefore appears to be on trajectory to deliver the 2014 ambition.	The key to achieving this aim is partnership working to make the most of the services that have already been commissioned locally. In 2012/13, the direct causes of the bulk of the inequalities in life expectancy were circulatory disease, cancer and respiratory disease. The tri-borough CCGs' Public Health Project Manager has been working with relevant area leads within the CCG, local authority colleagues and NHS England and has carried out a mapping exercise that focuses on interventions currently commissioned to support the reduction of PYLL for the top three causes of mortality as per the Joint Strategic Needs Assessment document

			A benchmarking report / performance dashboard has been completed that identifies practices that are outliers in performance across a number of Public Health areas (including immunisations, seasonal flu and screening) and we use this to make targeted improvements. Plans are being developed for the revised extended access service for GP practices to include the requirement to provide flu, pneumococcal immunisations and childhood immunisations. **Respiratory disease** The current community respiratory service provides faster access for patients with respiratory illness to specialist care within a community or home environment, a reduction in avoidable emergency admission/outpatient referrals and improved integrated care management between secondary and primary care and community specialist professionals. It helps enable: • Minimised disease progression via improved early identification - so that people recognise the symptoms of lung disease and seek assessment and advice

			from healthcare professionals. • Good quality early diagnosis – so that people get an accurate, quality assured, diagnosis and that there is clear differentiation of COPD from asthma and other diseases. When diagnosed, people get good quality information on the illness and on the services available, both at diagnosis and throughout the course of their care. • High-quality care and support following diagnosis – by developing an organised and proactive multidisciplinary approach to the management of respiratory illness, including both chronic and acute care. Where admitted to hospital, specialist respiratory assessment on the referral will ensure that people with COPD are dealt with in a pathway that most meets their clinical needs. • Improved access to end of life care services. • Equity in care provision for people with severe COPD, regardless of setting. • Reduction in inappropriate conveyances to hospital.

			Cardiovascular disease A business case is under development for a new integrated cardio-respiratory service which supports further prevention around cardiovascular disease. There are also NHS health checks available to adults in England aged 40-74 without a pre-existing condition to check circulatory and vascular health and assess a patient's risk of getting a disabling vascular disease. **Cancer** • There is collaborative work under way improving cervical screening uptake across the three inner North West London CCGs in conjunction with NHS England and LA colleagues via quarterly joint CCG public health meetings. • Snapshot performance data is provided to relevant forums (practice nurses and practice managers). • A cancer clinical lead has been identified to offer professional input/guidance for H&F CCG. • Reviews are currently underway to look at latest practice profiles around cancer screening, diagnosis rates, referrals and

			referral to diagnosis conversion rates as part of PYLL project. • The “Transforming cancer services for London” team will be invited to attend future joint public health meetings to provide local intelligence and identify top cancer mortality areas. In addition to the above, childhood immunisations and flu immunisations help to improve PYLL by protecting spread of disease within the population, particularly to high risk groups. **Childhood immunisation** • Following on from the MMR1 local priority project in 2013-14, we are now continuing to work on improving children’s immunisations uptake across all vaccination areas for children aged 0 to 5 years. • There are regular updates to localities and practices plus snapshot performance pages are planned on each CCG extranet . • We are working with Imperial college and the Local Authority on providing additional support to member practices with low immunisations uptake.

			• We have developed a GP balanced scorecard that will be available to all member practices on the CCG's extranet with benchmarking uptake data across all immunisations, including RAG rating. • We have developed 'Good practice guidance' on immunisations due to be revised to reflect current and new programmes which will then be shared with member practices. • There is a Particular focus on improving uptake for MMR1 and MMR 2. This will now include Public Health Consultants from local authorities. **Seasonal Flu** • Seasonal flu planning starts in April-15. • The public health project manager provides weekly trend analysis of seasonal flu immunisation to the CCG using 'inform' from December (week 36) to end of January, with special focus on children's flu uptake during the campaigning period from October to end of March.

Improving the health related quality of life for people with long-term conditions, including mental health conditions	E.A.2 (annual) - Health related quality of life for people with long-term conditions	In 2013, the CCG delivered an improvement of 2.92%. We aimed for a further 0.2% improvement in 2014 against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan	Our Better Care Fund plan includes some specific policy developments to enhance patient and service user experience. A core focus is on providing joined up support for individuals with long-term conditions and complex health needs, including schemes to enable improved self-management and to extend current arrangements for personal health budgets. There has been broad engagement (including patients with long-term conditions and voluntary groups that represent them) to inform development of approaches to self-management. In addition, the ability to access personal health budgets (PHBs) is already starting to help those with continuing healthcare and mental health needs to make informed decisions around their care. Through the BCF, it is expected that PHB access will begin to be extended to those with long-term conditions. We have led development of a diabetes strategy across CWHHE with a focus on educational elements for patients, access to their own care plan and online

			communities. This is evidenced to improve outcomes and experience for diabetic patients. Please also refer to Community Independence Service and Whole Systems Integrated Care (WSIC) in section E.A.4.
Reducing the amount of time people spend avoidably in hospital	E.A.4 (quarterly) - Quality Premium Composite measure on emergency admissions	In 2013, the CCG delivered an improvement of 2.82%. In 2014 we aimed for a further reduction in avoidable admissions of 2.58% against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan	Significant redesign programmes are underway within Hammersmith & Fulham CCG to improve health related quality of life, reduce emergency admission and support older people to live independently at home following discharge. These are the Community Independence Service Plus and Whole Systems Integrated Care, which are outlined below. **Community Independence Service Plus** The Tri-borough CCGs and local authorities are commissioning a single, integrated Community Independence Service (CIS) in 2015/16. This builds upon the H&F "virtual ward" scheme which officially launched in 14/15. The Community Independence Service will provide a range of functions, including rapid response services to prevent people going into hospital, in reach services to support people with early

			discharge from hospital, and rehabilitation and reablement, which enable people to regain their independence and remain in their own homes. The single integrated CIS specification that has been developed for 2015/16 will ensure that there are consistent standards and services available across the Tri-borough. The specification proposes an integrated, multidisciplinary model of care that includes: • A Single Point of Referral into the service. • A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days. • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds for between 6 and 12 weeks. • 7 day support to help people

			leave hospital. This improved, integrated and standardised service aims to address an anticipated increase in demand for intermediate care services. It will also meet demand for care and support services in the community, especially home care and, for people with acute and complex needs to be safely cared for where appropriate. The integrated CIS will improve the person's and practitioner's experience of community- based care and drive improved quality and savings by treating people outside of the acute hospital setting. **Whole Systems Integrated Care (WSIC)** Hammersmith and Fulham CCG is building on its Whole Systems model of care in 2015/16. Our aim is to transform patient care by further developing our Community Independence Service (CIS), enhancing primary care and developing new approaches to prevention and self-care for a more comprehensive and proactive approach to keeping people healthy at

			home. Key elements of our 2015/16 programme of work include: • Building on existing programmes of work, such as the implementation of Patient Knows Best (an IT solution to share care information across primary and secondary care). • Working with the Lead Health and Lead Social Care Providers to implement the Tri-borough CIS. • Rolling out 19 new Out of Hospital contracts to enhance primary care locally. • Developing a second and third health and well-being hub in the centre and south of the borough. • Putting on a series of 'Simulation Event' workshops to identify and implement improvements to our care model (e.g. care planning, MDT working, case management and self-care) together with local patients and clinicians. This programme of work is designed to contribute to the successful first stage implementation of capitated budgets in

<table>
<tr><td></td><td></td><td></td><td>the borough by April 2017.</td></tr>
<tr><td>Increasing the proportion of older people living independently at home following discharge from hospital</td><td>E.A.S.3 (annual) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td><td>Note: as CCGs are not required to submit data against this measure, please include details of the ambition set in your Better Care Fund plan and any improvements against baseline.

<table><tr><td></td><td>Baseline (2013/14)</td><td>Planned 14/15</td><td>Planned 15/16</td></tr><tr><td>Annual %</td><td>92.9</td><td>89.2</td><td>89.8</td></tr><tr><td>Numerator</td><td>260</td><td>252</td><td>253</td></tr><tr><td>Denominator</td><td>280</td><td>282</td><td>282</td></tr><tr><td>Annual change in proportion</td><td></td><td>-3.7%</td><td>0.5%</td></tr><tr><td>Annual change in %</td><td></td><td>-3.9%</td><td>0.6%</td></tr></table>
Note: the 13/14 baseline data used is considered to be inaccurate (too high) owing to the changes in the law around data sharing between agencies</td><td>A key component of the BCF plan is the additional investment in health and social care through the CIS (see section E.A. 4) to enhance rehabilitation and reablement services. This should result in a reduction in residential and nursing home admissions as well as hospital re-admissions. Services will be integrated across health and social care, operating 8am to 8pm, 7 days a week, providing time-bound support for referrals via a single point of referral.

Other enabling schemes – such as commissioning and procurement of a new homecare service, and enhancements to social work components of hospital discharge – will support the CIS and help to maintain older people’s independence at home.

In summary, the BCF plan aims to support joint working to reduce long-term dependency across the health and social care systems, promoting independence and driving improvement in overall health and wellbeing.</td></tr>
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Increasing the number of people having a positive experience of hospital care	E.A.5 (annual) – Proportion of people having a positive experience of hospital care	In 2013, CCG reported an improvement of 5.24%. We aimed in 2014 for an improvement of 1.03% against the 2012 baseline. This needs refreshing now that the 2013 baseline is available.	The CCG is committed to working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population. More specifically, the CCGs are committed to ensuring both the continuous improvement in patient experience and the overall quality of care that is provided locally. The CWHHE Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders. It has identified key priority areas that the CCG has committed to resourcing and these are reflected in the core quality schedule for 14/15. These include: • Ensuring that providers produce quarterly patient experience reports which: ○ Incorporate qualitative as well as quantitative data ○ Compare feedback from weekday and weekend services ○ Capture feedback that reflects the diversity of their patient and carer population ○ Include actions and evidence

			of improvements to address gaps in satisfaction and experience • Promoting patient and lay voice at a strategic level and in collaboration with CWHHE and North West London CCGs by ensuring that the following committees have lay partner representation: ○ Clinical Quality Groups ○ CCGs Quality, Patient Safety and Risk Committees ○ NWL Quality Working Group ○ CWHHE Quality, Patient Safety and Risk Committee which is also chaired by a Lay Member
Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community	E.A.7 (annual) – Proportion of people having a positive experience of care outside hospital, in general practice and the community	In 2013, CCG delivered an improvement performance of 4.71%. We aimed in 2014 for an improvement of 13.4% against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan.	As part of the Prime Ministers Challenge Fund initiative, the CCG is supporting the GP Federation to further develop existing Patient Participation Groups. They will all be subscribing to the National Association of Patient Participation (NAPP) and workshops will be held with NAPP in the 2nd Quarter of 2015/16 to provide practices with the training and the techniques that they need to get the most of their Patient Participation Groups. The Federation is

			also working to ensure that there are mechanisms to capture real time patient feedback to influence service change and improve patient satisfaction with services. The CCG will be commissioning a suite of 19 Out of Hospital Services that patients across the borough are able to access. Patient engagement and feedback on the delivery of these out of hospital services will be a key and will form part of the regular reviews that the CCG will be having with the GP Federation. The CCG is also working in collaboration with health and social care organisations through the Whole Systems Integration and Transforming Primary Care Programmes to embed patient and carer experience at every stage of development and implementation of the Out of Hospital Strategy. This will include: • Ensuring that patients are actively involved in shared decision making and supported by clear information that it is appropriate to their needs. • Improving staff learning and experience (see workforce section).

			• Undertaking a Community Independence Service insight project in order to capture patients', service users' and carers' insight to enable us to have a baseline on which we can evaluate impact in the future.
Making significant progress towards eliminating avoidable deaths in our hospitals	E.A.8 (annual)	*Note: Indicator in development, this should be available for measuring a national ambition in Autumn 2015 and local ambitions in 2016/17.For the purpose of your 2015/16 operating plan, please outline any local measures currently in use and any improvements against baseline.*	The CCG's have been monitoring the Summary Hospital-level Mortality Indicator (SHMI), all providers are either 'as expected' or 'below expected' for the SHMI scores at present and throughout the year. One Trust has displayed a significant downward trend across a two year period. We are seeking further clarity as to the change that led to this positive trend. We await the full guidance later this year.

2. Improving Health: Your planned outcomes from taking the five steps recommended in the "commissioning for prevention" report

	Commentary
What analysis have you undertaken of key health problems?	As part of the QIPP review for 2015/16, the CCG has undertaken a comprehensive review of NHS England's "Commissioning for Value" packs which serve as a benchmarking tool to compare pathways across similar CCGs. The work included discussions and workshops which included clinical leads and management team members. We also work closely with public health colleagues who have supported us to identify priority areas of work relating to specific health needs in our population (see section 3). Over the year we will seek to build further our business intelligence capability to provide a more comprehensive view of past and current performance by providers at local level that will help us inform potential misalignment or variances in planning assumptions as part of our QIPP monitoring, but also as part of our planning exercise for 2016/17. This is underpinned by a major business intelligence project (WHYSE) to implement an easier front-end to access data. See response to E.A.1 for further information on our local early intervention programmes.
Based on this analysis, what are your priorities and common goals?	Our draft strategic objectives are as follows: • Objective 1: Enabling patients to take more control of their health and wellbeing • Objective 2: Securing high quality services that improve patients' experience and outcomes for patients and addressing health inequalities • Objective 3: Developing the mechanisms by which we can deliver high quality commissioning such as co-production with patients and co-commissioning primary care with NHS England • Objective 4: Working with partner organisations to deliver improved integration of services • Objective 5: Delivering strategic change programmes in the areas of primary care transformation,

mental health, whole systems integrated care, and hospital reconfiguration
- Objective 6: Delivering our statutory and organisational duties

As part of 'Breaking the cycle week' commencing 27th April-15, we will be able to refresh our strategic objectives.

Our contracting intentions give more details on our commissioning priorities:

FINAL HFCCG contracting intentions

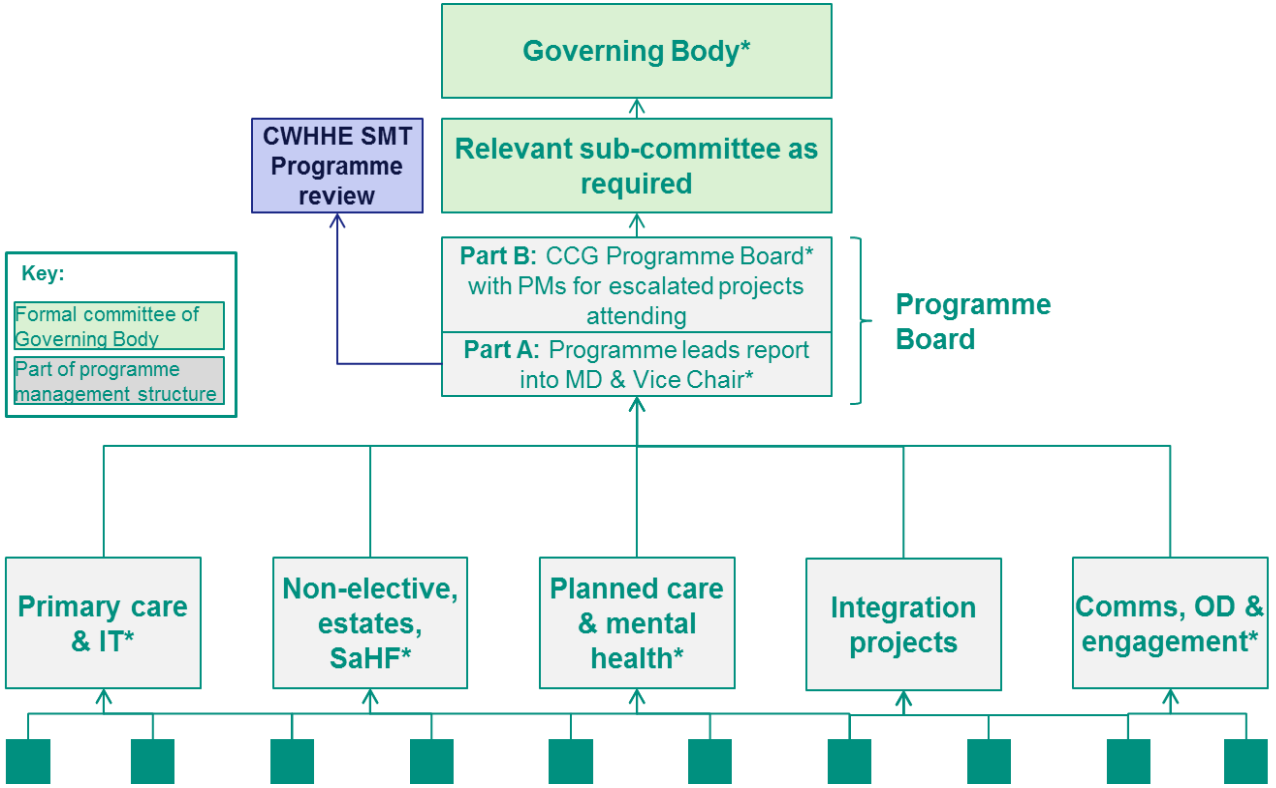
Have you identified your high impact programmes?

Priority projects which will support delivery of each our strategic objectives are as follows:

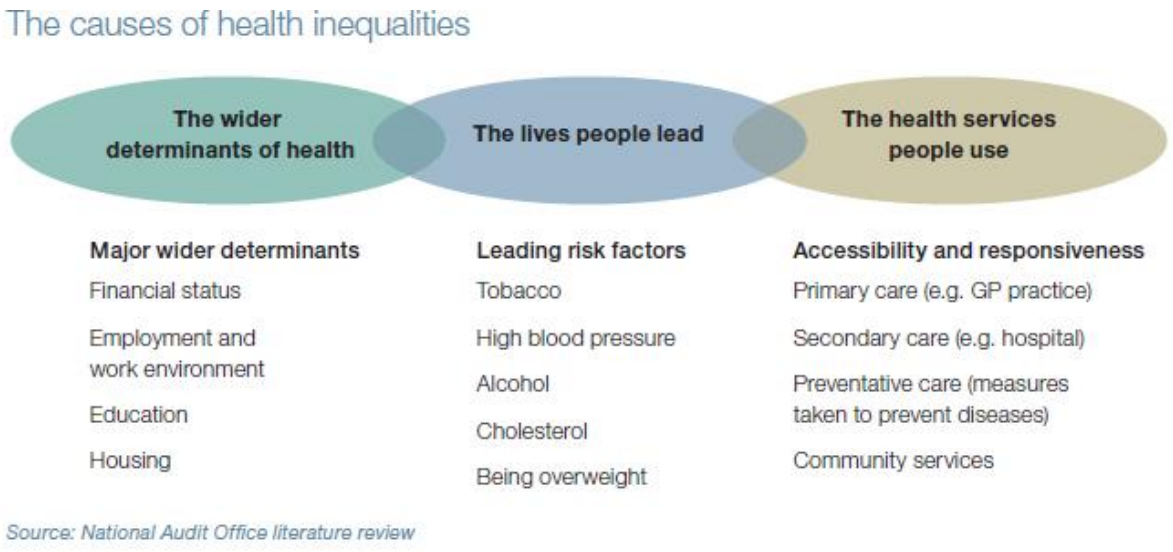
Strategic Objectives	Annual Objectives / Priority Projects	Outcome measure
Objective 1: Enabling patients to take more control of their health and wellbeing	• Diabetes self-management programme • Access to own records • Whole Systems Integrated Care • Children's hubs (north: live and south: planned) • Better Care Fund programmes (Community Independence Service, Nursing & residential care) • Prime Ministers Challenge Fund • Developing the business case for self-management Commissioning framework	• Measures in development through Better Care Fund programme and Whole Systems programme • NEL admissions reductions linked to CIS plus - 5% • Increase update of personal health budgets • Excess bed days reduction

	Objective 2: Securing high quality services and improved outcomes for patients	• IAPT- access, recovery, waiting times • Dementia / Dementia service procurement • Primary care transformation • Improving access to GPs • Urgent care centres • Mental Health • Out of Hospital Services	• IAPT targets in operating plan- access (16%), recovery (50%), waiting time to first treatment (85.4% in 6 weeks and 86% in 18 weeks) • Dementia diagnosis rate target in operating plan- 67% • Primary care targets in operating plan- experience of GP surgery (87%), experience of making appointment (72%) • Hammersmith & Charing Cross UCCs moved to 24/7 • Mental Health- psychiatric liaison service, PCMH workers
	Objective 3: Putting in place the infrastructure to deliver high quality commissioning	• MSK • Gynaecology • Ophthalmology • Developing our approach to patient involvement in commissioning (project)	• Performance reporting via QIPP schemes • NEL admissions reductions linked to CIS plus- 5% • Outpatient attendance activity shift into community
	Objective 4: Building relationships with local authorities and Health & Wellbeing Boards to deliver the Better Care Fund plan, and	•BCF work streams •Planned care •Public health (prevention) •Connecting care for children	•CIS Plus - reduction in NEL admissions of 5% •Outpatient attendance activity shift into community •PYLL and quality of life

	developing and delivering joint plans with other CCGs across North West London		•Local priority targets
	Objective 5: Delivering the Out of Hospital Strategy and acute hospital changes set out in the SaHF Strategy	• SaHF • Out of Hospital services • Formation of GP Federation • Whole Systems Integrated Care • Better Care Fund programmes (Community • Independence Service, Nursing & residential care) • Dementia service procurement • Urgent care reprocurement • IT plan • OD plan development	Primary care targets in operating plan • Experience of GP surgery (87%), experience of making appointment (72%) • Activity levels in hospital and community services
	Objective 6: Delivering our statutory and organisational duties	•NHS Constitution •Operating plan standards •Financial plans •QIPP plans •OD Plan development •IT strategy	•NHS Constitution measures •Financial reporting •QIPP performance •Operating plan measures
What are your plan resources?	Every Project Initiation Document (PID) includes a resource section which details resource required for the project. We also use a consistent scoring framework to assess proposed investments across the CCG and make decisions based on this framework.		

How will you measure progress?	See table above for measures against individual strategic objectives. We will use the following programme management structure to monitor progress in 15/16 with all of these meetings taking place on a monthly basis: 

3. Reducing health inequalities

Which groups of people in your area have the worst outcomes and experience of care? How are you planning to close the gap?	The people with the worst outcomes in Hammersmith and Fulham include those under the age of 75. Hammersmith and Fulham has a higher than average early death rate (in people under 75), particularly with CVD and cancer. This is much worse in areas of higher deprivation. Childhood obesity is also higher than the national average. The CCG has equalities objectives in place to ensure that there are better health outcomes for all as well as improved patient experience. The CCG collaborative is currently developing an equalities strategy across the five CCGs to ensure that these health inequalities are addressed. This will include a stakeholder survey to identify key priority areas across the Boroughs. Also refer to section E.A.1. for further information on prevention activities.
Does this include implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities?	The NAO report has identified 5 leading risk factors below: 

	In addition, there are 3 cost-effective high impact interventions recommended in the report: 1. Increasing the number of smoking quitters through smoking cessation services; 2. Improving control of blood pressure through prescribing anti-hypertensive to patients at risk of or already diagnosed with cardiovascular disease; and 3. Reducing cholesterol levels through prescribing statins to patients at risk of or already diagnosed with cardiovascular disease. The CCG and local authority partners are committed to delivering interventions in each of these three areas: **1. Smoking Cessation** Stopping Smoking is one of the top priorities for public health in H&F. We have commissioned a stop smoking quitting and prevention service. The service runs three national and three local prevention campaigns each year and works in schools and with young people to prevent the uptake of smoking. In addition, the service works with GPs, pharmacies, community groups, hospitals and mental health trusts to promote and develop the stop smoking agenda, with specific targets for 4 week quitters (this refers to the number of people who have aimed to quit smoking and have then not smoked for a 4 week period). The targets are focused on areas of deprivation and amongst communities where smoking rates are highest. Work is also commissioned to support smoke free homes and cars; smoke free hospital grounds; and work with maternity services to reduce smoking amongst pregnant women. The Smoke free Alliance brings together all agencies involved in tobacco control across the three boroughs, reviews KPIs on underage sales, illicit tobacco, counterfeit tobacco, compliance with the health act, numbers of quitters, and reviews progress across all the Smoke free agenda. **2. Ambulatory Blood Pressure Monitoring - Out of Hospital (OOH) Service** A key part of the H&F OOH strategy is the intent to support the continued development of high quality primary care at both a practice level and network of practices level. As part of this work, the

	CCGs are commissioning an Ambulatory Blood Pressure Monitoring service from practices. This service is aimed at adults who need a diagnosis of primary hypertension, particularly for patients with suspected "white-coat hypertension," and also in patients with apparent drug resistance, hypotensive symptoms with antihypertensive medications, episodic hypertension, and autonomic dysfunction to provide reliable, convenient and accurate blood pressure readings. The service will enable further assessment, enabling a more accurate assessment of blood pressure for those patients where this is clinically indicated. Practices will be expected to implement best practice prescribing guidelines as part of the model. **3. Supporting patients with cardiovascular disease** Hammersmith & Fulham CCG plan to procure a new community cardiology and respiratory service in 2016/17, which will support treatment and management of patients in community settings, closer to home. In addition the CCG is working to tackle obesity amongst adults and children in the H&F. Childhood obesity is one of the top five public health priorities in H&F. Data is collected on obesity for children through the National Child Measurement Programme. High rates of overweight and obese children have led to the recommissioning of children's weight management services and public health dietetics services. These interventions will bring all groups to work together around reducing childhood obesity through a series of bi-monthly meetings led by public health. For adults in tri-borough CCGs, including H&F, the NHS health check evaluation reveals that amongst otherwise healthy adults between 40-74 the proportion of overweight adults is 31%, obese adults 18% and physically inactive adults 17%. Following a health check, referrals are made to services including health trainers, Weight Watchers (with free vouchers), community dieticians, and physical activity programmes. In addition diabetes champions, community champions and physical activity champions all raise awareness in the community and signpost people to prevention programmes and services. **4. Other: Alcohol** 2015-16 will be a year of transformation for substance misuse services due to the re-procurement of

	core drug and core alcohol services. The new system, due to go live in April 2016, will have a greater focus on outreach and will be equipped to respond to a broader range of substance misuse to reflect local need. During the year there will be a number of alcohol initiatives developed with the intention of engaging residents who drink problematically but are treatment naive. Particular attention will be given to improving access to community alcohol detoxification within primary care and developing joint initiatives to help identification and engagement via the local hospitals. By strengthening pathways, we will aim to improve access for residents to community based treatment services and will reduce the burden that alcohol related hospital admissions has on the NHS.
How are you planning to reduce health inequalities for Looked After Children and people with a Learning Disability and offenders?	The CCG is working with the Local Authority and Safeguarding Children Board to: • Ensure that health assessments are completed in a timely way and are embedded into the individual child's care plan. • Use the care plans to inform the development of a clear profile of children looked after by Hounslow including age, gender, culture, specific health needs. • Identify specific areas of vulnerability for LAC such as child sexual exploitation. • Consider location of placement and identify gaps in provision whether locally or out of borough. • Agree priorities for 2016/17 commissioning intentions for LAC to address gaps. • Ensure that LAC is kept visible at LSCBs and that both borough and system wide views are taken. • The tri-borough CCGs all have action plans from the LD SAF to improve health outcomes and reduce health inequalities for people with Learning Disabilities. Adults reducing re-offending services are commissioned across tri-borough. The services work with offenders to try and reduce their offending. As part of this, they will produce a care plan to identify any support needs they may have and refer on to specialist agencies as required.
What progress have you made in implementing Equality Delivery System (EDS2)?	The CCG has published progress against equality objectives for 2013 in accordance with EDS2 Requirements. The Equalities Objectives have been identified in consultation with patients, service

	users and 3rd sector organisations. The priority areas include:
	
	• Improving the quality of data collection in relation to patient experience by providers by ensuring that all data reports for 15/16 include:
	  ○ 80% of data relevant to equalities groups within the local area
	  ○ Relevant to reasons for access and non-access
	  ○ Actions taken to improve equalities outcomes
	• Health and wellbeing for young carers.
	• Health and wellbeing for adults with autism.
	• Reducing social isolation for adults with learning disabilities.
	• Reducing social isolation for older adults.
	• Improved access to bilingual counselling.
	• Improved access to mental health services , including 'Improved Access to Psychological Therapies' (IAPT) for:
	  ○ Older adults
	  ○ Young people (18 – 25)
	  ○ People with a long term condition
	  ○ Carers
	  ○ BME communities
	
	The CCG is also working in partnership with Collaborative CCGs through the CWHHE Equalities Reference Group to:
	
	• Promote peer learning and review of equality plans and progress.
	• Embed Equalities Analysis in all aspects of CCG business - the inclusion of equalities analysis within all policies/proposals being sent to governing bodies across the CWHHE collaborative. For purposes of quality assurances, all equalities analysis will have to be sent and approved by the Assistant Director of Equalities before proposals are submitted to governing bodies.
	• Implementing Governing Body Leadership in Equalities Seminar

4. Quality - Responding to Francis, Berwick and Winterbourne View

	What quantifiable progress has been made in 14/15?	What quantifiable ambitions are in place for 2015/16? What action plans are agreed to deliver this and over what timeframe?	Supporting documents / references
What is your ambition for quality improvement in response to Francis, Berwick and Winterbourne View	Winterbourne View project across 8 CCGs	Develop commissioning framework across the 5 CCGs for Winterbourne View to improve access to local community services with specialist support.	Mental Health - LD.docx
What is your ambition for reducing the number of inpatients beds for people with a learning disability and improving the availability of community services for people with a learning disability?	Work has been achieved to reduce the number of people placed in inpatient beds. This is reported to NHS England on a fortnightly basis. The CCG has cooperated with NHS England in carrying out Care and Treatment Reviews on those where there are difficulties in finding appropriate placements.	There are discharge plans in place for any patient who remains in an inappropriate ATU placement. By the end of Q2 a business case will be developed by each of the CCGs to consider and that will provide options for the commissioning of local services to reduce the need to use out of area assessment and treatment places and to improve the local crisis, respite responses and potentially specialist community services including those to support some clients with a forensic history.	WinterB reducing the number of inpatients WinterB reducing the number of inpatients

Quality – Patient Safety

How are you addressing the need to understand and measure the harm that can occur in healthcare services? *For example, duty of candour, HCAI and CQC themes and action reports related to providers from 2014/15.*	Using information from the reporting and investigation of serious incidents, the Quality and Safety Team works with colleagues across the five CCG's to improve the quality and safety of NHS commissioned services across The North West London Collaborative of Clinical Commissioning Groups. The sole purpose of reporting serious patient safety incidents is to generate and share learning to prevent harm to patients recurring. The Key Performance Indicators for providers for the Reporting and Investigating of Serious Incidents are: • To report on the Strategic Executive Information System	In addition to safety assurance activity, the Collaborative Patient Safety Strategy (2015-16) will outline plans for a health system-wide improvement programme aimed at reducing harm from Pressure Ulcers. Pressure Ulcers continue to reflect a high human and financial cost and the success of provider trust approaches to reduce Pressure Ulcers is often an indicator of quality and safety in the organisation. The programme will use the Breakthrough Series Collaborative approach pioneered by the Institute for Healthcare Improvement and used with great success in the QIPP Safe Care Programme in 2011-12.	CQG ToR - Final Draft.pdf

	(STEIS) within 48 hours, the details of healthcare incidents meeting the nationally agreed definition of a Serious Incident. • To investigate using robust and reliable investigation techniques and submit a report to commissioners within 45 working days. • To develop an action plan designed to prevent recurrence and submit with the investigation report. • To be open and transparent with patient and their families about the incident, it's investigation and outcomes. • To demonstrate an open patient safety culture through high reporting numbers, and by learning lessons from investigations and not repeating the same		

	mistakes. These KPI are subject to amendment in the new National Framework for Reporting and investigating Serious Incidents which is due to be published in March 2015. This revised Framework will provide the basis for the Collaborative Patient Safety Strategy. The Patient Safety Team quality assures investigation reports received from providers, returning reports which fail to meet quality standards. A monthly report to Quality, Patient Safety and Risk Committees details provider performance over a six month period. This report will identify themes and trends from investigations. The Assistant Directors work together to identify remedies and to agree approaches with providers to improve quality and patient safety.		

	Data from a number of sources is used to create a broad picture of the organisational patient safety culture. In addition to STEIS, data form the National Reporting and Learning Service and the NHS Safety Thermometer help to understand the approach a provider has to safety, to data and to the use of data for improvement.		
How are you increasing the reporting of harm to patients, particularly in primary care with a focus on learning and improvement?	GPs are encouraged to report their concerns and CCGs have systems in place to gather intelligence on primary care services. The CCGs supported and funded the Practice Nurse Development Programme for primary care nurses in CWHHE.	The quality team will work closely with NHS England to develop systems and processes to further support the development of a reporting and learning culture in primary care. In 15/16 the CCGs and HENWL have supported the creation of fixed term posts to support the further development of practice nurses.	
How are you tackling sepsis and acute kidney injury?	• The Sepsis alert (Sept 14) was sent to all Trust IPC teams and discussion has taken place with them regarding its implementation: http://www.england.nhs.uk/wp-content/uploads/2014/09/psa-sepsis.pdf	• A quality indicator on Sepsis has been included in Trust Quality Schedules for 2015/16 (acute, community and mental health), which Trusts will be required to report on quarterly to CQGs. • Work will take place to encourage Trusts to adopt the NHS urinary catheter passport, to improve	

	• A Sepsis Workshop was jointly coordinated with NHSE and the UK Sepsis Trust in Feb 2015, attended by 40 senior clinicians from across the health economy, to discuss and share approaches. • All cases of MRSA sepsis are reviewed (whether Trust or CCG attributed) for any lessons to be learnt and action plans are monitored. • All RCAs from SIs linked to sepsis are reviewed by the Quality Team.	communication on catheter management between all care providers and avoid associated sepsis. The need for this has been identified through MRSA Post Infection Reviews in 2014/15 identifying catheters as a risk for sepsis. • The Sepsis CQUIN – is being implemented in trusts who have accepted the 14/15 tariff arrangements and the plan is that it will locally negotiated for those trust who have not accepted this. • Acute kidney information is being included in the templates for discharge from hospital.	
How are you improving antibiotic prescribing in primary and secondary care and how?	**Primary Care** Each CCG has had initiatives in 2014/15 which focus on improving antibiotic prescribing. All CCGs monitor antibiotic prescribing and identify GP practices which our outliers when compared with others. Ealing and West London CCGs have been working with their local acute trusts to produce local antimicrobial prescribing guidelines. All the other CCGs in CWHHE have antibiotic prescribing indicators within their	**Primary Care** Each CCG has agreed initiatives which will continue to focus on antibiotic prescribing in 2015/16. In each CCG there will be 2 indicators within GP Prescribing Incentive Schemes which focus on: • Overall volume of antibiotic prescribing measured as quantity of antibiotics prescribed per 1000 antibiotic STAR PU • Appropriate choice of antibiotic measured as, for example, number of oral cephalosporin quinolone and co-amoxiclav items as a percentage of all antibiotic	 Trust IPC guidance.docx

	Prescribing Incentive Scheme which focus on both quantity of antibiotics prescribed and choice (reflecting national guidelines). CCG Medicines Management Pharmacists are members of the multi-disciplinary Infection Clinical Network. CCG pharmacists have taken the opportunity to present to GP networks on good antimicrobial stewardship and promote resources such as the TARGET tool-kit. **Secondary care** • This issue is discussed with IPC teams/antimicrobial prescribing leads at quarterly meetings and is a standing item on the quarterly Infection Clinical Network agenda. • Results of Trust antimicrobial prescribing audits have been reviewed during 2014/15 and scrutiny applied to the development and implementation of action plans.	items or percentage of preferred antibiotics prescribed Exact targets for improvement will be set when e-PACT data for 2014/15 is released. Each CCG has plans to discuss whether additional actions are required to address the antibiotic elements of the Quality Premium. Regular meetings between primary care and secondary care pharmacists to discuss cross-sector antimicrobial issues are being planned from quarter 1 2015/16. **Secondary care** • A quality indicator on antimicrobial prescribing is included in acute Trust Quality Schedules for 2015/16. • Trusts will participate in the data validation exercise linked to the CCG Quality Premium in 2015/16 (one large acute Trust participated in the pilot exercise). CCGs await further information on the detail of this, and in due course the prescribing indicators anticipated for 2016/17. • The CCG Antimicrobial Lead Pharmacist will attend the Imperial Antimicrobial Review Group to	

		provide oversight for commissioners on the effective management of this function.	

Quality – Patient Experience

Have you set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice. How will you deliver against your ambitions? *Suggestions include FFT, PPG development – reference to CQC and action reports.*	The CCG is committed to working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population. More specifically, the CCGs are committed to ensuring both the continuous improvement in patient experience and the overall quality of care that is provided locally. Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders, to ensure it has identified key areas of priorities that the CCG has committed to resourcing and these are reflected in core quality schedule for 14/15. These include: Ensuring that providers produce quarterly patient experience reports which: ○ incorporate qualitative as well as quantitative data including FFT data and narrative comments ○ compare feedback from weekday and weekend services ○ capture feedback that reflects the diversity of their patient and carer population ○ Where poor experience has been identified, the report will include actions and evidence of improvements to address gaps in satisfaction and experience Working in collaboration with Health and Social Care organisations through the Whole systems Integration and Transforming Primary Care Programmes, embed patient and carer experience at every stage of development and implementation. More specifically to: ○ Ensure that patients are actively involved in shared decision making and supported by clear information that it appropriate to the patient and carer needs ○ Improve staff learning and experience

	○ To undertake a Community Independent Service insight project in order to capture patients, service users and carers insight to enable us to have a baseline on which we can evaluate impact in the future Promoting patient and lay voice at a strategic level and in collaboration with CWHHE and North West London CCGs by ensuring that the following Committees have lay and patient representation: ○ Clinical Quality Groups ○ CCGs Quality, Patient Safety and Risk Committees ○ NWL Quality Working Group ○ H&F CCG Finance & Performance Committee and Patient Reference Group is chaired by a Lay member ○ H&F CCG OD and Engagement Committee is also attended by 2 Lay members, once of whom is the vice-chair
How will you assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for patients? *Suggestions include CQC reports, care homes and domiciliary care.*	• The CCG Quality, Patient safety and Safeguarding teams work closely together, have established links with local Healthwatch and now have a structured formalised process for reporting of 'Dignity Champions' visits to provider organisations. These reports are received and then shared with the Clinical Quality Groups where actions are monitored. • There is a provider concerns meeting at which the CCG, safeguarding and local authority partners come together to discuss care homes causing concern or to take a joint approach to addressing issues that arise. • Safeguarding Information Sharing panels have been established in each borough to which the CQC are also invited participants.
How will you demonstrate improvements from FFT, complaints and other feedback?	The CCGs will work closely with the provider organisations that are required to produce quarterly reports addressing patient experience through information from FFT, complaints and the link with incident reporting.
How will you ensure that all the NHS Constitution patient rights and commitments to patients are met?	The CCGs will ensure that the principles of the NHS constitution enable patients' rights to be met through working closely with lay partners as equals at committees, in procurement. In our review and assurance of the services commissioned by the CCGs.
How will you ensure that the recommendations of the Caldicott Review relevant to patient experience are implemented?	During 2014/15 the CCGs have been working with a diverse range of stakeholders to further the principles outlined in the Caldicott 2 review. A governance framework has been established across the health economy to facilitate the sharing of patient records for direct patient care. A memorandum of understanding (MOU) for the sharing of records for direct patient care has been developed that

	sites best practice and legal frameworks that apply across the NHS. This MOU has been cited as good practice in the Independent Information Governance Oversight Panel's report to the Secretary of State for Health in 2014. All provider Trusts in North West London, all other healthcare providers and all primary care providers have signed up to the memorandum of understanding. Patient and staff information materials have been produced and circulated initially across all GP practices (see attached example leaflet). Also during 2014/15 GP practices have enabled the functionality to provide online access for patients to their GP held records. During 2015/16 the CCG will be embedding and deploying the preparatory work carried out during 2014/15. This will involve : • Enabling IT systems across the health economy to adhere to the mechanisms outlined in the memorandum of understanding. • Further establishing a NW London regular forum of data controllers in common for the governance and management of patient information flows and increase confidence in organisations and patients in the secure sharing of patient records. • Establishing workflow processes where patients are routinely asked to provide explicit consent to share their records at point of registration and referral. • Increasing public and staff awareness across the health economy to understand the principles and mechanisms of patient record sharing. • Encouraging more patients to access their online records and on line services through their GP practice through awareness raising campaigns. • Establishing a website and a help line for further information provision or queries from staff and patients.

Quality – Compassion in practice

How will you ensure that local providers are delivering against the six action areas of Compassion in Practice?	The 2015/16 quality schedules include specific requirements for all providers to report on how the nursing and quality strategies demonstrate Compassion in Practice.
How are you working with providers to ensure the roll out 6C's across all staff groups?	• The CCG's Quality Strategy is in development – provider organisations have been given the opportunity to contribute to the strategy and to link us with local provider strategies. • The CCGs are supporting providers through clinical walk rounds, peer reviews, and patient experience feedback systems which are discussed at monthly Clinical Quality review groups. Where areas are causing concern there are direct discussions with the nursing and medical directors by the clinical leads within the CCGs to address those areas. • In the tri-borough area Compassion in Practice has been a focus for care homes.

Quality – Staff Satisfaction

What is your understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others? *Suggestions include FFT for staff, annual staff surveys, care homes and domiciliary care.*	The factors impacting on staff are multifactorial and include staff satisfaction; in areas where this is low it is clear that patient experience and FFT are also low. CWHHE have captured patient, service user and carer feedback as part of the engagement with patients, service, users, carers and frontline staff to co-design the Patient Experience Strategy (attached below). The strategy makes explicit reference to the impact of staff experience on improving patient experience. The Quality team has produced an annual review of data relating to patient experience, which also captures staff experience (attached below). The report is shared with all providers to enable for discussion and action at the Clinical Quality Group Meetings.  CWHHE Patient Experience Strategy .  Annual Patient Experience Quality R

How will you ensure measureable improvements in staff experience in order to improve patient experience? *Suggestions include London BME standards, linkage to patient staffing surveys.*	In 2015/16 the CCGs' quality teams will be requesting providers to analyse the link between the ward staffing submissions, staff experience and patient experience, assessing how the planned and actual staffing is impacting on patient care.

Seven Day Services

How will you make significant progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working, supported by a Service Delivery and Improvement Plan (SDIP) with providers?	There are two key work streams in Hammersmith & Fulham CCG to progress implementation of 7 day services in 2015/16:
	
	1. **Commissioning and contracting**: to commission providers to deliver services in line with the national seven day standards, including:
	  ○ SDIP: working collaboratively with Imperial College Healthcare NHS Trust (ICHT) to develop an SDIP plan to implement at least 5 clinical standards for seven day working, and then monitoring implementation over the course of 2015/16.
	  ○ CQUINs: regional 7 day working CQUINs have been developed for acute, mental health and community providers, and while the selected ICHT tariff does not support CQUINs, H&F CCG will ensure that community providers, including Central London Healthcare NHS Trust (CLCH), develop their 7 day working CQUIN in collaboration with other stakeholders across the local health and care system, through the Imperial Urgent Care Board.
	
	2. **System design**: to lead the design and implementation of the local 'out of hospital' changes required to support 7 day admission avoidance and discharge, including through:
	  ○ The Imperial Urgent Care Board, with representation across the local urgent care pathway
	  ○ The Triborough Better Care Fund, including the new 7-day Community Independence Service delivering integrated 7 day rapid response and discharge support services

	(including social care). In addition, North West London CCGs are working collaboratively as an 'Early Adopter' for Seven Day Services, and a set of key activities that can be 'done once and shared' will be prioritised on a pan-NWL basis for completion in 2015/16.

Safeguarding: Adults and Children

How do you plan to meet the requirements of the Accountability and Assurance Framework for protecting vulnerable people (adults and children)? *Suggestions include the Care Act Implementation, Prevent, FGM and CSE.*	The CCG will maintain and develop the safeguarding team to ensure that it continues to meet the requirements of the Accountability and Assurance Framework. The priorities for 2015/16 for safeguarding children are: • Ensure that the statutory roles are filled and any vacant posts are filled within appropriate timescales • Develop the strategic aspects of the Designated LAC roles to embed within the work of the CCGs • Complete the review of the provision of FGM services across the area and use this to inform service design • Work with the LSCB to develop the CSE strategy and identify health services to support those abused The priorities for 2015/16 for safeguarding adults are to: ○ implement the Care Act (2015) requirements for safeguarding through reviewing capacity, roles and responsibilities ○ improve the functions in relation to the CCG responsibilities for Prevent and MCA ○ work with the Safeguarding Adults Board to develop a learning and improvement framework through safeguarding adult reviews ○ strengthen the monitoring of compliance by commissioned services
What is the ambition for quality improvement in child and adult safeguarding?	The CCG will work with partners to satisfy legislative requirements e.g. the Children Act 2004 and Care Act 2014 through contractual measures and quarterly reporting on how commissioned providers maintain safe structures and leadership for safeguarding, training compliance, evidence of

Suggestions include the identification of a baseline including preventing harm (minimisation of SCRs for adult and children through integration with the Local Authority and early help and domestic violence agenda).	learning from cases and reports both local and national. Additionally, the CCG will continue to have an overview of the whole local health economy in relation to issues that impact on the welfare of children and young people, including gathering information from services not commissioned by the CCG. The CCG will continue to work with the Local Authority, partners, Health and Wellbeing Board and Local Safeguarding Boards to: • Utilise the JSNA and serious case reviews (from the previous 5 years) to identify the vulnerability factors for children and adults • Review the outcome frameworks for children and adults in providing evidence of quality Improvement • Continue to encourage health engagement with local safeguarding boards for children and adults • Review the health involvement with the Violence Against Women and Girls Strategic Group to ensure that commissioned services are engaged and that CCG is effectively informed in developing its commissioning intentions for 2016/17 • Review effectiveness of service design in addressing known vulnerability factors such as mobile families, marginalisation of young people and adults, child sexual exploitation and FGM, dementia and others with care and support needs
How will improvement be achieved in the application of the Mental Capacity Act (House of Lords Recommendation 2014)? *Please take into account Cheshire West (DOLS) and Commissioning for Compliance.*	As a CCG we wish to be assured that the services we are commissioning on behalf of our local populations are being delivered in a way that respects and supports the rights of individuals in particular those that may not be able to take decisions on their own behalf. This is the policy framework that the CCGs expect the providers to have in place and to report on: • An MCA policy • An MCA lead • Evidence of MCA-compliant capacity assessments and best interests decision-making documentation and procedures • Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning, policies, guidance and training • Evidence that the MCA is linked into the provider's systems and processes relating to improving service users' experience and the quality of their care and treatment

	• Evidence of patient access to advocacy Following the Cheshire West judgement the CCG acknowledges that the threshold for DoLs has been altered and, therefore, the CCG will be seeking assurance that care providers: • Are aware of the Supreme Court judgement • Have plans in place to map requirements for Best Interest Assessors (BIAs) and work collaboratively with other providers to reduce training costs The CCG will undertake deep dive audits of case files in collaboration with care providers and the Local Authority to assess the level of health compliance with the Cheshire West judgement. The CCG will work with the Safeguarding Adult Board to undertake an annual review of progress. For DOLs the CCG expects: • Evidence the provider is aware of their responsibility to report DoLS authorisation applications and the outcome to the CQC • Evidence that the safeguards feature in reports relating to the care and treatment of at risk patients particularly those with dementia, a mental illness or learning disability, acquired brain injury etc • Staff has access to the DoLS Code of Practice • Staff have access to legal advisors who are familiar with the safeguards and can brief them on necessary DoLS related case law • There is policy and procedure covering DoLS in providers' MCA policy or a separate policy but linked to the MCA policy • There is staff training on the DoLS safeguards • Guidance and training on care planning covers the importance of staff being aware of the safeguards in cases where restriction and restraint might be in the patient's best interests • Staff knows how to access the various DoLS authorisation forms, have had training on their completion and know where they should be submitted Following the Cheshire West judgement the CCG acknowledges that threshold for DoLs has been altered and, therefore, the CCG will be seeking assurance that care providers: • Are aware of the Supreme Court judgment

	• Have plans in place to map requirements for Best Interest Assessors (BIAs) and work collaboratively with other providers to reduce training costs The CCG will undertake deep dive audits of case files in collaboration with care providers and the Local Authority to assess the level of health compliance with the Cheshire West judgement. The CCG will work with the Safeguarding Adult Board to undertake an annual review of progress.
What improvements will be made through the Implementation of the Care Act from April 2015? *Please take into account statutory requirements including the Statutory Duty to Corporate with the Local Authority and widening of scope of safeguarding to include Human Trafficking, Domestic Violence and Modern Slavery, self-neglect.*	The CCG will continue to work with the Local Authority to ensure that there is effective cooperation in recognising and responding to safeguarding issues. This will include further development of the Safeguarding Adult Board to ensure it receives the resources to implement its strategic plan to intervene in cases of abuse and neglect and work to identify vulnerability factors and establish preventative measures.
How will you measure the requirements set out in plans in order to meet the standards in the prevent agenda (taking into account Tier 1-3 priority areas)?	The CCG will work with commissioned services, partners and the Local Authority to develop and implement a strategic Prevent plan. This will focus on improving the awareness and training of staff across agencies. Prevent training compliance has been included in the quality schedule for 2015/16 with commissioned services required to report on compliance on a quarterly basis.

Workforce

What are the workforce implications from your 2015/16 operational plans and how will these be addressed?	**Non-elective** The Lead Health Provider for the Community Independence Service is working closely with HENWL and partners in the health and social care system to develop new workforce models and to anticipate

	and plan for changes in health care provision over the next 5-10 years, addressing specific gaps in the GP workforce, therapists and community and district nursing. Some of the forecast deficit in these areas will result in retraining of existing staff and some will be met by the establishment of a new pipeline of appropriately skilled staff to work in integrated, community-based models. **Planned care** We are focussed on maintaining a stable permanent workforce throughout all our transformational programmes. There are a number of TUPE implications of planned care service changes in 15/16. Nursing staff are expected to TUPE from the local community provider to secondary care for TB. Staffs are expected to TUPE from secondary care to the new Community Ophthalmology Service which is due to go live during 15/16. We are expecting to implement a Tri-borough Tissue Viability service during 15/16 and a small increase in clinical workforce will be required in this area for Hammersmith and Fulham as a result. The Community Dermatology service will also be increasing in capacity requiring the recruitment of a small clinical workforce in early 2015/16. During 15/16 we are developing plans to implement a Dementia Memory Service to go live in April 16; the service model is expected to shift from a secondary care focussed model to one centred on primary care delivery. We are therefore in the process of identifying the workforce implications of this for GPs, consultants and other support roles. **Paediatric care** The key objectives of the Connecting Care for Children project are to increase the skills and capacity within primary care to manage patients in the community and avoid unnecessary unscheduled care and inappropriate referrals to paediatric outpatient clinics. This will be achieved through • GPs leading joint community paediatric GP clinics with consultant paediatricians and specialist allergy clinicians and by sharing case studies at the MDTs • Involving and improving links with other professionals such as health visitors, social workers and school nurses

	Primary Care The delivery of the full range of Out of Hospital Services by GP Practices working under the GP Federation umbrella will have implications on workforce capacity. Through funding received through Health Education North West London(HENWL), a programme of training to provide relevant staff with the skills that they need to provide the new services (as per service specifications) will be delivered in the first quarter of 2015/16. In addition to this and as part of the HENWL funds, the CCG will also be providing training for the following: • Accredited training for Health Care Assistants so that they can develop their role within the practice to play an active part in the delivery of OOH services • Receptionist / customer care training, to ensure that practice staff have the appropriate skills to offer the best customer service experience to our patients • Empathy training for our clinicians to ensure that they have the tools to effectively manage difficult and aggressive patients to again ensure that patients have the best experience and make the best use of practitioners time • Developmental training opportunities to support Practice Managers and their staff to anticipate the challenges that lie ahead in terms of service delivery and workforce implications • Practice nurse appraisal training so that Practices Nurses can develop their role in the Practice to play an active part in the delivery of OOH services HENWL have also block commissioned two additional training areas: • Motivational Interviewing – to provide clinical staff with an understanding of the specific interventions associated with the motivational interviewing counselling style. This training programme aims to enable staff to acquire competence, confidence and capability to work in partnership with patients and carers in order to promote healthier lifestyles and understand the techniques to encourage and support behaviour change and health gain. • Introduction to primary care workforce planning - to provide staff working in general practices with an understanding of the basic principles of primary care workforce planning in order to

	support future service delivery. The course will provide an overview of all aspects of workforce planning including the acquisition and analysis of data, the development of a supporting narrative to accompany staffing figures and forecasting future workforce requirements, particularly in the context of whole systems service redesign in North West London.
How are you developing a workforce that is able to work across acute and community boundaries?	**Whole Systems Integrated Care (WSIC)** Our series of Simulation Events, used to engage with a range of patients, carers and health and social care professionals, in April 2015 will be used to identify improvements to be made to Hammersmith and Fulham's Whole Systems model of care. Following these events, an implementation plan will be developed to embed improvements, accounting for workforce development requirements in the medium to long -term. One way that we will develop our Whole Systems workforce is through engagement with the Change Academy, which is a workforce and organisational development programme, procured by North West London, targeted at three levels: • Senior system sponsors; • System leaders; and • Integrated care teams and team leaders. See section E.A.4 for more detail on the WSIC programme.

5. Constitution Standards – RTT, A&E, Cancer, Mental Health Plans should demonstrate the commissioning of sufficient services, based on robust demand planning, to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B of the planning guidance and how they will be maintained during busy periods. Where standards have not been met in 2014/15, details should be provided of specific steps being taken to ensure improvement this year, measureable ambitions for improvement and timelines for delivery.	
RTT and Diagnostics	
Does your provider have residual RTT backlogs - patients waiting over 18 weeks on either admitted or non-admitted pathways - who will need to be treated in 2015/16 in order to support sustainable delivery of the RTT standards?	ICHT - Yes West Middlesex - No Chelsea & Westminster - No LNWHT - Yes
If yes, have you agreed an additional activity profile with that provider (which is likely to be above and beyond BAU activity) to manage those backlogs?	Via the contracting round additional activity is being identified at specialty level to ensure that any residual backlogs going in to 15/16 are commissioned for and delivered. Detailed capacity and demand work has been and is being undertaken early in 15/16 to ensure that providers have critically reviewed their service and understand what recovery and sustainability looks like going forward. The NWL performance team are leading this work and monitoring delivery action plans to ensure commitments are met. Some risks remain around date quality with ICHT which is being reviewed on a weekly basis.
Have you agreed the timeline required for this additional activity –ensuring that patients are treated as quickly as possible?	This is being agreed through the contract process and is being supported by the NWL performance team. Providers and Commissioners focus is on treating patient is order of wait ensuring the longest waiters are treated as a priority. ICHT currently has a data quality RAP in place due to on-going Cerner issues.
Have you agreed performance trajectories based on the profile of backlogs and the timeline required to clear them? I.e. managing backlogs is likely to mean that the performance measures may not be achieved until	Recovery trajectories are in place for challenged providers, Performance is not being achieved at ICHT or LNWHT and is subject to the process described above to ensure recovery and delivery going in to Q1 of 15/16.

they are managed back to a sustainable level.	
Have you and the provider agreed a RTT recovery plan based on the above information?	This work is underway for our challenged providers (ICHT and LNWHT), a key part of this is the conclusion of the detailed Demand & Capacity work and the completion of the contracting round where agreement will be reached for additional activity required to recover performance as well as delivering.
Has your provider(s) completed detailed demand and capacity modelling at speciality level for non-admitted and admitted activity – and have they shared this with you?	ICHT is the last remaining provider to complete the full Capacity & Demand work, this is being undertaken in April with support and will inform the conclusion of the contracting round to ensure the right level of activity is commissioned to recover any underperformance and maintain that level of performance through the year.
Has this been used to calculate elective capacity and activity for 2015/16?	For all providers this will be used to inform the contracting round.
Does the Trust have sufficient capacity to meet demand or will alternative providers need to be identified and agreed?	The expectation is that the providers of elective services will undertake the required level of activity to deliver the standards as agreed via the contracting round.
If the Trust(s) has backlogs to clear in 2015/16 have these been profiled against BAU demand and capacity/run rates?	Yes, this has been included for providers where this has been identified.
Does the Trust(s) have sufficient capacity to deliver both BAU run rates and clear backlog or will alternative providers need to be identified to support the backlog activity and ensure that patients are treated as quickly as possible?	The expectation is that the providers of elective services will undertake the required level of activity to deliver the standards as agreed via the contracting round.

<table>
<tr><th colspan="2">A&E Waits</th></tr>
<tr><td>By each A&E provider, provide your performance against the 4 hour standard for each quarter of 2014/15. How did this vary from your planned trajectory?</td><td>
<table>
<tr><th colspan="5">All Types A&E Performance</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>ChelWest</td><td>97.38%</td><td>95.92%</td><td>95.65%</td><td>96.46%</td></tr>
<tr><td>ICHT</td><td>95.87%</td><td>95.58%</td><td>91.21%</td><td>92.00%</td></tr>
<tr><td>LNWHT</td><td></td><td></td><td>87.33%</td><td>88.57%</td></tr>
<tr><td>EHT</td><td>97.31%</td><td>96.30%</td><td></td><td></td></tr>
<tr><td>NWLHT</td><td>92.06%</td><td>91.66%</td><td></td><td></td></tr>
<tr><td>THH</td><td>95.47%</td><td>95.28%</td><td>92.47%</td><td>93.64%</td></tr>
<tr><td>WMUH</td><td>96.45%</td><td>96.90%</td><td>93.39%</td><td>93.50%</td></tr>
</table>
*Please note this is provider performance not CCG registered population
</td></tr>
<tr><td>Where 4 hour performance did not meet trajectory, have the major factors affecting performance been identified?</td><td>There have been a significant number of varying and complicated issues impacting A&E performance during 14/15. NWL providers have all had a challenging winter period with increased levels of demand. McKinsey have been working with both ICHT and LNWHT to develop a single version of the truth. This work is being jointly managed across providers and commissioners. This work is yet to be completed and has been extended in scope and sites covered. The various SRGs are sighted on this work and will be taking on the monitoring and implementation of recovery plans that come out of that work.

The main issues have been identified as
Patient flow
Demand
Senior decision makers at the front door
Step down capacity of the appropriate type.
This is an example of some of the issues and the basis of our Resilience Planning for 15/16</td></tr>
<tr><td>What are the proposed mitigating actions to recover / maintain progress against your trajectory for 2015/16?</td><td>A number of actions have and are being undertaken to recover performance at our challenged providers. Work is on-going to identify the full scale of the issues through the McKinsey work and resulting actions will be taken through SRGs. NWL performance on DToC has been a focus and has resulted in significant reductions in DToC. Further work is being done across health and social care to identify the larger ‘pathway’ cohort to improve flow out of acute sites.</td></tr>
</table>

Has your plan taken into account the impact of various schemes and investment? E.g. QIPP, NETA, BCF	All of our plans have been cross matched against any activity reduction plans (BCF/QIPP). This has been reflected in our operating plan submissions and contracting agreements.
Cancer waits – 62 day	
By each provider, what is current performance against 2014/15 plan?	62 Day Standard Chelsea and Westminster Hospital NHS Foundation Trust: Apr 100.0, May 82.6, Jun 85.7, Jul 91.3, Aug 92.0, Sep 81.5, Oct 95.7, Nov 100.0, Dec 97.6, Jan 92.6 Ealing Hospital NHS Trust: Apr 88.6, May 88.5, Jun 78.6, Jul 86.1, Aug 86.4, Sep 85.0, Oct 66.7, Nov 89.3, Dec 90.5, Jan - Imperial College Healthcare NHS Trust: Apr 89.1, May 86.8, Jun 80.8, Jul 85.6, Aug 87.1, Sep 83.1, Oct 85.5, Nov 82.5, Dec 88.7, Jan 77.7 North West London Hospitals NHS Trust *: Apr 83.8, May 82.4, Jun 76.0, Jul 81.3, Aug 83.9, Sep 79.4, Oct 81.6, Nov 80.2, Dec 92.8, Jan 77.0 Royal Brompton and Harefield NHS Foundation Trust: Apr 80.0, May 80.0, Jun 69.2, Jul 71.4, Aug 38.5, Sep 46.7, Oct 71.4, Nov 77.8, Dec 68.8, Jan 69.2 The Hillingdon NHS Foundation Trust: Apr 93.3, May 88.5, Jun 95.3, Jul 97.2, Aug 83.3, Sep 94.0, Oct 89.4, Nov 97.7, Dec 91.7, Jan 88.2 West Middlesex University NHS Trust: Apr 81.6, May 77.8, Jun 72.2, Jul 73.9, Aug 82.0, Sep 80.4, Oct 86.9, Nov 88.5, Dec 88.2, Jan 88.5 *Please note this is provider performance not CCG registered population
Where performance is not meeting trajectory, has a comprehensive action plan and recovery date been agreed with the provider?	Improvement has been seen across 14/15 across all cancer waits, a joint NWL action plan is in place as well as specific recovery and improvement plans for challenged sites
How will you work with the provider to sustain improvement in 2015/16 to meet your trajectory?	NWL has a joint action plan agreed across all providers. This plan and process includes a number of out of area Trusts where there is a patient transfer flow. This plan has seen some success in informing performance. On top of the formal contract and performance meetings NWL holds a bi monthly meeting with providers to monitor progress against the action plan. This is supported by a dedicated Senior Performance Manager. In addition the Collaborative Performance Committee, represented by CCG Cancer Leads and Clinical Chairs, undertakes a deep dive on a rolling quarterly basis where senior provider leads present progress and agrees next steps.
Mental Health	
IAPT: By April 2016, at least 75% of adults should have had their first treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks. How are you working	The new access and waiting time standards for IAPT and Psychosis have been introduced directly into the Quality Requirements Schedule for the 2015-16 Contract. These standards will be measured through the Review of Monthly Service Quality Performance and as a consequence of

<table>
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<td>with providers to achieve new waiting time standards for people entering a course of treatment in adult IAPT services?

Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.</td>
<td>breach General Condition 9 will be applied which would include a Remedial Action Plan.

We have worked with our IAPT provider throughout 14/15 to ensure that they will meet these access targets, and have invested additional funding to ensure we meet this target. The Trust is already performing above the new access standards and we are in the process of trying to agree targets within contracts.

We are waiting on agreement of trajectories from providers.</td>
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<td>Early intervention in psychosis (EIP): By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services. How are you working with local secondary mental health providers to ensure this waiting time standard is met?

Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.</td>
<td>Actions supporting the delivery of EIPS are included in the SDIP agreed with the provider:
<table>
<tr><th>Milestone</th><th>Timescale</th><th>Expected benefit</th></tr>
<tr><td>Undertake a baselining exercise of where the EIPS service is against the measure- more than 50% of people experiencing there first episode of psychosis have a maximum wait of two weeks from referral to treatment</td><td>By end of Month 4</td><td>CCGs and WLMHT will understand where they stand in relation to national requirements</td></tr>
<tr><td>Undertake an assessment to determine if the EIP service is providing patients with a NICE concordant treatment</td><td>By end of Month 4`</td><td>CCGs and WLMHT will understand where they stand in relation to national requirements</td></tr>
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	Test the existing pathway for referral to treatment to ensure it meets the measure using the national expected approach to the measurement of the standard	By end of Month 6	CCGs and Provider will understand what is required to deliver the national requirements
	Agree a plan to deliver the pathway to meet the standard	By end of Month 6	CCGs and Provider will understand what is required to deliver the national requirements
	Develop an action plan to ensure that all treatments meet the NICE requirements as detailed within the national supporting guidance document	By end of Month 6	
	Determine whether any additional funding is required in addition to the recurrent investment already made in 1516 for EIPs services	By end of Month 7	
	Ensure that there is capacity in place to deliver the target at the start of Q4	By start of Month 9	One quarter to ensure the pathway delivers within 2 weeks and treatments are compliant providing CCGs and provider with assurance they are delivering ahead of 16/17
	Guidance document to be used for this indicator unless superseded by further national guidance. http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf		

	Trajectories: Developing and monitoring during 2015/16 with delivery from April 2016.
Have you agreed a Service Delivery and Improvement Plan (SDIP) as part of contracts with mental health providers? Does this plan set out how providers will prepare for and implement the new standards for EIP and IAPT during 2015/16 and achieve them on an on-going basis from 1st April 2016?	It has been agreed with Providers that the new access and waiting time standards for IAPT and Psychosis targets to be delivered by April 2016 will be included in the Service Delivery and Improvement Plan – the trajectories are to be agreed with Providers. The new access and waiting time standards for IAPT and Psychosis have been introduced directly into the Quality Requirements Schedule for the 2015-16 Contract. These standards will be measured through the Review of Monthly Service Quality Performance and as a consequence of breach General Condition 9 will be applied which would include a Remedial Action Plan.
Have you ensured the provision of mental health support as an integral part of NHS 111 services? If not, what do you currently have in place instead? Do you have plans to build this into future procurement specifications?	NHS 111 services are currently being reproduced across NWL, this will include evidence based, best practice. The 111 procurement board includes the NHSE lead ensuring alignment across London.
In commissioning mental health services and working towards meeting new standards, have you developed robust demand and capacity plans? Please provide details of these.	We have worked with our mental health Trust and primary care through our mental health transformation board to ensure that there is enough capacity in the system to meet these standards. We have achieved a successful enhanced primary care service which enables patients to be discharged from community mental health teams to a less intensive setting, i.e. their local GP practices, and we have invested in primary care mental health workers to support our GPs to meet the mental health needs of their patients. We also ensure that any patients who are referred into secondary care have an opportunity to be seen in our enhanced primary care service, and all referrals into secondary care are discussed between the GP and Psychiatrist who have an advisory phone line accessible to GPs.
How are you working with other local commissioners to invest in community child and adolescent mental health	The National CAMHS Taskforce will report on the 17th of march 2015, the CCG will digest this carefully and benchmark local services in line with the recommendations of the task force, this will then inform future investment and commissioning intentions.

services?	1. The pilot of a dedicated CAMHS Out of Hours Service across the NWL CCGs will offer a number of benefits: a. Access to specialist child and adolescent mental health services from first contact an improved face-to-face experience for young people from a specialist child and adolescent mental health service b. Specialist CAMHS advice for General Practitioners, Accident & Emergency staff, paediatricians, police, emergency duty teams, young people and families c. The pilot will collect a wide range of data to ensure that we commission an appropriate service going forward. 2. The NWL CCGs will, through CQUINs for 2015/2016, ensure that the nationally supported CYIAPT programme is introduced fully into the local CAMHS services, to ensure that evidence based practice is utilised and that session by session outcome measures are embedded. 3. West London, Central London and Hammersmith and Fulham CCGs were involved in the Tri-borough CAMHS Task and Finish Group which reported to Health and Wellbeing boards in December 2014. The CCGs are committed to supporting the recommendations of the group and the implementation of these. An example of this is that all three CCGS will via the contractual process ensure that there are comprehensive changes to transition process to support a better experience for young people needing to access Adult Mental health services at the age of 18 years. 4. There will be an additional CAMHs Task and finish group in Hammersmith and Fulham and the CCG have committed to supporting this and working with the local authority to produce an action plan with realistic recommendations that improve services and that are tailored to meet the local needs of the population. The task force is looking at all aspects of young peoples' mental health; joining up commissioning (schools, Public Health, Social care and CCGs), identifying gaps and hearing direct from young people. It will build on the recent national reports and the 12 recommendations from the inner London CCG CAMHS Task & Finish Group (2014) as endorsed by the Children's Trust and all three Health and Well Being Boards.

6. Operational resilience

Have you extended all of your operational resilience schemes from 2014/15 into April 2015 and beyond?	All resilience schemes have been extended during April, a review process is underway where decisions will be made on making more exceptional resilience schemes BAU if appropriate
If no and where you are stopping specific schemes, has this been approved by your SRG? Are you assured there will be no impact on performance?	N/A, due to allocations being made in baselines work is underway to agree resilience plans for 15/16, this will build on the last 2 years' experience and will be agreed and managed through SRGs.