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# Health and Wellbeing Board

**Date:** **TUESDAY, 22 JULY 2014**

**Time:** **2.30 PM**

**Venue:** **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

**Meeting Details:** Members of the Public and Press are welcome to attend this meeting

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**Statutory Members (Voting)**
Councillor Raymond Puddifoot MBE (Chairman)
Councillor Philip Corthorne MCIPD (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Douglas Mills
Councillor Scott Seaman-Digby
Councillor David Simmonds
Dr Ian Goodman (CCG)
Jeff Maslen (Healthwatch Hillingdon)

**Statutory Members (Non-Voting)**
Statutory Director of Adult Social Services
Statutory Director of Children's Services
Statutory Director of Public Health

**Co-Opted Members**
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group (officer)
Hillingdon Clinical Commissioning Group (clinician)
LBH - Deputy Director: Public Safety & Environment
LBH - Corporate Director of Residents Services & Deputy Chief Executive (VOTING)

**Published:** Monday, 14 July 2014

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***Putting our residents first***

**Lloyd White**
**Head of Democratic Services**
London Borough of Hillingdon,
3E/05, Civic Centre, High Street, Uxbridge, UB8 1UW
www.hillingdon.gov.uk

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# Agenda

## CHAIRMAN'S ANNOUNCEMENTS

| | | |
|---|---|---|
| **1** | Apologies for Absence | |
| **2** | Declarations of Interest in matters coming before this meeting | |
| **3** | To approve the minutes of the meeting on 1 April 2014 | 1 - 4 |
| **4** | To confirm that the items of business marked Part I will be considered in public and that the items marked Part II will be considered in private | |

## Health and Wellbeing Board Reports - Part I (Public)

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| **5** | Review of the Board's Membership and Terms of Reference | 5 - 14 |
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| **7** | Public Health Action Plan 2014/2015 | 35 - 42 |
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## Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

*The reports listed above in Part II are not made public because they contain exempt information under Part I of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it.*

**17** Any other items the Chairman agrees are relevant and urgent

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# Minutes

**HEALTH AND WELLBEING BOARD**

**1 April 2014**

**Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW**

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| | **Statutory Board Members Present:**<br>Councillor Ray Puddifoot (Chairman)<br>Councillor Philip Corthorne (Vice-Chairman)<br>Councillor Keith Burrows<br>Councillor Douglas Mills<br>Dr Ian Goodman – Hillingdon Clinical Commissioning Group<br>Stephen Otter – Healthwatch Hillingdon (substitute)<br><br>**Statutory Board Members:**<br>Merlin Joseph – Statutory Director of Children's Services<br>Sharon Daye – Statutory Director of Public Health<br>Tony Zaman – Statutory Director of Adult Social Services<br><br>**Co-opted Members Present**:<br>Jean Palmer – LBH Deputy Chief Executive and Corporate Director of Residents Services<br>Nigel Dicker – LBH Deputy Director: Public Safety & Environment<br>Maria O'Brien – Central and North West London NHS Foundation Trust (substitute)<br>Dr Kuldhir Johal – Hillingdon Clinical Commissioning Group (Clinician) (substitute)<br>Ceri Jacob – Hillingdon Clinical Commissioning Group (Officer) (substitute)<br>Nick Hunt – Royal Brompton and Harefield NHS Foundation Trust (substitute)<br><br>**LBH Officers Present:**<br>Kevin Byrne, Glen Egan and Nikki O'Halloran<br><br>**LBH Councillors Present:**<br>Councillors Beaulah East and John Major<br><br>**Press & Public:** 1 public |
| 63. | **APOLOGIES FOR ABSENCE** *(Agenda Item 1)*<br><br>Apologies for absence were received from Councillors Jonathan Bianco, Keith Burrows and Scott Seaman-Digby, Mr Jeff Maslen (Mr Stephen Otter was present as his substitute), Mr Shane DeGaris, Ms Robyn Doran (Ms Maria O'Brien was present as her substitute), Mr Robert Bell (Mr Nick Hunt was present as his substitute), Dr Tom Davies (Dr Kuldhir Johal was present as his substitute) and Mr Rob Larkman (Ms Ceri Jacob was present as his substitute).<br><br>It was noted that, as Dr Tom Davies and Mr Mike Robinson had stood down, the following vacancies had arisen on the Board:<br>1. The Hillingdon Hospitals NHS Foundation Trust<br>o VACANCY = substitute non-voting co-opted representative<br>2. Hillingdon Clinical Commissioning Group<br>o VACANCY = non-voting co-opted (clinician) representative |

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| | Formal nominations would be sought from the relevant organisations for appointment at the next Board meeting on 17 June 2014. |
| 64. | **TO APPROVE THE MINUTES OF THE MEETING ON 6 FEBRUARY 2014** *(Agenda Item 3)*<br><br>**RESOLVED: That the minutes of the meeting held on 6 February 2014 be agreed as a correct record.** |
| 65. | **TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)*<br><br>This was confirmed. |
| 66. | **BETTER CARE FUND: HILLINGDON PLAN** *(Agenda Item 5)*<br><br>Consideration was given to the report in relation to the Better Care Fund plan. It was noted that feedback had been received from NHS England and the Local Government Association in relation to the Hillingdon Better Care Fund (BCF) draft plan. The revised plan provided high level information in relation to 11 schemes with an emphasis on the frail and elderly. It was noted that the plan would need to be translated into an action plan that would specifically meet the needs of the Borough. To this end, it was recognised that residents should be engaged in the process.<br><br>Furthermore, it was agreed that an additional aim/objective be included in plan with regard to engagement (Section 2b). Namely, "we will ensure that we undertake regular engagement and communication with residents to show progress against all aspects of the plan." It was also agreed that, in the governance section of the plan (Section 2e), the phrase "The board therefore takes *full* strategic oversight for health and care systems in the Borough..." be amended by deleting the word "full".<br><br>With regard to the administration of the BCF budget, it was suggested that this be undertaken by the Council. The Board noted that the BCF budget would sit with the Health and Wellbeing Board and, as the Board had been formed as a Committee of the Council, it was a logical step for the administration of the budget to be undertaken by the Council. Significantly, this would also mean that the Council would be directly accountable for any consequences. However, it was acknowledged that a governance structure would need to be put in place below the Board to provide assurance to the partners.<br><br>Concern was expressed that, with regard to the administration of the budget, consideration would need to be given to practical issues such as the Section 75 agreement. Section 75 partnership agreements allowed budgets to be pooled between local health and social care organisation and authorities. Alignment of the different organisations' working practices would need to be worked through.<br><br>It was noted that risks, and the proposed mitigation, had been identified within the plan (Section 4). Of these risks, it was agreed that further consideration would need to be given to the implications of the proposed eligibility criteria and how this would work locally.<br><br>It was suggested that the composition and terms of reference of the Health and |

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| | Wellbeing Board Sub Committee be revisited to include responsibility to review the risks identified in the BCF plan. It was anticipated that this would help to ensure that, during the course of the next municipal year, further improvements were made to the plan prior to its implementation in 2015/2016.<br><br>It was thought that the governance arrangements and reconfiguration of the Sub Committee membership and redrafting of its terms of reference would be key to the success of BCF in Hillingdon. As a way forward, it was suggested that a formal or informal Executive Group be set up to comprise the CCG Chairman (plus one other representative) and the Leader of the Council (plus one other representative). This Executive Group could then be used to discuss any issues addressed by the Sub Committee that had proved challenging. It was agreed that finance officers could be included in the membership. Board members were asked to come forward with their thoughts on this as soon as possible so that appropriate action could be taken.<br><br>It was recognised that the BCF was providing the Borough with an opportunity to do things differently. It was suggested that it would be helpful to resolve the logistical considerations within the next 3 months.<br><br>**RESOLVED: That:**<br><br>**1. the Board agrees the Hillingdon Better Care Fund (BCF) plan and the financial summary at Appendices 1 & 2 for submission to NHS England and that the BCF budget be administered by the London Borough of Hillingdon;**<br><br>**2. the Board instructs the core officer group to develop business cases and implementation plans for the 11 schemes, in accordance with the governance arrangements in the plan, for discussion at the Board's next meeting on 17 June 2014; and**<br><br>**3. the composition and terms of reference of the Health and Wellbeing Board Sub Committee be revisited.** |
| 67. | **HILLINGDON CCG 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATING PLAN**<br>*(Agenda Item 6)*<br><br>Consideration was given to the Hillingdon CCG five year strategic plan and two year operating plan. It was noted that the strategic plan had been drawn up by a collaboration of eight North West London CCGs.<br><br>Hillingdon's two year operating plan would need to be submitted by 4 April 2014. Concern was expressed that the new operating plan format was not particularly user friendly, in that it comprised a series of spreadsheets. It was acknowledged that this format was significantly different to the previous year but that the key targets had been highlighted within the report.<br><br>The CCG would report the Board's comments about the plans needing a more readable flow back to the NWL CCGs. It would also report the Board's feelings that reference to local issues within the report needed to be strengthened. Furthermore, rather than referring to a percentage reduction target, it was thought to be more useful to identify how many people/instances that percentage would equate to locally in Hillingdon. |

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| | With regard to the operating plan, the Board was advised that further work would be undertaken on the spreadsheets to include more explanatory text. This revised document would then be circulated to Board members outside of the meeting.<br><br>Although concern was expressed that the CCG had not yet liaised with the Royal Brompton and Harefield NHS Foundation Trust in relation to the Friends and Family Test (FFT), it was noted that the majority of the Trust's contract sat with NHS England. It was recognised that the FFT was key and that hospitals' five year ambitions for improvements to care needed to align with *Shaping a Healthier Future.*<br><br>The Board was advised that, as the strategic plan needed to be submitted by 20 June 2014, it would be included for final consideration on the agenda of the next Health and Wellbeing Board meeting on 17 June 2014. It was noted that the strategic plan had taken account of core principles and other considerations and was intended to address the challenges set out in a 'Call to Action'.<br><br>Concern was expressed that the strategic plan had not included any information about how it was going to be implemented or monitored over the five year period. Whilst it was acknowledged that NHS England required CCGs to submit 5 year plans across a wider geographical footprint than individual borough level, Hillingdon was generally recognised as having a relatively self contained health economy. As such, taking a wider perspective was not seen as being particularly relevant to Hillingdon. It was suggested that, in order to highlight this as an issue, the Hillingdon CCG make representations to NHS England about this unnecessarily bureaucratic process.<br><br>The Board was advised that a stakeholder engagement event would be held in April / May. In addition, a major pan-North West London stakeholder event would be held in June 2014, prior to the Board's next meeting.<br><br>It was agreed that, because of the points already made at the meeting, and as there was not enough information available, the Board would note both the five year strategic plan and two year operating plan. As such, the operating plan would be submitted noting that it had not been signed off by the Board and the strategic plan would be reconsidered at the Board's next meeting on 17 June 2014.<br><br>**RESOLVED: That the Health and Wellbeing Board:**<br><br>**1. noted the 5 year strategic plan noting the final submission date of 20 June 2014; and**<br><br>**2. noted the local priority set out in the 2 year planning documents and requested additional information.** |
| 68. | **HILLINGDON CCG 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATING PLAN - APPENDIX 2** *(Agenda Item 7)*<br><br>Consideration was given to the Hillingdon CCG Draft 5 Year Strategic Plan.<br><br>**RESOLVED: That the plan be noted.** |
| | The meeting, which commenced at 2.30 pm, closed at 3.15 pm. |

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

# REVIEW OF THE BOARD'S MEMBERSHIP & TERMS OF REFERENCE

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Ray Puddifoot |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Nikki O'Halloran, Administration Directorate |
| **Papers with report** | Appendix 1 – Board Membership<br>Appendix 2 – Board's Terms of Reference & Standing Orders |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | The Health and Wellbeing Board has been established since 1 April 2013. Board members are now asked to review its membership and Terms of Reference. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy |
| **Financial Cost** | None |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | N/A |

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

1. **notes the Statutory Board Membership and the Co-opted Members, as set out in Appendix 1, and considers any amendments (including appointments to the vacancies);**
2. **reviews the Board's Terms of Reference and Standing Orders in Appendix 2 and considers any amendments; and**
3. **notes that all non-voting Co-opted Members will be required to sign a confidentiality agreement.**

## 3. INFORMATION

**Supporting Information**

Terms of Reference

The Health and Social Care Act 2012 required the Council to establish a Health and Wellbeing Board from 1 April 2013 as a Committee of the Council to oversee the production of the Joint

Health & Wellbeing Strategy, Joint Strategic Needs Assessment and to encourage integrated health working to improve the quality of life for local residents.

At the Council's AGM on 9 May 2013, the new Health and Wellbeing Board was formally approved as a Committee of the Council. As such, any amendments made to the Board's Terms of Reference need to be formally agreed at a Council meeting.

The Council's Democratic Services Team is responsible for supporting the operation of the Board and the Chairman. Whilst the Board operates similarly to a Committee, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 brought in some unique differences in terms of membership and voting.

Membership

The Board is chaired by the Leader of the Council. It has Statutory Members, as required by law, which includes officers of the Council, a representative of local Clinical Commissioning Group and a representative of Healthwatch Hillingdon.

The Local Trusts and NHS representatives are invited to attend Board meetings as Co-opted Non-Voting Members. Statutory Members and Co-opted Members are allowed a single nominated/named substitute.

It is possible that, during the course of the yearly cycle of meetings, different organisations will approach the Board seeking to join as Co-opted Members. The Terms of Reference provide for the Board to agree any such appointments on an ad hoc basis.

Board Member Vacancies

There are currently two vacancies that have arisen on the Board:

1. The Hillingdon Hospitals NHS Foundation Trust - **Substitute** Non-Voting Co-opted representative
2. Hillingdon Clinical Commissioning Group - Non-Voting Co-opted (clinician) representative

These vacancies are for non-voting co-opted members and, as such, they can be agreed by the Board without the need for the appointments to be ratified by Council. The Board is therefore asked to consider nominations for appointment.

Voting Rights

In addition to Councillors, the statutory representatives from the local Clinical Commissioning Group and Healthwatch Hillingdon (and their substitutes if required) will be entitled to vote at meetings but Co-opted Members and Council officers will not.

The only exception to these voting rights is that the Deputy Chief Executive and Corporate Director of Residents Services, as a Co-opted Member, has voting rights. This is due to her significant corporate and resident facing remit across a whole range of Borough-wide services, including public health.

The national regulations surrounding the Board require that all 'voting' members sign up to the Council's Code of Conduct. The Code of Conduct is a set of golden rules by which Elected Councillors must follow to ensure high standards in public office. It includes a public declaration

of any interests. It should be noted that the term “Co-opted Member” so far as the Code of Conduct is concerned is different to that of a Co-opted Member on the Board.

The Board requires that the confidential nature of reports containing exempt information within the meaning of section 100I of the Local Government Act 1972 (commonly known as Part II reports) is observed at all times and by all members of the Board. As Co-opted non-voting members of Hillingdon's Health and Wellbeing Board are not bound by the Council’s Code of Conduct, these members are asked to complete a confidentiality agreement. This agreement notes the confidentiality requirement and the need to refrain from discussing or disclosing any aspect of confidential reports to any individual or body outside of the meeting.

**Financial Implications**

There are no financial implications arising from the recommendations in this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

N/A

**Consultation Carried Out or Required**

Consultation with the Chairman of the Board and relevant officers.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no financial implications arising from the recommendations in this report.

**Hillingdon Council Legal comments**

Section 194 of the Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board to comprise a number of Statutory Members and such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Sections 195 and 196 of the Health and Social Care Act 2012 specify the functions of the Board. These duties are to encourage persons engaged in the provision of any health or social care services "to work in an integrated manner" and to "provide advice, assistance or other support" to encourage joint working between local authorities and NHS bodies. Section 196 also specifies that the Board is to exercise the Council's functions under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 - assessment of health and social care needs in the Borough and the preparation of the Joint Health and Wellbeing Strategy.

In addition, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out how the Board should operate as a Committee of the Council. Regulation 6 provides that the existing legislation on voting rights need not apply

unless the Council so directs. However, before making such a direction on voting rights, the Council is required to consult the Board. Regulation 7 makes there no requirement to have all political groups within the Council represented on the Board.

Section 49(7) of the Local Government Act 2000 requires any external members of a Council committee to adhere to the Members Code of Conduct if they have an entitlement to vote at meeting of the committee.

## 6. BACKGROUND PAPERS

NIL

**APPENDIX 1**

**HEALTH AND WELLBEING BOARD MEMBERSHIP 2014/2015**
*subject to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.*

| Organisation | Name of Member | Substitute |
|---|---|---|
| **STATUTORY MEMBERS (VOTING)** | | |
| Chairman | Councillor Puddifoot | Any Elected Member |
| Vice-Chairman | Councillor Corthorne | Any Elected Member |
| Cabinet Members | Councillor Simmonds | Any Elected Member |
| | Councillor Mills | Any Elected Member |
| | Councillor Bianco | Any Elected Member |
| | Councillor Burrows | Any Elected Member |
| | Councillor Seaman-Digby | Any Elected Member |
| Healthwatch Hillingdon | Mr Jeff Maslen | Mr Stephen Otter |
| Clinical Commissioning Group | Dr Ian Goodman | Dr Kuldhir Johal |
| **STATUTORY MEMBERS (NON-VOTING)** | | |
| Statutory Director of Adult Social Services | Mr Tony Zaman | Mr Nick Ellender |
| Statutory Director of Children's Services | Ms Merlin Joseph | Mr Tom Murphy |
| Statutory Director of Public Health | Ms Sharon Daye | Ms Shikha Sharma |
| **CO-OPTED MEMBERS (VOTING)** | | |
| LBH | Ms Jean Palmer | N/A |
| **CO-OPTED MEMBERS (NON-VOTING)** | | |
| The Hillingdon Hospitals NHS Foundation Trust | Mr Shane DeGaris | ***VACANCY*** |
| Central and North West London NHS Foundation Trust | Ms Robyn Doran | Ms Maria O'Brien |
| Royal Brompton and Harefield NHS Foundation Trust | Mr Robert J Bell | Mr Nick Hunt |
| LBH | Mr Nigel Dicker | N/A |
| Clinical Commissioning Group (Officer) | Mr Rob Larkman | Ms Ceri Jacob |
| Clinical Commissioning Group (Clinician) | ***VACANCY*** | Dr Kuldhir Johal |

**APPENDIX 2**

## HEALTH AND WELLBEING BOARD TERMS OF REFERENCE
## (Updated and agreed at Council on 12 September 2013)

### (a) Introduction

In accordance with the Health and Social Care Act 2012 and any subsequent related legislation, the Health and Wellbeing Board will seek to improve the quality of life of the local population and provide high-level collaboration between the Council, NHS and other agencies to develop and oversee the strategy and commissioning of local health services.

The Board will operate as a Committee of the Council in accordance with the Committee Standing Orders and Access to Information Procedure Rules set out in this Constitution.

The core functions of the Board are not executive functions and are not therefore subject to any scrutiny call-in procedure.

The Board will seek to comply with its duties under the Equality Act 2013, Freedom of Information Act 2000 and the Data Protection Act 1998.

### (b) Membership

Statutory Members

The Chairman of the Board shall be the Leader of the Council. The Vice-Chairman of the Board shall be the Cabinet Member for Social Services, Health & Housing.

Other Statutory Members that may attend meetings are:

1) Cabinet Members from the London Borough of Hillingdon
2) A representative from the Clinical Commissioning Group covering Hillingdon
3) A representative from Healthwatch Hillingdon
4) Statutory Director of Adult Social Services
5) Statutory Director of Children's Services
6) Statutory Director of Public Health

Political Balance

There is no requirement to have all political groups within the Council represented on the Board.

Substitutes for Statutory Members

Cabinet Members may nominate any other Elected Member of the Council as a substitute. Other Statutory Members of the Board must nominate a single individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

Co-opted Members

From time to time and upon the agreement of the Board other individuals or representatives may attend Board meetings as Co-opted Members. Co-opted Members may nominate a single, named individual who may substitute for them in the event that they are unable to attend a meeting, e.g. representatives of local NHS Hospitals or Trusts.

Voting rights

Voting rights will apply to the following Statutory Members:

- All Elected Members of the Council on the Board;
- The representative from the Clinical Commissioning Group covering Hillingdon; and
- The representative from Healthwatch Hillingdon.

Voting rights will apply to the following Co-opted Member:

- The Deputy Chief Executive and Corporate Director of Residents Services.

Subject to consultation with the Board, the Council may then direct whether or not voting rights apply to any other Statutory Member or Co-opted Member.

Code of Conduct

All voting Members of the Health and Wellbeing Board will be bound by the Council's Code of Conduct for Members, as adopted.[1]

**(c) Sub-Committees and Working Groups**

The Board may establish and appoint to sub-committees and working groups. The Board may delegate any of its functions to sub-committees or working groups or request them to undertake task and finish reviews or project work in the pursuit of the Board's goals.

Members of a sub-committee or working group may be a Statutory or Co-opted Member of the Board or any Elected Member of the London Borough of Hillingdon. Additional members of a sub-committee or working group will be agreed by the Board.

Sub-committees and working groups will cease to exist upon a decision by the Board.

**(d) Terms of Reference**

1. To fulfil statutory requirements to improve the health and wellbeing of the local population, specifically to:

[1] Non-voting Co-opted members are required to complete a Confidentiality Agreement.

(a) Lead on the duty to assess and publish information about the needs of the local population (joint strategic needs assessment (JSNA);

(b) Deliver the duty to prepare and publish a Joint Health and Wellbeing strategy based on the JSNA, to consider Health and Social Care Act flexibilities in developing the strategy and involve local residents and others as appropriate;

(c) Promote integrated and partnership working across areas, including through the promotion of joined up commissioning plans across the NHS, social care and public health; and

(d) Support, be involved in and provide opinion on joint commissioning plans and the review of how well the Health and Wellbeing strategy is meeting needs. This includes providing an opinion on how well the Clinical Commissioning Group (CCG) contributes to the delivery of the joint Health and Wellbeing strategy.

2. To be responsible for:

(a) Providing leadership in developing a strategic approach for health and wellbeing in Hillingdon;

(b) Developing the statutory Health and Wellbeing Strategy;

(c) Ensuring that the Health and Wellbeing Strategy is informed and underpinned by the JSNA and is focused upon:
- Improving the health and wellbeing of the residents of Hillingdon;
- The continuous improvement of health and social care services;
- The reduction of health inequalities;
- The involvement of service users and patients in service design and monitoring; and
- Integrated working across health and social care where this would improve quality;

(d) Reviewing performance on delivering the Health and Wellbeing Strategy and other key strategic targets;

(e) Holding partner agencies to account for performance on agreed priorities in conjunction with the External Services Scrutiny Committee;

(f) Influencing and approving the Clinical Commissioning Group (CCG) commissioning plan and annual update;

(g) Collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance;

(h) Monitoring the performance of Public Health and reviewing services in conjunction with the External Services Scrutiny Committee; and

(i) Reviewing the Terms of Reference and operation of the Board regularly, making recommendations to Council as required.

## HEALTH AND WELLBEING BOARD STANDING ORDERS

These Committee Standing Orders apply to the Health and Wellbeing Board set out in Article 8 of the Constitution, with the following exceptions to these rules taking precedence at any time:

1. Any speaking rights for Elected Members who are not Members of the Board do not apply to meetings of the Board or any of its sub-committees or working groups.

2. A Quorum of the Board shall be 50% of its statutory membership. A Quorum of any sub-committees or working groups of the Board shall be 50% of their membership or 3 members (whichever is the greater).

3. Any meeting of the Board may establish and appoint to its sub-committees or working groups.

4. Upon any recommendations from the Board, Statutory Membership will be approved by full Council.

5. Upon request from an organisation, approval of any appointments to the Board as a non-statutory Co-opted Member will be agreed by the Board, in consultation with the Chairman and the Head of Democratic Services.

6. Decisions shall be made on the basis of a vote and show of hands of a majority of members present. Subject to the vote being tied, the Chairman will have a second or casting vote.

7. The Board and any sub-committees or working groups shall meet as required, with the agreement of the Chairman and/or in the circumstances where the Chairman receives a request in writing by more than 50% of the Statutory Members of the Board.

# JOINT HEALTH & WELLBEING STRATEGY ACTION PLAN UPDATE 2013/2014

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Ray Puddifoot<br>Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Kevin Byrne, Administration Directorate |
| **Papers with report** | Appendix 1 – Action Plan Update |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This report presents progress on key actions to deliver Hillingdon's Health and Wellbeing Strategy priorities. The Board is asked to consider and comment on the update. |
| **Contribution to plans and strategies** | This paper helps the Board to see the progress being made to deliver the key actions to underpin Hillingdon's Health and Wellbeing Strategy. |
| **Financial Cost** | There are no direct financial implications arising directly from this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**The Health and Wellbeing Board is asked to:**

1. **review and comment on the performance achievements for the year 2013/14.**
2. **consider and agree to bring together into one update report for the next meeting of the Board progress on the Health and Wellbeing Strategy, the Better Care Fund Plan and the Public Health Action Plan.**

## 3. INFORMATION

### Supporting Information

3.1 Attached to this report (Appendix 1) is an update of the 2013/14 Health and Wellbeing Action Plan to the end of March 2014. The Action Plan has been structured to see easily how actions being taken align to the priorities in Hillingdon's Health and Wellbeing Strategy. The actions focus on those areas identified to promote health improvement and reduce differences in health.

3.2 The updates to the Action Plan indicate where progress is being made and will contribute to the range of indicators which measure improvement within the outcomes frameworks for health, public health and adult social care.

3.3 Where information is available, the updates to the Action Plan also include local information about the difference services are making to improve peoples' lives.

3.4 A summary of the achievements to date against each of the priorities set out in the Health and Wellbeing Strategy are as follows:

***Priority 1 – Improving health and wellbeing and reducing inequalities***

The priority set out in Hillingdon's Health and Wellbeing Strategy is to increase the number of people taking part in regular exercise and tackling obesity.

| Key Targets | Progress | Status |
|---|---|---|
| • An additional 7,000 people take part in regular exercise by March 2015 | • Just under 4,000 additional residents (estimated) are now taking part in regular exercise since April 2012.<br>• A range of new activities are available for Hillingdon residents of all ages and abilities, including free swimming, co-ordinated cycle rides, healthy walks, dances and targeted exercise programmes for children and young people, people with disabilities and older residents. | On track. |

***Priority 2 – Invest in prevention and early intervention***

The priorities set out in Hillingdon's Health and Wellbeing Strategy are to reduce reliance on acute and statutory services; children's mental health and risky behaviours; dementia and adult mental health; and sight loss.

| Key Targets | Progress | Status |
|---|---|---|
| • More than 50% of people receiving intensive re-ablement do not require care following the service. | • A rising proportion of residents who benefit from a re-ablement service do not need ongoing support or care following re-ablement. To the end of March 2014, 68% of residents do not require ongoing care or support (60% for 2012/13). | Exceeded Target. |
| • Complete a review of the CAMHS service and recommend changes for the care pathway. | • Ongoing. A review of the CAMHS service has been completed. This includes an evaluation of the service and recommendations for developing the service to meet needs. | On track. |
| • Continue to achieve a high percentage of children and older people being immunised to protect them from infection. | • Historically Hillingdon has a high take-up level of immunisations.<br>• The latest data for MMR shows high take-up.<br><u>MMR data for October – December 2013</u><br>MMR 24 months = 91%, England 93%<br>MMR (1 dose) 5 years = 92.7%, England 94.4% | On track. |
| • Establish a plan to maintain healthy sight and manage the impact of sight loss. | • A review is underway led by the Pocklington Trust. This includes an analysis of current and future needs. Recommendations will be presented to the Board for consideration. | On track. |

***Priority 3 - Developing integrated, high quality social care and health services within the community or at home***

The priorities set out in Hillingdon's Health and Wellbeing Strategy are to develop integrated approaches for health and wellbeing, including telehealth; and the Integrated Care Programme (ICP).

| Key Targets | Progress | Status |
|---|---|---|
| • Full rollout of the Integrated Care Programme (ICP) to all GP practices by the end of 2013. | • As at 31st March 2014, most (87%) GP practices are participating. An early evaluation of the first 12 months is showing very positive results. 65% of professionals attending an integrated care planning arrangement reported they have changed their practice. This work is a key part of the Better Care Fund plan. | On track. |
| • Extend the TeleCareLine service to 3,000 additional people by March 2015 (750 additional people per year over 4 years). | • As at 31st March 2014, 2,760 new service users were in receipt of a TeleCareLine equipment service. The technology is helping people to live safely and independently at home. The take-up of TeleCareLine is exceeding the target of 750 new service users set for each year of the scheme. TeleCareLine is free to older people and has been extended to residents aged 80 years or older from April 2014. | On track. |
| • Provide extra care and supported accommodation to reduce reliance on residential care. | • The supported living building programme is currently being reviewed to ensure it meets the current and future needs.<br>• Bespoke small schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation. | On track. |

***Priority 4 - A positive experience of care***

The priorities set out in Hillingdon's Health and Wellbeing Strategy are to develop tailored, personalised services; and establish an ongoing commitment to stakeholder engagement.

| Key Targets | Progress | Status |
|---|---|---|
| • Increase the percentage of adults and older people in receipt of a personal budget to at least 70% | • As at 31st March 2014, overall a higher 76.9% of all social care clients (2,807 clients in total – adults and older people) were in receipt of a personal budget (based on services which are subject to a personal budget). Take-up of personal budgets is higher for older people (82.2%, 2,173 older people). | On track. |

**Development of the Report for the Board**

To bring together updates on performance from across partners, this report proposes that the updates on the Health and Wellbeing Strategy, the Better Care Fund and the Public Health action plan are combined into one report for the Board. The 2014/15 reports to the Board will include a wider set of information to support the review and ongoing monitoring of the Better Care Fund plan. The plan requires a specific focus on further integration and the guidance sets out the national measures as:

- Admissions to residential and care homes;
- Effectiveness of reablement;

- Delayed transfers of care;
- Avoidable emergency admissions; and
- Patient / service user experience.

Subject to agreement from the Board, changes will be made to the report scheduled to be presented to the Board in September 2014.

**Financial Implications**

There are no direct financial implications arising from the recommendations set out in this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

The update of the action plan for Hillingdon's Health and Wellbeing Strategy supports the Board to see progress being made to towards the key priorities for health improvement in the Borough.

**Consultation Carried Out or Required**

Updates of actions to the plan have involved close working with partner agencies to provide information.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no direct financial implications arising from the recommendations set out in this report.

**Hillingdon Council Legal comments**

The Health and Social Care Act 2012 ('The 2012 Act') amends the Local Government and Public Involvement in Health Act 2007. Under 'The 2012 Act', Local Authorities and Clinical Commissioning Groups (CCGs) have an equal and joint duty to prepare a Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) for meeting the needs identified in JSNAs. This duty is to be delivered through the Health and Wellbeing Board (HWB).

HWBs are committees of the Local Authority, with non-executive functions, constituted under the Local Authority 1972 Act, and are subject to local authority scrutiny arrangements. They are required to have regard to guidance issued by the Secretary of State when undertaking JSNAs and JHWSs.

## 6. BACKGROUND PAPERS

Nil.

# Appendix 1 - Hillingdon Health and Wellbeing Strategy - Partnership Action Plan 2013/2014

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| ***Priority 1 - Improved health and wellbeing and reducing inequalities***<br>As a priority we will focus on physical activity and obesity. | | | | | | |
| 1.1 To increase physical activity levels by 5% each year for the next three years to improve health, wellbeing and help tackle levels of obesity | Develop and begin to implement a three year strategy to increase participation in physical activity | Physical Activity Strategy Group | Increase the number of residents participating in regular exercise by 7,000 people through a range of targeted initiatives including;<br><br>a) Develop a programme to increase activity for adults and older people | (a)-(h) 31/03/15 | On track. Just under an estimated 4,000 additional adults, older people, children and young people are now taking part in regular exercise since the programme commenced from April 2012.<br><br>a) A range of programmes have been developed and delivered which is proving successful in engaging residents of all ages and abilities in regular exercise. These include:<br>• Programme of dances delivered (tea dance, disco, bollywood and line dancing). There has been an estimated 2,338 people attending these dances since during 2013/14. July 2013 evaluation: 51% valued tea dances as a way of being active and 77% reporting wellbeing benefits.<br>• Chair based exercise class at Wellbeing days delivered - Northwood 45 people, Harefield 40 people.<br>• Back to sport programme proved successful - 498 new participants - 137 being new to sport (participating in sport less than 5 times in the last 2 days). 856 people registered on database with 38% going on to join a regular B2S programme. Continued evidence of adults joining clubs from back to sport programmes (7 Hockey, 4 Fencing, 3 Tennis).<br>• Take-up of free swimming sessions for older people has been high. During 2013/14 a total of 25,971 free swimming sessions have been taken up by older people: 27% higher (+5,438 swims) than the same time last year. Typically 1,900 older people take up the free swimming every year.<br>• The 'drummunity' project for people with dementia is proving successful. Sessions continued at Grassy Meadow, Triscott House and Asha Day Centre. 31 people regularly take part in sessions. New sessions offered in 2 new settings. Feedback from relatives, carers and staff has been very positive. Participants were observed to be happier and with greater strength in their drumming.<br>• Jog it off programme - 6 weekly sessions averaging 20 runners per week. All sessions have a Run England trained leader. Total attendance for all sessions during 2013/14: 788 | GREEN |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| | | | b) Develop a programme to increase activity for children and young people | | (b) Regular drop in sports sessions developed as a 'StreetGames' programme for young people now includes football, girls football, boxing, dodgeball and multisport. Additional activities planned for the Uxbridge area. Throughput - 2519, Participants - 222, New Participants - 55<br><br>School walking and cycling (2013-14)<br>• 1,048 children completed bikeability level 1 and 2<br>• 5,411 children completed pedestrian safety training<br>• We are currently in the process of recruiting additional cycle instructors and pedestrian trainers to allow an increase in training that can be provided. | GREEN |
| | | | c) Set up travel plans | | (c) Travel plans required for new residential and commercial development. 74 identified business travel plans in the database and 22 plans are being monitored.<br>For schools, 27 schools registered for Key stage 1 'Walk once a week': 53 schools involved with Walk-on-Wednesday. | |
| | | | d) Show an increase in cycling and walking | | (d) New information has been produced during the year to encourage residents to 'Explore Hillingdon'. 3 new volunteers trained to deliver Walk Hillingdon programme. Over 400 volunteering hours given through Walk Hillingdon programme. 60 cycle rangers in place. The Healthy Walks programme - there are 150 registered walkers who walk a minimum of once a month. 172 adults received cycle training (2013-14). | |
| | | | e) Recruit volunteers to support local networks | | (e) 'Sportunity' volunteering programme for 14-25 yr olds set up that provides incentives for young residents interested in sports leadership. Green spaces volunteering opportunities – approx 70 people with 10 new volunteers in last 12 months. Estimated 70+ volunteers at Eastcote House Gardens. New Cycle Ranger programme developed to help deliver LBH biking Borough programme. | |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| | | | f) Review and support opportunities for people with disabilities<br><br>g) Set up care pathways with Primary Care and Public Health<br><br>h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity. | | (f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. Programmes continue. 30 participants in Panathlon. DASH sessions average 140 people per week<br><br>(g) Reviewed delivery of existing cardiac referral scheme. Let's Get Moving programme - 2 advisers recruited. Presentation to 30 pharmacy managers. Links identified within clinical care pathways and referral linked to NHS Healthchecks. Links made with CCG Communications.<br><br>(h) Lamppost banners promoting a wide range of opportunities. Regular articles in Hillingdon People. | GREEN |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 1.2 Help to tackle fuel poverty to improve health and wellbeing | Reduce fuel poverty | LBH | (a) Improve 70 private sector homes for older vulnerable people.<br><br>• 30 heating measures<br>• 30 insulation measures<br>• Complete essential repairs to 10 homes for vulnerable & older households<br><br>(b) Deliver Age UK Hillingdon's Housing Options Service and Winter Warmth Campaign | (a) 31/03/14<br><br>(b) 31/03/14 | (a) Since April 2013, improvements have been made to 121 homes of older people in Hillingdon as follows (some older people benefited from more than one of the following):<br><br>• Heating improvements have been made to the homes of 44 older people.<br>• 63 homes with improved insulation measures.<br>• 104 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks.<br><br>Overall, the target has been exceeded.<br><br>(b) Ongoing – The campaign was promoted at the Older Persons day on 1st October 2013 including an event held in Uxbridge Town Centre. The event held was very successful with a good variety of stands offering a comprehensive range of information to older people and a good flow of visitors throughout the day. The Age UK Hillingdon Information and Advice stand saw 144 people and specifically gave out 21 Winter Warmth leaflets, following discussion with visitors about the campaign.<br><br>Age UK continue to provide advice and guidance to older people through their outreach work to help older people keep warm and well this winter. | GREEN |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| ***Priority 2. Prevention and early intervention***<br>As a priority we will focus on:<br>• Reducing reliance on acute and statutory services;<br>• Children's mental health and risky behaviours;<br>• Dementia and adult mental health;<br>• Sight loss. | | | | | | |
| 2.1 Reduce reliance on acute services and prevent avoidable hospital attendances, admissions and readmissions. Deliver the out of hospital strategy. | Develop and implement plans to prevent avoidable admission or readmission into hospital and avoidable demands on social care services by 31/03/15. | Integrated Care Steering Group | (a) Integrated Care Program to increase the number of people with long term conditions who have a multidisciplinary care plan, specifically targeting at risk groups with diabetes, respiratory disease and the frail elderly | (a) 31/03/14 | (a) Ongoing - The Integrated Care Programme (ICP) went live in 2012 providing a joined up approach to patient care across health and local authority services based around case discussion at GP practices. Most (87%) GP practices have now signed up to the new ICP services. The programme is targeting residents with complex care needs (older frail people, those with diabetes, people with mental health needs, chronic obstructive pulmonary disease and patients with cardiac difficulties).<br><br>The programme is showing positive results including higher rates of agreed care plans completed, positive feedback from patients, high levels of involvement from teams and changes in the way of working which are delivering efficient practices. | GREEN |
| | | | b) Enhance the number of people who are transferred home with support from emergency assessment beds at Hillingdon Hospital | (b) 31/03/14 | (b) Ongoing. Key services are in place and delivering benefits. This includes TeleCareLine, reablement and essential support from the voluntary sector through the 'prevention of admissions and re-admissions' service from Age UK. | |
| | | | c) Increase the complexity of people managed in the community by intermediate care services to include dementia and older people with mental health needs | (c) 31/03/14 | (c) On track – A flexible service will be commissioned to meet bed-based care needs on a short-term basis. | |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 2.2 Improve access to local Child and Adolescent Mental Health Services (CAMHS) | A review of mental health provision for children and young people across the following sectors in the borough: the NHS, social care, education, schools, public health, criminal justice, third sector, adult social care. | CAMHS | (a) Clarify statutory responsibilities for all delivery partners regarding services in scope<br>(b) A map of local CAMHS/mental health and Learning Disabilities/Challenging Behaviour provision at all tiers for services in scope: service provision, service capacity, referral access<br>(c) Identify local population needs and initial recommendations regarding meeting service gaps<br>(d) An evidence review of "what works"; and feedback from users<br>(e) Whole systems service design for child mental health support | a) 31/12/13<br>b) 31/12/13<br>c) 31/12/13<br>d) 31/01/14<br>e) 31/03/14 | (a-e) Senior Team to Team meeting was established with health commissioners as overarching steering group.<br><br>CAMHS Working Group formed with health commissioner, local authority and provider representatives.<br><br>The review of CAMHS has been completed and the recommendations are being considered. | GREEN |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 2.3 To continue to reduce teenage pregnancy rates and reduce STIs in young people. | To promote awareness of the risks and to increase take-up of screening. | Public Health | (a) Pilot the extension of the Outreach Contraception and Sexual Health Advice to vulnerable Young People: Children Looked After, Homeless Young People, Young Carers, Drug and Alcohol Users. | a) 31/03/14 | (a) Teenage pregnancy was at its lowest in 2012. There were 139 conceptions recorded and a conception rate of 27.7 per 1,000 females under 18 years old. The maternity rate (those who choose to keep their baby) rose to 12.6 from 7.8 in 2011 along with the lowest abortion rate of 15.2 that Hillingdon has experienced since the baseline period of 1998. The percentage of conceptions leading to an abortion in 2012 was 54.7% - a significant reduction from 2011 when it was at its highest at 72%. (Note: The 2013 teenage conception data will be released in April 2015).<br><br>The changes may be due to a number of initiatives– which include the appointment of a Sexual Health Outreach Nurse working with young people who ordinarily would not access mainstream community sexual health services; the SRE Officer who worked closely with schools; the commissioned Chlamydia Screening Team's outreach work in educational settings including - Colleges and Brunel University; the 'trusted professionals' sign posting young people to local services. | GREEN |
| | | | (b) Increase the Chlamydia Screening uptake by the Brunel University population: a) Increase Awareness of the Chlamydia Screening service on Campus, b) Refocusing the service to repeat Chlamydia testing annually or on change of partner/s. | (b) 31/03/14 | (b) Throughout 2013/14 Terrence Higgins Trust providers of Chlamydia Screening investigated and implemented various ways to increase Chlamydia Screening awareness at Brunel University (eg. via the university Intranet/emails). Training was provided for the University Medical Centre and Pharmacy in (Oct-Dec); rolling out of the C-Card across campus; 7 training workshops for 30 members of staff across five outlets; Targeted awareness raising of the risks on campus focusing on Chlamydia/C-Card and Transgender issues/HIV.<br><br>In Q3 and Q4 of 2013/14 the Chlamydia Screening Service increased its focus on delivering a more targeted approach using the Diagnostic Outcomes Measure (DOM) and reducing the 'mass screening' approach. | |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| | | | (c) Develop a proposal to extend the current Emergency Hormonal Contraception service, from under 18yrs to under 25yrs and based on local evidence, include a further 9 Pharmacies in the revised TP hotspot wards (ONS 2011) | (c) 31/03/14 | (c) Patient Group Direction (PGD) for Emergency hormonal contraception (EHC) and Chlamydia Treatment developed and signed off in 2013 as well as training for the 28 Pharmacists participating in the scheme. Community Pharmacists are now delivering Condom Card Service as part of the EHC PGD. The proposal to extend the Emergency Hormonal Contraception service to under-25 year olds was developed and is currently being piloted. | |
| 2.4 Develop the model of care for dementia | Reduce dependency on institutional care, including hospital bed days and care home settings. | Mental Health Delivery Group | (a) Finalise and begin to implement a joint plan for dementia services to include a service model that delivers effective assessment, treatment and community based support and intervenes earlier in the course of the disease.<br><br>(b) Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy. | a) 31/03/14<br><br>b) 31/03/14 | (a) Adult Mental Health strategy in place including dementia. A mental health task and finish group has been established to co-ordinate and implement the agreed plan for adult services of all ages. The plan will complement work already underway and being delivered which includes befriending services, dementia cafes, programmes which promote healthy living and health improvement and increasing early intervention for memory assessment.<br><br>(b) Ongoing. Plan will be recommended for consideration by the Health and Wellbeing Board. | GREEN |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 2.5 Improve pathways and response for individuals with mental health needs | To ensure information and access to support is available for people with mental health needs, and that pathways are in place to enable appropriate responses to need | CCG | (a) to develop crisis response and ongoing support of 14 weeks for older people with mental health needs including dementia | (a) 31/03/14 | (a) Service developed to an integrated model, which is embedded across the new service elements; the rapid response, ICP, memory service and intermediate care for people with mental health and dementia. The new provision will equip carers with the appropriate skills and resources to navigate patients away from unnecessary admissions and access home based care and support patients to be discharged back to home. | GREEN |
| | | | (b) to implement urgent assessment pathways and with all mental health providers to enable a consistent response and standards of care across the whole system | (b) 31/03/14 | b) To implement common standards for urgent assessment and care so that service users experience a consistent response when referred for an urgent need. This will include:<br>1. develop and implement standardised processes for urgent referral agreed with stakeholders. Standards have been agreed.<br>2. Identify and address training needs and appropriate health and social care record-keeping to support effective shared care and provide a high quality care pathway - local implementation plan under development with providers.<br>3. Ensure onward pathways are developed to support improved patient experience when accessing services via urgent referral - on track. | |
| | | | (c) to evaluate the liaison psychiatry pilot programme and identify benefits to improved liaison between physical and health care needs for 14/15 . | (c) 31/04/13 | c) The psychiatric liaison pilot - interim evaluation showed benefits to services using qualitative and quantitative methods. Further work to review the extension of service model will require the development of a business case. Service Specification has been developed. LPS service will be based on costed service model for 14/15. | |

| Objective | Key Task | Lead | Subtasks | Dead-line for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 2.6 Reduce alcohol-related harm for hazardous, harmful and dependent drinkers in Hillingdon | Commission a range of interventions to reduce alcohol-related harm and to increase the numbers of alcohol clients referred from acute and primary care settings into community-based treatment services. | Public Health | (a) Increase numbers of alcohol clients presenting to the treatment system and in structured treatment<br><br>(b) Increase the numbers and rate of alcohol clients successfully completing and exiting treatment. | (a) 31/03/14<br><br>(b) 31/03/14 | (a) 528 clients in treatment in Quarter 4, a reduction of 12%.<br><br>(b) Successful completions (Q4 – 2013-14): 176 clients successfully completed treatment in the 12 months ending Q4 2013/14. This represents a successful completion rate of 33.3% which is slightly lower than the baseline period (ie. 36.4%). (please note: Successful completions is a key measure of a recovery focussed treatment system. On average, alcohol dependent clients assessed as requiring structured treatment, stay in treatment for 6-7 months).<br><br>Trend Analysis: A request has been made to Public Health England to receive data on performance over the past five years in order to gain a clearer understanding of performance over time.<br><br>Category Management: The commissioning of substance misuse services (drugs and alcohol) is currently under review as part of the BID Transformation review process. The aim of the review is to fully understand the current position in terms of: the range and quality of services being provided; assessing whether services are meeting the needs of residents and to identify priorities for a future model of delivery.<br><br>The existing substance misuse contracts that are due to end on 31st October 2014 will be extended to 31st March 2015. A full competitive tender exercise for these services will be undertaken. | GREEN |

<table>
<tr><th>Objective</th><th>Key Task</th><th>Lead</th><th>Subtasks</th><th>Deadline for Subtask</th><th>Progress Update</th><th>RAG</th></tr>
<tr>
<td>2.8 to reduce the extent of low birth rate<br><br><u>Smoking in Pregnancy:</u> Babies from deprived backgrounds are more likely to be born to mothers who smoke and to have much greater exposure to secondhand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.</td>
<td>To develop a targeted programme in geographical areas with high rates of low birth weight babies, to increase the confidence and participation of parents/women to have healthy babies.</td>
<td>Public Health</td>
<td>(a) <u>12 week assessments</u> -Increase the percentage of women who have seen a midwife or a maternity healthcare professional, or had an assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy. (National indicator target 90%)<br><br>(b) <u>Low Birth Weight</u> - Decrease the percentage of Live and Still Births less than 2500 grams.<br><br>(c) Low Birth Weight of Term Babies: (ie. less than 2,500 grams):</td>
<td>(a) 31/03/14<br><br>(b) 31/03/14<br><br>(c) 31/03/14</td>
<td>(a) There has been a proactive effort to ensure that our target rate has been achieved.<br><br>12 Week Assessment - 2012/13 Performance:
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>79.9%</td><td>79.9%</td><td>94.3%</td><td>90.2%</td></tr>
</table>
The Commissioning Support Unit have confirmed that the Department of Health will commence the collection of maternity assessment data in 2014 and that it will be obtained directly from the providers rather than CCGs.<br><br><u>(b + c) Task and finish group ('Having a Healthy Baby')</u>: Questionnaire has been developed to establish what having a healthy baby means for women (ie. those of child bearing age and older women. The latter often advise younger women on pregnancy) living in the South of the borough and how this impacts on the uptake of pre-conception and maternity services. The questionnaires are being administered via the children's centres and the Maternity Services Liaison Committee's 'Walking the Patch' Team.<br><br>Stocktake of 'Conception to Age 2 Framework' has been completed. The outcomes of this assessment has been fed into Public Health and Early Years Group and Perinatal Depression Group to inform and align work around local maternity services. In addition the key outputs regarding Perinatal Mental Health issues have been fed into the children and young people's commissioning group.<br><br>Continuing actions include:<br>• Regular training to maternity and children centre staff.<br>• Circulation of national promotion/ media.<br>• Ensure all monitors and equipment maintained and in use across all sites.<br>• Provide assertive support to pregnant smokers.</td>
<td>GREEN</td>
</tr>
</table>

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 2.9 To prevent vaccine preventable childhood diseases | To increase uptake of childhood immunisations | NHS England | To provide independent scrutiny and challenge the plans of NHS England, Public Health England and providers.<br><br>(NB The national target for childhood immunisations is 95% for each of the vaccines for the under-fives childhood immunisation schedule and 90% coverage for HPV in school-aged girls). | 31/03/14 | Historically Hillingdon has a high take-up level of immunisations.<br><br>The latest data for MMR shows take-up is high and Hillingdon is close to being on par with England take-up rates.<br><br>From the latest available data;<br><br>MMR data for October – December 2013, (quarter 3)<br>MMR 24 months = 91%, England 93%<br>MMR (1 dose) 5 years = 92.7%, England 94.4% | GREEN |
| 2.10 Tackling the issues which can cause sight loss | To develop support and services locally which reduce the effects of sight loss | Vision Strategy Working Group | (a) Working with the Thomas Pocklington Trust and other local partners develop a vision plan and local support services. | (a) 31/03/14 | (a) Pocklington Trust is in the process of collating needs information provided by stakeholders. A project group meeting took place in December 2013 to review needs data and identify gaps. An action plan will be developed for consideration. | GREEN |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| ***Priority 3. Developing integrated, high quality social care and health services within the community or at home***<br>As a priority we will focus on:<br>• Integrated approaches for health and well-being, including telehealth;<br>• Integrated Care Pilot for frail older people as well as diabetes and mental health. | | | | | | |
| 3.1 Assist vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care | Increase independent accommodation in line with housing support plan | LBH Officer Group/HIP | (a) Provide adaptations to homes to promote safe, independent living.<br><br>(b) Extend the TeleCareLine service to a further 750 people<br><br>(c) Provide extra care and supported accommodation to reduce reliance on residential care | (a) 31/03/14<br><br>(b) 31/03/14<br><br>(c) 31/03/14 | (a) A total of 260 homes have had adaptations completed to enable disabled occupants to continue to live at home. This includes adaptations to the homes of 170 older people.<br><br>(b) As at 31st March 2014, 2,760 new service users were in receipt of a TeleCareLine equipment service. The technology is helping people to live safely and independently at home. The take-up of TeleCareline is exceeding the target of 750 new service users set for each year of the scheme. The scheme has been extended to be free to people aged 80 years or older.<br><br>(c) On average 1 placement is made per month into extra care for older people who would otherwise have to move into residential care. Glenister Gardens, a 12 bed supported living scheme for clients with learning disabilities, is fully occupied.<br><br>The supported living building programme is currently being reviewed to ensure it meets the current and future needs.<br><br>Schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation. | GREEN |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| 3.2 Deliver end of life care and support services | Improve the quality of end of life care for residents | End of Life Forum | (a) Develop work with the ICP programme to assist in identification of 1% people expected to die within a 12 month period. | (a) 31/03/14 | (a) The ICP for Frail Elderly patients is well developed and in use by GP's to develop advanced care plans utilising 'Co-ordinate My Care' (CMC). CMC is an electronic patient care record system that allows all organisations with access to an N3 connection to view the patients care plan and their wishes in terms of the end of life phase of their illness. Macmillan and Hillingdon CCG are working in collaboration to fund a three year GP clinical lead to provide assistance in the form of education and training to Hillingdon GPs with the process of identification of patients who should have an advanced care plan. | GREEN |
| | | | (b) Develop information sharing protocols between statutory, voluntary, private and independent sector partners regarding early identification of people approaching end of life. | (b) 31/03/14 | (b) A three year strategy (2013-2016) has been documented by the Pan Hillingdon End of Life Forum. | |
| | | | (c) Develop a process for measuring quality for end of life care in Hillingdon. | (c) 31/03/14 | c) Agreements are in place to measure quality in relation to documented preferences as recorded in the CMC Care plan. Patients who have their preferences recorded on CMC are more likely to achieve their preferred place of care at end of life. Figures received in November 2013 demonstrated that for the first 6 months of this financial year, 50% of patients died in hospital – compared to the previous 6 months when 68% died in hospital. | |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update | RAG |
|---|---|---|---|---|---|---|
| ***4. A positive experience of care***<br>As a priority we will focus on:<br>• Tailored, personalised services;<br>• An ongoing commitment to stakeholder engagement. | | | | | | |
| 4.1 Deliver personalised adult social care services through the Support, Choice and Independence programme. | Increase the number of people in receipt of a personal budget. | LBH | (a) Promote take up of personal social care budgets to provide greater choice and control | (a) 31/03/14 | (a) A personal care budget gives people who need care and support a greater say on deciding their support arrangements to suit their own needs. As at 31st March 2014, overall 76.9% of social care clients (2,807 clients) were in receipt of a personal budget (based on services which are subject to a personal budget). Take-up of personal budgets is higher for older people (82.2%). | GREEN |
| 4.2 Ensure that local residents have opportunities to get involved in and have a say about services which improve health and wellbeing. | Develop opportunities for residents to get involved. | Task and Finish Group to review | (a) Establish the current requirements and arrangements for stakeholder engagement across health and the Council to support improvements in health and wellbeing<br><br>(b) Make recommendations to the Health and Wellbeing Board to establish a co-ordinated plan of stakeholder engagement in Hillingdon for Health and Wellbeing | (a) 31/03/14<br><br>(b) 31/03/14 | (a) On track. A group has met to review and co-ordinate stakeholder engagement across health and social care. The leads for engagement across health and social care will develop recommendations for consideration. The recommendations will be practical and focus on supporting meaningful involvement of local residents to support improved health and wellbeing.<br><br>(b) Completed – under the auspices of the Better Care Fund work, a one-off meeting of a small stakeholder group was held on 17th January 2014 to discuss engagement. Further work will take place on engagement during 2014/15. | GREEN |

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# PUBLIC HEALTH ACTION PLAN 2014/15

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Sharon Daye, Public Health |
| **Papers with report** | Appendix 1 - Public Health Action Plan 2014/15 - Update |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This is an action plan update regarding the integration of Public Health into the Council post transfer on 1 April 2013. |
| **Contribution to plans and strategies** | The Council now has certain statutory duties in respect of Public Health under the Health & Social Care Act 2012. The delivery of the Council's Public Health functions are driven by the Health and Wellbeing Strategy. |
| **Financial Cost** | There are no financial costs associated with the recommendations in this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes the report and action plan at Appendix 1.**

**Reasons for recommendation**

To ensure that the Health and Wellbeing Board is aware of progress made against the Public Health Action Plan.

## 3. INFORMATION

**Supporting Information**

An integrated delivery model for Public Health in Hillingdon has been adopted. This is model is consistent with the Council's operating model and aligns functions, exploits synergies and maximises benefit to residents.

Under this approach, common activities such as finance, contracts, performance management and business support will be incorporated into existing Council services.

**Financial Implications**

All costs associated with the implementation of the action plan set out in Appendix 1 are being met from the ring-fenced Public Health grant (£15.7m in 2014/15). There is no direct financial cost associated with the recommendations contained within this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

The approach taken to integration of Public Health into the Council should enable effective delivery of mandatory functions and Public Health priorities.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Legal comments**

The Borough Solicitor confirms that all the matters included in the Action Plan are the responsibility of the Council under the National Health Service Act 2006.

## 6. BACKGROUND PAPERS

NIL.

**APPENDIX 1** **PUBLIC HEALTH ACTION PLAN 2014/2015**

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update |
|---|---|---|---|---|---|
| ***1. Integration of Public Health*** *(Post Transfer)* | | | | | |
| **1.1 Ensure the delivery of mandatory and non-mandatory services is centred the Councils vision of putting residents first.** | To deliver improved outcomes, including improved health | Jean Palmer<br><br>Aileen Carlisle<br><br>Matthew Kelly<br><br>Sharon Daye/Nigel Dicker | 1.1a Apply Council's contract management framework, incorporating category management for commissioning activities.<br><br>1.1b Undertake review of mandatory and non-mandatory services:<br><br>***Mandatory:***<br><br>§ National Child Measurement Programme;<br>§ NHS Health Checks;<br>§ Core Offer to Clinical Commissioning Groups (CCGs);<br>§ Public Health responsibilities for Health Protection;<br>§ Sexual Health.<br><br>***Non-mandatory***<br><br>§ School nursing (i.e. Healthy Child Programme for school age children)<br>§ Local health improvement programmes to improve diet / nutrition, to promote<br>§ physical activity and prevent / address obesity; | October 2013 | 1.1a Category management approach in place. Procurement Team working closely with Public Health and work ongoing.<br><br>1.1b Full BID and category reviews of services and service specifications, liabilities and commitments ongoing.<br><br><u>Sexual Health:</u> Contract for 2014/16 with CNWL for community sexual and reproductive health services and the Hillingdon Hospital for genitourinary medicine services is nearing finalisation. Specification and pricing is finalised. Awaiting sign off of terms and conditions and Legal.<br><br><u>School Nursing:</u> Contract for 2014/15 with CNWL is nearing completion. Specification and pricing is finalised. Awaiting sign off of terms and conditions and Legal. |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update |
|---|---|---|---|---|---|
| | | | § Drug misuse and alcohol misuse services;<br>§ Tobacco control including stop smoking services and prevention activity.<br><br>1.1c Recommendations to Cabinet for approval | TBC | Substance Misuse: The current contract runs to October 2014. Category Management approach continues, to include market sounding and specification development.<br><br>Primary Care Contracts: Work on local authority primary care contracts ongoing. Services covered include: NHS Health Checks; Smoking cessation including; Shared Care for substance misusers; Supervised methadone consumption; needle exchange; Chlamydia screening and treatment Emergency Hormonal Contraception. |
| **1.2 Integration of ring-fenced public health budget.**<br><br>(Note: Additional public health grant funding has been awarded over a 2 year period – 2013/14 & 2014/15) | To apply Council's robust approach to medium term financial forecasting, including value for money | Jean Palmer<br><br>Aileen Carlisle<br><br>Sharon Daye<br><br>Nigel Dicker | 1.2a To undertake an exercise to identify projects or schemes across Council's key service area that would support implementation of priorities identified in the JSNA across the 4 public health domains of:<br><br>Domain 1: Improving the wider determinants of health;<br>Domain 2: Health Improvement;<br>Domain 3: Health Protection;<br>Domain 4: Healthcare public health and preventing premature mortality. | Early July 2013 | Exercise Undertaken |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update |
|---|---|---|---|---|---|
| | | | 1.2b To raise awareness of Council staff about new Public Health responsibilities in order to identify projects. | Early July 2013 | Four workshop briefings undertaken in June /July 2013<br><br>Public Health Team working with a range of Teams across the organisation on a number of cross cutting areas/issues [eg. obesity, dementia; needs assessments – including: children and young people, mental health, suicides) and perinatal mental health, pharmacy needs assessment]. This working is ongoing. |
| ***2. BID Review of Public Health Team*** | | | | | |
| **2.1 To review the work of the transferred Public Health Team, using BID principles.** | To reshape the service to support the Council's operating model and focus on building capacity and resilience. | Aileen Carlisle<br><br>Jean Palmer | 2.1 a To place the Public Health Team including the Specialist Health Promotion and Smoking Cessation Teams into Residents Services.<br><br>2.1b Restructure of Public Health and Specialist Health Promotion Teams as part of the integration of the Team into the Council. | | Completed.<br><br>Revised structure, job descriptions and person specifications now evaluated by Human Resources.<br><br>It is proposed to advertise the DPH post in the coming weeks. |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update |
|---|---|---|---|---|---|
| | To test the new service delivery model, through prototype working. | | 2.1b Public Health Consultants to continue providing analysis and advisory support to delivery teams.<br><br>2.1c Broaden the remit of Public Health Consultants to include developing the strategic relationship with the local health economy including the CCG, local providers, and the hospital Trusts<br><br>2.1d Operational Public Health officers to:<br><br>§ Build local capacity and resilience;<br>§ Support people to employment<br>§ Support the Family Information Service<br>§ Support Education and training provision for young people<br><br>2.1e Build a broader delivery (ie. 'Community Public Health Service') providing and facilitating a greater array of services to support residents to make positive, well informed decisions. | Ongoing | Ongoing.<br><br>)<br>)<br>)<br>)<br>) Restructure of Public Health and Health<br>) Promotion Team - ongoing.<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br><br>BID Transformation Review Process underway |

| Objective | Key Task | Lead | Subtasks | Deadline for Subtask | Progress Update |
|---|---|---|---|---|---|
| ***3. Effective Partnerships Working*** | | | | | |
| **3.1 Agreement of Memorandum of Understanding (MOU) between the Council and Hillingdon Clinical Commissioning Group (CCG)**<br><br>(Note: The Health and Social Care Act 2012: Mandatory responsibility for local authorities) | Ensure local NHS commissioners receive the necessary public health advice so that they can discharge their statutory duties.<br><br>Agreement of Action Plan to support implementation of the MOU between the Council and Hillingdon CCG | Sharon Daye/ Nigel Dicker | 3.1a To develop MOU for 2013/14 that can be jointly agreed by both the Council and Hillingdon CCG.<br><br>3.1b To develop action plan for 2013/14 that can be jointly agreed by both the Council and Hillingdon CCG | | MOU Agreed at September 2013 meeting of the Health and Wellbeing Board.<br><br>Action Plan agreed. Implementation of the Action Plan supported by the Consultants in Public Health and Interim DPH. A number of major projects are underway and are due for completion by end July 2014 – including:<br><br>§ Mental Health Needs Assessment<br>§ Suicide Prevention Needs Assessment<br>§ Children and Young People Needs Assessment<br>§ Review of Perinatal Mental Health and assessment of needs<br><br>Outputs to be used to inform the CCGs commissioning intentions for 2015/16. |

# HEALTHWATCH HILLINGDON UPDATE

| | |
|---|---|
| **Relevant Board Member(s)** | Jeff Maslen |
| **Organisation** | Healthwatch Hillingdon |
| **Report author** | Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon |
| **Papers with report** | Appendix 1 |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | To receive an update report from Healthwatch Hillingdon, following their establishment on 1 April 2013, replacing the Hillingdon Local Involvement Network. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy |
| **Financial Cost** | None. |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | N/A |

## 2. RECOMMENDATION

**That the Board note the report received.**

## 3. INFORMATION

### Supporting Information

Hillingdon Healthwatch is the new independent consumer champion created to gather and represent the views of Hillingdon residents. Healthwatch will play a role at both national and local levels and will make sure that the views of the public and people who use services are taken into account.

### Financial Implications

There are no financial implications arising from the recommendations in this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

N/A.

**Consultation Carried Out or Required**

N/A.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no financial implications arising from the recommendations in this report.

**Hillingdon Council Legal comments**

There are no legal implications from this update.

## 6. BACKGROUND PAPERS

NIL.

healthwatch Hillingdon

# Telling Your Story to Influence Change

## Annual Report 2013-14

## Contents

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## Healthwatch Hillingdon

Giving adults, young people, children and communities a stronger voice to influence and challenge how local health & social care services are provided in Hillingdon

## Chairman's Statement

Most members of the general public believe that the NHS and social care need to be improved and that big changes are necessary to make this happen. Healthwatch is here because there is a problem with these services and we can help; the Prime Minister has said that his hope is that Healthwatch is taken seriously by those in the health service. We intend to vigorously pursue our goal of improved services.

### Our First Year

Our job in Healthwatch is to persuade those running our health and social care services to listen to the people who use their services more and understand the problems and difficulties they encounter when using those services. When we have this information and understanding, we then talk to hospitals, doctors and managers and help them to improve their services.

Much of our time in our first year has been spent;

- *setting up our new organisation*
- *talking to as many people as possible who can tell us how residents in the borough feel about their local services*
- *getting the Healthwatch name more widely known*

Using information given to us by the public, we have also been contacting key people in hospitals, surgeries and social care about the problems people are having in obtaining the care they need. We are pleased to be able to say that in many cases, we are being listened to and changes have already been made. Some of these improvements are outlined in this report.

It is important to recognise that these improvements are made as a direct result of recording and reporting poor service suffered by Hillingdon residents. They are therefore based on people's actual and real experience of using services over the past year.

### Next Steps

We welcome the opportunity that our agenda gives us to challenge NHS and social care services. In the extremely busy and demanding year that awaits us, we will:

- *gather even more information from patients about their experiences*
- *attempt to understand more clearly the problems faced by seldom-heard groups, such as older people living alone*
- *learn about good practice and positive experiences in other areas which could be used in Hillingdon*
- *build our credibility with the NHS and social care so that our voice is listened to*
- *help individuals to find the care services they need, and*
- *enter and view care establishments where we think there may be problems*

# Chairman's Statement

It is a significant task for Healthwatch to monitor these multi-million pound services and we do need help. As most of our work is carried out by volunteers, we put considerable effort into recruiting and training volunteers and this will be a continuing priority.

We have also identified some services where people in the Borough have told us that improvements are needed. These include GP services, mental health especially for children and adolescents, home care and services for children and young adults. We will be carrying out some dedicated work in relation to these areas.

In summary, our first year has been one of building capacity and capability but also achieving changes which will improve quality of service in the future. We have already made a difference. We have been active in our Hillingdon community, listening to people's issues and look forward to helping to bring about further improvements in services.

# What We Have Done


## A Summary of Our First Year

- Launched 1st April 2013
- 9 Directors, 1 Chairman, 4 employees
- Recruited nearly 40 volunteers
- Who contributed over 2000 hours
- 8 Enter and View Representatives trained
- 8 Assessors trained for Patient-Led Assessments of the Care Environment
- 3000 leaflets and 100s of posters distributed to nearly 40 GP surgeries, 17 libraries, 13 clinics, 5 children's centres, 1 urgent care centre, 28 wards and outpatient departments
- Nearly 150 events, workshops and presentations attended, 150 people attended our launch
- Promotions at 3 supermarkets, 2 Bus garages, 3 hospitals and 6 community fairs
- Articles published about us in the Uxbridge Gazette and Hillingdon People
- Advertising campaign in Hospital Radio magazine and on 9 bus routes
- 5000 newsletters distributed, 127 people signed up for our monthly E-News email
- Over 6000 people a month visit our website, 333 followers on Twitter, 226 Facebook friends and 5 videos published on our YouTube channel
- 300 responses to our GP survey
- A total of 71,648 people directly engaged with and over 100,000 indirectly
- 368 residents signposted to services, or supported with advice and information
- Key relationships formed with health and social care commissioners and providers
- Promoting residents views and experiences at over 300 meetings
- Strategically involved in 4 major change programs for health and social care in Hillingdon
- Patient experiences and people's views presented and 100s of recommendations made to influence service design and delivery
- Challenging quality, safety and fair access to services and positively affecting people's lives
- 60 people in Hillingdon, 2000 in London and over 5000 in England can now potentially have knee operations they would have been refused before

**TELLING US YOUR STORY CAN HELP TO IMPROVE LOCAL SERVICES**

# About Us


## Who We Are

Healthwatch Hillingdon was established by The Health and Social Care Act 2012 and replaced Hillingdon Local Involvement Networks (LINk) on 1st April 2013. We are part of a national network of 152 local Healthwatch organisations, led and supported by Healthwatch England.

Hillingdon Council has a duty to commission a local Healthwatch, as all local authorities have. A consultation with Hillingdon residents revealed a strong desire to build on the success of the LINk and use the expertise, knowledge and relationships they had developed. Hillingdon Council responded by setting up Healthwatch as an independent organisation, with a Board of Directors and Trustees recruited through an open process. The LINk staff were transferred to the new organisation, which was incorporated as a Company Limited by Guarantee and registered as a Charity with the Charities Commission.

A smooth transition meant that Healthwatch Hillingdon was launched seamlessly just as LINk closed. As a new organisation, we had to set up business functions, meet legal corporate requirements and develop our governance[1], strategies and operational models. We did this while delivering our Healthwatch functions from the first day of operation.

## Our Role

The role of Healthwatch Hillingdon is to give local people the platform to improve how their health and social care services are delivered, monitor local services and where necessary, use statutory powers to hold those services to account.

## Our Aim

Our aim is to become the influential and effective voice of the public. We want to give adults, young people, children and communities a greater say in - and the power to challenge - how health and social care services are run in Hillingdon.

## What We Do

- Gather the views and understand people's experiences of the health and social care services in Hillingdon and encourage providers, regulators and planners to hear directly from our residents

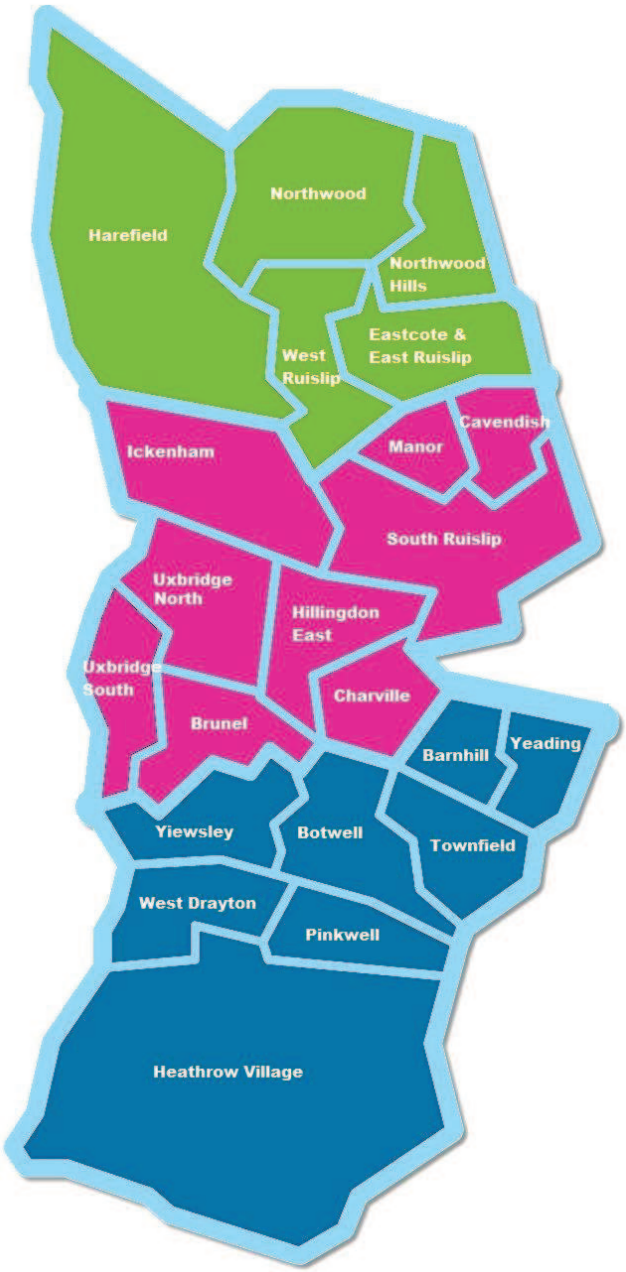
[1] During this year we have developed and produced a number of policies, procedures and strategies which help us to govern the organisation. These can be viewed and downloaded from our website at: http://healthwatchhillingdon.org.uk/index.php/aboutus/governence-documents/

# About Us

- Make the views and experiences of members of the general public known to health and social care commissioners and providers
- Enable local people to have a voice in the development, delivery and equality of access to local care services
- Empower, train and develop the skills of volunteers and the wider community to give them a voice to review, monitor, challenge, influence and shape how health and social care services are commissioned and provided in Hillingdon

**your experience**

**Giving feedback takes minutes, but the impact could last a lifetime**




- Support and empower people to make informed choices and decisions about their care by providing information and advice about local health and social care services. Signpost people to appropriate service providers according to their needs
- Recommend an investigation or special review of services via Healthwatch England or directly to the Care Quality Commission
- Make the views and experiences of people known to Healthwatch England (and to other Healthwatch Organisations) and give input to help it carry out its role as a national champion

**The London Borough of Hillingdon is the westernmost borough in Greater London. It has a population of 273,936 (2011 Census) and is the second largest of the 32 London boroughs by area.**

**It is home to Hillingdon, Mount Vernon and Harefield hospitals, Heathrow Airport, RAF Northolt, and both Brunel and New Bucks Universities.**

**The borough has good transport links, with the A40 and M4 offering direct access to central London, and with the M25 in close proximity, routes out to the rest of the UK.**

**London Underground's Metropolitan and Piccadilly lines run into Uxbridge, and Hayes and Harlington Station is a gateway to Britain's National Rail network.**

# The Contribution of Volunteers

**Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised.**

> I find volunteering for Healthwatch a privilege and the opportunities for training and carrying out a range of activities from hospital inspections to committee work means there are opportunities for all.
>
> **Wendy Pursey, Volunteer**

Healthwatch Hillingdon is a volunteer-led organisation, and volunteering lies at the heart of all that we do. We rely on the range of experiences and skills that all our volunteers bring to our organisation. Our volunteers find the experience rewarding and interesting, giving them genuine opportunities to change and improve health and social care within the Borough. It is important to us that we make a difference to local services; and we are committed to providing the support, encouragement and structures to enable our volunteers to make positive change a reality.

During our first year, we recruited nearly 40 volunteers in a number of varied roles, including volunteer Board members. Together they contributed over 2000 hours of their time to support delivery of our Healthwatch functions. Our volunteers take on a variety of roles - administrative, signposting to services, providing information, engagement, communications, and representation at meetings and committees. Whatever the role, all our volunteers are actively involved in promoting the organisation, gathering the views of people, informing and supporting individuals to make choices and talking to commissioners and providers about the patient's experiences of service quality.


In one project, volunteers carried out an audit of signs at Hillingdon Hospital. The hospital found the visit by the Healthwatch team to be very worthwhile and adopted the six main recommendations. As a result it is easier for visitors and patients to find their way around the hospital.

Our Mystery Shopper programme is a popular choice of activity for volunteers who attend a number of medical appointments. Participants write a diary of their experiences and report to us regularly about the positive and negative aspects of their care.

Several volunteers have attended important 'Shaping a Healthier Future' meetings, representing the views of Hillingdon residents as the future of hospital and community services are being discussed and shaped. Our volunteers also played a pivotal role in overseeing the tendering process for the commissioning

# The Contribution of Volunteers

of the Urgent Care Centre at Hillingdon Hospital. They are involved in the procurement of the Community Dermatology Service and Hillingdon Council's tender for the Home Care service.

We have recruited and trained eight volunteers as 'Enter and View Representatives' to carry out our programme of monitoring visits. These visits will provide an informed view of the quality and scope of health and adult social care services provided for the residents of Hillingdon, and will be used to make recommendations for service improvement backed by evidenced.

> It was a great experience to be part of a team of volunteers and hospital staff visiting a number of wards to see how they were managed in the interests of patients
>
> **Roger Dewey, Volunteer**

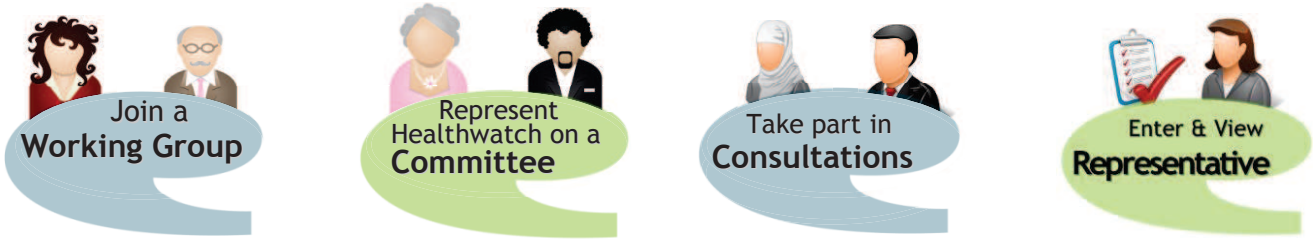
A number of the Enter and View Representatives were also among the eight volunteers we have trained as 'Patient Assessors for The Patient-Led Assessments of the Care Environment' (PLACE) programmes. Patient Assessors make up 50 per cent of the assessment teams which focus on the environment in which care is provided, as well as looking at cleanliness, food, hydration, and the extent to which patient privacy and dignity is supported.

When we asked Wendy Pursey what she thought about volunteering for us, she said:

**"Healthwatch has given me the opportunity to have meaningful input into what impacts our community and contributing to the safeguarding of some of the most vulnerable within it. The Healthwatch team are not only approachable and professional but are looking at new ways to extend their influence and reach. I find volunteering for Healthwatch a privilege and the opportunities for training and carrying out a range of activities from hospital inspections to committee work means there are opportunities for all."**

Board member Martin McElreavey also told us about his experiences as a volunteer.

**"Listening is an important skill for a Healthwatch volunteer. One of the most frustrating things for people that don't receive the care that they should is the feeling that no one is listening, no one cares. As a volunteer, I have listened to patients talk about the service they receive from the NHS. Whether it's a meal they receive in hospital or the politeness of the receptionist at their local GP surgery, I have been able to learn much more about what health care is like in Hillingdon. For the patient, sharing concerns with a sympathetic person is generally helpful in itself. The additional value we can add to this as a Healthwatch volunteer is that we use the concerns of patients as evidence to help change the level and types of services provided by the NHS and Hillingdon Council, to better meet the needs of the people in our community."**



# Gathering Views & Providing Advice and Support

- **Gathering views and understanding the experiences of patients and the public.**
- **Providing advice and information (signposting) about services and support for making informed choices.**

Healthwatch Hillingdon has started a wide engagement and communication programme to reach out across the borough to promote the organisation and hear about residents' experiences of health and social care services in Hillingdon.

As part of our campaign we have distributed 100s of posters and over 3000 leaflets to nearly 40 GP surgeries, 17 libraries, 13 clinics, five children's centres, the urgent care centre and the wards and outpatient departments at Hillingdon Hospital. We held promotions at various other locations across the borough, including three supermarkets, Uxbridge Bus garage, Hillingdon, Mount Vernon and Harefield Hospitals. We have attended numerous events, workshops with community organisations, presented at public events, had articles published in the Uxbridge Gazette, circulated over 5000 newsletters and advertised in Hillingdon Hospital Radio magazine and on the backs and interiors of buses on the routes out of Hayes Garage.


Our new website was launched in August 2013 and we have seen a rapid growth in the number of people using the site. In the first eight months we have recorded nearly half million hits and during March 2014 over 6000 people accessed our website.

We have also been making good use of social media, ending the year with 333 people following us on Twitter, 226 friends on Facebook and five videos uploaded to our YouTube channel.

In September 2013, our official launch was attended by over 150 people. Delegates included members of the public, service users, carers, members of the Voluntary and Community Sectors, as well as senior representatives from the Hillingdon Clinical Commissioning Group, The Hillingdon Hospitals Foundation Trust, Central & North West London Foundation Trust and the London Borough of Hillingdon. Participation was very enthusiastic and extremely encouraging and a full report of the event is available at:

http://healthwatchhillingdon.org.uk/index.php/aboutus/launch-event/

# Gathering Views & Providing Advice and Support

Through events, workshops, presentations, meetings and outreach activities, staff and volunteers have reached out across the borough to promote the organisation and gather the views of Hillingdon's residents. These initiatives have included meetings with seldom-heard groups, through organisations including: the Tamil Mother & Toddler Group, Hayes Citizen Group, Irish Travellers Group and the Amigo's Vision Impaired Group. We have engaged with children and young people at Uxbridge College and Children's Centres, and older people through the Parkinson's Society Group, Assembly for Older People, Older Residents Forum and Age UK groups. As we look to develop the programme in our second year, we will focus on engaging hard-to-reach / seldom-heard groups, and children and young people through a targeted look at Children's and Adolescent Mental Health Services.


We measure and assess the number of people we have directly engaged with through data collection and monitoring. This year, the total number of people who we have had direct contact with – through our activities and functions, signposting, events, consultations, surveys, workshops, presentations, meetings, e-news, or via interaction with the website and social networking sites – is 71,648. This includes 368 residents who have been signposted to services, or been supported with advice and information.

**71,648**
people directly engaged with

**368**
people received signposting, support & information

**100,000 +**
people indirectly engaged with

Although difficult to fully quantify, we estimate the number of residents indirectly engaged - through our network of partners in the voluntary and community sector; the articles published in the Uxbridge Gazette; the stalls at Sainsbury's and other venues; the bus advertising; our poster and leaflets and advertising campaign and the thousands of visitors to the Pavilions Shopping Centre – to be more than 100,000.

# Gathering Views & Providing Advice and Support


Our shop within the Pavilions Shopping Centre in Uxbridge is a great way to promote Healthwatch and it allows people immediate access our services. The shop is an information hub and also gives visitors the chance to tell us about their experiences of care. We signpost the general public to other organisations within Hillingdon offering health and social care services and inform, support and empower them to make choices about the care they receive.

The contacts we receive through the shop are varied. Whatever the purpose, we are very happy to help and get great satisfaction from positively affecting people's lives.

**"… without your intervention I would probably have had to wait several weeks more"**

**"… you have been an absolute lifeline to me ever since I first contacted you"**

| You Told Us | We Helped |
|---|---|
| We were contacted by a gentleman with an environmental issue who was concerned about the bins in the park outside his house, as they were being filled by residents with household waste and it was attracting rats. | We contacted Public Health and reported the issue for the gentleman. He has since contacted us to say thank you, as the council have put up signs telling people not to dispose of household waste in the bins and are imposing fines. |
| Member of public was concerned about a 91 year old man who had been in hospital for 2 months, with almost no visitors, his glasses had been lost on admission and he had nothing to do all day. | We spoke to the hospital who arranged for some glasses for him and ensured more interact with the patient from staff, whilst looking to provide a volunteer visitor. |
| Gentleman discharged from hospital without referral to a district nurse for wound care. Living in Hillingdon with his GP in Ealing was causing a problem with referral. | We spoke to community health who agreed to see him and spoke to the hospital to facilitate a referral. |
| Gentleman had been waiting over 5 weeks for an appointment at Watford General Hospital for low iron in blood, was concerned as had a previous tumour. | We gave him details of Outpatients and some information on what to do. He felt empowered, followed our instructions and quickly arranged an appointment. |
| A mother of a 2 year old boy who was suffering from 'locked knee' was told by her Uxbridge GP he was unable to refer her to a paediatric physiotherapist, as the service had moved and he didn't know where to refer to. She had already been waiting several weeks and was at a loss as to what do to. | We contacted the manager of the Children's Development Centre in Hillingdon, on her behalf, to clarify where the service the GP should be referring to. We were then able to pass this information on to both the mother and the GP practice. 'Without your intervention I would probably have had to wait several weeks more.' |

# Working Together With Partners

- **Making the views and experiences of people known to health and social care commissioners and providers.**
- **Making the views and experiences of people known to Healthwatch England (and to other Healthwatch organisations) and providing input to help it carry out its role as a national champion.**
- **Recommending an investigation or special review of services via Healthwatch England or directly to the Care Quality Commission.**

## "Critical Friend"

A trusted person who asks provocative questions, provides information to be examined from another point of view, and offers evaluation of a person's work as a friend.

A critical friend takes the time to fully understand the context of the work and the outcomes being worked toward.

The critical friend is an advocate for the success of that work[1]

Healthwatch Hillingdon has continued to build upon the strong operational relationships LINk had with organisations within the NHS, Local Authority and the Voluntary Sector. The development of these close working relationships has seen us become a **"critical friend"** and valued partner for Hillingdon's health and social care providers. Our partnership working and stakeholder engagement gives us considerable strategic input into the shaping of Health and social care services, ensuring that the experiences of patients and the public are not only heard, but are influencing decisions and improving health and social care in Hillingdon.

North West London is leading the country on a number of change programmes and important pilots, which will radically change how health and social care is delivered in Hillingdon.

- Shaping a Healthier Future
- Whole Systems Integration
- Seven Day Working Pilot
- The Better Care Fund

These are good examples of partnership in action and demonstrate how Healthwatch, social services, the CCG, hospital, community health, mental health and the voluntary sector are all working closely together in Hillingdon. Our pivotal involvement in all these initiatives is putting residents at the forefront of service change in Hillingdon.

Healthwatch Hillingdon has a statutory seat on the Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA). This ensures that Healthwatch Hillingdon has a role in promoting public health, health improvements and in tackling health inequalities.

Hillingdon Clinical Commissioning Group also invited us to sit at their Governing Body meeting. This important seat enables us to put the views and experiences of patients at the heart of decision-making on the commissioning of services.

1. Costa, A. and Kallick, B.(1993) "Through the Lens of a Critical Friend". *Educational Leadership* 51(2) 49-51

# Working Together With Partners

We have been encouraged this year by the increasing number of committees, working groups and meetings that we have been invited to. During the last year we have contributed at over 300 meetings. Many of these have significant decision-making roles which has enabled us to be centrally involved in the key topics effecting Hillingdon, promoting residents views and making numerous suggestions and recommendations on a wide range of strategic and other issues.

The relationships we have built mean we are able to approach both commissioners and providers directly at senior executive levels to report when patients are not receiving the appropriate standard of service or care. We have worked closely with commissioners and providers to ensure that when these failings are bought to our notice that immediate action is taken to improve services.

The Trust has continued to work in close partnership with Healthwatch Hillingdon and appreciates the valuable contribution that Healthwatch provides to the organisation.

Representatives from Healthwatch have regularly attended focus groups and committees and are regular attendees at our People in Partnership meetings. Healthwatch Hillingdon is a regular member of the Trust's Experience and Engagement Group which meets quarterly and has a remit to consider and respond to all aspects of patient and staff experience making recommendations and monitoring actions to improve the patient experience.

The Trust has engaged with Healthwatch in compiling its equality objectives for 2014-15 and has worked closely with Healthwatch on the consultation for the priorities for the quality report, Patient-led Assessment of the Care Environment (PLACE) inspections and follow up action.

The Chief Officer of Hillingdon Healthwatch holds regular meetings with the Trust's Chief Executive and Director of Patient Experience & Nursing to discuss health care issues.

Shane Degaris, Chief Executive Officer, The Hillingdon Hospitals NHS FT

Healthwatch are members of key CCG Boards and meetings including Governing Body Meetings, Quality Committee and the Patient Public Engagement Committee. They will also be present in our integration planning meetings in the coming year. Engagement at the strategic level supports CCG work to ensure the patient's voice is heard at all levels of our organisation.

In addition to engaging at a strategic level Healthwatch provides a valuable route through which concerns (and compliments) about health services can be brought to our attention so that we can take the appropriate action. In addition to highlighting concerns Healthwatch has supported patients to raise their concerns directly with us. A recent example is a meeting chaired by Healthwatch where they supported a patient to set out system failings to senior representatives from the CCG, health providers and the local authority. We would welcome further constructive challenge and feedback on the quality of our services from Healthwatch.

Ceri Jacob, Chief Operating Officer, Hillingdon Clinical Commissioning Group

# Working Together With Partners

An example of partnerships and where we have been closely working with all the NHS Trusts in Hillingdon is the Patient Led Assessment of the Care Environment (PLACE). Healthwatch Hillingdon has trained and provided a number of Patient Assessors who joined the staff of Hillingdon and Mount Vernon Hospital, Harefield Hospital and the acute sites in Hillingdon for Central North West London NHS FT to carry out PLACE assessments during April and May 2013.

Healthwatch Assessors also took part in Harefield Hospital's annual assessment in March 2014 and will be part of the teams that assess the other Hillingdon Trusts in 2014.

In addition to the annual assessment, we have been working with The Hillingdon Hospitals NHS FT as part of their PLACE improvement programme and our Patient Assessors have carried out mini-PLACE assessments at Hillingdon and Mount Vernon Hospitals periodically throughout the year. As a result of this involvement we have seen a marked improvement and we are currently working with Hillingdon Hospital to audit meal time provision across the Trust as part of this programme.

We have strong relationships with the Voluntary Sector, working closely with a number of organisations. In addition to signposting to each other and providing information on services to our respective clients, we regularly share information and we work together to highlight the issues facing Hillingdon residents in health and social care.


Hillingdon age UK

**Age UK Hillingdon has developed an excellent relationship with Healthwatch, working in partnership to ensure that the views of local residents are heard at a time of considerable change in health and social care services. As well as assisting individual clients with their specific queries and signposting between our organisations where appropriate, we were delighted that Healthwatch sponsored a conference on dementia awareness specifically for older residents from the Black and Ethnic Minority communities. This conference was an excellent example of the collaboration between our two organisations; building on existing initiatives to create an opportunity for conversation and collaboration between the BME elders and professionals to improve services and support for BME people with dementia and their carers.**

Sharon Trimby, Acting CEO
Age UK Hillingdon

Our shop, secured through the excellent relationship built with The Pavilions Shopping Centre and their generous provision, is providing an excellent opportunity, in a central shopping location, to have a local hub to promote Healthwatch and the wider voluntary sector. We advertise numerous events in our shop window and on our notice boards and offer a wide range of health and social care leaflets with information on different health conditions and services.

# Working Together With Partners

We are also able to give other organisations within Hillingdon, who offer health and social care services, or advice and advocacy, a space to deliver services. HDAS (Hillingdon Drug and Alcohol Service) and HAGAM (Hillingdon Action Group for Addiction Management) have run regular activities for a number of local residents. The Stop Smoking Service has also been running a weekly drop-in to help Hillingdon's residents quit smoking.

We have built other important relationships with the Care Quality Commission, NHS England, Healthwatch England, local Healthwatch organisations across London and VoiceAbility - the NHS Complaints Advocate for Hillingdon. These connections and partnerships allow us to escalate and share issues which affect not only Hillingdon but our neighbouring boroughs and beyond.

Both Healthwatch England and VoiceAbility presented at our Launch Event in September 2013 to give attendees an overview of how we all work together locally and nationally to provide the Healthwatch "package". We work very closely with VoiceAbility locally, exchanging information on Hillingdon patient issues and specific areas of concern.

We meet with the Care Quality Commission regularly to share information. When they carried out their routine inspection of Hillingdon Hospital in October 2013, we were pleased that evidence provided by us of recent patient experience was used to inform their decision on which areas to inspect. We also spoke with the Care Quality Commission about our concerns that there were some carer organisations who were providing services within the local authorities 'Extra Living Accommodation' who were not registered with them. We have since been informed by the Care Quality Commission that this situation has been rectified.

We also wrote to NHS England (London), Monitor and The NHS Trust Development Authority, in support of Hillingdon CCG and Hillingdon Hospitals Trust, to express our deep concern that Hillingdon had not been allocated any of the additional £250m funding made available to NHS Trusts to help relieve A&E and winter pressures this year. We highlighted the serious and

**CNWL have a longstanding history of engagement with a number of external bodies including Healthwatch Hillingdon. As a Trust we have a programme of regular engagement to seek feedback and help shape our services and quality priorities.**

**At a local level, there is a mature relationship between the Trust and Healthwatch Hillingdon. Regular meetings are in place between Healthwatch senior officers and the CNWL Borough Director and Divisional Director of Operations. We recognise the valuable contribution of our local Healthwatch as the advocate for our service users and as a critical friend to the organisation to support improvement in service delivery. Dialogue between the organisations is open and transparent which enables early intervention.**

**Healthwatch Hillingdon has worked with the Trust on a variety of issues. They have supported us in assessing user experience in our Hawthorn Intermediate Care Unit by undertaking exit questionnaires with patients at discharge and providing independent feedback on a monthly basis. They have also taken part and fed back into various key groups to support service redesign including intermediate care and urgent care services. They are a key member of the in-patient PLACE inspection team.**

**We continue to value their challenge and contribution to us at a local level to drive continuous improvement.**

**Maria O'Brien,**
**Divisional Director of Operations,**
**Central and North West London**
**NHS Foundation Trust**

negative effect this may have on providing safe care for the residents of Hillingdon; our concerns being published in the local paper.

www.getwestlondon.co.uk/incoming/hillingdons-hospitals-fear-impact-missing-6193783

We also join other London Healthwatch to meet NHS England to highlight patient experiences of specialist services and outline some of the results of this work later in this report. As part of our signposting role, we also communicate with them to help individuals make complaints about their GP Practices, where necessary.

We work closely with the other local Heathwatch organisations in Northwest London, as members of The Patient and Public Review Reference Group (PPRG), to oversee the implementation of the Shaping a Healthier Future programme, which has implications for the residents of all the boroughs in Northwest London. The chief officers also meet to discuss other issues and areas of joint working. This has led to us sharing an advertising campaign with Ealing and Hounslow Healthwatch on the buses which travel between our boroughs.


We have provided Healthwatch England with evidence about several issues. One of these referrals followed the announcement of the Care.data programme which aims to share information on patient's GP records with the Health and Social Care Information Centre. We received numerous calls from confused and concerned residents and contacted Healthwatch England, who, with our evidence and that gathered from across the Healthwatch Network, successfully persuaded NHS England to postpone the rollout of the programme.

We have also escalated our concerns about the inequality of Individual Funding Requests for Planned Procedures with a Threshold which we have outlined in greater detail on page 19.

Healthwatch Hillingdon has a number of statutory powers which are available for us to use, should we feel it is necessary to do so. With the exception of social care facilities for children and young people, we have the statutory power to 'Enter and View' premises delivering health and social care services, to allow authorised representatives of Healthwatch to observe the nature and quality of services at the point of delivery. During this year, we have not had cause to 'Enter and View'.

## Statutory Powers

Local authorities and NHS bodies have a statutory responsibility to answer our requests for information within 20 working days. There is also a requirement for them to respond to our reports and recommendations, and although there is no obligation on them to implement these,

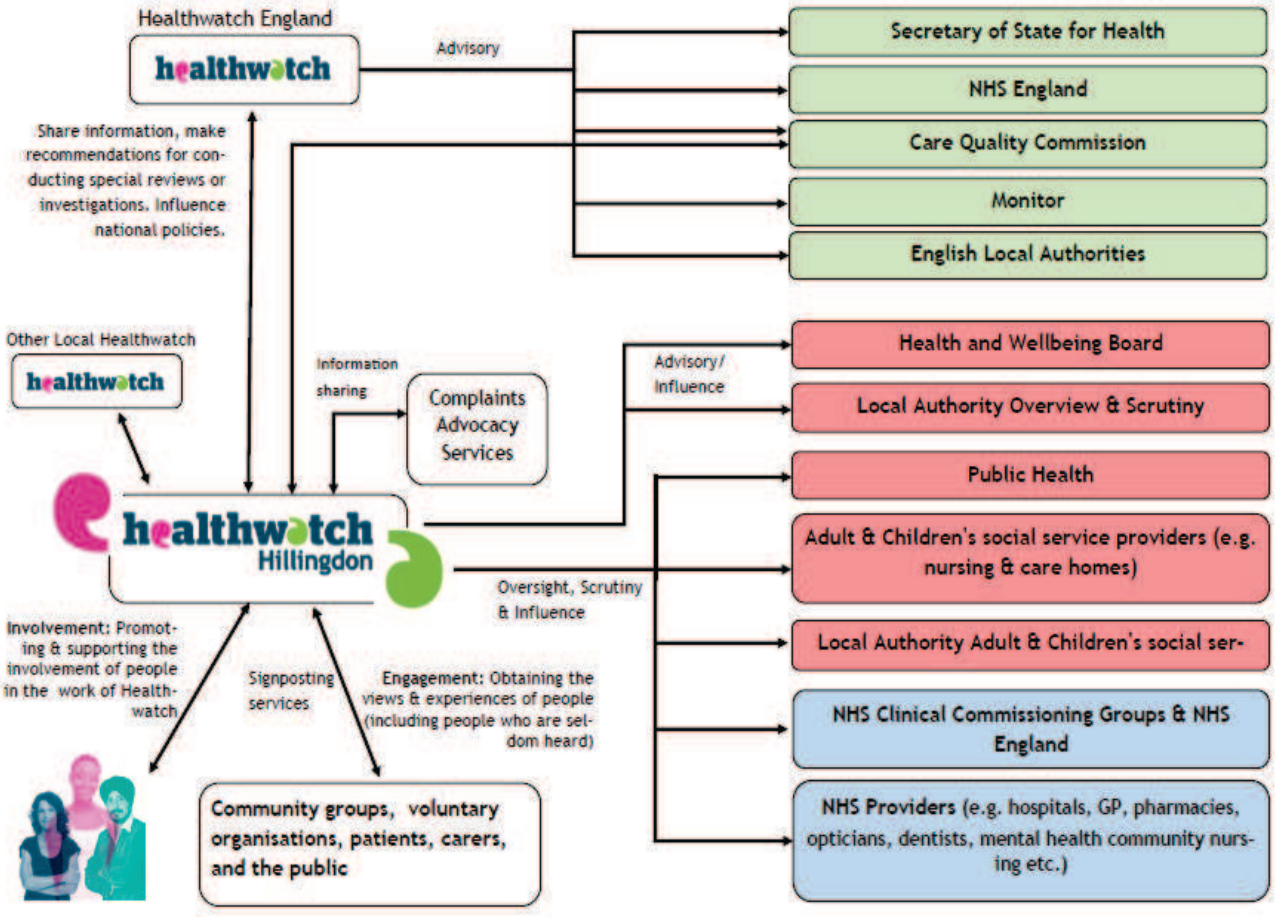
they have a duty to advise us why they have taken their decision not to do so, and we have a duty to publish their response. Due to the close working relationships we have with both commissioners and providers, we have not had to make any formal requests for information as all informal requests made have been responded to.

**The fact that we have not had to use our statutory powers this year is testament to our excellent relationships with commissioners and providers and the close way in which we work together.**

We have also made many recommendations and suggestions on service change through the course of our work. Due to the good relationships we have with commissioners and providers, who respond positively to our input and value our involvement, we have not had to make formal recommendations this year.

In addition to Healthwatch England and the Care Quality Commission, Healthwatch Hillingdon also has a duty to make referrals and recommendations to Hillingdon's External Services Scrutiny Committee (ESSC), on issues may which require investigation or special review. As part of our informal protocol with the ESSC we are able to meet and discuss issues with the chairperson and, if needed, attend scrutiny sessions where we can ask questions on behalf of the general public.

**Healthwatch Hillingdon relationship diagram**



# Impact and Effectiveness

## Impact and Effectiveness

At our launch event last September we asked the participants how they felt Healthwatch Hillingdon could demonstrate its value after the first year. There were many suggestions but most wanted us to show two things.

> **Thank you sincerely for the willingness that you have shown in helping and guiding me through this staggering and unnecessarily complex and very demanding complaints procedure.**
>
> Carer of 83 year old lady

1. What impact had we made?

2. How effective had we been?

In this report we have outlined a number of the ways we have been effective. Explaining how we have worked to listen to the experiences of the public, and the relationships we have built that ensure we are in a strong position to influence and shape Hillingdon's health and social care services. We have shown how we are involving Hillingdon residents through our volunteering scheme in monitoring services and how our signposting, advice and support role is having a positive impact on people's lives.

### So how are we changing services and what impact have we had?

Advising the Care Quality Commission of the experiences of patients has led to a detailed action plan being put in place at Hillingdon Hospital to improve services for patients.

After being contacted with information on the experience of patients, we contacted and have worked with Hillingdon Hospital on a number of recommendations and service changes over this year, which are benefiting patients and visitors. In the emergency department changes were implemented to improve patient care, with additional training being carried out and changes made to the staff induction programme. Procedures have been tightened to respect patient privacy and dignity and that electrocardiogram (ECG) tabs are removed in a timely manner to prevent allergic reaction. The Trust Management have agreed to work on a solution which will allow patients a free copy of the treatment record on their discharge from A&E. We have also intervened on behalf of residents who had delayed Rheumatology department appointments, and those who are not receiving outpatient letters in a timely manner. We have also made sure that there is now a drop off point outside the elderly day centre, making it easier for the infirm to get to their appointments.

There have been a number of issues facing elderly patients on discharge from hospital which we have been involved in this year. We have supported these patients and their carers in complex cases involving social service and care packages.

We have also highlighted issues in services for those with learning difficulties and the users of Children and Adolescents Mental Health Services. These services are now seen as a risk and a lot of work is being carried out in the borough to ensure improvements.

# Impact and Effectiveness

**One of the prime examples of where we have been both effective and made a major impact is our work on Funding Requests (IFR) and Planned Procedures with a Threshold (PPwT).**

**Through receiving just one telephone call and listening to one patient's story, Healthwatch Hillingdon now has the potential to change thousands of lives.**

Patient contacts us because he has been refused a knee replacement operation because of his weight

We investigate and gather evidence about PPwT and IFR talk to hospital, look at NICE guidance, look at Equalities Act

Decide policies are unfair and bring to the notice of Hillingdon Clinical Commissioning Group through our seat on the CCG Quality Safety and Risk Committee

Refer to London Healthwatch Forum asking for further evidence from local Healthwatch

Refer to Healthwatch England as a concern and recommend they investigate nationally

Get invited to attend the NWL CCG Policy Development Group which is reviewing PPwT policies, including knee replacement

NWL CCG Collaborative Policy Development Group agree to recommend change to PPwT policy for knee replacement and remove weight restriction

An estimated 1,920 people per year in London could now eligible for knee operations who were previously refused

A possible 5,422 people per year in England could be eligible for knee operations who were previously refused

**Potentially 60 people per year in Hillingdon now eligible for knee operations who were previously refused**

**We are currently involved in the review of 46 treatments[1] through our role on the NWL CCG Policy Development Group. Having highlighted the inequalities of PPwT in NWL, we now have an opportunity to positively affect thousands of local people's lives.**

1. All procedures currently treated under the PPwT and IFR are list at: http://www.northwestlondon.nhs.uk/publications/?category=6089-Policies-d

# Financial Statement

| Financial Statement From 1st April 2013 To 31st March 2014 | |
|---|---|
| | £ |
| **Income** | |
| Funding received from the local authority | 175,000 |
| Additional Income | 2,219 |
| **Total Income** | **177,219** |
| **Expenses** | |
| Staff | 127,705 |
| Other expenses | 35,072 |
| **Total Expenses** | **162,777** |
| **Surplus C/F to 2014/15** | **14,442** |

# Contact Details


## Contact Information

### Board of Directors and Trustees

Jeff Maslen - Chairman
Stephen Otter - Vice Chairman
Richard Eason – Treasurer
Tony Ellis (resigned Dec 2013)
Martin McElreavey
Turkay Mahmoud
Baj Mathur MBE
Keritha Ollivierre
Edlynn Zakers

### Staff Team

Graham Hawkes - Chief Executive Officer
Dr Raj Grewal – Healthwatch Operations Coordinator
Nina Earl – Engagement & Communications Officer
Pat Maher - Administration & Support Officer

### Address

Healthwatch Hillingdon
25 Market Square
The Pavilions Shopping Centre
Uxbridge
UB8 1LH

**Telephone:** **01895 272997**

**Email:** **office@healthwatchhillingdon.org.uk**

**Website:** **www.healthwatchhillingdon.org.uk**

**Company Number:** **8445068** | **Registered Charity Number:** **1152553**

Healthwatch Hillingdon  @healthwatch_LBH  Healthwatch Hillingdon

# Glossary

**Individual Funding Requests (IFR):** Are requests made by a clinician on behalf of their patients, for treatment that is not normally commissioned by Clinical Commissioning Groups or NHS England.
http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf

**Joint Strategic Needs Assessment (JSNA):** analyses the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. https://www.hillingdon.gov.uk/jsna

**Patient-Led Assessments of the Care Environment (PLACE):** is the patient led system for assessing the quality of the environment of public funded hospitals, day treatment centres and hospices. http://www.england.nhs.uk/2013/02/19/place/

**Planned Procedures with a Threshold (PPwT):** are treatments where a patient has to meet set 'evidence-based' criteria before being able to access treatment. Clinician makes a decision whether a patient meets the criteria (thresholds) as defined by CCG's PPwT Policy.
http://healthwatchhillingdon.org.uk/index.php/publications/?did=1457

**Seven Day Working:** NWL is an 'early adopter' for Seven Day Working. With support from NHS England and NHS Improving Quality, Clinical Commissioning Groups, health and care providers and local authorities are working together to deliver the appropriate NHS services seven days a week, to ensure that people are treated at the right place, at the right time.
www.healthiernorthwestlondon.nhs.uk/news/north-west-london-lead-way-seven-day-nhs-services

**Shaping a Healthier Future (SaHF):** is a programme to improve NHS services for the two million people who live in North West London. It looks to reconfiguring services at the 9 hospitals and deliver as much care as possible nearer to people's homes in community settings. http://www.healthiernorthwestlondon.nhs.uk/

**The Better Care Fund (BCF):** nationally amounts to £3.8billion in 2015/16 which is to be spent locally on 'adult social care services which also have a health benefit' to drive closer integration and improve outcomes for patients, service users and carers. http://healthwatchhillingdon.org.uk/index.php/publications/?did=1455 or http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-itf-sup-pck.pdf

**Whole Systems Integrated Care (WSIC):** NWL is 1 of 14 pioneers in the UK leading the way to deliver better joined up care. The aim of the programme is to make health and social care services work together to provide better support at home, and earlier treatment in the community, to prevent people needing emergency care in hospital or care homes. http://integration.healthiernorthwestlondon.nhs.uk/

**Other Main References**

| | |
|---|---|
| Care Quality Commission | www.cqc.org.uk/ |
| Central and North West London NHS Foundation Trust | www.cnwl.nhs.uk/ |
| Healthwatch England | www.healthwatch.co.uk |
| Hillingdon Clinical Commissioning Group | www.hillingdonccg.nhs.uk/ |
| London Borough of Hillingdon | www.hillingdon.gov.uk/ |
| Monitor | www.gov.uk/government/organisations/monitor |
| NHS England (London) | www.england.nhs.uk/london/ |
| Royal Brompton and Harefield NHS Foundation Trust | www.rbht.nhs.uk/ |
| The NHS Trust Development Authority | www.ntda.nhs.uk/ |
| The Hillingdon Hospitals NHS Foundation Trust | www.thh.nhs.uk/ |
| Urgent Care Centre Hillingdon | www.greenbrook.nhs.uk/Urgent_Care |
| VoiceAbility | www.voiceability.org/ |

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# UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Ray Puddifoot |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Jales Tippell, Residents Services |
| **Papers with report** | Appendix 1 |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This paper updates the Board of the progress being made in allocating and spending contributions towards the provision of healthcare facilities in the Borough. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy |
| **Financial Cost** | None. |
| **Relevant Policy Overview & Scrutiny Committee** | Social Services, Housing and Public Health<br>Residents' and Environmental Services<br>External Services |
| **Ward(s) affected** | N/A |

## 2. RECOMMENDATION

**That the Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.**

## 3. UPDATE ON PROGRESS

1. Since the last report to the Health and Wellbeing Board in February 2014, there has been good progress in moving identified schemes forward.

**GP expansion schemes**

King Edwards Medical Centre – Additional GP consulting room

2. A total of £20,000 from two s106 health facilities contributions was formally allocated to this scheme (Cabinet Member Decision 06/12/2013). NHS Property Services has advised that the scheme, to carry out internal alterations to provide an additional GP

consulting room, has been satisfactorily completed and the funds have been transferred towards the scheme.

Southcote Medical Centre – Extension to existing premises

3. The proposed scheme involves an extension to the current premises to provide an additional GP consulting room, clinical training room and increased waiting area. A Cabinet Member report to formally request the allocation and release of funds from the s106 health facilities contribution held at H/15/205F (£184,653) towards this scheme was approved by the Leader and the Cabinet Member for Finance, Property and Business Services on 9 January 2014. Following a formal request from NHS Property Services, the funds have been transferred towards the cost of implementing the scheme which is expected to be completed by September 2014, in line with the Service Level Agreement.

Wallasey Medical Centre – Extension to existing premises

4. This scheme to extend the existing GP surgery to provide two GP consulting rooms and a clinical training room has been completed and, following the approval of a Cabinet Member report in January 2014 for formal allocation and release of the funds held at H/19/231G (£193,305) towards the scheme, the funds were released to NHS Property Services in February.

Pine Medical Centre – Additional GP consulting room

5. This scheme involves the conversion of an existing meeting room into a GP consulting room. Following some delay, the practice has now provided further details of the scheme in order to allow NHS Property Services to make a formal request for the allocation of s106 funds. A Cabinet Member report to request release of £1,800 from the contribution held at H/18/219C towards the scheme will therefore be formally submitted to the Leader and the Cabinet Member for Finance, Property and Business Services in July.

**Hesa Health Centre expansion**

6. Following the transfer of three s106 contributions totalling £264,818 to NHS Property Services, work on site is progressing well with the first phase (post office conversion) completed in June 2014. Phase 2 of the scheme is now on site and due for completion in August 2014. NHS Property Services has confirmed that they have invested over and above the s106 allocation towards developing the HESA scheme, which has a budget in excess of £1 million.

**Proposed new Yiewsley Health Centre (former Yiewsley Pool site)**

7. A planning application to redevelop the former Yiewsley Pool site to provide a new health centre, gym and 12 supported housing units (planning reference 18344/APP/2013/3564) was approved at the Council's Major Application's Committee on 6 March 2014 subject to the satisfactory completion of a s106 agreement**.**

8. All parties have now agreed the terms of the required s106 agreement which was signed on 5 June 2014 and planning permission has now been issued. Subject to satisfactory completion of the Council's tender process, the scheme is expected to begin on site in September 2014 and complete by February 2016.

9. The funding required to meet the fitting out costs associated with the scheme are not likely to be needed until 2015/2016. As this would be too late to spend three of the s106 contributions which were earmarked towards these costs, NHS Property Services agreed to the Council utilising the contributions (totalling £70,672) towards the costs associated with the submission of the planning application. This was formally agreed by the Leader and Cabinet Member for Finance, Property and Business Services on 3 March 2014. All three contributions have now been fully spent towards the scheme.

**Unallocated s106 health contributions**

10. Appendix 1 attached to this report details all of the s106 health facilities contributions currently held by the Council (figs as at 31 March 2014).

11. NHS Property Services has reaffirmed that they will be requesting that any unallocated health contributions received from developments in the south of the Borough are allocated towards either the Hesa extension or the new Yiewsley health centre where s106 agreements allow. In the north of the Borough, in line with the process that was agreed with the London wide Medical Committee (LMC) in August 2013, GP practices in the area will be asked to express an interest in spending these contributions towards eligible expansion schemes. NHS Property Services are due to meet with the NHS/Clinical Commissioning Group (CCG) to begin this process in early July.

**St Andrews Park**

12. The developer has provided evidence to show that, in accordance with Schedule 6 of the s106 agreement, they have genuinely been trying to reach agreement with the NHS/Clinical Commissioning Group (CCG) over the provision of a GP Surgery on the site at St Andrews Park, which was approved as part of the outline planning permission. In these circumstances, the legal agreement provides that the developer should be released from the requirement to provide an onsite health care facility and instead pay the healthcare contribution (£624,507.94). The developer has advised that they are currently obtaining the requisite internal approvals to make this payment.

13. The CCG is in the process of preparing a strategic case for the provision of a health hub in Uxbridge and developing an outline business case for submission to NHS England. An outline business case for the Uxbridge Hub is being developed and a full non-financial options appraisal is being undertaken. The CCG would like to include the St Andrews Park development site as an option but, due to the current position of the developer, other property searches are being conducted.

**FINANCIAL IMPLICATIONS**

As at 31 March 2014, there is £1,192k of Social Services, Health and Housing s106 contributions available, of which £262k has been identified as a contribution for affordable housing and £50k towards a social services scheme. The remaining £880k is available to be utilised towards the provision of facilities for health. It is worth noting that £476k of the health contributions have no time limits attached to them.

Transfers of contributions to NHS Property Services since the previous report include the following:

Allocated to expansion at Southcote Clinic - Funds transferred to NHS PS Feb 14

| S106 Funding Reference | Development | Amount | Time Limit to Spend |
|---|---|---|---|
| H/15/205F | RAF Eastcote, Ruislip | £186,499 | Sept 2014 |
| **Total** | | **£186,499** | |

A total of £186,499 including interest was transferred to NHS Property Services in February 2014 for the above project.

Allocated to King Edwards Medical Centre - Funds transferred to NHS PS Feb 14

| S106 Funding Reference | Development | Amount | Time Limit to Spend |
|---|---|---|---|
| H/12/197B | Windmill P.H, Ruislip | £11,473 | Feb 2014 |
| H/9/184C | 31-46 Pembroke Road, Ruislip | £8,584 | Jul 2015 |
| **Total** | | **£20,057** | |

A total of £20,057 including interest was transferred to NHS Property Services in February 2014 for the above project. There is still a remaining balance of £13,115 which must be spent by 1 July 2015 or be returned to the developer.

Allocated towards expansion of GP Practice in Wallasey Road - Funds transferred to NHS PS Feb 14

| S106 Funding Reference | Development | Amount | Time Limit to Spend |
|---|---|---|---|
| H/19/231G | RAF West Ruislip, Ickenham | £193,857 | Nov 2017 |
| **Total** | | **£193,857** | |

A total of £193,857 including interest was transferred to NHS Property Services in February 2014 for the above project.

Allocated to new Yiewsley Health Centre – Fund fully spent

| S106 Funding Reference | Development | Amount | Time Limit to Spend |
|---|---|---|---|
| H/5/161C | Fmr Honeywell Site, West Drayton | £51,118 | Mar 2014 |
| H/14/206C | 111 – 117 High St, Yiewsley | £10,651 | Aug 2014 |
| H/1/152C | Fmr Middlesex Lodge, Hillingdon | £8,903 | Jul 2014 |
| **Total** | | **£70,672** | |

The full amount of the above S106 contributions totalling £70,672 was spent on the Yiewsley Health Centre development project at 31 March 2014.

## LEGAL IMPLICATIONS

Under the provisions of section 111 of the Local Government Act 1972, a local authority has the power to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of its functions. The work to be carried out in accordance within this report would fall within the range of activities permitted by Section 111.

Regulation 122 (2) of the Community Infrastructure Levy Regulations 2010 states that a planning obligation may only constitute a reason for granting planning permission for the development if the obligation is:

1. necessary to make the development acceptable in planning terms;
2. directly related to the development; and
3. fairly and reasonably related in scale and kind to the development.

Circular 2005/05 goes further than Regulation 122 and suggests that a planning obligation must also be:

4. relevant to planning; and
5. reasonable in all other respects.

The monies must not be used for any other purpose other than the purposes provided in the relevant section 106 agreement. Where monies are not spent within the time limits prescribed in those agreements, such monies should be returned to the payee.

When the Council receives formal bids to release funds, each proposed scheme will need to be assessed and reported to the Leader and Cabinet Member for Finance, Property and Business Services in order for the monies to be released. As part of that process, the Council's Legal Services will review the proposal and the section 106 agreement that secures the funding, to ensure that the Council is permitted to spend the section 106 monies on each proposed scheme. The content of the section 106 agreements in relation to King Edwards Medical Centre, Southcote Medical Centre, Wallasey Medical Centre and Pine Medical Centre referred to in this report have been assessed and approved in line with those procedures prior to release of the capital monies for the schemes.

The use of section 106 monies for future schemes mentioned in the report will need to be assessed against their respective agreements when these are finalised on a case by case basis.

## BACKGROUND PAPERS

None.

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| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | DETAILS OF OBLIGATION |
|---|---|---|---|---|---|---|
| | | | AS AT 31/03/14 | AS AT 31/03/14 | | |
| H/8/186D *54 | Yiewsley | 92-105, High St., Yiewsley 59189/APP/2005/3476 | 15,549.05 | 15,549.05 | 2015 (Apr) | Contribution received towards the cost of providing additional primary heath facilities in the Borough. Funds not spent by 20/04/2015 must be returned. **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to formal allocation request and approval.** |
| H/9/184C *55 | West Ruislip | 31-46, Pembroke Rd, Ruislip 59816/APP/2006/2896 | 21,675.10 | 13,115.10 | 2015 (Jul) | Contribution received towards primary health care facilities within a 3 mile radius of the development. Funds not spent by 01/07/2015 must be returned to the developer. **£8,560 allocated towards additional consulting room at King Edwards Medical Centre (Cabinet Member Decision 6/12/2013). Funds transferred to NHS PS Feb 14.** |
| H/10/190D *56 | Uxbridge | Armstrong House & The Pavilions. 43742/APP/2006/252 | 43,395.00 | 43,395.00 | 2015 (Jul) | Contribution received towards primary health care facilities in the borough. Funds must be spent within 7 years of receipt. Funds not spent by 29/7/2015 are to be returned to the developer. |
| H/11/195B *57 | Ruislip | Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 | 3,156.00 | 3,156.00 | No time limits | Funds to be used to support the provision of local healthcare facilities arising from the needs of the development. No time limits. |
| H13/194E *59 | Uxbridge | Frays Adult Education Centre, Harefield Road, Uxbridge. 18732/APP/2006/1217 | 12,426.75 | 12,426.75 | No time limits | Funds received towards the provision of healthcare facilities in the Borough. No time limits. |
| H/16/210C *68 | Botwell | Hayes Stadium, Judge Heath Lane, Hayes. 49996/APP/2008/3561 | 105,044.18 | 105,044.18 | 2015 ( Mar) | Funds received as the healthcare facilites and places contribution towards the cost of providing; the expansion of health premises to provide additional facilites and services to meet increased patient user numbers or new health premises or services in the local area. Funds to be spent by March 2015. **Earmarked towards HESA extension, subject to request for formal allocation.** |
| H/18/219C *70 | Yeading | Land rear of Sydney Court, Perth Avenue, Hayes. 65936/APP/2009/2629 | 3,902.00 | 3,902.00 | No time limits | Funds received towards the cost of providing health facilites in the Authorities Area. No time limits. **£1,800 earmarked towards improvements to Pine Medical Centre, subject to formal approval.** |

| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | DETAILS OF OBLIGATION |
|---|---|---|---|---|---|---|
| | | | AS AT 31/03/14 | AS AT 31/03/14 | | |
| H/20/238F *72 | West Ruislip | Former Mill Works, Bury Street, Ruislip. 6157/APP/2009/2069 | 31,441.99 | 31,441.99 | 2018 (Jun) | Contribution received as the health facilities contribution towards providing health facilities in the Authority's Area. Funds to be spent towards (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient or user numbers or, new health premises or services at local level or, any new facility required to compensate for loss of health facility caused by the development. First instalment to be spent by February 2018. Second instalment to be spent by June 2018**.** |
| H/21/237D *73 | Eastcote | Bishop Ramsey School (lower site), Eastcote Road, Ruislip. 19731/APP/2006/1442 | 22,455.88 | 22,455.88 | 2016 (Feb) | Contribution received towards the provision of primary health care facilities in the Uxbridge area. Funds to be spent within 5 years of receipt (February 2016). |
| H/22/239E *74 | Eastcote | Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 & 10622/APP/2009/2504 | 7,363.00 | 7,363.00 | No time limits | Funds received towards the cost of providing health faciities in the Authority's Area including (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient numbers or, any new facility required to compensate for the loss of a health facility caused by the development. No time limits. |
| H/23/209K *75 | Yiewsley | Tesco, Trout Road,Yiewsley. 60929/APP/2007/3744 | 37,723.04 | 37,723.04 | 2016 (Mar) | Contribution received towards the provision of local health service infrastructure in the Yiewsley, West Drayton, Cowley area. Funds to be spent by March 2016. **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to formal allocation request and approval**. |
| H/25/244C *77 | Townfield | 505-509 Uxbridge Road, Hayes. 9912/APP/2009/1907 | 20,269.97 | 20,269.97 | 2018 (Jun) | Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. Funds to be spent within 7 years of receipt (June 2018). **Earmarked towards HESA extension, subject to formal allocation.** |

| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | DETAILS OF OBLIGATION |
|---|---|---|---|---|---|---|
| | | | AS AT 31/03/14 | AS AT 31/03/14 | | |
| H/26/249D *78 | Townfield | Former Glenister Hall, 119 Minet Drive, Hayes. 40169/APP/2011/243 | 33,219.40 | 33,219.40 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend. **Earmarked towards HESA extension, subject to formal allocation.** |
| H/27/262D *80 | Charville | Former Hayes End Library, Uxbridge Road, Hayes. 9301/APP/2010/2231 | 5,233.36 | 5,233.36 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend. |
| H/28/263D *81 | South Ruislip | Former South Ruislip Library, Victoria Road, Ruislip (plot A). 67080/APP/2010/1419 | 3,353.86 | 3,353.86 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend |
| H/29/267D *83 | Botwell | Fmr Ram PH, Dawley Rd, Hayes 22769/APP/2010/1239 | 6,068.93 | 6,068.93 | No time limits | Funds received towards the cost of providing expansion of health premisies to provide additional facilities and services to meet increased patient numbers or new health premisies or services in the local area. No time limits for spend. **Earmarked towards HESA extension, subject to formal allocation.** |
| H/30/276G * 85 | Townfield | Fmr Hayes FC, Church Road, Hayes. 4327/APP/2009/2737 | 68,698.26 | 68,698.26 | 2019 (Jul) | Funds received as the first **and second** instalment towards the cost of providing health facilities in the Authority's area including the expansion of health premises to provide additional facilities, new health premises or services (see legal agreement for details). Funds to be spent within 7 years of receipt (July 2019). **Earmarked towards HESA extension, subject to formal allocation.** |
| H/31/278D *86 | Botwell | 6-12 Clayton Road, Hayes. 62528/APP/2009/2502 | 4,649.84 | 4,649.84 | No time limits | Funds received towards the cost of providing expansion of health premisies to provide additional facilities and services to meet increased patient numbers or new health premisies or services in the local area. No time limits for spend. **Earmarked towards HESA extension, subject to request for formal allocation.** |

| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | DETAILS OF OBLIGATION |
|---|---|---|---|---|---|---|
| | | | AS AT 31/03/14 | AS AT 31/03/14 | | |
| H/32/284C *89 | Yiewsley | Former Honeywell site, Trout Road, West Drayton (live/work units). 335/APP/2010/1615 | 5,280.23 | 5,280.23 | No time limits | Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend. **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to formal allocation.** |
| H/33/291 *91 | West Drayton | Former Swan PH, Swan Road, West Drayton. 68248/APP/2011/3013 | 5,416.75 | 5,416.75 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises at local level. Any new facility required to compensate for loss of a health facility caused by the development. **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to formal allocation.** |
| H34/282F *92 | West Ruislip | Lyon Court, 28-30 Pembroke Road, Ruislip 66985/APP/2011/3049 | 15,031.25 | 15,031.25 | 2019 (estimated) | Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 5 years of completion of development. Estimated spend deadline 2019. |
| H/36/299D *94 | Cavendish | 161 Elliot Ave (fmr Southbourne Day Centre), Ruislip. 66033/APP/2009/1060 | 9,001.79 | 9,001.79 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of of a health facility caused by the development. |
| H/37/301E *95 | Northwood | 37-45 Ducks Hill Rd, Northwood 59214/APP/2010/1766 | 12,958.84 | 12,958.84 | 2018 (July) | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. |

| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | DETAILS OF OBLIGATION |
|---|---|---|---|---|---|---|
| | | | AS AT 31/03/14 | AS AT 31/03/14 | | |
| H/38/303E *96 | Botwell | 70 Wood End Green Rd, Hayes 5791/APP2012/408 | 13,750.73 | 13,750.73 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to request for formal allocation.** |
| H/39/304C *97 | Yeading | Fmr Tasman House, 111 Maple Road, Hayes 38097/APP/2012/3168 | 6,448.10 | 6,448.10 | 2020 (Aug) | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. |
| H/40/306D *98 | Hillingdon East | Fmr Knights of Hillingdon, Uxbridge 15407/APP/2009/1838 | 4,645.60 | 4,645.60 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. |
| H/41/309D *99 | Uxbridge South | Fmr Dagenham Motors, junction of St Johns Rd & Cowley Mill Rd, Uxbridge 188/APP/2008/3309 | 12,030.11 | 12,030.11 | 2020 (Oct) | Funds received towards the provision of healthcare services in LBH as necessitated by the development. |
| H/44/319D *44 | Northwood Hills | 117 Pinner Road, Northwood 12055/APP/2006/2510 | 24,312.54 | 24,312.54 | No time limits | Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. |
| H/42/242G *100 | West Drayton | West Drayton garden Village off Porters Way West Drayton. 5107/APP/2009/2348 | 334,574.00 | 334,574.00 | No time limits | contribution received towards providing additional primary healthcare facilities in the West Drayton area (see agreement for details) . **Earmarked towards fitting out costs associated with the new Yiewsley Health centre development, subject to request for formal allocation.** |
| | | **TOTAL CONTRIBUTIONS TOWARDS HEALTH CARE** | **889,075.55** | **880,515.55** | | |

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# PHARMACEUTICAL NEEDS ASSESSMENT

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Kevin Byrne, Administration Directorate |
| **Papers with report** | None |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | From 1 April 2013, the statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services for the population in its area transferred to Health and Wellbeing Boards from Primary Care Trusts. This statement is known as the 'pharmaceutical needs assessment' (PNA). The PNA assists in the commissioning of pharmaceutical services to meet local priorities. NHS England also use the PNA when making decisions on applications to open new pharmacies.<br><br>This paper presents to the Health and Wellbeing Board (HWB) a programme of work to complete and publish Hillingdon's pharmaceutical needs assessment (PNA). HWBs are required to publish their first PNA by 1 April 2015, and a revised, updated assessment within three years. |
| **Contribution to plans and strategies** | An up-to-date pharmaceutical needs assessment contributes to the development of Hillingdon's Health and Wellbeing Strategy. |
| **Financial Cost** | There are no direct financial implications arising from the recommendations set out in this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**The Board is asked to note:**

1. **the requirement to prepare and publish a pharmaceutical needs assessment (PNA) for Hillingdon by 1 April 2015.**

2. **the timetable to review Hillingdon's PNA with a consultation draft coming to the next Board for approval prior to commencing the statutory minimum 60 day consultation.**

## 3. INFORMATION

### Background to the Pharmaceutical Needs Assessment (PNA)

3. The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) to improve the health and wellbeing of the local population and to reduce health inequalities. The Act transferred the responsibility to develop and update pharmaceutical needs assessments (PNA) from Primary Care Trusts to HWBs, effective from 1st April 2013.

4. The PNA is a statement of the services and needs for pharmaceutical services of the population in area of the HWB. The PNA allows consideration to be given to applications for new pharmacies or changes to existing services by seeing how the services provided will meet an identified need. The PNA also assists in identifying if changes to commissioned services are required to ensure current and future needs are met.

5. HWBs are required to publish their first PNA by 1 April 2015, and to publish a revised PNA within three years of the first assessment. Non-compliance with the regulations may lead to a legal challenge, for example where a party believes that they have been disadvantaged following the refusal of their application to open a new pharmacy business.

6. For the purpose of the assessment, pharmaceutical services include:

   - Essential services - which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service. This includes the dispensing of medicines, promotion of healthy lifestyles and support for self-care.

   - Advanced services - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary. These are currently Medicines Use Reviews (MUR) and the New Medicines Service from community pharmacists and Appliance Use Reviews and the Stoma Customisation Service which can be provided by dispensing appliance contracts and community pharmacies.

   - Locally commissioned services - known as enhanced services. These could include the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out-of-hours services.

7. The PNA must align with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA). The pharmaceutical needs assessment should be a statement which has regard to the following:

   - the demography of the area;

   - the pharmaceutical services available in the area of the Health and Wellbeing Board;

   - whether in the area there is sufficient choice with regard to obtaining pharmaceutical services;

   - any different needs of different localities within the area; and

- the pharmaceutical services provided in the area of any neighbouring HWB which affect:
  - the need for pharmaceutical services; and
  - whether further provision of pharmaceutical services in the area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type (this could include for example new services in response to new housing developments).

8. When making an assessment of local pharmacy services, each HWB must take account of likely future needs having regard to likely changes to the number of people who require pharmaceutical services, the demography, and the risks to the health or well-being of people in the area. Specifically the assessment should identify potential gaps in provision that could be met by providing a greater range of services offered by pharmacies or through opening more pharmacies.

9. A survey of existing Pharmacies in Hillingdon and in neighbouring areas has commenced, with the support of Local Pharmaceutical Committee. This will collect robust and up to date information from each pharmacy to support the initial analysis for the assessment of need.

10. It is expected that the statement will also include information about:

- How the assessment was carried out – the localities in the area and how these were determined, the different needs across the localities including those people who share particular characteristics and a report on the consultation undertaken.
- Maps – HWBs are required to include a map in their PNA identifying the premises at which pharmaceutical services are provided. The Board is required to keep the map up to date.

**Proposed Timetable to Update the Pharmaceutical Needs Assessment**

11. The following presents a proposed list of key actions and the timetable to produce the first HWB pharmaceutical needs assessment by 1 April 2015. A PNA task and finish group with representatives from the local authority, CCG, Healthwatch and Local Pharmacy Committee will be established to complete the update of the PNA. The Board is asked to agree to the proposed timetable and actions.

| Ref | Timescale | Action |
|---|---|---|
| 1 | April – June 2014 | • Complete a desk top analysis of key pharmaceutical services data for Hillingdon.<br>• Prepare an updated analysis of the population and health needs data for the assessment.<br>• Work with partners to review the draft needs data. |
| 2 | July – September 2014 | • Collate supplementary information through survey of existing pharmacies.<br>• Finalise the draft assessment with the PNA task and finish group.<br>• Prepare draft conclusions and draft recommendations for review and agreement with the HWB. |

| Ref | Timescale | Action |
|---|---|---|
| 3 | September – November 2014 | • Undertake the statutory minimum 60-day consultation for the PNA. |
| 4 | November – December 2014 | • Feedback from stakeholder consultation considered by task and finish group.<br>• Draft assessment amended for the HWB. |
| 5 | December 2014 – February 2015 | • Present to the HWB the final PNA for consideration and agreement. |
| 6 | By 1 April 2015 | • Publish the updated PNA. Notify NHS England. |

**Statutory Consultation**

12. The HWB is required to undertake consultation on the draft pharmaceutical needs assessment for a minimum period of 60 days. The HWB is required to consult with a number of prescribed stakeholders, including Healthwatch, NHS England, the Local Pharmaceutical Committee, the Local Medical Committee, local pharmacies and any dispensing doctors listed for its area, neighbouring HWBs and any NHS trust or NHS foundation trust in the area.

13. This report recommends to the Board to delegate to the Chairman of the Health and Wellbeing Board the approval of the arrangements for the 60-day consultation, including the approval of the draft PNA document for consultation.

**Financial Implications**

There are no direct financial implications arising from the recommendations set out in this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

The recommendations will inform future commissioning decisions to ensure sufficient and effective provision of pharmaceutical services to meet local needs. Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services.

**Consultation Carried Out or Required**

None at this stage. The PNA action plan and timetable presented to the HWB includes consultation with key stakeholders on the draft pharmaceutical needs assessment for a minimum period of 60 days.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no direct financial implications arising from the recommendations set out in this report.

**Hillingdon Council Legal comments**

From the 1 April 2013 *The Health and Social Care Act 2012* placed a statutory obligation on local authorities, through Health and Wellbeing Boards (HWBs), to develop and update Pharmaceutical Needs Assessments (PNAs). Pursuant to *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* HWBs are required to produce their first PNAs by 1 April 2015, and reviewed every three years thereafter. Schedule 1 of the *2013 Regulations* sets out matters to be covered in the PNAs.

HWBs are committees of the Local Authority, with non-executive functions, constituted under the Local Authority 1972 Act, and are subject to local authority scrutiny arrangements.

There are no direct legal implications arising from the recommendations set out in this report.

## 6. BACKGROUND PAPERS

Nil.

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# BETTER CARE FUND: HILLINGDON IMPLEMENTATION PLAN

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Tony Zaman, LBH Adult Social Care<br>Ceri Jacob, Hillingdon Clinical Commissioning Group |
| **Papers with report** | Appendix 1 - Letter from DH, DCLG, LGA and NHS England re: Better Care Fund dated 11 July 2014<br>Appendix 2 - Further letter from DH & DCLG dated 11 July 2014 |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | The Board agreed the Hillingdon Better Care Fund Plan at its meeting on 1 April 2014. This report provides the Board with a progress report in respect of the plan as it moves towards implementation from 2015/16. |
| **Contribution to plans and strategies** | Hillingdon's Joint Health & Wellbeing Strategy<br>Hillingdon's Joint Strategic Needs Assessment<br>Hillingdon's Out of Hospital Strategy |
| **Financial Cost** | Hillingdon's Better Care Fund, from reallocation of existing budgets, is £17.991m for 2015/16 |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**The Health and Wellbeing Board is asked to note:**

1. **the progress on workstreams for the Better Care Fund; and**
2. **that the section 256 money for 2014/15 has been agreed between LBH and HCCG, thereby enabling this money to drawn down from NHS England.**

## 3. INFORMATION

### Reasons for recommendations

3.1. To make progress in implementing the Better Care Fund programme in Hillingdon.

### Financial Implications

3.2. The Government has made available through NHS England and Hillingdon CCG s256 funding of £4.772m for LBH in 2014/15 with the objective of supporting social care services where they benefit health. This sum is made up of the £3.9m previously announced for 2014/15

plus additional funding amounting to £0.868m to prepare for the new Better Care Fund arrangements.

3.3. The condition attached to the transfer of the additional funding of £0.868m was that both organisations must jointly agree and sign off two year plans for the Better Care Fund: these where were provided to NHS England on 4 April 2014. The 2014/15 year, therefore, will in effect be a transitional year, during which time both Hillingdon CCG and LBH develop the Better Care Fund plan setting out how they will achieve the agreed outcomes of the fund.

3.4. In accordance with the BCF requirements, a s.75 arrangement will be in place to formally monitor the financial arrangements and delivery of the BCF outcomes by 2015/16. A working group has been convened to develop the s.75. Membership includes finance and legal representation. Consideration will need to be given in particular to the decision making process as well as risk and benefit sharing in relation to the pooled funds. Timeline for completion is by quarter 3.

3.5. Recent correspondence at Appendices 1 and 2 set out new arrangements for performance and risk sharing. This includes a new requirement for a local target on reducing emergency admissions to hospital which will now form the sole indicator for performance payment under the BCF.

**Legal Implications**

3.6. The Borough Solicitor confirms that the legal implications are included in the body of the report.

## 4. BACKGROUND

4.1. The Board agreed Hillingdon's Better Care Fund plan at its meeting on 1 April 2014 and this was submitted as required and on time to NHS England on 4 April 2014. The plan agreed sets out 11 schemes, grouped into 4 workstreams, which build on existing activity from integrated care pilots around falls to new pathways for early supported discharge from secondary care, these are set out further below.

4.2. The only feedback received on the plan so far relates to some technical questions from NHS England regarding the metrics set and these have been answered. We were led to understand, therefore, that the plan met all requirements set nationally and should form the basis for implementation.

4.3. However, the recent correspondence at Appendix 1 and Appendix 2 sets out new arrangements for performance and risk sharing. It is now intended that each plan should reflect local proposals to reduce emergency admissions and set a local target against a guideline of 3.5% reduction, to do so. A proportion of the current performance allocation (a £1bn pot nationally) is dependent upon achieving this and will be the sole indicator used to set the performance element of the BCF. Further guidance is promised "shortly" and NHS England will request additional financial data around metrics, planned spend and projected savings. It is suggested that areas will be asked to resubmit plans "at the end of the Summer". Depending on the specific requirements and dates set, this seems likely to require urgent attention over the holiday period. Hopefully, it would permit an update of the BCF to come to next scheduled Board meeting on 23 September 2014, before submission.

**Programme Management**

4.4. As per the plan, the core officer group has continued to meet regularly to oversee its implementation. Scheme leads have been identified to take forward detailed planning and to bring in partners as required to ensure effective delivery. The wider delivery group including providers has been established and will continue to meet monthly. An overall programme initiation document has been agreed. A programme management system has been developed to capture progress. At the end of quarter 1, all workstreams are on track.

4.5. Notable achievements over quarter 1 of the 2014/15 preparatory year include:

**Workstream 1 - Integrated Case Management.**

A workshop is planned for 1 August 2014 to consider with key operational staff and partners the scope, operational design and co-dependencies of the schemes within this workstream.

**Scheme one: Joined up tool for health and social care risk stratification*:***

- The Integrated Care Programme has triangulated the use of the "Birt2" risk stratification tool, frequent users of acute hospitals data and GP practise intelligence. This forms the basis for identification of high risk patients currently.

- HCCG is working with NHS Institute for Health Research (CLARHC) to develop a predictive tool which enables health and social care to better understand the triggers and risk factors associated with a number of 'common conditions'. This will help us to plan and work differently with Hillingdon residents as part of the expert patient programme. Timescales for testing the assumptions within the CLARHC tool are set for end of Quarter 2.

**Scheme three: Further development of care plans that are shared, agreed and implemented jointly**

- A key component in the scheme is the Integrated Care Programme (ICP) where high risk patients, through the use of risk stratification tools detailed in Scheme 1, are identified and managed through the development of health and social care, care plans.

- From July 2014 GPs have the tools to implement active monitoring of care plans. In conjunction with the recruitment of Health and Social care co-ordinators who are currently being inducted into their new roles, this scheme remains on track to deliver the agreed outcomes of care plans shared and actively reviewed.

**Scheme four: Integrated case management and care coordination**

- The ICP originally piloted in 2012 was reviewed and a revised model of care agreed commencing in April 2014 shifting from a condition specific pathway to one based on risk stratification.

**Scheme eight: Better care for people at the end of their life (EoL)**

- Building on the work already underway within the End of Life forum, the EoL Scheme Lead is developing criteria for the revised service with key partners. Specification and business case are on track to be developed by end of September 2014.

**Scheme eleven: Development of IT system across health and social care with enhanced interoperability**

- The use of NHS numbers remains a key requirement for the BCF plan. Good progress has been made on the testing and roll out of NHS numbers across Adults and Children's services.

- NHS England has made available capital funding for 2014/15 and 2015/16 through the Integrated Digital Care Technology Fund. The CCG will be supporting bids by Hillingdon Hospital Trust to (1) develop an integrated digital care record across THH's clinical services and CNWL, and (2) support the implementation of Virtual Wards.

- The workstream will consider scoping the ICT integrated requirements in case of future funding opportunities.

**Workstream 2- Intermediate Care**

- The integrated approach builds on mature schemes which need to be re-considered as part of an integrated approach.

- A workshop is planned for 25 July 2014 to consider with key operational staff and partners the scope, operational design and co-dependencies of the schemes within this workstream.

**Scheme six: Rapid response and joined up Intermediate Care**

**Scheme seven: Early Supported Discharge**

- The ESD (Home safe service) supporting people to leave hospital with enhanced support services is working well with patients over 65 years. We are looking to increase the scope of this multi agency project which is led by THH, the detail of which will be scoped out from the forthcoming workshop.

**Workstream 3 - Seven Day Working**

**Scheme ten: Seven day working**

- A task and finish group has been set up to undertake a gap analysis of the 7 day working requirements across the health and social care system.

- ASC is proposing to test 7 day working by supporting transfers of care from THH on a Saturday and Sunday with a control group of patients during July 2014.

**Workstream 4 - Seamless Community Services**

- As with workstreams 2 and 3, the integrated approach builds on mature schemes which also need to be re-considered as part of an integrated approach at the workshop planned for 25 July 2014.

**Scheme nine: Care Homes Initiative**

- The care homes initiative has started with the identification and re-configuration of Community Matrons aligned to GP networks with a clear focus on care homes and improving quality within the homes.

- Next steps include a scoping exercise to align the intelligence from HCCG including emergency admissions to hospital from Care Home residents and quality / safeguarding alerts from Adult Social Care. This will provide a framework and set of priorities for the staff to work to locally.

**Scheme five: Review and realignment community services to emerging GP networks**

- Scheme leads have been allocated across organisations to progress this scheme.

**Communications and Engagement Plan**

4.6. A Communications and Engagement plan has been developed as part of the BCF implementation, to deliver on the commitment in the plan that providers, the voluntary sector and residents would be fully involved in the implementation of service improvements:

- Strategy to date has focused on informing stakeholders of the BCF and the mandated requirements.
- A Customer Engagement strategy has been developed and shared with the delivery group.
- Wider LBH BCF staff briefing sessions are being developed.
- LBH external and internal website updated to include BCF briefing and opportunity to comment.
- Further engagement will commence as the individual schemes develop

4.7. The next phase of the plan is to move on from the "Informing" stage and to actively involve residents in developing services through engagement and co-design.

**Risk Management**

4.8. The Programme Risk Register has been reviewed. The risk regarding potentially overlapping schemes remains current and the core group has endeavoured to reach a situation whereby performance information is collected once and reported separately as necessary. This will continue to be kept under review.

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Department of Health

Department for Communities and Local Government

Dear Health and Wellbeing Board Chair

11 July 2014

**BETTER CARE FUND**

Thank you for the progress you have made so far with your preparations to implement the Better Care Fund. We know that local plans contain a clear commitment to ensure more people receive joined-up, personalised care closer to home. This letter sets out how you will continue to be supported to get the plans ready for implementation from April 2015. Following the recent announcement on the Better Care Fund, we also want to tell you about some changes we are making to further develop the programme.

We remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals. That is the way we can preserve people's dignity by enabling them to stay in their own homes, and to receive care and support when and where they want and need it. That is why the Government remains fully committed to the Better Care Fund and are clear that pooled health and care budgets will be an enduring feature of future settlements.

The Better Care Fund is deliberately ambitious. The majority of local draft plans submitted in April showed that same ambition. We recognise the scale of the task of transforming local services and the plans show how significant progress has been made in bringing together organisations and moving to a new and more collective way of working. We were particularly pleased to learn that most of the plans were addressing key conditions such as a commitment to seven day working, better sharing of information and protection of social care services.

We know that we need to shift as quickly as possible from improving and assuring the plans to letting local areas get on with delivery. However, we believe there is more to do over the next few months to ensure a strong first year.

*Pay for Performance and Risk Sharing*

First, as announced earlier in the month we are finalising arrangements for the pay for performance element of the fund and, as part of that, putting in place a clear framework for local risk sharing.

We know that unplanned admissions are by far the biggest driver of cost in the health service that the Better Care Fund can affect. We need the plans to demonstrate clearly how they will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

We are therefore asking each Health and Wellbeing Board to propose their own performance pot based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent. A proportion of your current performance allocation (i.e. your area's share of the national £1bn performance element of the fund) will be paid for delivery of this target. That proportion will depend on the level of ambition of your target. Where local areas do not achieve their targets the money not released will be available to the CCGs, principally to pay for the unbudgeted acute activity.

The balance of your area's current performance allocation (i.e. the amount not set against the target for reduced admissions) will be available upfront to areas and not dependent on performance. Under the new framework, it will need to be spent on out-of hospital NHS commissioned services, as agreed locally by Health and Wellbeing Boards.

In reality we know of course that a lot of the investment from the Fund will be in joint services. We welcome that and will find a simple way to account for that investment.

This change will mean that while it is likely that local authorities will continue to receive the large majority of the Better Care Fund, the NHS will have the assurance that plans will include a strong focus on reducing pressures arising from unplanned admissions.

This change also means that, because of its importance in terms of driving wider savings, reductions in unplanned admissions will now be the sole indicator underpinning the pay for performance element of the BCF. Performance against the other existing metrics will no longer be linked to payment. However, we will still want to see evidence of strong local ambition against them as part of the assurance of plans.

*Plan Improvement and Assurance*

Second, certain aspects of local plans need to be strengthened to ensure we are ready to deliver from April 2015. NHS England and the LGA will shortly be issuing guidance on what a good final plan should look like. NHS England will also be publishing exemplar plans from a small number of areas to help the process.

In addition, NHS England will issue a revised plan template which will request additional financial data around metrics, planned spend and projected savings. They will also provide further detailed guidance on the revised pay for performance and risk sharing arrangements.

We expect that areas will be asked to submit revised plans and any further information at the end of the summer. NHS England, supported by the LGA, will also set out the assurance

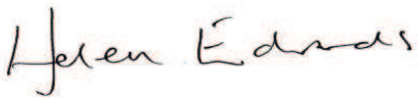
and moderation process. Where localities need support to complete their plans NHS England, supported by the LGA, will discuss how best to provide this.

The plans will be further reviewed by DCLG Permanent Secretary Sir Bob Kerslake and NHS Chief Executive Simon Stevens in the autumn prior to submission to Ministers to ensure they are ambitious enough to achieve improvements in care and that every area is on track to begin in April next year.

*Better Care Fund Programme Team*

Third, in order to drive this through at pace an expanded joint Better Care Fund programme team has been established, working across Whitehall, local government and the NHS. Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, will take on overall responsibility for delivery through this team. The expanded team is headed by Andrew Ridley as the new BCF Programme Director. A key priority for the new team will be ensuring that, given the fast-moving nature of the programme, you are kept fully up to date and provided with the support you need to deliver effective plans and move into implementation. Andrew will be writing to you shortly to outline his plans for doing this, and to begin a regular programme of communication with local areas.

We recognise that in order to make integrated services a reality, you have achieved a lot already over a short space of time. We would like to thank you again for your hard work, and to reiterate that the Government remains absolutely committed to making the Better Care Fund and integrated services a success. We know that you share our ambition to transform local services for the benefit of all who use them.



**JON ROUSE** **HELEN EDWARDS**

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11 July 2014

Dear Health and Wellbeing Board Chair

**BETTER CARE FUND PROGRAMME TEAM**

Helen Edwards and Jon Rouse have written to confirm a number of important developments on the Better Care Fund. This included my appointment as the new Better Care Fund Programme Director, and the establishment of an expanded joint programme team. I am writing now to begin a regular programme of communication, and to set out my plans for working with you to help make a success of the BCF. I would encourage you to share my thoughts with colleagues and partners working on BCF plans locally.

As set out in Helen and Jon's letter, I am heading up an expanded joint team that includes colleagues from NHS England, the LGA, DH and DCLG, working under the leadership of Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, who will take on overall responsibility for the programme. The team, reporting to me, has been brought together to ensure we drive forward progress and provide local areas with the support they need. I have prioritised a number of work areas, in order to take the programme forward with clarity and purpose:

- Establishing a programme management office, which will work to quickly ensure a shared understanding of key deliverables and deadlines – when we have clear dates and deadlines we will share them
- Developing an effective offer of support to local areas to ensure they are fully supported to develop the best plans possible – including how the plans of 'fast track' areas can act as exemplars
- Clarifying a revised, nationally consistent and robust assurance process, including being clear on what is being asked from local areas
- Strengthening communications and stakeholder engagement to ensure that all partners and stakeholders communicate clearly and consistently across the programme

This is a fast-moving programme working to challenging deadlines and I recognise the fluidity recent events have created in the system. To ensure you are kept fully up to date going forward, I am planning to issue a weekly communication to all areas. This will begin next week. If it would be helpful for any colleagues in your area to be included in this communication, please email bettercarefund@dh.gsi.gov.uk with their details.

The recent letter from Helen and Jon confirmed that a revised plan template and guidance will be issued to support the further improvement of plans locally and to underpin the strengthened pay for performance and risk sharing arrangements. I recognise that this will

mean additional work and that we will need to review current timescales, and in this context I am clear that we also need to ensure areas have the time necessary to adequately prepare for implementation from next April.

I also recognise the need to ensure local areas are fully supported to agree and implement ambitious, deliverable plans. I will communicate the next steps on this as soon as I can and in any case before the end of the month. In the meantime, I would like to clarify a couple of specific points that have been brought to my attention.

First, I wanted to clarify arrangements around the areas subject to a “fast-track” process, as announced last week. The aim of this process, which is underway, is to take a sample of the best draft plans and support those areas to further improve the plans ahead of publication of refreshed guidance. These plans have not been approved but have been identified as ones which exhibit strong potential, and which we envisage can provide ‘exemplar’ plans for other areas to use as part of improving their own plans.

Second, I would like reassure you that we will be issuing refreshed guidance that includes further detail on the changes to the risk sharing and pay for performance framework outlined in the letter from Helen and Jon Rouse. This will include more detail on the full range of performance metrics. I appreciate there is a degree of uncertainty over the details of these changes, so I would encourage you to wait for this detailed guidance to fully understand the implications for the BCF planning process.

I look forward to working with you.

**Andrew Ridley**
**BCF Programme Director**

# BOARD PLANNER & FUTURE AGENDA ITEMS

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Ray Puddifoot |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Nikki O'Halloran, Administration Directorate |
| **Papers with report** | Appendix 1 – Board Planner |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | To consider the Board's business for the forthcoming cycle of meetings. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy |
| **Financial Cost** | None |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | N/A |

## 2. RECOMMENDATION

**That the Board considers and provides input on the Board Planner, attached at Appendix 1.**

## 3. INFORMATION

### Supporting Information

Reporting to the Board

The Board Planner, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Chairman's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Chairman.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Chairman, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The following dates for the Board meeting were agreed by Council on 16 January 2014 and will be held at the Civic Centre, Uxbridge:

- Tuesday 23 September 2014 at 2.30 pm - Committee Room 6
- Thursday 11 December 2014 at 2.30 pm - Committee Room 6
- Tuesday 17 March 2015 at 2.30 pm - Committee Room 6

Board meeting dates for 2015/2016 will be considered by Council in due course as part of the authority's Programme of Meetings for the new municipal year.

**Financial Implications**

There are no financial implications arising from the recommendations in this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

N/A

**Consultation Carried Out or Required**

Consultation with the Chairman of the Board and relevant officers.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no financial implications arising from the recommendations in this report.

**Hillingdon Council Legal comments**

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

## 6. BACKGROUND PAPERS

NIL

**APPENDIX 1**

# BOARD PLANNER

| **23 Sept 2014**<br><br>2.30pm Committee Room 6 | **Business / Reports** | **Lead** | **Timings** |
|---|---|---|---|
| | Reports referred from Cabinet / Policy Overview & Scrutiny (SI) | LBH | **Report deadline:** 3pm Friday 5 September 2014<br><br>**Agenda Published:** 15 September 2014 |
| | Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI) | LBH | |
| | Public Health Action Plan 2014/2015 (SI) | LBH | |
| | Hillingdon CCG Financial Recovery Plan Update (SI) | HCCG | |
| | Healthwatch Hillingdon Update (SI) | Healthwatch Hillingdon | |
| | Update – Allocation of S106 Health Facilities Contributions (SI) | LBH | |
| | Better Care Fund (formerly the Integration Transformation Fund) - Progress Report | LBH | |
| | Board Planner & Future Agenda Items (SI) | LBH | |

| **11 Dec 2014**<br><br>2.30pm Committee Room 6 | **Business / Reports** | **Lead** | **Timings** |
|---|---|---|---|
| | Reports referred from Cabinet / Policy Overview & Scrutiny (SI) | LBH | **Report deadline:** 3pm Friday 21 November 2014<br><br>**Agenda Published** 3 December 2014 |
| | Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI) | LBH | |
| | Public Health Action Plan 2014/2015 (SI) | LBH | |
| | Hillingdon CCG Financial Recovery Plan Update (SI) | HCCG | |
| | Healthwatch Hillingdon Update (SI) | Healthwatch Hillingdon | |
| | Update – Allocation of S106 Health Facilities Contributions (SI) | LBH | |
| | Better Care Fund (formerly the Integration Transformation Fund) - Progress Report | LBH | |
| | Board Planner & Future Agenda Items (SI) | LBH | |
| | Hillingdon's Joint Strategic Needs Assessment | LBH | |

| 17 Mar 2015<br><br>2.30pm Committee Room 6 | Business / Reports | Lead | Timings |
|---|---|---|---|
| | Reports referred from Cabinet / Policy Overview & Scrutiny (SI) | LBH | **Report deadline:** 3pm Friday 27 March 2015<br><br>**Agenda Published:** 9 March 2015 |
| | Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI) | | |
| | Public Health – Action Plan 2014/2015 (SI) | LBH | |
| | Hillingdon CCG Financial Recovery Plan Update (SI) | HCCG | |
| | Healthwatch Hillingdon Update (SI) | Healthwatch Hillingdon | |
| | Update – Allocation of S106 Health Facilities Contributions (SI) | LBH | |
| | Better Care Fund (formerly the Integration Transformation Fund) - Progress Report | LBH | |
| | Board Planner & Future Agenda Items (SI) | LBH | |
| | HCCG 5 Year Strategic Plan and 2 Year Operating Plan | HCCG | |
| | Local Safeguarding Children's Board (LSCB) Annual Report | LBH | |
| | Safeguarding Adults Partnership Board (SAPB) Annual Report | LBH | |

** SI = Standing Item*

## Other possible business of the Board:

1.

# PROTOCOL BETWEEN THE HEALTH AND WELLBEING BOARD AND HILLINGDON SAFEGUARDING BOARDS

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor David Simmonds and Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | John Higgins, Adult Social Care |
| **Papers with report** | Appendix 1: Protocol with Hillingdon Adults Safeguarding Board |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This report seeks the Board's agreement to a protocol between the Health and Wellbeing Board and the Hillingdon Adults and Children Safeguarding Boards. |
| **Contribution to plans and strategies** | N/A. |
| **Financial Cost** | No financial implications |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Board agrees the protocol between the Hillingdon Health and Wellbeing Board and the Hillingdon Local Safeguarding Children Board (LSC) and the Safeguarding Adults Partnership Board (SAPB).**

## 3. INFORMATION

### Supporting Information

The Hillingdon Health and Wellbeing Board, at its meeting on 6 February 2014, agreed that a protocol should be drafted setting out the proposed relationship that should exist between itself and the Children and Adult Safeguarding Boards operating in the Borough. A copy of the protocol has been attached as Appendix 1 to this report.

### Financial Implications

There are no financial implications from the recommendations of this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

It is expected that the protocol between the Health and Wellbeing Board and the Safeguarding Boards will enhance the joint work between the Boards and ensure that the Boards can integrate priorities, which will result in vulnerable Hillingdon residents being better safeguarded.

**Consultation Carried Out or Required**

None required.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

There are no financial implications associated with this report.

**Hillingdon Council Legal comments**

There are no legal implications arising from the recommendations set out in this report.

## 6. BACKGROUND PAPERS

NIL.

**PROTOCOL IN SUPPORT OF THE RELATIONSHIP BETWEEN THE HILLINGDON HEALTH AND WELLBEING BOARD, THE HILLINGDON LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) AND THE SAFEGUARDING ADULTS PARTNERSHIP BOARD (SAPB)**

The Hillingdon Health and Wellbeing Board, at its meeting on 6th February 2014, agreed that a protocol should be drafted setting out the proposed relationship that should exist between itself and the children and adult safeguarding boards operating in the Borough. This paper sets out a proposed framework and protocol within which we will secure effective joint-working between the three Boards.
This protocol sets out the distinct roles and responsibilities of the Boards, the inter-relationships between them in terms of safeguarding and wellbeing and the means by which we will secure effective co-ordination and coherence between the Boards.

**The Purpose of Health and Wellbeing Boards**

Health and Wellbeing Boards were established by the Health and Social Care Act 2012. They provide stratghic leadership across health and social care services in areas. They are a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Each top tier and unitary authority must have its own Health and Wellbeing Board. Board members are expected to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

**What do they do?**

- Health and Wellbeing Boards have strategic influence over commissioning decisions across health, public health and social care through the development of a Health and Wellbeing strategy.
- Boards strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The Boards also provide a forum for challenge, discussion, and the involvement of local people.
- Boards bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This includes recommendations for joint commissioning and integrating services across health and care.
- Through undertaking the JSNA, the Board drives local commissioning of health care, social care and public health and creates a more effective and responsive local health and care system. Services that impact on health and wellbeing, such as housing and education provision are also considered within the JSNA

**The Purpose of Safeguarding Boards**

**Hillingdon Local Safeguarding Children Board (LSCB)**

The key objectives of the LSCB are set out in 'Working Together to Safeguard Children' ( March 2013), Section 13 of the Children Act 2004 requires each local authority to establish a LSCB for their area, and specifies the organisations and individuals that should be represented on LSCBs.

The statutory objectives and functions of the LSCB ( section 14 Children Act 2004) are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area;
- To ensure the effectiveness of what is done by each such person or body for those purposes

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and
- Taking action to enable all children to have the best outcomes

Full functions of LSCBs are laid out in regulation 5 of the Local Safeguarding Children Board regulations 2006. Minimum requirements are to;

- Assess the effectiveness of the help being provided to children and families, including early help
- Assess whether LSCB partners are fulfilling their statutory obligations set out in Working Together chapter 2
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learnt
- Monitor and evaluate the effectiveness of training, including multi agency training, to safeguard and promote the welfare of children.

LSCBs do not commission or deliver front line services. They do not have the power to direct other organisations, but do have a role in making clear where improvement is needed. Each Board partners retains their own line of accountability for safeguarding.

Every LSCB has to have an independent chair who can hold all agencies to account. The chair must produce an annual report on the effectiveness of child safeguarding in the local area. This report should be submitted to the Chief Executive, Leader of the Council, local police and crime commissioner, and the Chairman of the Health and Wellbeing Board

**Safeguarding Adults Partnership Board (SAPB)**

Safeguarding Adult Boards are not currently statutory bodies but this is likely to change with the passage of the forthcoming Care Bill. Currently Boards operate within the framework promoted by 'No Secrets' which was published by the Department for Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005.

The focus of the work of Safeguarding Adults Boards is 'vulnerable' adults. The forms of abuse which the Board aims to prevent and address are: physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, discriminatory abuse.

The role of the SAPB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to vulnerable adults by individual agencies and to ensure the effective interagency working in this respect.

Both the LSCB and the SAPB have identified agreed objectives and priorities for its work which include clear policy, procedural and practice arrangements, mechanisms to secure coordination of activities between agencies, the provision of training and workforce development in support of safeguarding and quality assurance and performance management arrangements to test the effectiveness of safeguarding and the impact of the Board.

**The need for effective communication and engagement between the Boards.**

Safeguarding is everyone's business. As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people in Hillingdon are safe and their wellbeing is protected.

The Joint Health and Wellbeing Strategy is a key commissioning strategy for the delivery of services to children and adults across the Borough and so it is critical that in drawing up, delivering and evaluating the strategy there is effective interchange between the Hillingdon Health and Wellbeing Board and the two safeguarding boards.

Specifically there needs to be formal interfaces between the Health and Wellbeing Board and the safeguarding board at key points including:

- The needs analyses that drive the formulation of the annual Health and Wellbeing Strategy and the Safeguarding Boards' Business Plans. This needs to be reciprocal in nature ensuring both that safeguarding boards' needs analyses are fed into the JSNA and that the outcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of the Health and Wellbeing Strategy and the individual Board Business Plans in a context of mutual scrutiny and challenge;
- Annually reporting evaluations of performance of Plans again to provide the opportunity for reciprocal scrutiny and challenge and to enable Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

In the revision of 'Working Together' there are a number of statements driving towards a formalised relationship between the Health and Wellbeing Board and the Local Safeguarding Children Board particularly in relation to the JSNA and the presentation of the LSCBs Annual Report. It is likely that this will be replicated for Adult Safeguarding Boards if they are set on a statutory footing.

The opportunities presented by a formal working relationship between the Hillingdon Health and Wellbeing Board and the LSCB and SAPB can, therefore be summarised as follows:

- Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA, in line with the draft Working Together guidance
- Aligning the work of the LSCB and SAPB business plan with the HWB Strategy and related priority setting.
- Ensuring safeguarding is ‘’everyone’s business’’, reflected in the public health agenda and related determinant of health plans and strategies.
- Evaluating the impact of the HWB Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health outcomes
- Identifying coordinated approach to performance management, transformational change and commissioning
- Cross Board scrutiny and challenge and ‘’holding to account’’: the Health and Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the HWB Strategy.

**Arrangements to secure co-ordination between the Boards.**

In order to secure the opportunities set out above it is proposed that the following arrangements would be put in place to ensure effective co-ordination and coherence in the work of the three Boards.

1. Between September and November each year the Independent Chairs of the two Safeguarding Boards would submit to the Hillingdon Health and Wellbeing Board their Annual Reports outlining performance against Business Plan objectives in the previous financial year. This would be supplemented by a position statement on the Boards' performance in the current financial year, and the effectiveness of safeguarding arrangements in the borough. This would provide the opportunity for the Health and Wellbeing Board to scrutinise and challenge the performance of the Boards, to draw across data and key to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Hillingdon Health and Wellbeing Strategy.
2. Between October and February the Hillingdon Health and Wellbeing Board to present to the safeguarding boards the review of the Health and Wellbeing Strategy, the refreshed JSNA and the proposed priorities and objectives for the refreshed Health and Wellbeing Strategy to enable the safeguarding boards to scrutinise and challenge performance of the Hillingdon Health and Wellbeing Board and to ensure that their refreshed Business Plans appropriately reflect relevant priorities set in the refreshed Health and Wellbeing Strategy
3. In April/May the Boards will share their refreshed Plans for the coming financial year to ensure co-ordination and coherence.

**Conclusion**

The role of the LSCB and SAPB in relation to the Health and Wellbeing Board would be one of equal partners underpinned by this protocol.

The role of Hillingdon Council Scrutiny Committees, to scrutinise performance of safeguarding boards and to be consulted on for policy changes and related service design and commissioning intentions, will remain unchanged, as will the governance committee of partner agencies to oversee and monitor respective agency contribution and performance to prevent and protect.

# HILLINGDON CCG UPDATE

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Kuldhir Johal |
| **Organisation** | Hillingdon Clinical Commissioning Group |
| **Report author** | Mark Eaton and Ceri Jacob, Hillingdon Clinical Commissioning Group |
| **Papers with report** | None |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses:<br>• The Recovery Plan<br>• Prime Ministers Challenge Fund and the creation of GP Networks<br>• Integration of services within health |
| **Contribution to plans and strategies** | The items above relate to the HCCGs:<br>• Out of hospital strategy<br>• Financial strategy |
| **Financial Cost** | Not applicable to this paper. |
| **Relevant Policy Overview & Scrutiny Committee** | External Services Overview and Scrutiny Committee |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board note this update for information.**

## 3. INFORMATION

### 3.1 Financial Recovery Plan

In November 2012, Hillingdon CCG agreed a three year Financial Recovery Plan designed to bring the CCG back into financial balance. This Plan was revised in November 2013 to reflect new planning guidance and financial allocations. Specifically, it was noted nationally that CCGs with inherited deficits were underfunded against the national formula whilst CCGs with an inherited surplus were over funded against the

formula. For Hillingdon CCG this equates to being underfunded by approximately £23m per year.

In 2013/14, the CCG set a deficit budget of £12.25m. Through robust financial management and the delivery of recurrent savings of £9.177m as part of the QIPP programme, the CCG reduced this deficit significantly and closed the 2013/14 financial year with a reduced deficit of £5.007m.

A balanced budget has been set for 2014/15. This is dependent on agreement by NHS England of a North West London Financial Strategy. The QIPP programme for 2014/15 has been set at £10.3m and will be monitored through the CCG's Programme Management Office (PMO) function. A further £2m of savings are being sought for the programme. At Month 2, forecasts are based on very limited activity data. However, there are activity and financial pressures noted in non-elective admissions and some planned care areas such as dermatology and gynaecology. Mitigation actions are in place for these schemes.

Non-elective activity is an area of particular pressure both locally and nationally and has impacts across health and social care. A senior manager group has been clearly identify the causative factors and to align actions across organisations to maximise efficiency and manage an apparent increase in acuity of patient need and absolute numbers. Further updates will be provided to future Health and Wellbeing Board meetings as we enter the winter period.

### 3.2 Prime Ministers Challenge Fund and GP Networks

The 8 CCGs in North West London were successful in a joint bid against the Prime Ministers Challenge Fund (PMCF) money. This money is being used to support GP practices in developing new ways of working together and providing accessible care to their patients. Most of the funding is being released to GP networks that can show that they are bringing member practices into networks with the structure and governance to plan and deliver services at a greater scale. Six GP networks have formed in Hillingdon over recent months.

The money is particularly earmarked for improving the IT infrastructure to allow patients to book appointments online and have access to their own healthcare records; to enabling GP practices to share their skills and expertise and offer services to patients from other practices within the network; and to promote more consistently high quality primary care across network practices. Although the focus is on infrastructure and planning, the objective is to research and propose services which will expand access in primary care and join up delivery to patients.

### 3.3 Integration of services

Hillingdon CCG included in its 2012 Out of Hospital Strategy the intention to improve integration between health services. The national Whole Systems Integrated Care Pioneer Programme provided an opportunity to take that intention forward more rapidly. The 8 CCGs in North West London and 7 of the Local Authorities put forward a joint bid to participate in this programme and were successful. Under this programme, each CCG

is taking forward its aspirations for integration at a local level working with their local stakeholders, whilst benefitting from the lessons learnt in other CCGs and the ability to carry out some elements once across the 8 CCGs for example, legal advice on network formations.

Hillingdon is in an almost unique position in London in that it has a single main acute care provider, a single community and mental health provider and is co-terminous with the Local Authority. There are clear overlaps between this programme and the Better Care Fund. To ensure capacity is not diluted and to provide coherency for local providers the two elements of local integration have been aligned as far as possible. For example, both schemes are focusing on the elderly and use care planning and co-ordination as a central plank of delivery.

Whilst the BCF is targeted at all people over 75 years in Hillingdon, the pioneer project is being piloted in the north of the Borough and will focus on approximately 1000 patients in the first instance. Patients will be over 75 years of age and have one or more long term condition. GPs will remain at the centre of care provided to these patients but will work in very different ways with other care providers including the development of staff that will work across all organisational boundaries. Care will be more anticipatory in nature, prevent people from escalating to higher levels of dependency or crisis point and support more personalised self-management of long term conditions. Hillingdon is particularly fortunate to have five local voluntary sector providers that have chosen to work together in a consortium, called Hillingdon 4 All, in order to participate in this work. This will strengthen our ability to work on reducing social isolation as well as benefiting from innovation and experience from the voluntary sector.

Integral to this programme is the removal of organisational barriers to integrated working. This will be supported through the development of capitated budgets, longer term contracts and integrated IT structures. In preparation for this local health providers are beginning to explore different organisational forms (joint venture, alliance models, etc) to enable the development of a provider network and to consider the impact and opportunities for staff. The pilot proposal will be finalised in October 2014 with the service model anticipated to go live by April 2015.

## 4. FINANCIAL IMPLICATIONS

Hillingdon CCG is required to achieve its financial control total at year end.

## 5. LEGAL IMPLICATIONS

None in relation to this update paper.

## 6. BACKGROUND PAPERS

- Hillingdon CCG Financial Recovery Plan
- Hillingdon CCG Out of Hospital Strategy
- Hillingdon Primary Care Development Plan
- North West London Whole Systems Pioneer bid
- North West London Prime Minister Challenge Fund bid

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# HILLINGDON CCG 5 YEAR STRATEGIC PLAN

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Kuldhir Johal |
| **Organisation** | Hillingdon Clinical Commissioning Group |
| **Report author** | Joan Veysey, Hillingdon Clinical Commissioning Group |
| **Papers with report** | 5 Year Plan: Hillingdon Summary |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | The NHS planning guidance 2014-2018 "Everyone Counts" requires Clinical Commissioning Groups to develop and agree with the local Health and Wellbeing Board and NHS England a five year strategic plan with the first two years at operating plan level.<br><br>NHSE required CCGs to submit 5 year plans across a wider geographical footprint than individual borough level in recognition of the fact that patient's access services from across London and not just within their own borough. Hillingdon CCG's 5 year plan is written at a North West London (NWL) level reflecting existing shared work at a NWL level across key strategic programmes such as the *Shaping a Healthier Future* acute reconfiguration programme.<br><br>Included with this paper is the latest iteration of the plan submitted to NHS England on 20 June 2014. Feedback has not been received yet but may lead to further changes. (Appendix 2).<br><br>In addition to the full 5 year plan a Hillingdon summary version has been drafted and appended to this document (Appendix 1). |
| **Contribution to plans and strategies** | Sets the overall strategy for Hillingdon CCG for next 5 years. |
| **Financial Cost** | Not applicable to this paper. |
| **Relevant Policy Overview & Scrutiny Committee** | External Services Scrutiny Committee |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes this Hillingdon Summary of the North West London 5 year strategic plan.**

## 3. INFORMATION

See appended papers.

## 4. FINANCIAL IMPLICATIONS

Financial assumptions are that HCCG will set a break even budget in 2015/16 and will deliver a 1% surplus as required nationally in 2016/17.

## 5. LEGAL IMPLICATIONS

CCGs are required to deliver a 1% surplus each year.

## 6. BACKGROUND PAPERS

North West London 5 Year Strategic Plan.

# NORTH WEST LONDON 5 YEAR PLAN

## Hillingdon CCG Summary

The North West London Five Year Strategic Plan sets out ambitions and objectives for health care across the eight CCGs (Clinical Commissioning Groups) of North West London, of which Hillingdon is one. It is drawn up in partnership with NHS England who directly commissions a number of services, including primary care and specialised services. The plan sets out how and where we will be working with our local partners and other CCGs in North West London to deliver changes.

The plan describes key changes we want to make in order to achieve our ambitions for improved care, patient experience and health outcomes in Hillingdon. Our vision is to ensure that the residents of Hillingdon can access high-quality, evidence-based care in a setting appropriate to their needs by transforming the way care is delivered.

In summary these areas of change are:

**1. Health Promotion, Early Diagnosis and Early Intervention.**

The priorities drawn from Hillingdon's Health and Well Being Strategy include improving health & wellbeing and reducing inequalities, prevention and early intervention, developing integrated, high quality social care and health services within the community or at home and creating a positive experience of care.

This covers

a. Giving every child the best start in life and helping vulnerable families
b. Empowering communities to take better care of themselves
c. Improving mental wellbeing throughout life
d. Working together to support the most vulnerable adults in the community
e. Structured health improvement activities, reducing alcohol harm, tackling obesity, immunisation, children's mental wellbeing and teenage pregnancy rates.
f. Improved prevention programmes for
    - Falls
    - Dementia – early diagnosis and early intervention pathway
    - Improved uptake of screening and immunisations (NHSE)

**2. Out of Hospital Strategy including Primary Care Transformation.**

Our Out of Hospital strategy responds to needs set out in Hillingdon's JSNA and priorities set out in the Health and Wellbeing Strategy, and will deliver

- **Accessible care**: care that is responsive to patients' needs and preferences, timely and accessible,

- **Proactive care**: proactive planned care that is easy to access, convenient and able to utilise specialist skills where appropriate

- **Co-ordinated care** (including rapid response and supported discharge): care that is patient-centred, co-ordinated and offers continuity of care to high need patients.

**In Hillingdon this covers:**

- Strengthening out of hospital services to meet growing demand for care that can be delivered in primary and community settings, rapid response to urgent needs and appropriate time in hospital.
- Development of primary care to offer a flexible range of out of hospital services via service hubs in each of the 3 Hillingdon localities
- Better care closer to home, with outpatient and planned care services provided in the community (e.g. cardiology, ophthalmology, MSK and gynaecology)
- Improved access, responsiveness and consistency of high quality primary care
- Transformation of the wider primary care team to support an increase in the range of services provided out of hospital. This is underpinned by the development of GP Networks in Hillingdon. Specific networks will focus on children, care homes , elderly , mental health and long term health conditions
- Development of information sharing with information available to patients and carers to inform their choice and ability to self-manage

**3. Integrated Care in Hillingdon. This covers:**

- Hillingdon's Better Care Fund Plan will enable residents of Hillingdon to plan their own care; with professionals that work closely together. These professionals will understand the needs of those in their care and their carers ensuring services deliver what is important to everyone.
- We will deliver 11 schemes within our Better care Fund Plan that will focus on improving health outcomes for residents who are 75 years and over with one or more health condition or care need.
- Better and earlier identification of susceptibility to disease or exacerbation alongside joined up management of conditions.
- Better coordination of services including a much stronger focus on case management and prevention.
- Reducing the need for older people to go to hospital – and reducing the lengths of stay where they are admitted.
- Bringing greater coherence to our present pattern of service initiatives: especially in enabling older people to be treated at or close to their home wherever possible.
- Hillingdon's Whole Systems Integrated Care early adopter will focus on the same population cohort, developing more anticipatory care with GPs at the centre of care, working in very different ways with other care providers across all organisational boundaries including third sector
- Care will be more anticipatory in nature, prevent people from escalating to higher levels of dependency or crisis point and support more personalised, self-management of long term conditions, including people with risk factors such as social isolation and dementia
- The WSIC will be able to test the effectiveness of a proactive approach to care, and build on current case management approaches for this group of residents within two North Hillingdon GP networks.

4. **Transforming Mental Health Services. This covers:**

- Enabling more people with stable mental health conditions to be supported in the community, by GPs, care navigators and specialists as required.
- Psychiatric liaison services to ensure timely access to urgent mental health care in acute hospitals.
- Widening access and increasing capacity for people to enter into psychological talking therapies (IAPT), whilst ensuring good recovery outcomes
- Jointly reviewing the provision of local child and adolescent mental health services with health and social care partners, and reviewing out of hours and need for specialist admission with other CCG and NHSE partners
- Improving services for people with learning disabilities in line with annual self-assessment across health and social care and the Winterbourne review recommendations
- Improving access to community based care for people with dementia
- Reviewing perinatal services
- Rolling out standardised urgent referral pathways with other NWL CCGs

5. **Shaping a Healthier Future. This covers**
   - Ensuring that there is high quality and sustainable acute health care in North West London that is organised in a way that maximises the clinical and estates assets available in the area; centralising where necessary and localising where possible. Hillingdon Hospital remains a fixed point within this programme of work.
   - Meeting the London quality standards, which include the national standards for 7 day services, based on the review by the Medical Director of NHS England, Sir Bruce Keogh, for urgent care, which seek to reduce the variation in patient outcomes which occur at the weekends and out of hours. This initiative is included as an enabler within Hillingdon's BCF plan.

6. **Improved quality and safety of care. This covers:**
   - The plan further sets out the need to maintain a focus on essentials during this period of significant change across health and care services. In particular there will be a focus on maintaining quality, access and performance through ensuring that the CCG responds effectively to:
     a) the Francis, Berwick and Winterbourne View
     b) the need to improve patient experience
     c) the need to empower service users to take control of their own care
     d) ensuring compassion in practice values are embedded in all services that deliver care
     e) maintaining staff satisfaction
     f) ensuring high quality safeguarding services
     g) the need for better access to care
     h) ensuring progress to ensure parity of esteem between physical and Mental health care

**Measuring our Success**

The way we will measure our success will be based on the targets we have set for improvement within our outcome ambitions, which are national measures that have baselines and a target for improvement:

- People living longer and not dying prematurely
- People with Long Term Conditions maximising their quality of life
- People recovering from illness or injury resuming their lives
- People having a positive experience of care

- Treating and caring for people in a safe environment and protecting them from avoidable harm (i.e. people experiencing a safe care environment)

In addition, the plan demonstrates how the financial challenge arising from the following will be managed over the 5 year period in the light of:

a) Population growth
b) Increased care needs associated with an aging population with chronic health conditions
c) Physical condition of health buildings/estates

**Summary-HCCG Finance Overview**

- In 2013/14 Hillingdon CCG inherited an underlying deficit from the PCT and had an agreed deficit plan of £12.25m as part of a three-year recovery plan to restore underlying financial balance.
- The CCG's13/14 actual outturn was a reported deficit of £5m, which was £7m better than plan. However its underlying deficit at year end was an underlying deficit of £15.4m (on the assumption that the CCG's 2.5% headroom is treated as a recurrent commitment).
- In December NHSE confirmed that Hillingdon CCG was assessed as 9% under its target allocation, and as a result it has therefore received a larger than average increase in allocation in 14/15 and 15/16 of 4.3% and 4% respectively.
- The 14/15 financial plan (pre NWL strategy and assuming full application of NHSE Business Rules) would be a deficit of £25.6m. The agreement of the NWL financial strategy enabled the CCG to submit a balanced plan to be produced as follows:

| | |
|---|---|
| Total | £25.6m |
| Funding to negate repayment of 13/14 deficit | (£5.0m) |
| Funding to support14/15 planned deficit | (£7.7m) |
| Assumed retained 2.5% non-recurrent headroom | (£7.6m) |
| Funding to support Out of Hospital investment | (£5.3m) |
| Total (revised) | 0 |

- Within the balanced plan above, the CCG's 14/15 underlying deficit position is forecast to be c£7m (including the 2.5% headroom). Consequently the CCG plan in 2014/15 does fully not meet NHSE Business rules criteria as there remains an underlying deficit at the end of the year and there is also the absence of a 1% surplus.

- Agreement of the NWL strategy is essential to the delivery of the balanced plan in 2014/15 – it should be noted however that all aspects of the NWL financial strategy are subject still to NHS England agreement as part of their review and sign-off of 14/15 Operating Plans for all CCGs.
- The key assumptions embedded in the plan for 14/15 are as follows:-
- Prudent budget setting assumptions – e.g. allowance for demographic and non-demographic growth
- QIPP of £10.4m, equating to 3.6% which compares to recovery plan forecast of 4%, 13/14 actual of 3.1% (13/14 plan = 3.8%)
- Investments – includes plans for investment of £1.5m to ensure tailored care for older People (£5 per head) and also investment in schemes to reduce readmissions to hospital.
- In 2015/16 the CCG anticipates it will be able to deliver a balanced position (but not a 1% surplus until 2016/17). As a result it will not fully comply with NHSE Business Rules until 16/17. This is dependent on a number of key assumptions in particular:-
- **Better Care Fund is resource neutral;**
- **QIPP of 4% is achieved in both years, if the CCG delivered only 3% QIPP per annum, this would result in c£3m less per annum**.
- **Transition support for the THH continues to be available from NWL Financial Strategy, not the CCG.**

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# Transforming the NHS in North West London

Integrating health and social care with the leadership of local GPs and working in partnership with NHS England

*North West London - Five Year Strategic Plan 2014/15 - 2018/19*

*Draft –20th June 2014*

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# Executive summary

*Our five year strategic plan sets out how we will work collaboratively to transform the health and care landscape across NWL in order to achieve our shared vision, deliver improved outcomes and patient experience, ensure a financially sustainable system, and meet the expectations of patients and the public*

## Introduction

- Our vision for the future of North West London (NWL) health and care system is based on what people have told us is most important to them. We know that what people want is choice and control, and for their care to be planned, helping them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.
- It is in support of this person-centred vision that our NWL five year strategic plan sets out the collective plans and priorities of the eight Clinical Commissioning Groups (CCGs) of NWL, working in partnership with NHS England. This Plan sets out the vision and ambitions against which NHS England and each CCG's detailed two year operational plans have been set.
- Our plan is consistent with NHS England's vision, outcome ambitions, service models and essentials, and this alignment is articulated throughout the document.

## Our shared vision and outcome ambitions for North West London

Our overarching vision, co-produced with the people of NWL, is:

> *"To improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

Four overarching principles underpin our whole system NWL vision – that health services need to be:

1. **Localised** where possible
2. **Centralised** where necessary;
3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless person centred care. Individuals will be enabled to work with

frontline professionals, their carers, and their families to maximise health and wellbeing and address their specific individual needs.

4. The system will look and feel from a patient's perspective that it is **personalised** - individuals will be enabled and supported to live longer and live well.

In addition, commissioners will recognise our broader role in society (both as employers and commissioners), and address the wider determinants of health, working with our partners, including Local Authorities.

The health needs of the people of NWL are changing, the demands on our health services are increasing, and the way we have organised our hospitals and primary care in the past will not meet the needs of the future.

Each NWL CCG has considered the current state, and set levels of ambition against the following strategic objectives[1]:

1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring that people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Our other strategic objective is to ensure a financially sustainable health system for future generations.

All of the programmes and plans set out in our five year plan have been developed to achieve these strategic objectives.

### The essentials: quality and innovation

Patient Safety is at the heart of the NHS agenda, treating and caring for people in a safe environment and protecting them from avoidable harm.

The CCGS of NWL are responsible for the quality assurance of provider organisations they commission from, ensuring they are held to account for delivery of quality standards and contractual obligations. NWL has developed Quality Strategies that set out approaches to embedding quality into every part of the commissioning cycle. We also recognise that clinical leaders are at the heart of delivering high quality care. Key plans include:

1. **Response to Francis, Berwick and Winterbourne View:** the overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people at the centre of the NHS. The NWL CCGs have developed actions plans to address key identified issues, including responding directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff.
2. **Patient experience:** the CCGs are committed to ensuring both the continuous improvement in patient experience, as part of the overall quality of care that is provided locally.
3. **Compassion in practice:** '*Compassion in Practice*'[2] is a national three year vision and strategy for nursing, midwifery and care staff. The strategy sets out the 6 "Cs", i.e. the values and behaviours to be universally adopted and embraced by everyone involved in commissioning and delivering care

[1] For further detail on the NHS Outcome Ambitions, see *The NHS Outcomes Framework, 2014/15;* Department of Health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf

[2] *Compassion in Practice – Nursing, Midwifery and Care Staff*; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, December 2012: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

4. **Staff satisfaction:** NWL will strengthen our review of data and information regarding staff experience and satisfaction as part of our overall quality and safety monitoring and improvement processes.
5. **Safeguarding:** key priorities include working in multi-agency partnership, including with Local Authorities, to improve the quality of local Care Home provision, and address sexual exploitation, missing children and Female Genital Mutilation (FGM).

North West London has a world class research infrastructure, but navigating innovations through the healthcare sector can be difficult and complex. In addition, there is significant variation in healthcare at almost all levels, including in the management of long-term conditions. The gap between what we know and what we do is unsustainable if we want to improve the value of care provided in the NHS.

Each CCG therefore has a duty to promote innovation in the provision of health services, and to promote research and the use of evidence obtained from research.

This duty represents two distinct roles:

- To ensure the consistent uptake of existing good practice, including national guidance issued by the National Institute for Clinical Excellence (NICE); and
- To support developments in the pipeline of innovation, leading ultimately in turn to their uptake as recognised good practice.

NWL works closely with a number of partners in the promotion of both innovation and adoption.

### Our key transformation programmes

While each CCG is leading its own set of initiatives to address local priorities, including respective Health & Wellbeing Strategies (developed jointly with Local Authorities) and Quality, Innovation, Productivity and Prevention (QIPP) plans, a number of shared transformation programmes have been jointly developed to address the key themes identified in our Case for Change, NHS England's '*Call to Action*'[3] and through NWL's patient engagement and public consultation:

1. **Health promotion, early diagnosis and early intervention**: This programme of work is fundamental to achieving our outcome ambitions, particularly with regards to securing additional years of life for the population of NWL.

   Effective delivery will require close partnership working between Local Authorities, CCGs and NHS England.

2. **Out of Hospital strategies, including Primary Care Transformation:** NWL has embarked on a major transformation of care, from a system spending the majority of its funding on hospitals to one where we spend the majority of funding on services in people's homes and in their communities, i.e. "out of hospital".

   Significant transformation in primary care is planned to support integrated out of hospital service delivery:

   - Primary care will change to deliver out of hospital care;
   - Primary care will change to meet expectations for access; and
   - Primary care will change to meet rising quality expectations.

   In order to deliver these commitments, individual GP practices will build on the progress they have already made towards delivering services as networks – this will enable GP practices to provide the additional capacity, flexibility, limited specialisation and economies of scale needed to deliver to deliver the new model of care in a sustainable way.

[3] *The NHS belongs to the people –a call to action*; NHS England, 2013: http://www.england.nhs.uk/2013/07/11/call-to-action/

Delivering our vision requires us to invest in and to use our estate differently. Hubs, one of the configurations that we are exploring, are flexible buildings, defined as those that offer a range of out of hospital services and/or host more than one GP practice.

To support the transformation of primary care, we are working with NHS England to test ways we can co-commission primary care services.

3. **Whole Systems Integrated Care**: The whole plan is underpinned by our Whole Systems vision, which places the person at the centre of their provision and organises services around them. This includes our 'embedding partnerships' approach to the genuine co-design of services with patients and carers, as well with our partners in social care and the third sector. Our vision for integrated care is supported by three key principles:
    1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
    2. GPs will be at the centre of organising and coordinating people's care.
    3. Our systems will enable and not hinder the provision of integrated care.
4. **Transforming Mental Health Services**: Achieving parity of esteem for mental health is a national and NWL priority, as well as a priority within all of the respective Health and Wellbeing Strategies – NWL will provide excellent, integrated mental health services to improve mental and physical health.
5. ***Shaping a healthier future*** **(SaHF) acute reconfiguration:** A key principle that underpins the acute reconfiguration programme in NWL is the centralisation of most emergency specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care) into five major hospitals, as this will lead to better clinical outcomes and safer services for patients.

   Agreed changes will result in a new hospital landscape for NWL – the SaHF programme will see:

   - The existing nine hospitals of NWL transformed into **five Major Acute Hospitals**.
   - On the remaining sites there will be **further investment with Local hospitals**, developed in conjunction with a patients and stakeholders, at Ealing and Charing Cross;
   - There will be **a Specialist hospital** at Hammersmith; and
   - There will be **a Local and Elective Hospital** at Central Middlesex.

### Cross-cutting plans: Urgent and Emergency Care and Cancer Services

While the key transformation programmes are being implemented on a pan-NWL basis, urgent and emergency care plans are centred around acute trusts, with local Urgent Care Working Groups overseeing the implementation of changes across the continuum of emergency care from primary through to acute care.

In addition, cancer is one of the top priorities for outcome improvement across London, and NWL aims to achieve significant, measurable improvements in outcomes for patients, working with the London Cancer Alliance and London Cancer to localise and implement the Cancer Commissioning Strategy for London 2014/15 – 2019/2020.

### Challenges and Enablers

The ambition of the North West London strategic plan is enormous. No other health economy has managed to achieve this level of agreement on the scale of the changes and to deliver this scale of change with their acute providers. A huge amount of work has been carried out to get to the point where commissioners were able to make the

necessary decisions on the future of providers in NWL and for this decision to be robust so that it successfully withstood the inevitable legal challenges. Now it has done so, it faces the equal challenge of implementation. At the same time, the out of hospital services and whole systems integrated care work, including through the joint Better Care Fund and QIPP plans, needs to be delivered, to ensure that patients receive high quality care and only go to hospital when they need to.

A number of enabling workstreams have been developed to ensure successful implementation of the strategic plan, including Informatics and Workforce.

### Programme Investment Costs

Programme investment costs are based on the *Shaping a healthier future* Decision Making Business Case (DMBC) financial analysis produced in February 2013. (Appendix G provides further details and sets out the process for updating the overall economic and financial analysis.)

The DMBC outlined:

- In five years, we will be spending **£190 million more a year on out of hospital services** including integrated care, planned care and more access to general practice.
- In addition, we plan up to **£112m of capital investment in hubs**, offering a range of services closer to patients' homes, including outpatient appointments, general practice and care for patients with long-term conditions.
- Up to **£74m of capital investment in primary care** to ensure all our primary care services are offered in high-quality buildings that are accessible to the public.

### Programme Implementation Timeline

The high-level programme implementation timeline illustrates the timescales by which each of the programme's key milestones will be achieved, including:

- Sustainable network-based GP model in place by in 2015/16.
- Roll-out of Whole System approaches to commissioning and delivering services from April 2015.
- Consistently high standards of clinical care achieved across all days of the week by 2017/18.
- The full transition to the new configuration of acute services complete by the end of 2017/18.

### How We Work: embedding partnerships at every level

A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, service users, families and carers, building on the co-design approach developed through the Whole Systems Integrated Care programme. We will also continue to work collaboratively across the eight CCGs of NWL.

We also recognise that we will not achieve our outcome ambitions through internal actions only, but will need a concerted programme of change with our statutory and community partners, including local authorities and community groups (including through the Health and Wellbeing Boards). Effective partnership working will, amongst outer outcomes, reduce demand on the NHS by enabling residents to manage their own health, support one another, and improve their health and wellbeing in the community.

### What our Five Year Plan will achieve

Our five year plan will deliver two key outcomes: (1) improved health outcomes and patient experience (along with reduced health inequalities), as set out in our outcome ambitions; and (2) a financially sustainable health system for future generations.

- The CCG financial plans outline how a sustainable position is attained, one that is consistent with NHS England Business Rules (i.e. a 1% surplus) and includes contingency (at 0.5%) to respond to risks.

- The NWL CCGs' financial plans include the outcome ambitions.
- Non-recurrent implementation costs are assumed to be funded through the NWL financial strategy agreement to pool CCG / NHSE non-recurrent headroom (2.5% in 2014/15).
- All organisations aim to have clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks - there is a clear link between service plans, financial and activity plans, including how QIPP plans triangulate with BCF plans.

A detailed Finance Appendix is included in this Plan that sets out the relationship between the financial and activity modelling underpinning the *Shaping a healthier future* programme and Out of Hospital strategies, the CCG's two year operational plans (including QIPP), and the Better Care Fund plans.

Our five year strategic plan has set out how we will work collaboratively to transform the health and care landscape across NWL in order to achieve our shared vision, deliver improved outcomes and experience within a financially sustainable system, and meet the expectations of our public and patients.

# 1. Introduction

*The purpose of this five year strategic plan is set out the collective priorities of the eight CCGs of North West London, working in partnership with NHS England, over the next five years, in order to achieve our vision and outcome ambitions. It is developed in line with NHS England planning guidance 'Everyone Counts – 2014/15 – 2018/19'.*

### Purpose

Across the eight boroughs of North West London (NWL), the NHS comprises eight Clinical Commissioning Groups (CCGs), ten acute and specialist trusts, four community and/or mental health trusts and 400+ GP practices.

NHS England is also one of the largest commissioners of services in North West London.

The purpose of this North West London Five Year Strategic plan is to set out the collective plans and priorities of the eight CCGs of NWL, working in partnership with NHS England. This Plan sets out the vision and ambitions against which NHS England and each CCG's detailed two year operational plans have been set. The eight CCGs of North West London have been working closely together (and with local authorities) for several years to develop a shared strategic vision and plan, and this document reflects the latest iteration of these plans, along with the aspirations of NHS England for the services it is responsible for commissioning. It summarises the full range of plans that have been developed across NWL, from how we will ensure patient safety in all settings of care, to how we will support research and innovation, through to how we will design and implement new models of joined up, person-centred care to address the fundamental challenges facing our health and care system.

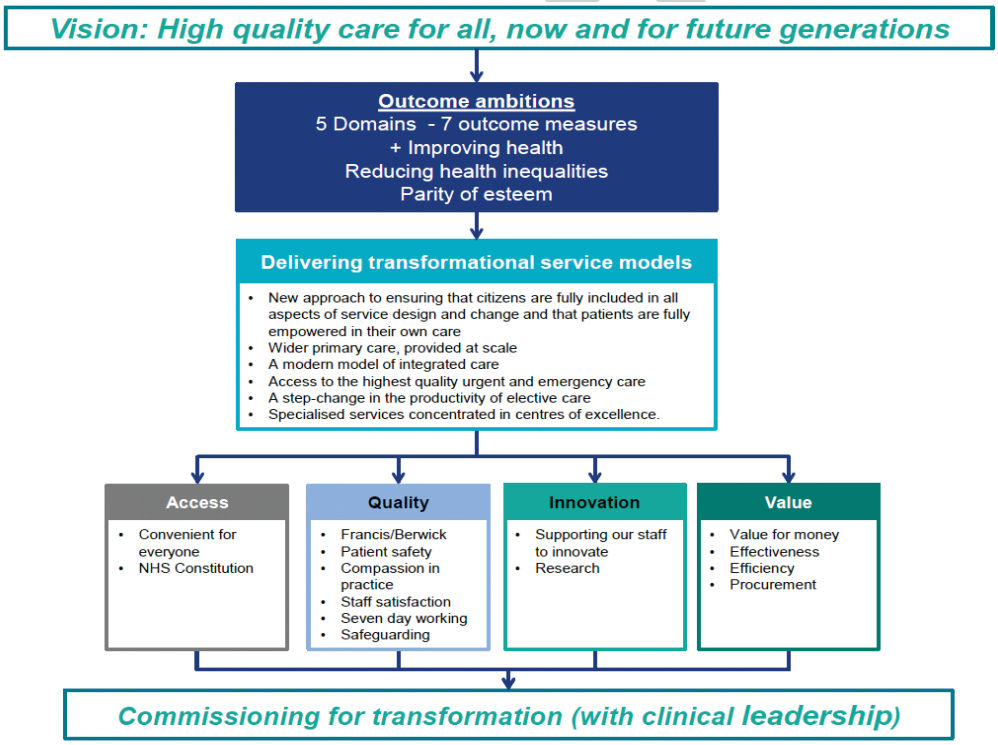
The Plan also articulates how we will work more closely than ever with patients and the public, building on work to embed and sustain co-production as a first principle, and seeking to enable and empower patients to maintain independence and to lead full lives. The Plan builds upon the significant strategic planning that has taken place over the past couple of years across NWL, including as part of the *Shaping a healthier future* programme, and articulates how the various workstreams and programmes fit together into a clear vision for the future that is sustainable and that tackles the challenges identified in NHS England's 'Call to Action'.

The Plan is also intended to demonstrate to NHS England that our plans are robust, comprehensive and fit-for-purpose.

Therefore, the document reflects the latest planning guidance as published in *Everyone Counts: Planning for Patients 2014/15 to 2018/19*[4], including 21 fundamental national planning requirements.

The NWL Plan is consistent with NHS England's vision, outcome ambitions, service models and essentials, as is articulated throughout the document:

NHS England vision for the NHS[5]




[4] *Everyone Counts: Planning for patients 2014/15 to 2018/19,* NHS England (December 2013) :http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

[5] Note within the 'Quality' box that "Francis" refers to implementation of recommendations from *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf), chaired by Robert Francis, QC; while "Berwick" refers to the recommendations within the *Berwick review into patient safety* (https://www.gov.uk/government/publications/berwick-review-into-patient-safety)

## North West London - context

### Population

North West London is a population of approximately 1.9 million people living in the boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The population of North West London is expected to grow to 2.1 million by 2021

(which represents 7.46% growth between 2011 and 2021)[6].

The area covered is densely populated, and there is wide variation in household income. Inner North West London has a higher population density than outer North West London. Some sections of the population are highly transient and there are sections of the community who are not counted in official statistics nor registered on GP patient lists.

The Joint Strategic Needs Assessments (JSNA) covering North West London all identify cardiovascular disease, cancer and respiratory disease as the most common causes of death, but as a result of earlier diagnosis and improved treatments, fewer people are dying prematurely from these diseases. These improvements mean that people are living longer and, therefore, the population as a whole is getting older. Over the last ten years, life expectancy in North West London has increased by about three years to 80 years for men and 84.5 years for women.

The population is relatively young: 3.7% of the male NWL population are over the age of 75, as are 5.8% of females – both of these figures are both below the national and London rates (although Harrow and Hillingdon rates are higher than London averages).

The percentage of males and females under the age of 19 (23.9% and 22.1% respectively) are in line with both England and London averages, although Kensington, Chelsea and Hammersmith & Fulham populations are below average[7].

Each of the eight London boroughs has a significant ethnic community with different communities in different areas. There is great breadth and depth of population diversity in our communities, which must be considered in ensuring equality of access to services and in our work to reduce health inequalities.

**Commissioning**

North West London (NWL) is comprised of eight Clinical Commissioning Groups (CCGs), 10 acute and specialist trusts, 4 community and/or mental health trusts, 400+ GP practices, and eight Boroughs. The three CCGs of Harrow, Hillingdon and Brent work jointly in some areas (and have a shared senior management team), as a 'federation', while the remaining CCGs operate similarly as a 'collaborative'.

NHS England is also one of the largest commissioner of services in North West London, and is responsible for commissioning all specialised services, early years including childhood immunisations, health visiting, child health information systems and family nurse partnerships; screening, including cancer screening, adult non cancer screening, and antenatal and newborn screening (in collaboration with CCGs); health in the justice system; military health; and primary care contracts (417 GP contracts, 390 dental, 484 ophthalmic and 515 pharmacy providers).

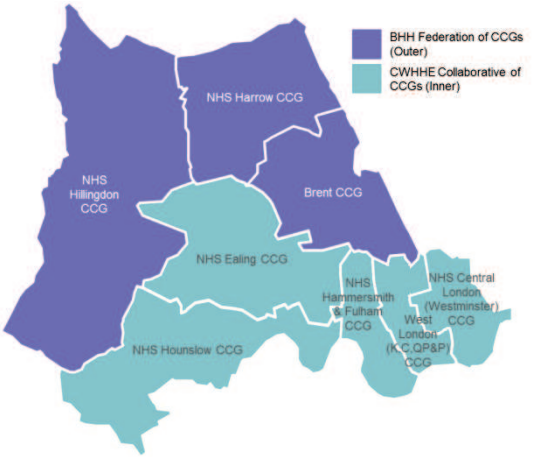
The NHS in NWL consists of eight CCGs that, with one small exception[8], are coterminous with the eight local authority boroughs.

[6] *North West London SPG planning document;* Monitor, TDA, NHS England (November 2013), based on GLA 2012 Round Demographic Projections, 2013

[7] North West London SPG planning document; Monitor, TDA, NHS England (November 2013)

[8] The area of Queen's Park and Paddington in the Borough of Westminster forms, with all of the Royal Borough of Kensington & Chelsea, NHS West London CCG. The remainder of the Borough of Westminster forms NHS Central London CCG.

NWL Clinical Commissioning Groups




It is a relatively self-contained health economy, within which over 90% of spending on providers for the NWL population is with providers located in the sector.

The CCGs work closely with their Local Authority partners in a number of areas, and have made a commitment to work co-productively with patients, service users, carers and the public.

**Providers**

The providers that the CCGs primarily use are categorised according to service type below.

Acute providers:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust. This includes Charing Cross Hospital, Hammersmith Hospital (including Queen Charlotte's Hospital), St Mary's Hospital and Western Eye Hospital)
- The Hillingdon Hospitals NHS Foundation Trust. This includes Hillingdon Hospital and Mount Vernon Hospital
- The North West London Hospitals NHS Trust. This includes Central Middlesex Hospital and Northwick Park Hospital
- West Middlesex University Hospital NHS Trust
- Ealing Hospital NHS Trust

Community providers:

- Central London Community Healthcare Trust (CLCH), covering Hammersmith and Fulham, Kensington and Chelsea and Westminster
- Hounslow and Richmond Community Healthcare (HRCH), covering Hounslow
- Central and North West London NHS Foundation Trust, incorporating Hillingdon Community service provider, covering Hillingdon
- Ealing Hospital Trust, incorporating Ealing Integrated Care Organisation, covering Brent, Ealing and Harrow

Mental health providers:

- West London Mental Health NHS Trust, covering Ealing, Hammersmith and Fulham and Hounslow
- Central and North West London NHS Foundation Trust, covering Brent, Kensington and Chelsea, Harrow, Hillingdon and Westminster.

In addition there are three specialist trusts located in NWL: The Royal Marsden NHS Foundation Trust, The Royal Brompton and Harefield NHS Foundation Trust and The Royal National Orthopaedic Hospital NHS Trust.

Emergency ambulance services are provided by the London Ambulance Service (LAS), a London-wide NHS Trust that is the busiest emergency ambulance service in the UK to provide healthcare that is free to patients at the time they receive it.

The benefits of being coterminous with local authority boroughs and being self-contained means that NW London as a whole is a logical level at which to effect strategic change.

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# 2. Our shared vision and outcome ambitions for North West London

*NHS England, in setting its ambition of "high quality care for all, now and in the future", has challenged commissioners across England to make substantive improvements across seven outcome ambitions.*

*Our vision and ambition in NWL is to improve the quality of care…empower and support people…to lead full lives".*

## Introduction

Across North West London service users, clinicians, commissioners, and providers know that by working together across the region we can transform the quality and effectiveness of services provided to our local population. Importantly, by adopting this collective approach we can ensure consistency of service where demand is common and balance this with local enhancements where demand is specific.

We have defined a vision that responds to and aligns with the national challenges laid out by NHS England, encompassing NHS England' *Call to Action*, Seven Day Services and the vision for Urgent and Emergency Care.

Our overarching vision, building on that set out by NHS England and developed in consultation with the people of North West London, is:

> *"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

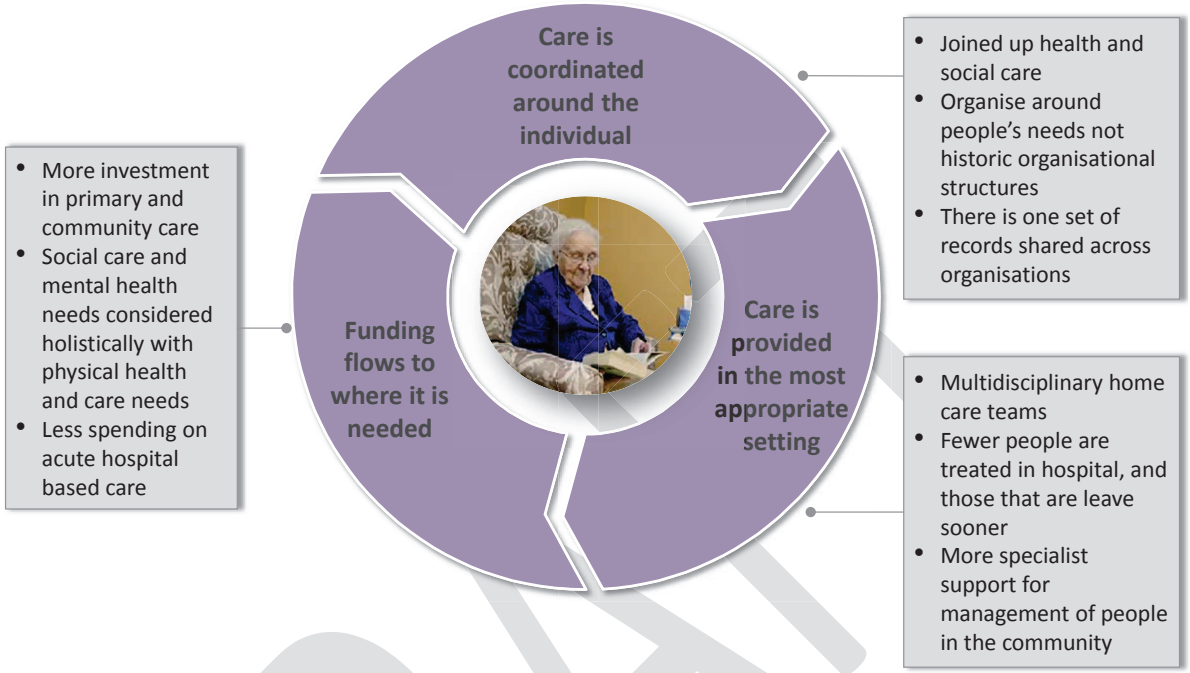
Four overarching principles underpin our whole system NWL vision – that health services need to be:

1. **Localised** where possible;
2. **Centralised** where necessary;
3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless person centred care. Individuals will be enabled to work with frontline professionals, their carers, and families to maximise health and wellbeing and address their specific individual needs.
4. The system will look and feel from a patient's perspective that it is **personalised** - empowering and supporting individuals to live longer and live well.

In addition, commissioners will recognise our broader role in society (both as employers and commissioners), and address the determinants of health.

NWL's vision for the health and care system is represented in the figure below:

NWL's vision for personalised care




The health needs of the people of NWL are changing, the demands on our health services are increasing, and the way we have organised our hospitals, community-based services and primary care in the past will not meet the needs of the future.

NWL, having developed our vision and the principles that underpin it in 2012, NWL initiated a strategic planning process to understand the challenges that our future plans need to address, and documented these in a NWL 'Case for Change.'

In addition to the findings of the original NWL Case for Change, NHS England has recently published a new report, '*The NHS belongs to the people: a call to action',* which sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The report states that the NHS must change to meet these demands and to make the most of new medicines and technology, and that it will not contemplate reducing or charging for core services.

NHS England wants to see a greater focus on preventative rather than reactive care; services matched more closely to individuals' circumstances instead of a one size fits all approach; people better equipped to manage their own health and healthcare, particularly those with long term conditions; and more done to reduce invest admissions to hospital and avoidable readmissions, particularly amongst older people.

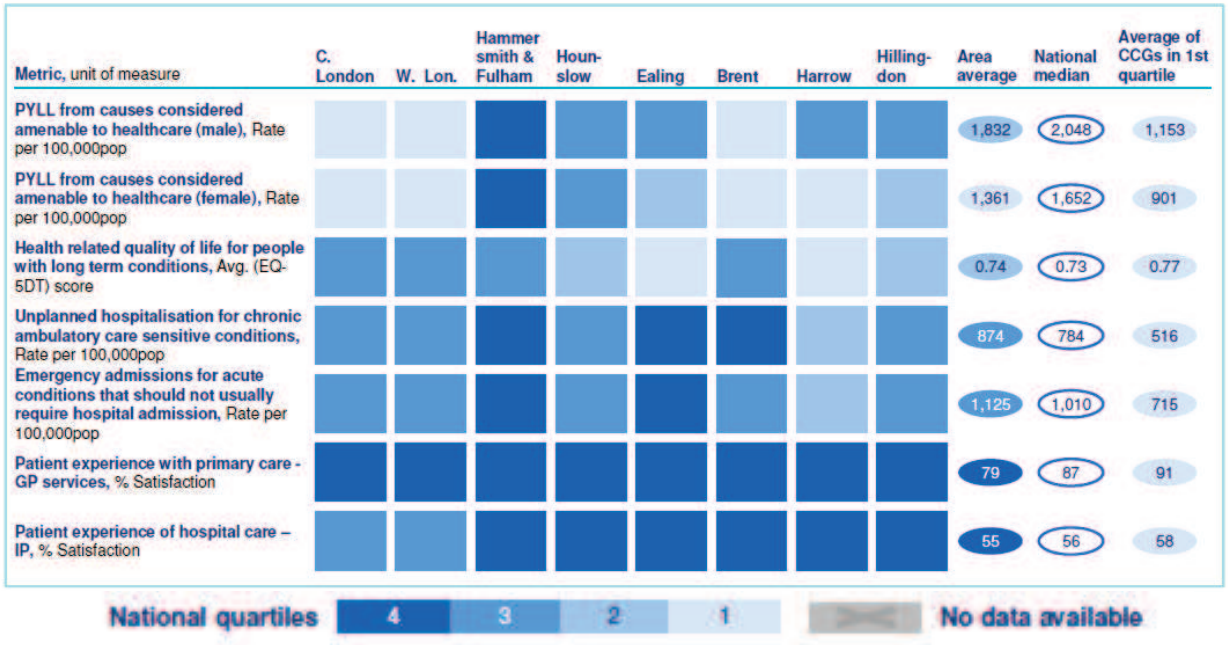
NHS England recognised that thinking strategically about how we use our resources and commission services over a five year period presents us with an opportunity to truly put outcomes at the heart of our commissioning plans.

All CCGs have therefore been asked to set levels of ambition against the NHS' five national strategic objectives and our NWL plans have been developed to achieve these objectives, which have also been mapped to national outcome ambitions/indicators (see the NHS Outcomes Framework for further details[9]):

1. Preventing people from dying prematurely (i.e. people living longer and not dying prematurely)
2. Enhancing quality of life for people with long-term conditions (i.e. people with LTCs maximising their quality of life)
3. Helping people to recover from episodes of ill health or following injury (i.e. people recovering from illness or injury resuming their lives)
4. Ensuring that people have a positive experience of care (i.e. people having a positive experience of care)
5. Treating and caring for people in a safe environment and protecting them from avoidable harm (i.e. people experiencing a safe care environment)

The baseline position across the NWL CCGs against the associated national indicators is summarised in the figure below.

Selected National Outcome Framework indicators – NWL[10]




(Note that the first quartile represents the best performance against the indicator).

Our Case for Change has therefore been set in the context of our current performance against these important outcome ambitions. We recognise that the wider determinants of health have an impact on achievement of all of these ambitions, and have noted specific examples of these in the following section where possible.

[9] *The NHS Outcomes Framework 2014/15*, Department of Health, November 2013 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf ); *Setting 5-year ambitions for improving outcomes: A how-to guide for commissioners*, NHS England, December 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/12/stra-op-how-to-guide1.pdf)

[10] *North West London SPG Planning document*; Monitor, TDA, NHS England (November 2013)

### Ambition 1:
### Securing additional years of life for local population with treatable conditions

As a region, NWL is currently performing slightly above the national average in relation to the indicator for this ambition: *Potential years of life lost (PYLL) from causes considered amenable to healthcare.* However, there are areas of real opportunity to improve – for example, cancer is the biggest cause of premature death in London, and every hour three more Londoners are diagnosed with cancer. However, in 2009, a number of challenges facing London's cancer services were identified, including late diagnosis of cancers with many cancers diagnosed at a late stage when successful treatment is less likely; variability in cancer outcomes across London for common cancers; and variability in cancer outcomes across London for rare and more complex cancers.

Other causes of death considered amenable to healthcare include cardiovascular disease, respiratory disease and some maternal/infant deaths.

The baseline performance of each CCG, along with the national quintile this represents, and the target for improvement over the next five years, is provided in the table below[11]:

Targeted reduction across NWL CCGs in 'Potential years of life lost from causes considered amenable to healthcare'

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| Hounslow | 1,929.9 | 3 | 2,060.8 | 1,640.0 | 15.02 |
| Hammersmith & Fulham | 1,998.2 | 2 | | 1,698.0 | 15.02 |
| Ealing | 2,018.4 | 3 | | 1,715.5 | 15.01 |
| West London | 1,822.7 | 2 | | 1,549.1 | 15.01 |
| Central London | 1,800.2 | 1 | | 1,530.0 | 15.01 |
| Hillingdon | 2,102.0 | 3 | | 1,787.0 | 15.03 |
| Brent | 2,516.0 | 5 | | 2,135.0 | 15.14 |
| Harrow | 1,987.9 | 2 | | 1,689.0 | 15.00 |
| **Aggregated** | **16,174** | | | **13,743** | **15.04** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

NHS England has suggested a minimum of 3.2% improvement per year and all of the NWL CCGs are targeting improvements in lines with this figure.

### Ambition 2:
### Improving the health related quality of life for those with long term conditions

There is a variable patient experience and support for people with long-term conditions across NWL. For example, when people are worried about their health, their first point of call is often NHS primary care – usually their GP. But patients in some parts of NWL cannot get a GP appointment, or access their GP and related services, very easily. When people need support from a number of different services their overall experience of care can feel disjointed and fragmented. Each person providing care may be doing a good job, but taken as a whole the individual and their family often experience care that is poorly coordinated and confusing. The growing number of people living with long-term conditions requires services to work together in different ways to meet rising and changing patterns of demand. People and their families should be supported to manage their own condition as far as they are able, drawing on the support of their community and local services to meet their personal outcomes and aspirations. Wider determinants of the quality of life for those with long-term conditions include social isolation and the availability of assistive technology.

Despite the challenges, the majority of CCGs within NWL are currently above the national average in relation to the indicator for this ambition: *Health-related quality of life for people with long-term conditions*.

[11] Note: Top quintile is 1, lowest quintile is 5.

Targeted improvement across NWL CCGs in the health-related quality of life for people with long-term conditions

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| Hounslow | 75.2 | 2 | 72.9 | 76.0 | 1.06 |
| Hammersmith & Fulham | 74.6 | 2 | | 76.1 | 2.01 |
| Ealing | 75.8 | 2 | | 76.1 | 0.40 |
| West London | 70.8 | 4 | | 76.1 | 7.49 |
| Central London | 73.3 | 3 | | 76.0 | 3.68 |
| Hillingdon | 75.2 | 2 | | 79.1 | 5.10 |
| Brent | 73.4 | 3 | | 77.2 | 5.09 |
| Harrow | 75.6 | 2 | | 79.5 | 5.1 |
| **Aggregated** | **594** | | | **616** | **3.71** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

The NWL CCGs have set a range of targets against this outcome, depending on their starting position.

### Ambition 3: Reducing the amount of time people spend avoidably in hospital

In NWL, too many people are admitted to hospital and this is shown in our below national average indicator score. Like other areas in the country, rather than relying on reactive, siloed and episodic units of care, across NWL we need to take a more preventative, personalised approach. Providers need to work with each other, other local services and communities to promote the long-term, sustainable wellbeing of the whole person, taking into account wider social determinants of health and wellbeing as well as personal circumstances and capacity for self-care. Our aim must be to prevent people going into hospital in the first place and when people do go in, we need to support them to regain independence and wellbeing at home as quickly as possible. Providing care closer to home will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals. Doing so could result in 20-30% of patients who are currently admitted to hospitals in NWL as emergencies being more effectively cared for in their community. Wider determinants of the amount of time people spend avoidably in hospital include the availability of housing and of social care services.

The baseline performance of the CCGs ranges from the second to the fifth quintile nationally in the related indicator for this ambition, a composite measure capturing the rate of avoidable emergency admissions per 100,000 of the population:

Targeted reduction across NWL CCGs of avoidable emergency admissions to hospital

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| Hounslow | 1,890.9 | 2 | 2,053.7 | 1,645.0 | 13.00 |
| Hammersmith & Fulham | 2,308.4 | 4 | | 2,008.3 | 13.00 |
| Ealing | 2,310.3 | 4 | | 2,010.0 | 13.00 |
| West London | 1,896.6 | 2 | | 1,650.0 | 13.00 |
| Central London | 1,781.2 | 2 | | 1,549.6 | 13.00 |
| Hillingdon | 2,064.0 | 3 | | 1,962.0 | 4.94 |
| Brent | 2,734.0 | 5 | | 2,600.0 | 4.90 |
| Harrow | 2,714.8 | 5 | | 2,582.0 | 4.89 |
| **Aggregated** | **17,700** | | | **16,007** | **9.6** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

As our 18/19 targets demonstrate, we have strong ambitions to address this and as is set out in future chapters, already have significant transformation programmes underway to make it a reality.

### Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital

While there are currently no measurable outcome indicators available nationally against this ambition, NWL's primary and community services for the terminally ill are variable; too often working in silos, access complicated by multiple referral approaches.

The National Voices narrative sets out patients' expectations of person-centred coordinated care; however, interviews with London community services have identified significant limitations in meeting such expectations.

Whist there are pockets of excellence in some service models, work so far highlights:

- **Standards of community nursing care are variable** resulting in postcode variation to clinical practice.
- **Patients want joined-up care, yet there is limited uptake of technology** to help people manage their care at home or improve continuity of care between providers - community nurses, GPs, social care, carers, GP out of hours, acute, etc.
- **Community nurses report low morale and spend less time with patients**.

To support people to live independently at home, care needs to be coordinated around the needs of the individual. GPs should be at the centre of bringing together a comprehensive network of support which responds to a person's total physical, psychological and social needs, drawing on what they can do for themselves as well as the contribution of their families, communities and public services. Personal budgets for both health and social care spend are a key mechanism to enable people to assume choice and control over how their needs are best met, taking a planned, proactive and personalised approach in collaboration with care professionals. Consistent and high quality support for carers will mean better outcomes for both the individual being cared for and carers themselves, enabling people to remain at home and independent for as long as possible.

Wider determinants of the proportion of older people living independently following discharge from hospital include the availability of housing and of social care services. Maintaining the health and wellbeing of carers is a key component of delivering care in the community.

### Ambition 5:
### Increasing the number of people having a positive experience of hospital care

When it is necessary for residents of NWL to be admitted into hospital we want to ensure that they have the best experience possible whilst receiving important and often lifesaving care.

Patient perception is that the hospital care they receive in NWL hospitals is below the national expectation, as reflected in the baseline figures below. We know that people there are big differences in the quality of care patients receive depending on which hospital they visit and when they visit.

As the table below demonstrates, all of the CCGs in NWL are below the national average in relation to the indicator for this ambition: *'Poor' patient experience of inpatient care*[12].

Targeted improvement across NWL CCGs in patient experience of inpatient care

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 164 | 4 | 142 | 142 | 13.41 |
| **Hammersmith & Fulham** | 158.1 | 4 | | 150 | 5.12 |
| **Ealing** | 173.1 | 5 | | 161 | 6.99 |
| **West London** | 159.3 | 4 | | 143 | 10.23 |
| **Central London** | 149.5 | 3 | | 139 | 7.36 |
| **Hillingdon** | 164.7 | 5 | | 157 | 4.92 |
| **Brent** | 167.1 | 5 | | 159 | 4.91 |
| **Harrow** | 171.6 | 5 | | 163 | 4.90 |
| **Aggregated** | **1,307** | | | **1,213** | **7.20** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

### Ambition 6:
### Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community

When people are worried about their health, their first point of call is often NHS primary care – usually their GP. But patients in some

[12] This national indicator is constructed based on responses to 15 'experience of inpatient care' questions within the national inpatient survey (a sub-set of potential responses have been selected as representing 'poor' experience of care). Note that the national inpatient survey is collected at provider level. NHS England has used the algorithm from the Quality Premium to attribute provider-level data on patient experience to a geographical CCG footprint.

parts of NWL cannot get a GP appointment, or access their GP and related services, very easily. Patients report low levels of satisfaction with primary and acute (both bottom quartile, nationally) across all CCGs[13]. NWL has also carried out its own street survey, as part of a broader review, in order to understand patient priorities for primary care.

As the table below demonstrates, all of the CCGs in NWL are below the national average in relation to the indicator for this ambition: *'Poor' patient experience of primary care*.

Targeted improvement across NWL CCGs in patient experience of primary care

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 8.9 | 5 | 6.1 | 6.1 | 31.46 |
| **Hammersmith & Fulham** | 8.5 | 5 | | 7.4 | 12.94 |
| **Ealing** | 11 | 5 | | 8.5 | 22.91 |
| **West London** | 7 | 4 | | 6 | 14.29 |
| **Central London** | 7 | 4 | | 5.9 | 15.71 |
| **Hillingdon** | 8.4 | 5 | | 8.0 | 4.88 |
| **Brent** | 10 | 5 | | 9.5 | 4.91 |
| **Harrow** | 8.2 | 5 | | 7.8 | 4.88 |
| **Aggregated** | **69** | | | **59** | **14.24** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

## Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

While there are currently no measurable outcome indicators available nationally against this ambition, recent analysis across London has shown that those people attending and admitted to hospital during evenings, nights or at the weekend are more likely to die than people admitted at times when more senior staff are available. Around 130 lives could be saved in NWL every year if mortality rates for admissions at the weekend were the same as during the week.

If the NHS is to provide more consistent high quality hospital care in NWL, it needs to ensure that senior doctors and teams are available more often, seven days a week, 24 hours a day. Much progress has been made – for example, in centralising heart attack care, major arterial surgery and stroke care in hospitals. This new approach to stroke care has already saved about 100 lives over the last year in NWL – but more needs to be done.

### Financial challenge

In addition to the health outcome and patient experience objectives we have set, NWL has a number of financial challenges that our five year plan will also address:

- **Population changes**: the population of North West London is facing major changes in its health needs and these are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia. The demand for health services in NWL will continue to grow.
- **Financial challenges:** from a commissioner perspective, if we do nothing we estimate we would need £365m more to keep pace with demand. Hospitals in NWL will also face significant financial challenges even if they become as efficient as they can be. This means services need to be redesigned to be more affordable.
- **Estates:** The physical condition of hospital buildings needs to improve. Good quality care environments improve the quality of care provided, as well as improving the working conditions of staff. Despite having three relatively newly built hospitals (Central Middlesex, Chelsea and Westminster and West Middlesex), NHS buildings in NWL are generally in a poor state.
- **Productivity:** NWL also has more hospital floor space per head of population than

[13] North West London SPG planning document, November 2013 (Monitor, TDA, NHS England)

in other parts of the country, and uses a greater proportion of the NHS budget on hospital care than average – but the productivity of NWL hospitals is lower than in other regions. This is not the best use of resources – resources which could be better used to help people to stay well in the community – and makes it even more important to change hospital services.

### Summary

The North West London baseline against the five measurable ambitions varies across CCGs. This mirrors the, in places, vast variance in affluence, deprivation and health that is characteristic of a large urban centre such as London. Whilst the region performs well against Potential years of life lost and *health related quality of life for people will long term conditions*, NWL is below the national average for the other three measures; avoidable hospital admissions and patient experience.

We therefore know that there is scope for improvement and have set ambitious targets to make improve across all CCGs as well as levelling out the imbalance between some localities, so that residents in every borough can expect a similarly high standard of care.

Where indicators don't currently exist to quantify our ambition we still have bold plans to make improvements to these outcomes across North West London and have set these out in the sections that follow.

# 3.The essentials: Quality, Safety, Access, and Innovation

*While NWL is implementing an ambitious set of transformation programmes, at the CWHHE collaborative and BHH federation level essential work continues to improve quality and performance through the commissioning cycle*

### Introduction

While the eight CCGs of North West London are collaborating to implement an ambitious set of shared transformation programmes, significant work to support improvements against the outcome ambitions also takes place at the CWHHE Collaborative (CCGs of Central London, West London, Hounslow, Hammersmith & Fulham and Ealing) and the BHH Federation (Brent, Harrow and Hillingdon). Both the Collaborative and Federation have chosen to work together in a number of areas, including Quality, safety, performance and delivery. These areas are essential to NWL's ability to achieve its outcome ambitions in terms of population health, clinical effectiveness, patient experience, and financial sustainability.

### Quality and Safety

Patient Safety is at the heart of the NHS agenda, treating and caring for people in a safe environment and protecting them from avoidable harm. The findings and recommendations of the Francis report have raised the national and political profile of safety issues. We recognise that clinical leaders are at the heart of delivering high quality care.

The CCGS of NWL are responsible for the quality assurance of provider organisations they commission from, ensuring they are held to account for delivery of quality standards and contractual obligations.

Both the BHH federation and the CWHHE collaborative have developed Quality Strategies that set out their respective approaches to embedding quality into every part of the commissioning cycle, ensuring that quality is at the heart of everything we do.

Ensuring patient safety is integral to all of our work as commissioners, and NWL has robust approach to understanding and measuring the harm that can occur in healthcare services.

The quality and safety governance structure in NWL includes:

- Commissioning Quality Group (CQG) meetings: these are held on a monthly basis with all key acute, community and mental health providers, and are the primary mechanism through which quality, safety and patient experience indicators are monitored, remedial action plans are developed, and from which significant risks are escalated to CCG Quality and Safety Committees for further action.
- CCG Quality and Patient Safety Committees: these meetings are convened as sub-committees of each of the Governing Bodies. These sub-committees discuss local quality issues, oversee and gain assurance on provider quality and performance issues, and escalate issues to the Governing Body or take other action where appropriate.

In addition, a CWHHE Collaborative Quality Committee meets to share potential areas of quality concern that are raised by individual CCG Quality and Patient Safety Committees.

A range of information inputs are triangulated for review and analysis within the established governance process.

Key performance indicators associated with harm and untoward incidents, including quarterly trend reports, are monitored by NWL CCGs with all key providers at a monthly CQG (Commissioning Quality Group).

### 6. Response to Francis, Berwick and Winterbourne View

How NWL addresses the outcomes of the government's final report on Winterbourne View and the Francis Report on Mid Staffordshire NHS Foundation Trust is a critical test of our ability to make a real difference to improving patient safety and to caring for some of the most vulnerable people in society.

The overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people at the centre of the NHS. This is about everything we do. Both BHH and CWHHE have developed actions plans with to address the issues raised within the Francis and Berwick[14] reports, including:

- Listening to and involving patients and carers in every organisational process and at every step in their care.
- Commissioning for quality standards, and monitoring the quality and safety of care constantly, including variation within the organisation.
- Responding directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff.
- Embracing complete transparency, including being recognisable public bodies, visibly acting on behalf of the public we serve and with a sufficient infrastructure of technical support.
- Training and supporting all staff all the time to improve the processes of care.
- Joining multi-organisational collaboratives, i.e. networks, in which teams can learn from and teach each other.

The NWL Quality and Safety teams are working with the NWL Academic Health Science Network (AHSN) to create a culture of continuous improvement and learning across the sector, adopting and implementing the recommendations of the Berwick Report. This will also provide the basis for the Collaborative for Patient Safety in NWL as part of the national initiative to be rolled out by NHS Improving Quality (IQ).

In addition, each individual CCG has developed an action plan in response to the Winterbourne View Review of services provided to people with learning disabilities.

[14] A promise to learn – a commitment to act; Improving the Safety of Patients in England; National Advisory Group on the Safety of Patients in England (August 2013): (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)

The Winterbourne plans address the following areas:

- Numbers of patients still cared for in an inpatient setting (with a view to reducing these where appropriate).
- Strengthening the operational, governance and oversight arrangements by which transfers from inpatient care are monitored.
- The frequency and robustness with which on-going care needs are assessed.
- The development of new services, with partner Local Authorities, to support these patients.
- Identification of future need for local provision of care for learning disability clients.
- Transition planning for children with learning disabilities.

**7. Patient experience**

The NWL CCGs are 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, as part of the overall quality of care that is provided locally.

The CCGs have therefore been working with patients and wider stakeholders to develop a patient experience strategy to inform decisions for commissioning person-centred care that is compassionate, safe and effective.

The definition and framework were created collaboratively by patients, carers, the wider community as well as Health and Social Care staff.

The strategy also sets out that from a patient's perspective - when I have a 'good experience' of care, I feel:

- Confident of receiving an accurate diagnosis
- Positive about receiving high quality, evidence based care
- Respected, safe, comfortable, peaceful and cared for
- Listened to and understood
- Informed and involved in decision making
- Able to take responsibility for and contribute to my own health as a partner in care
- Assured of having full access to all available resources

A *'good experience'* of care is enabled when:

- My care is planned with me and centred on my needs and is inclusive of my family and carers
- My care is co-ordinated across health, social and third sector services
- I have easy access to comprehensive services that are responsive, offer choice and provide me with timely treatment and care
- Equipment and resources are available to meet my needs and requirements
- I receive consistent and continued care which helps me to build relationships with staff promoting holistic approaches
- Staff have good communication skills and use clear and appropriate language, providing me with time to talk, ask questions, discuss issues and options, and to be given explanations and information
- Staff are effective at communicating and sharing information with me and also with other staff within and across health, social and third sector services
- I have access to information about services (what services are available, how services work and what they can expect), support, care, illness and health promotion that is relevant, useful, sensitive, up-to-date and available in different formats
- I, my family and carers have access to volunteers and the opportunity to learn and gain support from other patients
- I am provided with opportunities to get involved in shaping and influencing the service and the organisation as a whole

- The environments where I receive care are appropriate, accessible, clean, welcoming and enable my privacy and dignity to be maintained
- The staff/services/organisations are committed to learning and improving - a no blame culture in which people take complaints seriously, respond quickly and learn from mistakes
- Staff have a positive experience of work
- Services are valued and used responsibly by both patients and staff
- Staff:
    - Are professional, honest and accountable
    - Are approachable, kind, compassionate and empathetic
    - Maintain my confidentiality, privacy and dignity and treat everyone with respect
    - Are prepared and informed about me, my care needs and other services
    - Have the right knowledge, attitude and skills and adhere to policies
    - Work in partnership with me, my family and carers and other professionals
    - Are culturally aware and sensitive to my needs and state of mind, and those of my family and carers
    - Are willing to work across services and to connect with communities

A number of subsequent steps have been identified to ensure that patient experience is embedded into the commissioning process. To this end, the following Strategic Contracting Principle has been developed and is currently incorporated in CCG Commissioning Intentions:

> *"We expect all providers to work with us to ensure that patient experience is used to inform the provision of services that are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public"*

In the context of the commissioning process, the ***ultimate purpose of capturing the patient experience is to achieve excellence in care*** by using these experiences to create services that put patients at the heart of decision-making and improving quality and outcomes for physical and mental health through improving services so that they are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public.

NWL has identified a series of actions to take forward linked to the patient experience enabling factors, including:

- Deliver a Series of Seminars and Learning Events for Staff and Governing Body Members on *'Effective Leadership to enhance Patient Experience'.*
- Deliver a programme of training for CCG Lay Reps and Patient Champions to enable them to promote patient perspective at decision making levels and in considering CCG plans and proposals.
- Establish a NWL Patient Experience Leads Network whose aim will be to act as a Forum for:
    - Agreeing integrated patient experience reporting and evaluation mechanisms for inclusion in CQG meetings. Feedback from patient and service user representatives including Healthwatch has recommended that a range of tools are used to present the patient experience data by providers.
    - Deliver quarterly patient experience learning events themed around a specific service or issue across health and social care
- Map out the current data gathered on patient experience data against key themes associated with good patient experience, to enable the development of a pre-populated dashboard.
- Provide information and feedback on actions arising from patient experience reports from providers to patients, carers

and the wider community both at CCG Level and across North West London.

The measurable improvements in patient experience that are targeted through our patient experience strategies are reflected in the outcome ambition targets (see sections 2 and 12).

## 8. Compassion in practice

'*Compassion in Practice*'[15] is a three year vision and strategy for nursing, midwifery and care staff developed by the NHS Commissioning Board and Department of Health in 2012.

The strategy sets out the 6 "Cs", i.e. the values and behaviours to be universally adopted and embraced by everyone involved in commissioning and delivering care:

1. **Care**: Care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life.
2. **Compassion**: Compassion is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care.
3. **Competence**: Competence means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
4. **Communication**: Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.
5. **Courage**: Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.
6. **Commitment:** A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead.

In NWL, each provider has developed an action plan to implement the *Compassion in Practice* strategy, and from 2014/15 these will be reviewed on a quarterly basis as part of the standard contract management process. The six action areas to be taken forward by each provider organisation are:

- Action area #1: Helping people to stay independent, maximise well-being and improving health outcomes
- Action area #2: *Working with people to provide a positive experience of care*
- Action area #3: *Delivering high quality care and measuring the impact*
- Action area #4: *Building and strengthening leadership*
- Action area #5 *Ensuring we have the right staff, with the right skills, in the right place*
- Action area #6: *Supporting positive staff experience*

## 9. Staff satisfaction

The importance of staff, capabilities and culture is very clear in the learning from Mid-Staffordshire NHS Foundation Trust and Winterbourne View Inquiries. As part of the NWL CCGs' assurance frameworks we carry

[15] *Compassion in Practice – Nursing, Midwifery and Care Staff*; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, December 2012: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

out site visits to services in order to test the culture that exists within the service, using our agreed quality visit process.

Staff satisfaction across NWL providers is variable, and historically has been understood based on annual staff surveys, GMC surveys, and engaging with staff as part of Clinical Visits to providers. Building on the recommendations of these key reports, we will strengthen our review of data and information regarding staff experience and satisfaction as part of our overall quality and safety monitoring and improvement processes, routinely collecting (as part of the Integrated Performance reporting and monitoring process) a wider range of workforce indicators, including sickness, absenteeism and turnover rates, and staff feedback, in order to triangulate with other quality measures, including patient experience data, in order to assess the performance of organisations. Other key sources of information that we will review together include:

- Staff satisfaction surveys
- Staff training information
- Workforce/patient dependency – skills and capabilities
- Whistleblowing information.
- Soft and hard intelligence from Local Education Training Board
- Responses and implementing of workforce related policy such as 'Compassion in Practice'
- Local Education and Training Board (LETB) and General Medical Council (GMC) training survey

**10. Safeguarding**

The NWL CCGs have safeguarding plans in place to ensure that NWL meets the requirements of the accountability and assurance framework for protecting vulnerable people, as follows:

- The CCGs seek assurance that providers have arrangements in place to safeguard and promote the welfare of adults and children in line with national policy, guidance and locally identified areas of concern.
- Providers identify safeguarding issues relevant to their area and we challenge providers to demonstrate that policies and procedures are in place and implemented.
- We review staff training to ensure staff are appropriately trained, supervised and supported and know how to report safeguarding concerns.
- The CCGs require providers to inform them of all incidents involving children and adults including death or harm whilst in the care of a provider.
- We monitor our own staff training.
- Full details are captured in CCG Safeguarding policies.
- We work closely with our partners to participate in Serious Case Reviews and Domestic Homicide Reviews and ensure findings are included in our triangulation of data.
- We lead institutional safeguarding investigations for health funded clients within nursing care homes and those receiving domiciliary packages of care.

The safeguarding plans include the need for seven day services, i.e. access to information to support decision-making with regards to safeguarding adults and children seven days a week. The systems are being put in place to ensure that the needs of vulnerable people are met, regardless of when they present within the health system.

<u>Safeguarding adults</u>

Implementing our safeguarding plans will ensure we continue to improve safeguarding practice in NWL, reflecting our commitment to prevent and reduce the risk of abuse and neglect of adults.

In 2014/15, the CCGs will assess what the training needs are across the health economy with regards to applying the Mental Capacity Act, and will develop a training plan

accordingly. NWL will also develop and implement a campaign of awareness in primary care and care homes, to ensure that the Act is consistently applied across all care settings.

A key priority for the CCGs is to improve the quality of the Care Home provision locally.

- The CCGs are engaged in the Better Care Fund work in conjunction with the Local Authorities.
- The CCGs are working with partners to monitor the quality of the provision and identify areas for improvement.
- Safeguarding advice is available for all contracts and quality monitoring.
- CCG Safeguarding Leads contribute to LA safeguarding investigations to assure the CCGs of the safety of their patients.

The *Prevent* Strategy is a cross-Government policy that forms one of the four strands of CONTEST – the Government's counter terrorism strategy. With over 1 million contacts with patients every 36 hours, the NHS is key to the support and delivery of the Government's Prevent Strategy and will work hard to embed it fully into everyday safeguarding activity, including mandatory training.

The *Prevent* agenda requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation and making safety a shared endeavour.

In NWL, providers report on delivery of the *Prevent* agenda standards as part of regular CQG meetings.

Safeguarding children

The CCGs are committed to supporting the development of national and local initiatives to improve outcomes for children. This is achieved through working with partners via the Local Safeguarding Children Board and ensures that learning is taken forward within commissioning actions.

Key areas include sexual exploitation, missing children and Female Genital Mutilation (FGM).

For FGM the CCGs are working with Local Safeguarding Children Boards and providers to improve the recording of FGM cases to enable clear identification of risk to girls. This will provide a more cohesive multi agency response to the preventing FGM and supporting the victims.

### Access

NWL will deliver good access to the full range of services, including community, mental health, and general practice, through achievement of the out of hospital and primary care standards. NWL has developed out-of-hospital quality standards across a number of domains, including the following standards for access, convenience and responsiveness:

**Access, convenience and responsiveness**:

- Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:
  - Individuals whose health needs are assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling.
  - For individuals whose health needs are assessed as not urgent and that cannot be resolved by phone, they will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours.

In primary care, the expectations with regards to access are that it will include:

- The principle is that care will be responsive to patients' needs and preferences, timely and accessible.
- This may be differentiated depending on patient types: urgent needs may be dealt with by GPs at a network level, whereas patients with long-term conditions may continue to only see their named GP.

As the detailed primary care standards are developed and agreed for London, these will be reviewed and adopted for implementation in NWL.

Each NWL CCG's operating plans are consistent with commissioning sufficient activity to deliver the NHS Constitution right and pledges for patients on access to treatment as set out in Annex B.

**Equality of access**

NWL Quality leads are working to incorporate additional Equality indicators into standard provider contracts, in order to measure how different groups may be treated at different stages of treatment and care, including uptake and use of services.

### Research, Innovation, and the Diffusion of Best Practice

North West London has a world class research infrastructure, but navigating innovations through the healthcare sector can be difficult and complex. Anecdotal evidence suggests that the lag time between research and adoption is around 17 years.

In addition, there is significant variation in healthcare at almost all levels. The gap between what we know and what we do is unsustainable if we want to improve the value of care provided in the NHS, as well as make the UK the place of choice for industry and academia.

Each CCG therefore has a duty to promote innovation in the provision of health services, and to promote research and the use of evidence obtained from research.

This duty consists of two distinct roles:

- To ensure the consistent uptake of existing good practice, including national guidance issued by the National Institute for Clinical Excellence (NICE); and
- To support developments in the pipeline of innovation, leading ultimately in turn to their uptake as recognised good practice.

NWL works closely with a number of partners in the promotion of innovation and adoption.

If we can overcome these barriers to delay between research and uptake, North West London would improve clinical outcomes, increasing life expectancy and reducing avoidable mortality, in line with our outcome ambitions. NWL could also become a UK-wide leader in commercial and non-commercial studies.

**Innovation, Health and Wealth**

In 2001 the Department of Health published '*Innovation, Health and Wealth – Accelerating Adoption and Diffusion in the NHS*'[16], setting out plans to support development and adoption of innovation in the NHS.

Innovation, Health and Wealth (IHW) set out a delivery agenda for spreading innovation at pace and scale throughout the NHS. It included a number of actions that are delivering significant improvements in the quality and value of care delivered in the NHS. NWL is adopting innovative approaches using the delivery agenda set out in this document as follows:

- **Reducing variation and strengthening compliance**: the NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals (recommendations on the use of new and existing medicines and treatments within the NHS). Innovation Health and Wealth identified the need to reduce variation and strengthen compliance of uptake of NICE Technology Appraisals.

  NWL is committed to achieving full compliance with NICE Technology appraisals – each CCG will therefore

[16] *Innovation, Health and Wealth – Accelerating Adoption and Diffusion in the NHS* (Department of Health, 2011): http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

continue to track its own compliance, including through the innovation scorecard[17]. Academic Health Science Networks (further details available within this section) have been set up to support providers and commissioners to accelerate the adoption and diffusion of best practice. NWL is therefore working with Imperial College Health Partners as well as NICE to identify NICE Technology Appraisals (TAs) and other established best practice that generate the greatest value in the local context, and that cannot simply be addressed through traditional commissioning levers. This will build on the existing NHS England Innovation Scorecard but also take into consideration the impact on health and fiscal indicators, as well as the size of the population that would benefit from the adoption. Following the prioritisation of TAs and other best practice using this approach, NWL and Imperial College Health Partners will look to develop a clear rationale and business case for uptake of the most beneficial TAs and work together with health system partners to develop an adoption programme.

- **Creating a system of delivery of innovation**: the North West London ASHN and CLARHC are the key bodies through which innovation is both identified and disseminated.
- **Developing our people**: one of the Health Education NWL funding priorities for 2014/15 includes 'Innovation, such as clinical simulation' (see the Workforce section in chapter 11 for further detail).
- **Leadership for innovation**: CCGs have a duty to seek out and adopt best practice, and promote innovation. The NWL CCGs are actively promoting innovation in the provision of health services, as demonstrated in our key transformation programmes, including:
    - Whole Systems Integrated Care (see chapter 7)
    - Primary Care Transformation (see chapter 6)
    - Transforming Mental Health Services (see chapter 8)

NWL Policy Development Group

While the NICE Technology Appraisals (TAs) are mandatory for implementation, not all other best practice guidance published by NICE is implemented, as it needs to be considered in the context of the wider commissioning priorities (for example, as adopting all recommendations is not affordable).

North West London CCGs have therefore established a Sector Wide Policy Development Group (PDG). The PDG group ensures there is a robust framework that supports evidence-based policies and that this provides equity in access of treatment provision across the North West London population.

The PDG uses commissioning intelligence gathered from Individual Funding Requests (IFR) to identify patterns of referrals that are no longer exceptional and therefore necessitate a policy appraisal. The PDG look at published evidence, both from NICE and other evidence based bodies, and more importantly, provide an innovative approach in the appraisal of evidence gathered from local clinicians, through a range of clinical workshops. The PDG also review current policies to ensure they reflect the most up to date published evidence, including NICE guidance, and ensure that recommendations provide sufficient information to enable CCGs to make decisions in the context of the wider commissioning priorities.

**Research and Innovation partners**

NWL works closely with its research and innovation partners, including the Imperial College Health Partners (the Academic Health Science Network) and NIHR CLAHRC, who are leading the research and innovation agenda in

17 http://ccgtools.england.nhs.uk/innovation/ISCCGMedTechT22/atlas.html

NWL. The relationship between these bodies is summarised as follows:

- Academic Health Science Centres (AHSC)/Biomedical Research Units (BRUs)/Biomedical Research Centres (BRCs): identify best practice through research and discovery.
- Collaboration for Leadership in Applied Health Research and Care (CLAHRC): studies and applies the translation of research into practice.
- Academic Health Science Network (AHSN): promotes diffusion and consistent adoption of best practice and innovation across the sector.

Further detail about how each of these organisations contributes to and promotes research is provided in the following sections.

Imperial College Health Partners - Academic Health Science Network (AHSN)

Imperial College Health Partners is a partnership organisation bringing together the academic and health science communities across North West London. It is also the designated Academic Health Science Network (AHSN) for North West London.

The AHSN partnership includes representation from academia, primary and community care, mental health, secondary and specialist care and the NWL CCGs. In addition to its partners, the AHSN works closely with local government and social care, technology and pharmaceutical industries, opinion leaders, research bodies and patients and the public.

The AHSN is intended to deliver demonstrable improvements in health and wealth for the people of North West London and beyond through collaboration and innovation. As a partnership organisation and an AHSN, it will act as a driving force for collaborative working across NWL.

The core strategic objectives of the AHSN are:

- Enable the discovery of best practice
- Adopt best practice systematically
- Support wealth creation in the sector and beyond

The core strategic objectives act to form a work programme space in which the projects undertaken fit into one or more of these objectives. The priority programmes of the NWL AHSN are well-aligned to the NWL strategic priorities and key improvement interventions, and are as follows:

- **Alignment and dissemination of research**: to standardise a path for 'ready-to-go' research to get to the patient as fast as possible as well as identify opportunities for greater collaboration and innovation in research across the sector.
- **Cancer:** to oversee (with the South London AHSN) the London Cancer Alliance's extensive programme of work that covers 20 themes.
- **Cardiovascular Rehabilitation**: to evaluate the MyAction programme - the CVD prevention and treatment initiative used in Westminster – to help decide whether it should be rolled out across NWL, and to establish the best practice for cardiovascular rehabilitation and the management of patients at high risk of cardiovascular disease.
- **Chronic Obstructive Pulmonary Disease (COPD):** to work with partners across the sector to identify and overcome remaining barriers to the uptake of COPD best practice and to support the CLAHRC in developing a care bundle for primary care while refining the secondary care bundle. This includes the development of an outcome based commissioning model for the provision of community based best practice services to ensure comprehensive access to high quality care across the population.
- **Collaboration with industry:** to help the NHS work better with industry by developing a "matchmaker" infrastructure for our NHS partners to systematically articulate their needs to industry, enabling industry to respond to this need in a standardised and transparent form.

- **Intelligent use of data:** to develop intelligent applications to the linked health data to ensure that maximum benefit is realised from it to drive further improvement in services, high standard observational and follow up research studies, and population surveillance for unexpected health issues.
- **Mental Health:** the partnership will build on previous and current work done across North West London and in particular work with the sector's Mental Health Programme Board. It will undertake a strategic profile of mental health need and care in North West London. It will create a forum that brings together academic and clinical experts to advise on service development and the implementation of research and innovation.
- **Overseas development:** to work with United Kingdom Trade and Investment (UKTI) organisation and some commercial partners to develop a comprehensive and systematic commercial offer for clients in a number of countries, and to develop a philanthropic offer on behalf of our partners
- **Patient safety:** to create a culture of continuous improvement and learning across the sector, adopting and implementing the recommendations of the Berwick Report. This will also provide the basis for the Collaborative for Patient Safety in NWL as part of the national initiative to be rolled out by NHS Improving Quality (IQ).
- **Supporting Whole Systems:** the AHSN has been asked by its members to support the Whole Systems programme by providing information on best practice from around the world and bring together thought leaders to enable partners to co-design the model effectively. In addition, the AHSN will develop, partly fund and manage an independent evaluation process to ensure the investment provides value for money and leads to measurable outcomes.
- **Neurorehabilitation:** to undertake a comprehensive review of neurorehabilitation services across the system (at the request of NWL CCGs). Note that this is consistent and aligned with the work of the London Neuroscience SCN.

<u>NIHR CLAHRC for North West London</u>

The National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care for North West London (CLAHRC NWL) is an alliance of academic and healthcare organisations working to develop and promote a more efficient, accelerated and sustainable uptake of clinically innovative and cost-effective research interventions into patient care.

CLAHRC has had a five year multi-method programme, working across primary and secondary interfaces of care, which has now been renewed for another 5 years, with a long term strategy of building capacity through improvement methodology and small cycle change. CLAHRC involves multi-disciplinary, including at its heart patient/public engagement, working amongst and across teams. While new research and innovation are always necessary, CLAHRC recognises that more can be done by effectively implementing existing evidence.

CLAHRC's overall goal has been to improve health outcomes and patient experience - delivering value within NWL and across the wider NHS through research and implementation. To achieve this goal CLAHRC developed a systematic approach to encourage better and faster uptake of clinically-proven, innovative and cost-effective care, closing the so-called second translational gap.

CLAHRC has support from all healthcare organisations within NWL to develop, implement and spread good practice across the sector with the aim to lead and influence the broader health and social care agenda.

Biomedical Research Units

The NIHR Biomedical Research Units (BRUs) undertake translational clinical research in priority areas of high disease burden and clinical need.

The BRUs are based in leading NHS organisations and Universities enabling some of our best health researchers and clinicians to work together to develop new treatments for the benefit of patients.

In NWL, there is a BRU based at the Royal Brompton & Harefield NHS Foundation Trust.

Biomedical Research Centres (BRCs)

NIHR Biomedical Research Centres (BRCs) drive progress on innovation and translational research in biomedicine into NHS practice. The Centres are leaders in scientific translation. They receive substantial levels of funding to translate fundamental biomedical research into clinical research that benefits patients and they are early adopters of new insights in technologies, techniques and treatments for improving health.

In NWL, there is a BRC at both Imperial College Healthcare NHS Trust and Royal Marsden NHS Foundation Trust.

Academic Health Science Centres (AHSCs)

An academic health science(s) centre (AHSC) is a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

In NWL, there is an Imperial College Healthcare AHSC.

North West London Research Hub

A North West London Research Hub has been created, which includes acting as host site for the London (North West) Comprehensive Local Research Network (CLRN) and National Research Ethics Service (NRES), and supportive site for the NWL CLAHRC, Primary Care Research, Patient Representatives, Trust R&D Pharmacy Unit and support for Intellectual Property.

# 4. Our key transformation programmes

*The North West London portfolio of transformation programmes is the basis by which will we collectively deliver our vision and ambitions*

### Introduction

While each CCG is leading its own set of initiatives to address local priorities, including respective Health & Wellbeing Strategies, Quality and Patient Experience strategies, and Quality, Innovation, Productivity and Prevention (QIPP) plans, a number of shared transformation programmes have been jointly developed to address the key themes identified in the Case for Change, the 'Call to Action' and through NWL's patient engagement and public consultation.

The core principles and values of NWL's strategy are that services and care be:

- Localised;
- Centralised/specialised;
- Integrated; and
- Personalised

These principles are embedded in and reflected across NWL's programmes. The initiatives are designed to improve health outcomes in NWL, in line with the seven NHS Outcome Ambitions, and to achieve a financially sustainable health system.

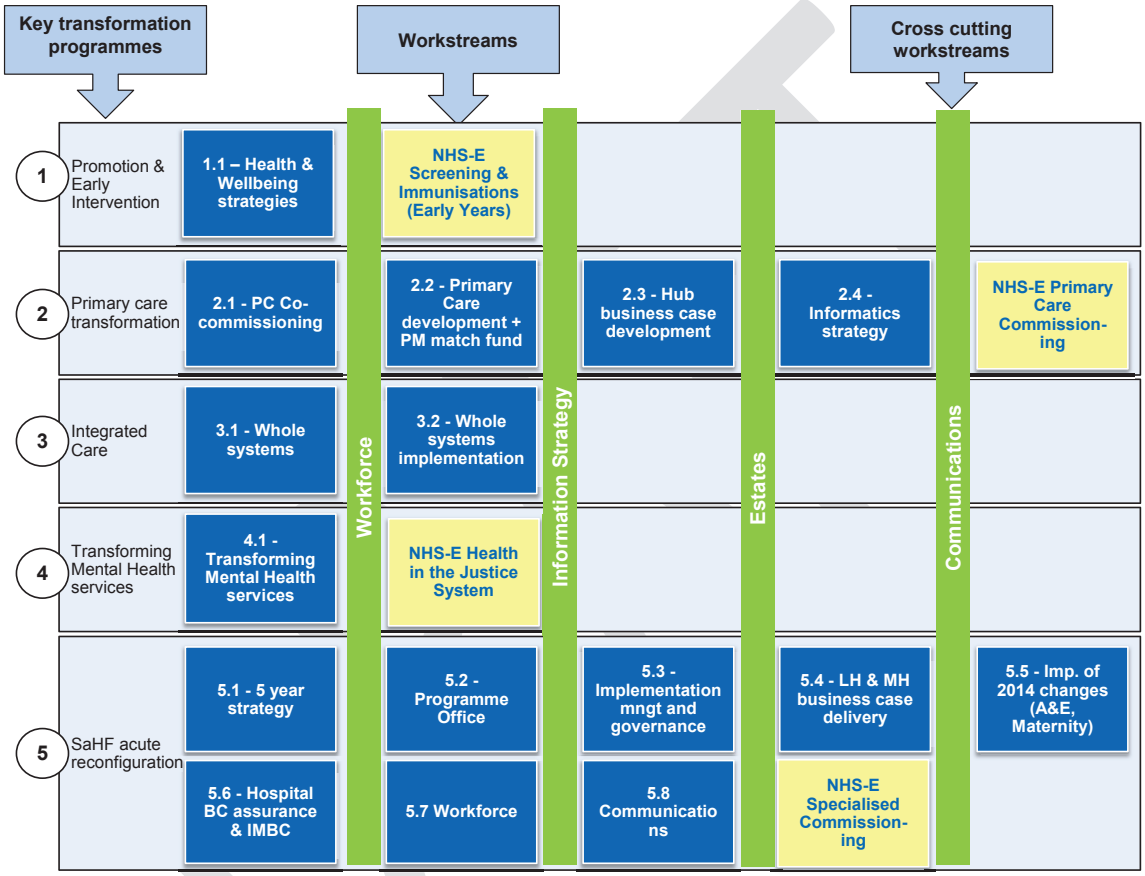
The delivery of the NWL vision is managed through a portfolio of programmes that are grouped into five themes, as depicted in the figure below:

1. Health Promotion, Early Diagnosis and Early Intervention
2. Out of Hospital strategies, including Primary care transformation
3. Whole Systems
4. Transforming Mental Health services
5. *Shaping a healthier future* Acute reconfiguration

This portfolio of programmes reflects the focus on personalised care for patients and families, and on the level and quality of services provided in the community. The areas of direct NHS England commissioning are also reflected with their related transformation programmes.

In addition to the NWL transformation programmes described below, London's Strategic Clinical Networks (SCNs) focus on priority services areas to bring about improvement in the quality and equity of care and outcomes of their population both now and in the future. The networks aim to reduce unwarranted variation in health and wellbeing services, to encourage innovation in how services are provided, and to provide clinical advice and leadership to support CCGs in their decision making and strategic planning. The networks will support developing all characteristics and improvements against all outcome ambitions.

Key NWL transformation programmes




*Note: blue boxes represent NWL's workstreams, while the yellow boxes represent areas of direct NHS England commissioning.*

Further detail about each transformation programme is provided in the following section, followed by further information about overall programme investment costs, the implementation timelines, programme risks and key enablers. Each of the SCN's plans has been included in the relevant transformation programme section, as have the associated NHS England direct commissioning plans.

**Our transformation programmes address our local case for change and align with the national outcome ambitions and transformational service models.**

In developing our plans we have considered in depth both the needs and views of our local population, as well as the national direction set out by NHS England and other leading bodies.

The NWL transformation programmes are supported by and reflected in the joint Medium Term Financial Strategy (MTFS) for NWL. This financial strategy, including the

pooling of some financial resources, will ensure that the strategy is successfully implemented across all eight Boroughs of NWL. It will also ensure that delivery of the NWL strategy has the financial impact required across the health economy.

The MTFS, along with the key improvement interventions, are approved and monitored by the CCG Collaboration Board (see Governance section in chapter 13).

# 5. Health Promotion, Early Diagnosis, and Early Intervention

*Health promotion, early diagnosis and early intervention are fundamental to achieving outcome ambitions, particularly with regards to securing additional years of life for the population of NWL.*

*Effective delivery will require close partnership working between Local Authorities, CCGs and NHS England.*

### Introduction

Health promotion, early diagnosis and early intervention are fundamental to achieving our outcome ambitions, and are the foundation of our transformation in NWL.

There are many partners involved in providing effective prevention and screening programmes across NWL, including Public Health teams within Local Authorities, NHS England Direct Commissioners for screening and early years (immunisations), Public Health England, and CCGs.

At the Local Authority and CCG level, each NWL Borough has worked with its local partners to develop a Health and Wellbeing strategy, building on each Borough's Joint Strategic Needs Assessment (JSNA).

The JSNA and joint Health and Wellbeing Strategies are the foundations upon which each Borough's Health and Wellbeing Boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education.

They enable the NWL commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes.

While each Borough's Health & Wellbeing strategy reflects the specific priorities of the Borough there are some key themes which are reflected across a number of strategies, including:

- Early Years –giving children the best start in life
- Childhood obesity
- Mental health and well-being (see chapter x for further detail)

See Appendix D for a summary of the key themes and priorities within each CCG's Health and Wellbeing Strategy, along with links to the full strategy documents.

In addition to the work of the Health & Wellbeing Boards, NWL CCGs work

collaboratively with its other partners in health promotion, prevention, early diagnosis and early intervention.

It is important that all partners take a proactive approach to managing future demand for healthcare services by working together to implement a multi-faceted and multi-partner approach to prevention and early intervention.

CCGs have a role to play in encouraging health promoting services as well as an improved focus on preventative approaches such as smoking cessation, healthy eating and exercises for frail elderly people to prevent falls. Health promotion requires a multi-faceted approach to improving people's health – key to this will be an improved focus on primary and secondary prevention and working towards wide-scale behaviour change that is sustainable in the longer term. For example, a number of the NWL Boroughs are working to develop a "making every contact counts" approach, and would be keen to explore how this approach can also be embedded across NHS services and culture.

Please see Chapter 10 for further details about North West London's plans to improve services across the continuum of cancer services, including prevention and early diagnosis.

### Screening: an integrated approach to screening and symptomatic services

While NHS England commission the majority of screening programmes, up to referral for treatment, CCGs commission all treatment arising from screening, as well as Antenatal and Newborn screening programmes (as part of the maternity tariff).

NHS England and NWL CCGs will therefore work collaboratively to meet the vision to commission screening programmes that provide a high quality, patient focussed service, meeting or exceeding national standards and targets, for all communities in NWL.

An integrated approach to screening and symptomatic services in NWL will result in:

- Increased screening coverage and uptake, including of cervical cytology.
- Ensuring all CCGs commission along the best practice commissioning pathways for the earlier detection of ovarian, lung and colorectal cancer to ensure patients a cancer diagnosis as quickly as possible.
- Supporting all GPs to be able to understand cancer referral patterns through the use of practice profile data as provided by the National Cancer Intelligence Network.
- Consolidation of screening services to achieve higher quality assurance, improve patient access and experience, increase accountability, and increase cost-effectiveness – this may include Diabetic Eye programmes, and a core administrative service for breast screening.
- High quality programmes that deliver the national standards, including reduced variation in performance.
- Service integration within the pathway and at hand off points (including treatment services, commissioned by CCGs).
- An improved antenatal/maternity pathway across NWL.

While there will be a national review of pathology laboratories, but there are not expected to be many implications in NWL as these are laboratories are in line with national requirements.

[*Placeholder for further detail from NHS England's direct commissioners of screening services*]

### Early Years - Immunisations

NHS England commissions immunisations services for NWL to reduce vaccine preventable diseases, ensuring individuals' risk is reduced and effective levels of herd immunity are reached. These services

contribute to securing additional years of life, by reducing the incidence of vaccine preventable diseases; improving the health related quality of life for those with long term conditions and the reduction of avoidable admissions to hospital such as that demonstrated by the flu vaccination programme.

NHS England (working with NWL) will ensure that every child has a complete clinical record across the health system, including immunisation regimes, so infants are ready for school and teenagers are ready for employment. NHS England will create Public Health Action Plans for each programme across the CCG, Local Authority, Public Health England and NHS England partnership to ensure London achieves, or exceeds the national target for uptake and coverage, especially in the non-registered and most vulnerable cohorts. NHS England will work to eliminate vaccine-prevented diseases from London by 2020.

Priorities for Early Years:

- Child Health Information System **(CHIS) will be linked** for all children's records across London by 2015 and nationally by 2018
- Health Visiting and Family Nurse Partnership commissioning be will via Local Government by 1st October 2015 and the **integration of these services into early years delivery by 2018**.

Priorities for Immunisation:

- An **integrated model** of vaccinations and immunisation, reflecting the technology changes within vaccinations delivery.
- **CHIS-to-GP-to-Other Provider** secure data transfer for COVER (0-5) and all immunisation regimes
- Implement an integrated delivery model of immunisations, involving all providers and the timely and secure sharing of clinical data from August 2014.
- Initiate the funding of new regimes, including annual Seasonal Flu for 7-8 year olds

NHS England is also taking forward work on immunisation to:

- Improve information and data flows.
- Improve uptake in specific communities where we know uptake is poor.
- Widen access by commissioning a range of alternative providers to complement existing GP practice and Community Health Service delivered immunisations: NHS England will work with CCGs to ensure an extended range of providers are delivering the national regimes, whilst send clinical data back to the registered GP for them to update the prime-clinical file. Focus of work with Community Pharmacists seen as a way to effectively increase uptake, especially as new methods of delivering move from injections, seen as more effective models. This will require strong partnership working in order to be effective.

[*Placeholder for further detail from NHS England's direct commissioners of immunisations*]

### Children's Services

Services provided to children and their families both in the early years and up to the age of sixteen are a key priority for all of the North West London CCGs and Boroughs, as reflected in the Health & Wellbeing Strategies. Considerable work is underway to strengthen services provided to this cohort at the local level, both to address the needs of children in general as well as specific cohorts of children who tend to have higher levels of need and benefit from an integrated approach. Key populations from a Children's Services perspective include children with disabilities as well as looked after children and care leavers. Meeting the needs of looked after children and care leavers is additionally complicated by the need for them to often be placed away from their "home" borough.

North West London will work to consider how and where a more joined-up and coordinated approach to caring for these cohorts of the population may further improve their outcomes. For example, a sub-regional plan could be an opportunity to ensure that the physical and mental health needs of children placed away from their "home borough" are better coordinated and met.

Early intervention for children with low level mental health difficulties is a particular issue for Children's Services, where significant proportions of children requiring early help, a child protection plan or needing to be looked after have parents who have a range of mental health difficulties.

Specific key initiatives to improve services provided to children in North West London also include the Child GP Hub, which is a major project that will, amongst other outcomes, reduce demand for acute services.

### Cardiovascular Disease

Cardiovascular disease is a significant cause of premature disease, and a priority for a number of CCGs, from prevention and early intervention, including supported self-management. The priorities of the Priorities for the London Cardiovascular SCN over the next five years include:

- Maximise opportunities across the whole patient pathway to **identify and manage people at risk** of developing CVD by ensuring that NHS Health Check Programme is offered everywhere.
- **All patients, pre and post diagnosis are offered education and information** on opportunities to access interventions, rehabilitation and support that decreases risk of developing CVD and/or CVD progression.
- Ensuring patients and carers have **appropriate access to psychological support** (in line with the Improving Access to Psychological Therapies (IAPT) work that is underway across each NWL CCG - see chapter 8, Transforming Mental Health Services).
- **Empowering patients** to be involved in decision-making, care planning and self-management of their CVD to improve health outcomes.
- London's CCGs to collaboratively commission some **tuberculosis services on a 'once for London basis'** and significantly reduce the London tuberculosis rate.

Specific programmes within this SCN are: cardiac and vascular, stroke, renal, diabetes, and tuberculosis.

# 6. Out of Hospital strategies, incl. Primary Care Transformation

*North West London has embarked on the biggest transformation of care, from a system spending the majority of its funding on hospitals to one where we spend the majority on services in people's homes and in their communities, i.e. "out of hospital".*

### Introduction

Successful achievement of the North West London vision for whole systems, including the principles of services being localised where possible and centralised where necessary, will rely on reducing demand for acute services.

In order to make this work, we need to strengthen our out-of-hospital services. There are many different types of out-of-hospital services in place already providing different aspects of out-of-hospital care. Many are excellent, but there needs to be more consistency. NWL has embarked on a major transformation of care to move from a system spending the majority of its funding on hospitals to one where we spend the majority on services in people's homes and in their communities, i.e. 'out of hospital'.

Our 'Our of Hospital' strategies aim to meet these changing needs by developing:

- Better care, closer to home
- A greater range of well-resourced services in primary and community settings, designed around the needs of individuals and reducing unwarranted clinical variation, including in the management of long-term conditions

For this reason, NWL has developed out-of-hospital quality standards. Achieving these standards will mean that patients can be confident in the standard of the care received out-of-hospital – these standards cover six domains:

1. Individual empowerment and self-care
2. Access, convenience and responsiveness
3. Care planning and multidisciplinary care delivery
4. Information and communications
5. Population and prevention-oriented
6. Safe and high quality

## Standards for out of hospital care[18]

| Domain | Out of Hospital Standards |
|---|---|
| A Individual Empowerment & Self Care | ▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing |
| B Access convenience and responsiveness | ▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:<br>▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling<br>▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours |
| C Care planning and multi-disciplinary care delivery | ▪ All individuals who would benefit from a care plan will have one.<br>▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care<br>▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists |
| D Information and communications | ▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care<br>▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers<br>▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan |
| E Population- and prevention-oriented | ▪ The provider has a responsibility to pro-actively support the health and wellness of the local population. This includes prevention (e.g. immunisation, smoking cessation, healthy living), case-finding (e.g. diabetes, COPD, cancer) and pro-active identification and support for patients from hard to reach groups |
| F Safe and high quality | ▪ Patients experience high quality, evidence-based care and clinical decisions are informed by peer support and review. Clinical data are shared to inform quality assurance and improvement |



[18] Note that where standard 3 references GPs working within multi-disciplinary groups, these groups also includes acute clinicians.

Each NWL CCG has developed its own 'Out of Hospital' strategy to support the require shift of activity from acute to community and primary care settings, and to ensure that all services meet these standards for out of hospital care. Each of the NWL CCGs has its own individual plan to achieve this, which has been tailored to meet the population's needs. However, there are a common set of initiatives working to similar objectives.

Primary Care has a significant role to play in providing out of hospital services.

### Primary Care Transformation

The scale of change that is required in primary care to achieve our quality, patient experience and financial objectives is truly significant, and our CCGs and GPs are determined to translate this vision into reality. In 2012, NWL commissioned a comprehensive review of patient priorities for primary care. The four stage process involved:

1. Literature review (October 2012)
2. Workshops (10/11 November 2012)
3. Street survey (late November 2012)
4. Final list of patient and public priorities (December 2012)

Additional engagement was carried out with CCG patient groups, patients with learning disabilities, non English speakers, patients from a variety of BME groups.

The report has already provided evidence to underpin the need to design new models of primary care that will support the delivery of the SaHF out of hospital strategy. The top three patient priorities were:

1. *I can quickly get an emergency appointment when I need one.*
2. *I have enough time in my appointment to cover everything I want to discuss.*
3. *I can rely on getting a consistently good service at my GP surgery.*

Based on this survey and other inputs, including our baseline position on the related Outcome Ambition measures, a key element in our case for change is the need to increase the overall quality and consistency of primary care across our eight boroughs.

The future model for primary care will be increasingly patient-centred, with networks as a central organising point. GPs are the centre of organising and co-ordinating people's care, and a new model of General Practice is emerging in NWL to build on the existing strengths of Primary Care. This new model of General Practice will also help to deliver the vision of *Shaping a healthier future* and Whole Systems Integrated Care.

We have an expectation that primary care will change in three ways to improve care for patients:

1. ***Primary care will change to deliver out of hospital care:***

The CCGs' Out of Hospital strategies (and the associated Delivery Strategies) are clear about the growing role for general practice in delivering improved, integrated care.

Central to this will be GPs working together in networks to deliver some of the innovations included in CCGs' plans for Out of Hospital care, including differentiated access and additional support for patients with long-term conditions.

While the overall model of care varies by CCG, there are some common principles that will be met. Based on the feedback of patients in North West London, our vision for primary care transformation is to offer:

- **Urgent**:
  - Patients with urgent care needs provided with a timed appointment within 4 hours.
  - Patients with non-urgent needs offered choice of an appointment within 24 hours, or at their own practice within 48 hours.
  - Telephone advice and triage available 24/7 via NHS 111.

- **Continuity**:
  - All individuals who would benefit from a care plan will have one.
  - Everyone who has a care plan will have a named 'care co-ordinator'.
  - GPs will work in multi-disciplinary networks.
  - Longer GP appointments for those that need them.
- **Convenience**:
  - Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.
  - Access to GP consultation in a time and manner convenient to the patient.
  - Online appointment booking and e-prescriptions available at all practices.
  - Patients given online access to their own records.
  - Online access to self-management advice, support and service signposting.

Note that increased online access will not replace face-to-face and other channels of information and support.

***2. Primary care will change to meet expectations for access:***

Our work with patients indicates an expectation of better access to primary care and including better continuity of care for people released from custody settings.

- The principle is that care will be responsive to patients' needs and preferences, timely and accessible.
- This may be differentiated depending on patient types: urgent needs may be dealt with by GPs at a network level, whereas patients with long-term conditions may continue to only see their named GP.
- Alongside this, NWL is promoting 7-day working across the system, which includes GPs. Again, this may be addressed at a network level.

***3. Primary care will change to meet rising quality expectations:***

- NHS England expects improvements in the quality of the core primary care they commission.
- This will include support for practices to improve but also contract management of poor quality practices across NWL.
- Alongside this, CQC has a range of expectations of quality and safety, including the safety and suitability of premises. We will therefore need to address any estate that does not meet these standards and manage the consequences.

Whilst the details may change as they are developed, this combines to suggest that the direction of travel is towards:

- GPs will deliver a wider range of services and lead the integration of care for patients with long-term conditions.
- Networks will support their member GPs to deliver services collectively and manage urgent demand.
- Other providers will deliver large-scale services across the CCG.

***In order to deliver these commitments, individual GP practices will build on the progress they have already made towards delivering services as networks.***

## General Practice Networks

North West London has made significant progress towards establishing GP practice networks, with every practice now part of a network for peer review purposes, and some networks already coming together to deliver services. However, getting networks to work properly is no small thing. Significant changes are needed in ways of working, workforce, organisational form, service design, capacity planning and IT/telephony infrastructure. Building this capability takes time but we will also deliver tangible service improvements for patients earlier.

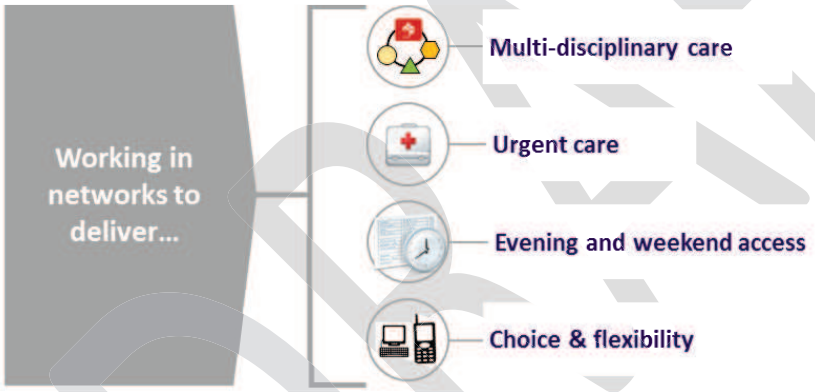
**We have done detailed work to understand General Practice Staff's ambitions for future working** *(From Good to Great* NWL workforce engagement, 2013*)*:

> *"Networks will create new career routes…allowing for progression; they will facilitate proper extended hours; [and] strategic planning for training & development", **GP***

> *"The range of services we provide will expand: more minor surgery, mental health services…LTC services",* **GP**

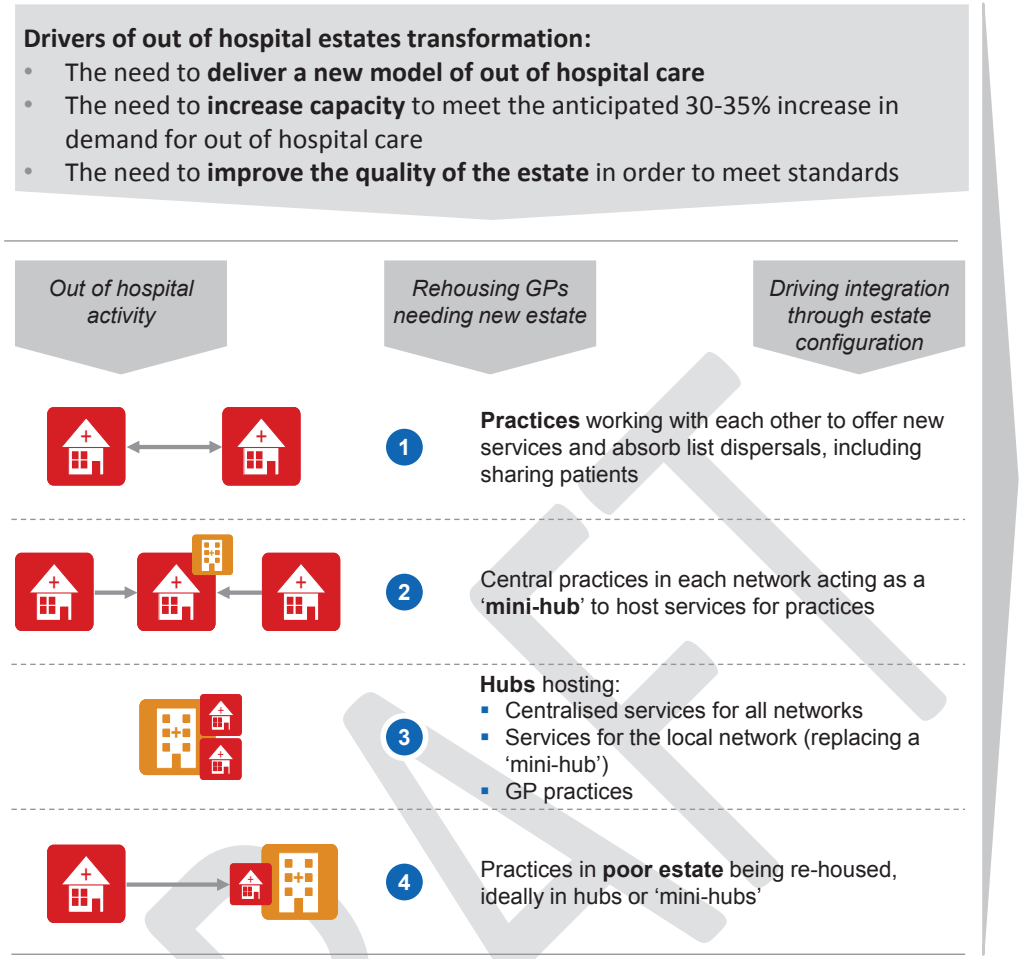
> *"When we pool resources together in networks, we can reduce inequities in provision…bringing all practices up to the standards of the best now",* **GP**

GPs will work in networks to deliver:




## Out of Hospital Care Settings

Delivering our vision requires us to invest in and use our estate differently. Hubs, one of the configurations that CCGS are exploring, are flexible buildings, defined as those that offer a range of out of hospital services and/or host more than one GP practice. Hubs will focus on delivering services that ensure patients' medical, social and functional stability. Investment in hubs and General Practice estate will help us deliver better care in North West London.



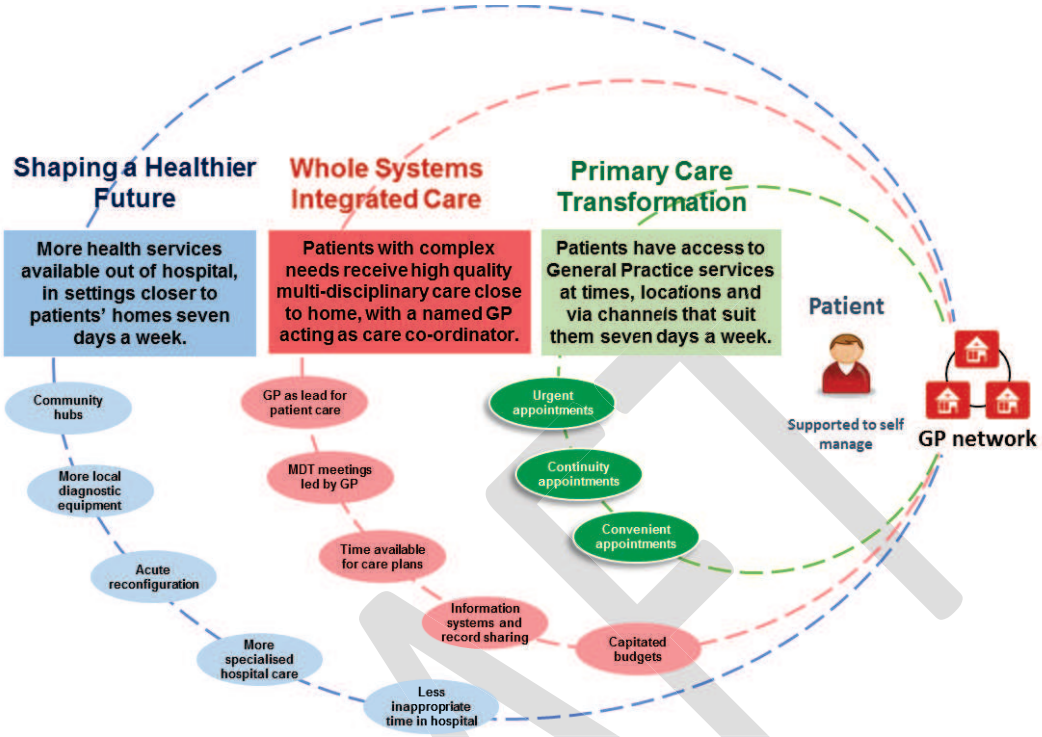

Through our estates transformation will ensure we can:

- **Deliver a greater volume of care in out of hospital settings** by utilising our current estate to maximum effect and by providing new hub spaces for care delivery.
- **Deliver improved access** by supporting networks to offer extended access and differentiated access models.
- **Deliver better planned care** by offering spaces for diagnostic equipment and community outpatient appointments.
- **Deliver whole systems integrated c**are by offering space for care co-ordination, multi-disciplinary working and sharing of key services.
- **Support the meeting of relevant standards** for access and integration of care.

The Primary Care Transformation programme is fundamentally linked to the other key transformation programmes, as GPs will be at the centre of organising and coordinating people's care (through the Whole System Integrated Care programme), while a key enabler of the successful realisation of the benefits of the *Shaping a healthier future* (SaHF) acute reconfiguration will be the effective implementation of the NWL 'Out of Hospital' strategies and associated reduction in demand for acute services. Supporting people in the community will require an integrated approach from both health and social care staff.

These important relationships are depicted in the following diagram:

Relationship between Primary Care Transformation and other transformation programmes



### NHS England's Primary Care programme in London

NHS England commissions many primary care services. It is responsible for primary care contracts and has a duty to commission primary care services in ways that improve quality, reduce inequalities, promote patient involvement and promote more integrated care. CCGs have a role to play in driving up the quality of primary medical care but will not performance manage primary-care contracts.

NHS England's priorities for the primary care programme in London include:

- **Maximise every opportunity to improve GP outcomes**: through an established and effective QIPP programme.
- **Developmental standards for Primary Care**: London's vision is underpinned by development standards that describe the potential service that could be offered by general practice in the future following a period of redesign, development and investment.

**Primary Care Co-Commissioning**

As described earlier the Plan, the NHS in NWL is facing a range of clinical and financial pressures and challenges, and doing nothing is not an option.

Primary care will play an increasingly important role, with general practice at the centre of coordinating people's care. NWL London is committed to significant additional investment in out of hospital care to make this vision a reality, including £190 million investment to support a re-distribution of activity from the acute hospital to out-of-hospital sector as part of *Shaping a healthier future* (SaHF). A significant proportion of this investment will be in general practice.

As commissioners, NW London CCGs and NHS England are aligned in their thinking about how to support primary care transformation and their strategies demonstrate this alignment. Both agree that care should be more responsive to patients' needs, and that this will require certain key factors such as a central role for primary care, GPs working in networks, and multidisciplinary teams for some patients.

Despite this, both NWL CCGs and NHS England are constrained in their ability to drive transformation in primary care. CCGs are unable to shift funding from other parts of the health system to primary care, or invest in enablers such as estates and IT. NHS England does not have the local management resource to drive change or proactively manage performance.

By commissioning together, NWL CCGs and NHS England will be able to:

- **Develop and implement a pan-NWL commissioning strategy** that delivers a consistent level of service from general practice and other out of hospital services (e.g. out of hours services).
- **Collaborate effectively with the LA at the borough level** as one unified health commissioner, to co-commission whole systems integrated health and social care.

In a number of areas, co-commissioning could allow specific changes, enabling NW London's vision for primary care to be achieved. For example:

- **Operating model**: NWL CCGs and NHS England could invest in the development of networks, allowing GPs to realise the benefits of scale associated with network working.
- **Contracts and money**: NWL CCGs could influence the PMS review, aligning it with their vision and ensuring that savings are reinvested in NWL.
- **Performance:** CCGs could be given a well-defined and active role focusing on improving outcomes at the practice and network level.

- **Estates:** NWL CCGs and NHS England could pool available estates funding and develop a clear five year investment pipeline.

For practices that are interested in exploring new ways of working, NW London and NHS England are proposing to develop a new, optional "opt in" service specification for general practice, defining services and additional payment more clearly.

Co-commissioning is about helping general practice to secure greater levels of investment, providing greater flexibility to innovate, and supporting practices to improve quality of care. It is not about reduced CCG control or CCGs taking on the role of managing poorly performing practices.

The exploration of co-commissioning takes place in the context of several programmes already underway in NWL to support general practice, which aims to improve the consistency of primary care across NWL, support GPs to work effectively in GP networks, and to enable these networks to collaborate with other providers. For example:

- Designing **new whole systems models of care** that deliver an enhanced range of services to meet the needs of specific patient groups in their homes and general practice.
- Standardising the range of **enhanced services** that CCGs commission and ensuring their availability to all patients (Central, West, Hounslow, H and F, and Ealing CCGs only).
- **Organisational development** for practices to support collaborative working, through the Prime Minister's Challenge Fund.
- Developing a **primary care estates strategy** for each CCG to support the delivery of new whole systems models of care.
- Developing a joint strategy with Health Education NW London (HENWL) to improve **training and career opportunities** for the primary and community workforce.
- Investing in **GP IT** to establish a common IT platform across each CCG.

# 7. Whole Systems Integrated Care

*The North West London five year plan is underpinned by our Whole Systems vision, which places the person at the centre of their provision and organises services around them.*

### Introduction

NWL's five year plan is underpinned by our Whole Systems approach, which places the person at the centre of their care provision and organises services around them.

Across the eight boroughs of North West London, 31 partner organisations have agreed to work together in pursuit of a shared person-centred vision for integrated care. Achieving this vision will require a five year change programme to develop entirely new ways of working. The name given to this vision and change programme is 'Whole Systems Integrated Care'.

The Whole Systems Programme is built on strong foundations, drawing on progress and learning from various local initiatives across our boroughs. In particular, the NWL Integrated Care Pilots and the Tri-borough Community budget pilot have looked at bringing people and professionals together in support of a more coordinated, proactive approach.

Building on these foundations, NWL partners have agreed to work together to go further and faster, developing plans to design and deliver joined up, person centred care across the system and wider community. Having made this collective decision, it was therefore timely that the Government subsequently announced its intention for all local areas to develop Better Care Fund plans, bringing together health and social care resources to deliver personalised, integrated care is a fundamental component of the Whole Systems approach and as such, BCF plans for each of our boroughs provide an important stepping stone in the journey to long term transformation.

Equally, the vision, principles and co-design work undertaken to date across NWL as part of this programme have been fundamental to the development of the Better Care Fund plans in each Borough, and to the further development of our out-of-hospital strategies, including for primary care.

The shared vision of the Whole Systems Integrated Care (WSIC) programme is:

*"To improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

This vision is based on what people have told us is most important to them. Through holding workshops with patients, people who use services and carers, and conducting interviews and surveys across NWL, we know that what people want is choice and control, and for their care to be planned with people working together to help them to reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

Our vision is therefore supported by three key principles:

The vision and principles for Integrated Care in NWL:

**Our shared vision of whole systems integrated care…**

"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community

**… supported by 3 key principles**

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Our systems will enable and not hinder the provision of integrated care.

Fundamentally, Whole Systems Integrated Care is a plan for a radically different way to provide care for people. This is different both in the nature of the care people receive and how the system is organised to deliver it. A Whole Systems approach means health and social care provider organisations forming new integrated care teams around the person - one co-ordinated team to deliver care. This care will be directed by the people receiving it, where they define the outcomes they want and are empowered to achieve them. General practice will be at the centre of co-ordinating these teams which will make innovative preventative interventions, often social care based, to prevent unnecessary deterioration of people's health and admission to hospital, as well as reducing variation in the management of long-term conditions based on best practice. Local authorities, CCGs and NHS England will pool budgets such that providers have collective responsibility for outcomes and for the budgets to deliver them. This collective responsibility will incentivise the integrated working of staff for the benefit of people, so they receive a seamless and efficient service. This new way of working will require major changes in cultures, behaviours and

system structures to achieve change. The sections below describe some of the efforts to date to provide support to local areas to make these difficult but worthwhile changes.

While the focus of our NWL integration work is WSIC, this aligns with and supports the implementation of changes for particular conditions and pathways (e.g. Cancer), and these are detailed in this section as well.

### Pioneer

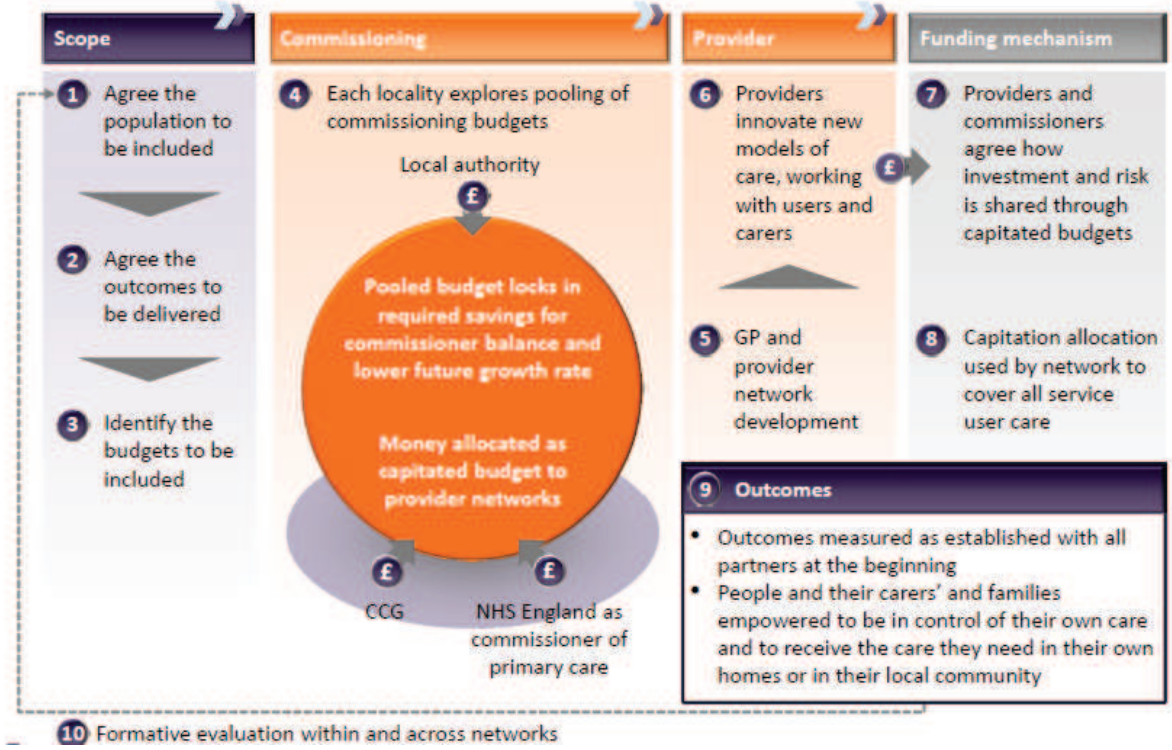
In June 2013, 31 partners across the eight boroughs of North West London submitted a joint pioneer application under a single vision. NWL was one of only 14 areas nationally to be awarded Pioneer site status. Pioneer areas will be provided bespoke and tailored support from government and national partners in order to move further and faster towards integrated care. In return, pioneers will share their learning with each other and other local places, including participation in a national evaluation.

### Approach - co-design with people and partners as our guiding principle

Through the NWL WSIC programme, local authorities, GPs, local hospitals, community care services, mental health services and the voluntary sector are working together to turn best practice, innovative care into 'business as usual' day-to-day care. These organisations have come together as partners to tackle organisational barriers, reduce duplication, and provide a more seamless care service for local people, many of whom have long term conditions, and are part of a population which is also getting increasingly older.

The high-level approach to achieve the vision and principles of Whole Systems is as follows:

Ten-step plan to achieve Whole Systems vision




In order to tackle the many difficult questions associated with a number of these steps, NWL has worked together to "co-design common solutions once". Together with lay partners we have

considered some of the difficult questions that this vision raises through the Whole Systems Integrated Care programme. Implementing Whole Systems Integrated Care in NWL will only be successful if it keeps the person who uses services at the centre of all decisions and design processes. To this end, from September 2013 to January 2014, over 200 people from across our health and care system came together in regular working groups to discuss the challenging design questions that we need to resolve in order to achieve our vision of integrated, person-centred care.

In our context, co-design means an inclusive and collaborative process with a breadth of stakeholders who can represent the varied interests of patients, people who use services, carers, their families, and their communities. This process has not only facilitated reaching a solution that everyone supports, but has also inspired more creative and effective ideas for the future of the system.

Whole Systems Co-Design Working Groups

**Embedding Partnerships**

**Population and outcomes**

- Instead of organisations or diseases, which groups of **people** should we organise care around?
- What are the opportunities to improve care for these people?
- What goals do people in these groups want to achieve?

**GP networks**

- What services could groups of practices provide better for people if they work together?
- How can these GP groups work with other care providers to deliver better services?

**Provider networks**

- What services could groups of providers provide better for people if they work together?
- How can incentives for providers make the right thing to do the easy thing to do?
- How do different providers of care decide to spend money in new ways without damaging existing care?

**Commissioning and finance**

- How can people get better care by not having different organisations paying for care with separate budgets?
- If there were one pot of money how do different commissioners make sure that people are getting the care they want?

**Informatics**

- What information is needed to provide better services to people?
- What information do commissioners need to make sure people are getting the care they need?
- What do we have and what is missing today?

**Embedding Partnerships'** is a cross-cutting workstream of the NWL WSIC programme. Its purpose is to support effective partnerships among professionals and with patients, people who use services, carers, and members of the local population, to ensure that changes are co-produced. There are over 100 lay partners involved in the Lay Partner Forum, reflecting the diverse demographic and spectrum of need level across the NWL population.

In order to support all programme partners with their development around working co-productively and what it means in practice, the WSIC lay partners worked collaboratively to produce a **co-production touchstone**. The lay partners also agreed a set of "I" statements to help keep the focus on all work on-going throughout the programme on how best to enable person-centred, accessible and proactive high-quality care. In effect, the lay partners act as the guardians of the programme's vision.

***Agreed NWL 'I' statements for people who use services and carers:***

- I can access my own health- and social-care data and correct any errors
- I can discuss and plan my care with a professional, focusing on my goals and concerns

- I know what I can do to keep myself as well and active as possible
- I know whom to contact and where to go when I need extra support
- I can make sure that the professionals who support me have access to my up-to-date health records and care plan
- I am regularly asked what I think about the care I am getting, I know that my feedback is listened to
- I know that when changes are being planned to services, my interests and those of people like me will be taken into account because we have been part of the planning process from the start

These are consistent with the "I" statements developed by National Voices, the national coalition of health and social care charities in England that works to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. These "I" statements provide a narrative for person-centred coordinated ('integrated') care[19].

*Our commitment to working co-productively in North West London means:*

1. Co-production for the Whole Systems programme starts with co-design, through which we can then embed co-delivery. This is the core of our programme and is embedded throughout the whole process.
2. We are dealing with new relationships for which we need a new language of inclusion: we will avoid "consultation" and aim at all times to have "conversations" for a genuine partnership.
3. We are people driven: we will actively reach out to those whose voice is rarely heard.
4. We are all responsible for driving progress and educating each other along the way.
5. We recognise the political and social context in which the programme sits.

**North West London Care Journeys**

Over the course of a month at the end of 2013, a small number of service users and carers with a range of different health and care needs worked with Ipsos Mori to document and reflect on their experiences of integrated care.

This insight is an integral component of the Whole Systems Integrated Care Toolkit, enabling NWL partners to better understand:

- Areas of good practice
- What people value most from integrated care
- Particular areas of need for certain groups
- How all aspects of a person's life can affect and be affected by their care and support needs

The method used to undertake this research included:

Research methods

[19] http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

**An initial in-depth filmed ethnographic interview which lasted a whole day**

**Capturing everyday experiences using photography**

**Diary writing over the course of a month**

**Bringing it all together**

*"The material in this ebook, put forward by individuals themselves, is the most powerful form of evidence about what it feels to live with a long-term condition or to be a carer. It shows the importance of coordination and continuity of care, as well as time, understanding and compassion from every health and social care professional.*

*Most importantly, it shows how whole systems means considering every aspect of a person's life, and all the clinical, statutory, voluntary and community support they receive. "*

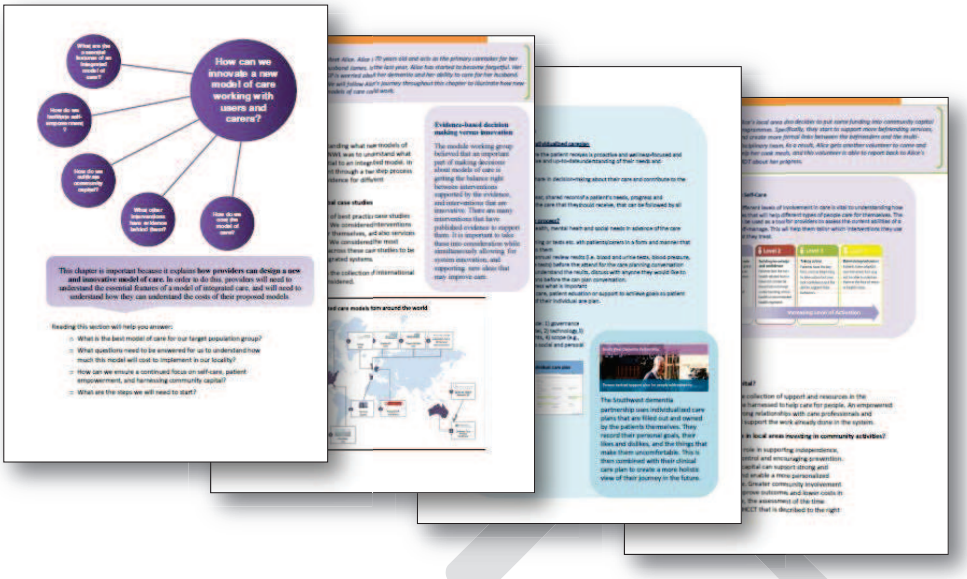
*Lay Partners Advisory Group*

The learning from the co-design process, which has engaged over 200 individuals across NWL, as well as the results from the ethnographic (care journeys) research has resulted in a North West London Whole Systems Integrated Care Toolkit, a practical how-to guide to support health and care partners as we move to local implementation.

### Whole Systems Integrated Care Toolkit

NWL has embedded its collective knowledge together into a living toolkit available to everyone across NWL. This toolkit distils the work of these groups into a web resource that is intended to be of use to commissioners, providers, voluntary organisations and communities, to help them design new and innovative models of care within North West London and elsewhere.

The toolkit is a living web-based resource and will be updated frequently as local areas implement their plans for integrated care and lessons are learned and shared.




Further information regarding the findings from the population segmentation co-design process is provided in the following section.

**Population segmentation - what population groups do we want to include?**

The toolkit explains why commissioners should organise care around people and their needs and lays out the Whole Systems proposals regarding thinking about people with similar needs. This grouping has been co-designed by professionals across health- and social-care, as well as lay partners.

In carrying out the grouping, the working group used three complementary methods. First, they gathered the judgement of multiple professionals and lay partners from across North West London. Then, they did an in-depth analysis of a fully integrated example data set gathered from Hammersmith and Fulham to test the hypotheses. Bringing together data from across acute, primary, community and social-care helped us to understand levels of service utilisation and cost for each group, which helps build a picture of population needs. Finally, they also looked at how populations had been grouped in other health systems both nationally and internationally. Using these three approaches, they reached consensus in the working group around how to group the population of North West London.

There are ten proposed groups that cut across health and social-care, and represent the holistic needs of the individuals that fall into those groups (see figure below). As such, a model of care surrounding the serious and enduring mental illness group would address all care needs of the people in that group, whether they are mental, physical or social, and would address these needs across organisations. The idea is to address the needs of individuals, rather than the specific conditions or the specific type of care.

Description of population segments

| | *Description of group* |
|---|---|
| 1 Mostly healthy adults <75 | ▪ People aged between 16-75 that are mostly healthy and do not have LTCs, cancer, serious and enduring mental illness, physical or learning disabilities and advanced stage organic disorders<br>▪ Includes those that have a defined episode of care, e.g. acute illness with full recovery, maternity |
| 2 Mostly healthy elderly (>75) people | ▪ Same as group 1 but for those that are above the age of 75 |
| 3 Adults (<75) with one or more long term conditions | ▪ People aged between 16-75 that have one or more long-term conditions, e.g. HIV, COPD, diabetes, heart disease<br>▪ Includes common mental illnesses, e.g. depression, anxiety |
| 4 Elderly (>75) with one or more LTCs | ▪ Same as group 3 but for those that are above the age of 75 |
| 5 Adults and elderly people with cancer | ▪ People aged above 16 that have any form and stage of cancer |
| 6 Adults and elderly people with SEMI | ▪ People aged above 16 that have a mental health problem (typically people with schizophrenia or severe affective disorder) that experience a substantial disability as a result of their mental health problems, such as an inability to care for themselves independently, sustain relationships or work |
| 7 All with advanced stage organic brain disorders | ▪ People aged above 16 who have a decreased mental function resulting from a medical disease rather than a psychiatric illness. Includes dementia as well as other conditions such as Huntington's and Parkinson's disease |
| 8 Adults and elderly people with learning disabilities | ▪ People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills<br>▪ Excludes mild conditions that does have an impact on social relationships or work |
| 9 Adults and elderly people with severe and enduring mental illness | ▪ People aged above 16 who have a FACS eligible physical disability<br>▪ Excludes physical disabilities, including sensory disabilities, that are not FACS eligible<br>▪ FACS eligibility includes an inability to perform 3 or more household tasks |
| 10 Socially excluded | ▪ People aged above 16 who have chaotic lifestyles who often have limited access to care<br>▪ Includes the homeless, alcohol and drug dependency |

The next step in establishing the grouping is to understand how individuals will be assigned to groups. Commissioners and providers will need to agree on this step because it is important for the capitated payment system to understand the process for moving in and out of groups. In order to deal with this issue, a preliminary categorisation was created for providers and commissioners to use to assign people to groups.

The groupings presented previously represent the primary organising logic. Within each of these groupings sit a set of cross-cutting themes or lenses to help us prioritise needs within the groups. These include age-related frailty, levels of economic well-being, behaviour, social connectedness, utilisation risk, presence of a carer, and a person's own caring responsibilities. In addition to people's clinical and social care needs, these lenses can have a significant impact on a person's capacity and willingness to manage their condition as well as their reliance on statutory services. These lenses should therefore also be taken into account to help target individual services to best meet those needs.

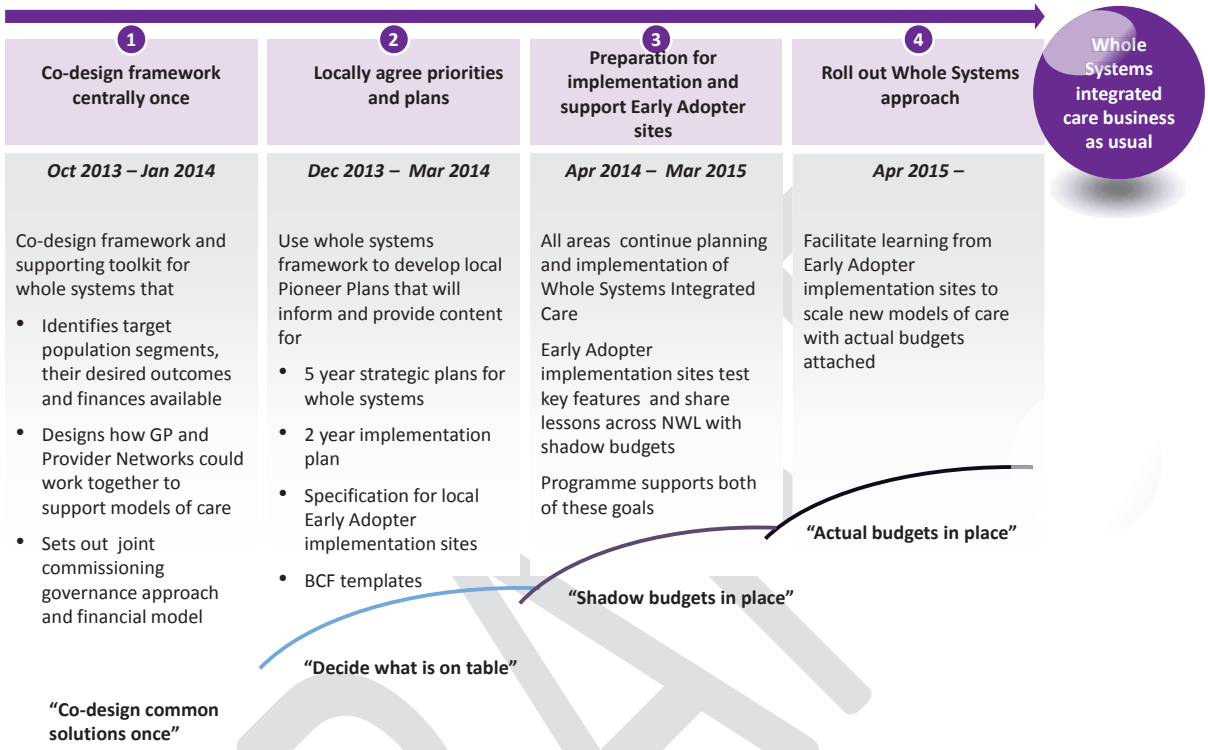
There are three factors which will need consideration when choosing a group: (1) potential financial opportunity; (2) potential impact on individual outcomes; and (3) implementation readiness.

The Whole Systems Integrated Care Toolkit provides further detail on population segmentation, as well as all of the other findings from the co-design process.

Note that while the population group of children has not been included within the Whole Systems Integrated Care programme in its first stage, many of the principles of integration also apply to these chorts of patients – please see the Children's section within the

The first stage of the WSIC programme is complete, as per the implementation timeline below:

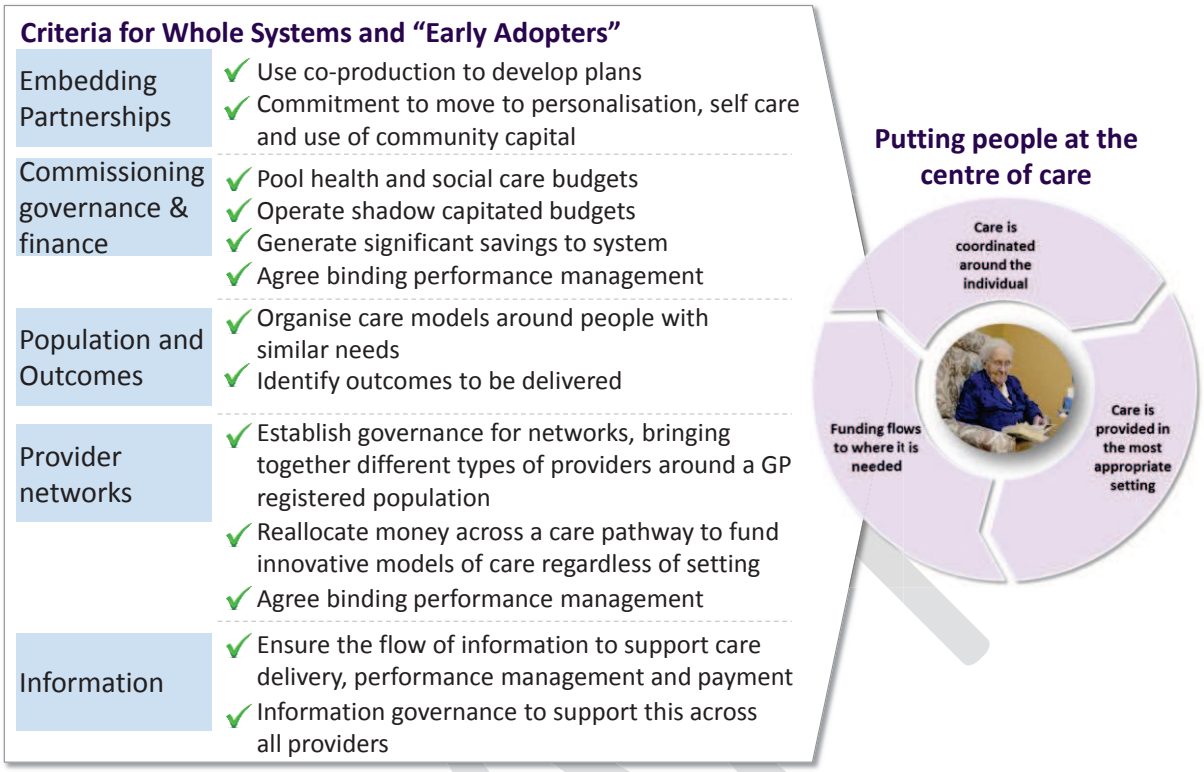
Whole Systems implementation timeline




The next step is to work with a number of Early Adopter sites, who will move further and faster and share learning across NWL**.** Across NWL, groups of commissioners and providers have expressed interest in becoming 'Early Adopters' of Whole Systems Integrated Care through defining a segment of their population for whom they wish to commission and provide health and social care in a new and integrated way.

Early Adopters must plan to implement the following criteria for Whole Systems:

Criteria for Whole Systems and "Early Adopters"




Selected Whole Systems Early Adopter site's plans will be developed, building on the toolkit, and will address in more detail the criteria set in the co-design phase which include:

- Co-production with lay partners to develop Early Adopter Plans
- Commitment to personalisation, self-care and use of community capital
- The pooling and capitation of health and social care budgets
- The organisation of care models around people with similar needs and the identification of outcomes for those groups
- The development of provider organisations around groups of registered GP populations and governance, resource allocation and performance management processes to support this
- Ensuring the flow of information to support care delivery, performance management and payment and the appropriate governance arrangements to support this

The Whole Systems Early Adopter Plans will be developed until October 2014, with an interim checkpoint in June to assure levels of ambition against the above criteria.

Whole Systems will be rolling out to become part of business as usual across NWL from April 2015, as per the high-level implementation timeline.

All eight boroughs across NWL are strongly committed to driving real change for the benefit of people using services. Each of the eight localities will retain their own approach to delivering services specific to the needs of their local population, taking strategic direction from their Health and Wellbeing Board. However, working together across eight boroughs will enable us to pool our collective time and expertise to tackle the common barriers to integrated care. It will also ensure

that where there are opportunities for closer, joint working this will happen, across borough and other boundaries, where this is in the best interests of the local population.

Localities can adopt and adapt the co-production touchstone, which was designed to serve as a set of behaviours against which actual group behaviour will be monitored, and will be a key tool underpinning the ways of working agreed by WSIC Early Adopters.

### Patient self-management and self-care

One of the three key strands of Whole Systems is self-care, i.e. that people will be empowered to direct their care and support and to receive the care they need in their homes or local community.

We have significant local evidence through our patient journey feedback that patients want to be in control of their condition and treatments and this project will support them to do so. As part of the Early Adopter and wider roll-out of Whole Systems, each NWL CCG will ensure that patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services they commission. This will be achieved through:

- Existing Expert Patient Programmes and patient user groups.
- The roll-out of Personal Health Budgets from April 2014 (building on learning from existing users to ensure they are deployed as effectively as possible).
- Online access to self-management advice, support and service signposting (also part of Primary Care Transformation – see chapter 6).
- The roll-out of care plans, developed with patients as part of Whole Systems Integrated Care.
- Self-management initiatives to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in and out of a hospital setting, including peer mentoring and local champions.

It is important that WSIC aligns with the proposals set out in the jointly agreed BCF plans with regards to self-management, patient experience and personal health budgets.

### Transforming end of life services in London

NWL will develop and implement effective end of life care integrated care models of commissioning and delivery which translate into a better end of life care experience for individuals, carers and their families.

As part of NWL's roll-out of NHS 111 services, NWL supported an electronic end of life care planning platform Coordinate My Care (CMC). CMC as a single electronic end of life care planning platform accessible to 111, GP Out of Hours (OOH) and London Ambulance Services (LAS) can enable a joined up approach to care at the end of life, particularly in crisis and out-of-hour periods.

Priorities for transforming end of life services in NWL include:

- To **maximise uptake of CMC** across all NWL CCGs, and to ensure it is used as part of an integrated care pathway.
- To **commission coordinated care**, centred on patients and planned between services who work together to understand patients and their carers.
- To **improve interfaces/joint working** between services including primary care, secondary care, social care, LAS and NHS 111.
- To support the **End of Life Care Alliance** sharing good practice and dialogue across London. The End of Life Care Pan-London Alliance was launched in 2013 to promote patient-centred, coordinated care commissioning and delivery across

London. The End of Life Care Pan-London Alliance is an inclusive membership group and is supported by an Executive Steering Group who will provide oversight and prioritise activities. The founding members are ADASS (London) Directors of Adult Social Services, Marie Curie and NHS England (London).

- To identify **issues and barriers to local success** such as workforce and training which require national and regional input, and agree approaches and activities to address.

### Transforming Community Services

The Community Health Services programme in London aims to support London's leadership in re-commissioning or redesigning community health services, maximising their contribution to delivery of integrated health and social care services where care is based on continuous healing relationships, personalised, proactive and patient driven, and where services provide high quality and safe care in the home, across all seven days of the week.

Priorities for the community health services programme in London include working with key commissioning and provider stakeholders to define **community health service principles and system design objectives** that contribute to personalised, proactive and patient driven care, and include:

1. Service responsiveness and access for both 'steady state' and 'crisis response'.
2. The extent to which people with complex needs can be appropriately cared for through the provision of intensive support in community.
3. Interfaces/joint working with other services including primary care, secondary care, social care, London Ambulance Service (LAS) and NHS 111.
4. Organisational and workforce development.
5. New contracting models, performance and quality monitoring.

The work of the Community Health Services programme in London will be taken forward in NWL as part of the Whole Systems Integrated Care programme and through the Better Care Funds. It is important that the Transforming Community Services guidance is applied to the integrated operational services being developed within the BCF.

In the Tri-borough CCGs (Central London, West London, and Hammersmith & Fulham), joint homecare provision with social care is believed to be one of the key enabler to wider health and social care integration and to supporting the vision for Whole Systems Integrated Care. The anticipated benefits of joint homecare provision include greater alignment of health and social care provision at home, closer working between professionals and greater continuity of care for residents.

A joint homecare procurement exercise is now underway, led by the Tri-borough CCGs and Tri-borough Local Authority, to establish joint/hybrid homecare provision.

Homecare providers will be required to perform both standard Adult Social Care tasks and low-level health tasks (bands 1-4) that may previously have been conducted by Community Nurses. This approach is intended to align homecare provision to the Multidisciplinary Function (MDT) function and to release case management time for Registered Nurses. The health tasks identified will not require nursing qualifications, and homecare providers will be supported by clinical staff in their local MDT, aligned to the intentions of Whole Systems Integrated Care led by GP's.

### London Neuroscience SCN

Priorities for the London Neuroscience SCN over the next five years include:

- Increasing the **priority of service developments and pathways** for patients with neurological conditions.
- Including patients with **long term neurological conditions** who are at high risk of unplanned care in local integrated care developments.
- Developing **local pathways** with local providers.
- Commissioning appropriate capacity for **community rehabilitation.**

NWL CCGs have asked the NWL Academic Health Science Network (ASHN) to undertake a comprehensive review of neurorehabilitation services across the system, in line with the priorities of the London Neuroscience Strategic Clinical Network (see chapter 7 (Neuroscience) for further details).

### North West London's Better Care Fund plans

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

The vision, principles and co-design work undertaken to date across NWL as part of this programme have been fundamental to the development of the Better Care Fund plans in each Borough.

In addition, as external factors such as poverty and a lack of affordable housing may prevent delivery of our Plan, it is important the local Better Care Fund plans are aligned with both the wider transformation programmes, including *Shaping a healthier future* and Out of Hospital strategies, as well as with wider local authority priorities including the regeneration of key areas to improve housing, health and wellbeing.

The BCF plans set out how each borough/CCG will progress the vision and principles for Whole Systems developed through the WSIC programme, including:

***People will be empowered to direct their care and support, and to receive the care they need in their homes or local community***

- Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.
- Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, and self-management to maximise their independence and wellbeing.
- The clinically-led *Shaping a healthier future* programme, describes what success in this area will require of, and mean for, our hospitals, with services adapting to ensure the highest quality of care is delivered in the most appropriate setting.
- The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and community provision, will mean we will eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.
- We recognise that there is no such thing as integrated care without mental health.

Our plans therefore are designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

- By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

***GPs will be at the centre of organising and coordinating people's care.***

- Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.
- We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

***Our systems will enable and not hinder the provision of integrated care.***

- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.
- Our CCG and Social Care commissioners will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities.
- In partnership with NHS England we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.
- In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.
- This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so live healthy and well lives.

Fundamentally, through each the CCG/Local Authority Better Care Fund plans we aspire to

tackle fragmentation across providers and across settings in order to ensure the best outcomes and noticeable improvements to patient experience, with CCG developing its local plan to achieve this with its respective Local Authority and through its Health and Wellbeing Board. The majority of the NWL BCF initiatives are part of the Whole Systems Integrated Care will therefore support delivery of the NWL and National Voices' "I" statements[20], as well as the key ingredients for integrating care identified by NHS England (see Appendix E).



20 http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

# 8. Transforming mental health services

*Achieving **parity of esteem** for mental health is a national and NWL priority – the NWL vision is to provide excellent, integrated mental health services to improve mental and physical health.*

### Introduction

Approximately 160,000 people with mental health problems are in treatment across North West London, almost 90% of who are in Primary Care. *Shaping Healthy Lives* (2012) set out a vision and actions to deliver:

- Care closer to home (*Shifting Settings*) – returning out of area placements to NWL, more resilient community 'hospital at home' services to reduce reliance on beds and promote recovery, transfer of patients from secondary to enhanced GP or primary care management.
- Liaison Psychiatry Service piloted in 4 acute hospitals pending roll out to all 10, to provide expert mental health services into A&E and wards, supporting colleagues in acute hospitals to better manage the pathway and avoid preventable admissions due to mental health issues.
- Better physical/mental health service integration, to reduce the excess morbidity and mortality associated with serious mental illness, and support treatment concordance among those with a long-term physical health condition.

Building on this, the Mental Health Programme Board[21] has developed the following draft vision statement for the development of mental health services across North West London:

[21] The Mental Health Programme Board is a partnership collaboration board of the 8 CCGs, Local Authorities, Police, NHS Provider Trusts and Academic Health Science Network.

Vision statement for the development of mental health services across North West London:

Excellent, **integrated** mental health services to improve mental and physical health, secured through **collaboration** and determination to **do the best for the population** of North West London. Services that:

- Are **responsive**, focussed on the **person**, **easy to access and navigate**;
- Provide care as **close to home** as possible, with **GPs at the heart**; where and **when it is needed**.
- Improve the lives of users and carers, promoting **recovery** and delivering **excellent health and social care outcomes**, including employment, housing and education.

Our Mental Health transformation strategy sets the framework for the significant re-patterning of mental health services across North West London.

### Shifting Settings of Care

Building on the success of initial work to shift settings of care to the least restrictive possible, efforts to secure a transformational step change will be made over the coming years.

Priorities for the community health services programme in London include working with key commissioning and provider stakeholders to define **community health service principles and system design objectives** that contribute to personalised, proactive and patient driven care and include:

**Access to Urgent Mental Health Services**

NWL is working with partners to ensure that those in mental health crisis have appropriate mental health community services on a 24/7/365 basis, to help them stay at home wherever possible, wherever they present in the system. Phase 1 of the Urgent MH Care Pathway Review set access standards, a single pathway and point of access, shared care principles and shared paperwork and IT solutions to smooth access to urgent mental health assessment and care. Core hours for community mental health are being extended to 8:00 – 20:00, which better matches GP working hours, pending a fuller transformation towards 24/7/365 and a single system-wide pathway.

Ahead of the launch of the *Mental Health Crisis Care Concordat (HM Government, February 2014),* NWL had already moved into the second phase of pathway redesign. All stages of the pathway, from referral prevention, through advice/support, referral, treatment and transfer/recovery are being mapped and the flow understood. Under the aegis of an Expert Reference Group established for this purpose by the Mental Health Programme Board, with Police, Ambulance, Housing and Third Sector alongside health, social care, users and carers, working on the pathway, its standards and support to providers for implementation.

Within the justice system, NHS England will (in alignment with CCGs) improve mental health liaison and diversion in police custody and court settings with robust referral pathways integrated into mental health, acute and community services.

**Quality and availability of urgent care services**

Building on the initial pathway focus of access and referral, a programme to ensure the quality, impact and availability of urgent mental health care services, securing balance between in-patient and community to reflect national and local policy and support greater independent living in the community by intervening earlier with intensive community support and robust crisis plans. Excellent

services, delivering high impact outcomes, value for money with the organising principle of care in the least restrictive setting possible, promoting independent living and self-efficacy.

See chapter 10 – Urgent and Emergency Care plans.

**Residential Rehabilitation Services**

A review of out of area placements, local provision, and pathway management to secure care close to home wherever possible, and better value for money and stability through a shift to locally commissioned services.

**Improving Learning Disability Services**

A programme to ensure that mental health services are appropriately accessible and responsive to those with learning disabilities, and to develop common pathways and standards for the future commissioning and delivery of services across NWL.

**Primary Care Enhanced Services**

Work to ensure a standardised GP-based service, targeting those with the highest SMI incidence, with support from primary-care based services where this is needed to support continued recovery and prevent crisis escalation where possible. It is recognised that supported housing, pathways to employment and social inclusion services for people with mental health services are also key to the delivery of the recovery model.

**Improving Access to Psychological Therapies (IAPT)**

All CCGs and its providers are committed to delivery of national standards for access to, and recovery within, its IAPT services. NHS England will also increase access to IAPT in prisons, immigration referral centres and sexual assault referral centres.

**Liaison Psychiatry in Acute Hospitals**

Bridging the gap between physical and mental health care is essential, and in acute settings liaison psychiatry plays a vital role. Liaison psychiatry teams see A&E attenders, as well as people referred from inpatient wards and outpatient clinics. They respond to the needs of the acute hospital and must be flexible enough to manage a diverse range of mental health problems.

Following successful piloting of models across four sites (West Middlesex, Ealing, Northwick Park and Hillingdon), services were evaluated and benchmarked for quality, efficiency and impact. A common service specification, with a comprehensive 'scorecard' of key indicators will be rolled out to all 10 sites in 2014-15.

### Whole Systems Transformation

Initial co-production work underway focuses on two key groups: (1) severe and enduring mental illness (SEMI) and (2) those with a long-term condition and a mental health co-morbidity.

For the former group, an Expert Reference Group, reporting to Mental Health Programme Board, has been established, and is working on defining the target population, the benefits being sought from such a radical service delivery change and proposed models of care. Consideration is being given to new service models to assertively engage with groups, for example, those with more chaotic lifestyles, those with LTCs whose mental health may mitigate against treatment concordance, and people with dementia whose needs can only effectively and efficiently be met by a range of providers working in an integrated manner and providing a range of 'social integration' initiatives (housing, training, employment, social networks) effectively 'wrapped round' the service user and their carers. The organising principle is around the GP and primary care. This will also provide an opportunity to address 'parity of esteem' between mental and physical health, for those with severe mental health problems as well as common conditions such as depression.

For those in Group 2, the emphasis is on ensuring the necessary expertise in mental health is integrated into care models and interventions for those target groups (as, for example, it is in Liaison Psychiatry Services in acute hospitals).

### London Dementia Strategic Clinical Network (SCN)

Priorities for the London Dementia SCN over the next five years include:

- Two-thirds of the estimated number of people with dementia in England to have a **diagnosis by March 2015**. Better identification of people with suspected dementia in primary care and acute settings and referring to robust memory services.
- Improve **access to post diagnostic support**, so that timely diagnosis includes improvement on the condition and referral to local services which are already available.
- **Use of technology**, systems such as *This is me* and embracing standards to be proposed by the network so that all services work together to ensure patients and carers are supported to manage the impact of their condition and avoid crisis.

NWL CCGs are developing Dementia strategies to address improve diagnosis rates and provide a fully integrated pathway of care for patients diagnosed with dementia.

### London Mental Health Strategic Clinical Network (SCN)

Priorities for the London Mental Health SCN over the next five years include:

- **Resilience in younger people**: the need to tackle mental ill health early has been noted and this is an area that the SCN is working in partnership with UCL Partners and Public Health England and the London Health Board.
- **Primary care: a** quarter of full time GP patients will need treatment for mental health problems in primary care, making it essential that mental health problems can be competently managed by the primary health care team, working collaboratively with other services, and with access to specialist expertise and a range of secondary care services as required. The SCN aims to develop principles, values and outcomes in mental health for primary care transformation across the commissioning landscape – including improved access to services and reduced waiting times for patients with mental health difficulties.
- **Psychosis/urgent care**: an improved response is needed when people are in urgent mental health need. This includes achieving consistency and clarity of urgent mental health care services and addressing the problems in prevention, response, treatment and support provision. The SCN is working to develop a standardised approach for urgent care in London - forming an improvement collaborative to share learning and transform services to enable easier access, improve quality and outcomes.
- **Integrating mental and physical health**: mental health is the commonest comorbidity and raises costs in all sectors. We are taking forward a piece of work to promote the integration of mental health support within physical health pathways. There will be an initial focus looking at access for mental health interventions for patients with diabetes, to act as a model for further conditions.

Other principles for mental health commissioning include:

- Ensuring there is a clear focus on **improving the physical outcomes of mental health patients** and reduce the inequalities and poor outcomes experienced by mental health patients, develop an approach that looks at the **whole care pathway or cycle of care** rather than fragmented aspects, fully

supports the **recovery model**, supports horizontal **integrated care** across primary care, social care and voluntary sector, as well as vertical care between primary and secondary care, and **involving people** with lived experience.

- Working with UCL Partners and GP leads, the SCN supports a **mental health CCG GP network** to share and develop good practice in mental health commissioning, and a second stage of the leadership programme is under development.

*[Placeholder for content from NHS England with regards to plans for commissioning Children and Adolescent Mental Health Services (CAMHS – a range of CAMHS services are required to address to address the wide continuum of need]*

### Health in the Justice System

Services commissioned by NHS England in NWL include the healthcare services in the justice system, including:

- Prisons (including Feltham Prison, Wormwood Scrubs Prison)
- Police Custody and Courts – Mental Health Liaison and Diversion
- West London Forensic Service: Westminster Magistrates Court Diversion team; Central & NW London NHS Foundation Trust (5 sites) and Uxbridge Magistrates Court Diversion Service
- Police Custody (transfer of commissioning): including Ealing (Acton), Hounslow (Chiswick, Hounslow), Hammersmith & Fulham (Hammersmith), Kensington and Chelsea (Notting Hill), Westminster (Belgravia, Charing Cross), Hillingdon (Uxbridge)
- Sexual Assault Referral Centres - Havens: St. Mary's Hospital, Imperial College Healthcare NHS Trust
- Immigration Removal Centres: Harmondsworth, Colnbrook
- Initial Accommodation for people seeking asylum

NHS England (London) is also responsible for children and young people in secure homes and training centres.

NHS England (London)'s joint vision, working with the Mayor's Office, is **"*working together to achieve excellence in Health in Justice outcomes for Londoners*"**.

Priorities for Health in the Justice System services include:

1. ***Equivalence and parity of esteem for Mental and Physical Health in NWL strategies by***:

- Co-commissioning integrated pathways including London s136 protocol and transport, secondary care, and improved access to IAPT.

2. ***Reduce re-offending by***:

- Assuring continuity of care from prisons: increase GP registration rates of prisoners (as currently only approximately 25% of prisoners are registered with a GP); develop onward referral pathways to mental health services where required.
- Earlier interventions and improved prevention: co-commission with NWL CCGs' Mental Health referral pathways to Liaison and Diversion schemes.

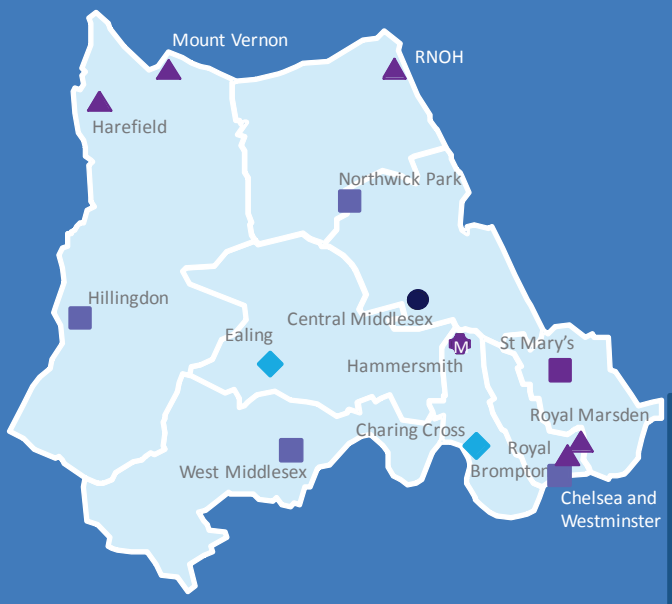
3. ***Strengthen leadership to improve efficiency, clinical-and cost-effectiveness from better co- commissioning*:**

- Develop a single multi-agency London performance dashboard for local use: to improve local outcomes for Borough Community Safety Partnerships and Health and Wellbeing Boards
- Co-commission improved integrated care for victims:
    - CAMHS, Paediatric and therapeutic support for raped/sexually assaulted children
    - Reduce Female Genital Mutilation (FGM): improved support and include FGM issues in safeguarding training, data collection and reporting, in line with NWL quality and safeguarding plans.

# 9. *Shaping a healthier future* (SaHF) acute reconfiguration

*Our new Local Hospitals will help ensure that where possible, care can be provided closer to home.*

*By consolidating our hospital services onto five Major Hospital sites we are ensuring that services are centralised where necessary to provide the best care.*




## Introduction

*Shaping a healthier future* (SaHF) is a clinically led, significant transformation programme to improve clinical outcomes and the quality of services by reshaping acute and out-of hospital health and care services across the region. It is driven by a number of NWL principles. A foundation principle that underpins the reconfiguration programme is the centralisation of most specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care), as this will lead to better clinical outcomes and safer services for patients.

The SaHF acute reconfiguration proposals have been subject to consultation and more recently, in mid-2013, review by the Independent Reconfiguration Panel (IRP). The IRP report, accepted by the Secretary of State, concluded that the "programme provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services."

The proposed changes will result in a new hospital landscape for NWL – the SaHF programme will oversee:

- The emergency services currently provided by nine existing hospitals in NWL will be concentrated on to **five Major Acute Hospital** sites.
- On the remaining sites there will be **further investment with Local hospitals**, co-developed with patients and stakeholders to deliver a new and innovative model of care, at Ealing and Charing Cross;
- Hammersmith will continue as a **specialist hospital** with a **24/7 UCC;** and
- Central Middlesex Hospital will host a **24/7 Urgent Care Centre, an elective centre and other community services.**

Specialist hospital

Local and Specialist hospital with obstetric -led maternity unit and UCC

Local and Elective hospital with UCC

Local and Major hospital with A&E and UCC

Local and Major hospital and specialist eye hospital and Hyper Acute Stroke Unit with A&E and UCC

Local hospital with A&E

The SaHF reconfiguration of NWL acute hospitals was defined in the Decision Making Business Case (DMBC), subject to consultation and finally agreed by the Joint Committee of PCTs in February 2013. The DMBC directly aligns to service model #6, specialist services concentrated in centres of excellence.

The SaHF acute reconfiguration also directly supports service model #5, a step change in the productivity of elective care, through the development of new Elective Hospital at Central Middlesex that, among other benefits, will deliver increased productivity as there will be no cancellations due to emergency activity.

Following the development of the DMBC trusts have been working with the SaHF programme to develop the more detailed Outline Business Cases (OBCs). It is the results of this work that are described in this chapter. To reflect the changes to the individual hospital solutions identified during the OBC stage, the SaHF programme is developing an Implementation Business Case (ImBC) to maintain that collectively the refined solution for North West London remains aligned with the clinical vision and remains affordable.

The anticipated benefits associated with each of the hospital solutions as proposed in the Trust OBCs are summarised below:

**Major hospitals**

- Saving at least 130 lives per year by having more specialist consultants on duty at all major hospitals at the weekend.
- Centres of excellence in emergency care which copy the way stroke and trauma has been centralised across London – something which was controversial at the time and now acclaimed by clinicians and politicians alike proving to save hundreds of lives every year.
- Meeting 4-hour A&E waiting time targets consistently, at all major hospitals across NWL, throughout the year.
- Dedicated senior medical cover present in critical care units 24/7, so that seriously ill patients always receive expert care.
- More obstetric consultants on duty 24/7 in labour wards (168 hours per week), reducing the number of serious complications during birth, and one to one midwifery care for women during established labour.
- More trained and experienced doctors on site 24/7 in A&E departments with a consultant presence 16 hours per day, seven days per week.
- More trained and experienced emergency doctors on site 24/7 in A&E departments ensuring patients are seen by senior specialist staff early in their treatment.
- Investment in mental health so psychiatric liaison services can better co-ordinate 24/7 care for vulnerable, mentally ill people.

**Local Hospitals**

- All nine key hospitals across NWL will have an Urgent Care Centre open 24/7 to see 70% of existing A&E activity, with a guaranteed waiting time of no more than hours.
- New custom-built, locally-tailored hospitals at Ealing and Charing Cross, delivering an innovative new model of care to deliver the specific services most needed in those local communities, ensuring we are responding to changing health care needs.

**Elective Hospitals**

- Safe, clean and modern facilities for planned operations like hip replacements and pre-planned procedures.
- Zero cancellations of planned operations due to facilities no longer having to be shared with potential emergency cases.
- Zero infection levels due to better, more modern buildings and no risk of cross-contamination from emergency cases.

**Chelsea and Westminster Hospital will redevelop adjacent land to create the maternity and non-elective capacity required under SaHF to meet increased demand**


**Chelsea & Westminster's solution delivers a number of benefits:**

- Establishes Chelsea & Westminster as a Major Hospital for North West London.
- Improves and expands maternity services.
- Expands the emergency department to handle demand more effectively.
- Adds theatres and imaging to handle the additional activity that will transition to the hospital.
- Enables achievement of SaHF clinical standards.

**Chelsea & Westminster Hospital continue to offer its full range of existing services to patients. Improvements include:**

- **ED**: provision of additional space to double existing capacity to 120,000 attendances p.a.
- **Wards**: Additional 68 acute beds on site, 60 intermediate beds off-site.
- **Theatres**: 2 additional theatres (1 elective, 1 non-elective).
- **Imaging**: Additional CT scanner, ultrasound facility & and mobile image intensifier.
- **Maternity**: MLU to increase capacity by 1,000 births and 2 HDU beds.
- **Neonatal**: 4 additional NICU cots.

## Northwick Park Hospital will develop the required additional capacity through internal re-configuration and some new build

**Northwick Park's solution delivers a number of benefits:**

- Establishes Northwick Park as a Major Hospital for North West London.
- Expands and improves efficiency of maternity services.
- Creates additional critical care capacity.
- Adds capacity to already stretched support services to meet increased demand.
- Enables achievement of SaHF clinical standards.
- Increased capacity to enable transfer of acute services from Central Middlesex Hospital.

**Northwick Park Hospital will continue to offer its full range of existing services to patients. Improvements include:**

- *Ward stock*: Additional 117 beds of accommodation.
- *Critical care*: 28 bedded high acuity unit; 24 bedded theatre recovery unit.
- *Maternity*: Increase in triage facilities to increase bed utilisation; Additional delivery suite and ultrasound room; Reconfiguration of post-natal, NNU and paediatric beds.
- *Support services*: Reconfigured mortuary, MRI and pharmacy.
- *Backlog maintenance*: Replacement of boilers and HV ring main.

## Hammersmith Hospital will concentrate on its primary role as a specialist hospital

**Hammersmith's solution delivers a number of benefits:**

- Hammersmith will concentrate on its primary role as a specialist hospital providing a variety of services for North West London and nationally.
- Transitions the current Emergency Unit activity to alternative sites that provide a 24/7 service.
- Maintains specialist expertise on the Hammersmith site.
- A 24 hour Urgent Care Centre.

**Services/improvements that Hammersmith Hospital will offer post reconfiguration:**

- Hammersmith will become one of North West London's specialist hospitals.
- It will not have an A&E but will offer highly specialised care in areas such as cardiothoracics and cancer.
- Obstetrics and midwifery will be retained at Queen Charlotte's and Chelsea Hospital.

**Hillingdon Hospital will establish a co-located Midwifery Led Unit and undertake a theatre and recovery space reconfiguration programme to generate additional capacity**

**Hillingdon Hospital's solution delivers a number of benefits:**

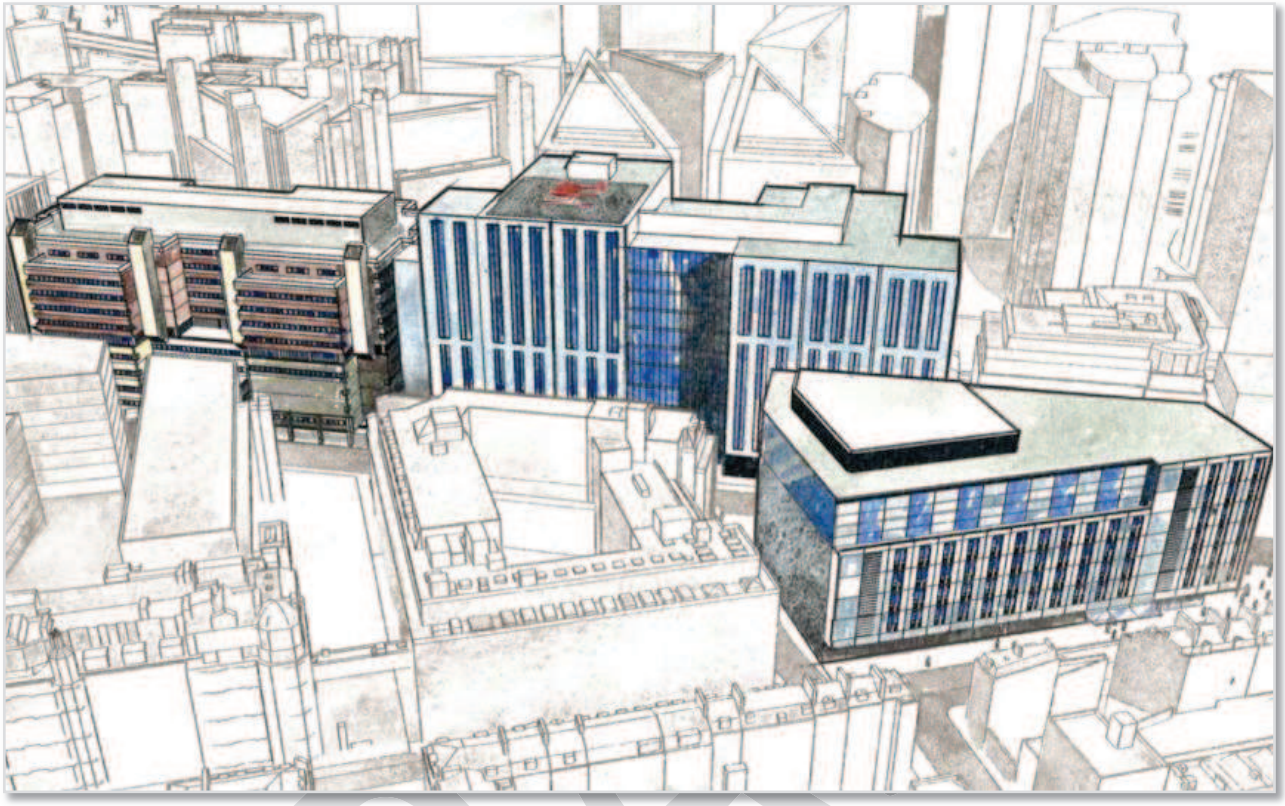
- Creates capacity for 6,000 births in a mixture of midwife-led and consultant-led specialist care.
- Delivers maternity clinical services in accordance with agreed quality standards
- Implements changes to increase non-elective capacity to meet SaHF requirements.
- Addresses over £17m of backlog maintenance.

**Services/improvements that Hillingdon Hospital will offer post reconfiguration:**

Hillingdon Hospital has already established an expansion of its A&E with a co-located Acute Medical Unit and it will continue to offer its full range of existing services to patients. Improvements include:

- Additional Midwifery Led Unit to work alongside consultant-led service.
- Additional recovery space to achieve greater theatre throughput.
- Re-allocation of Hillingdon and Mt Vernon theatres and refurbishment of one Hillingdon theatre.
- Additional A&E majors cubicles.

## St. Mary's will become Imperial's 'hot' site with HASU/Major Trauma Centre and a focus on emergency care



**The St. Mary's solution delivers a number of benefits:**

- Alignment with the Clinical Model.
- Co-locates the primary care & community Hub with the UCC and A&E.
- Consolidates major trauma services.
- Addresses significant maintenance issues.

**Services/improvements that St. Mary's will offer post reconfiguration:**

Services will include:

- A&E
- Urgent Care Centre & primary care hub
- Primary care front-end
- Trauma care
- Emergency surgery and intensive care
- Obstetrics & midwifery unit
- Inpatient paediatrics

**West Middlesex University Hospital will deliver 21st century maternity care through a new maternity unit and expand its non-elective capacity to meet increased demand**


**WMUH solution delivers a number of benefits:**

- Provides the additional capacity required to absorb displaced activity.
- Enables modern maternity healthcare standards to be met.
- Maintains Emergency Department standards with increased activity.
- Co-locates maternity unit with main building improving quality of care and patient experience.
- Increases efficiency of delivering maternity and related services (such as paediatrics), which share staff.

**Services/improvements that WMUH will offer post reconfiguration:**

WMUH will continue to offer its full range of existing services to patients. Improvements include:

- New maternity building to replace the aging Queen Mary maternity building.
- Reconfiguration of the ED footprint.
- Additional adult inpatient and paediatric beds.

## Central Middlesex Hospital will provide a suite of services to meet the needs of Brent residents and utilise the facility

**The Central Middlesex Hospital solution delivers a number of benefits:**

- Provides the best range of health services for residents whilst maximising site use.
- Improved quality.
- Increased primary care and community services.
- Improved direct access to diagnostics.
- More out-patients clinics.
- Improved mother and baby unit.
- Dedicated planned/elective care with proven model of care.
- Moving lab services allows Northwick Park to expand major hospital services.

**Services/improvements that Central Middlesex Hospital will offer post reconfiguration:**

- *Hub Plus for Brent* – major hub for primary care and community services including additional out-patient clinics and relocation of community rehabilitation beds from Willesden.
- *Elective Orthopaedic Centre* – a provider joint venture (Ealing Hospital Trust, North West London Hospital Trust, and Imperial College Healthcare Trust) delivering modern elective orthopaedic services.
- *Brent's Mental Health Services* re-located from Park Royal Centre for Mental Health.
- *Regional genetics service* relocated from Northwick Park Hospital.

**Ealing Hospital will transform delivery of health care for residents and will be a platform for community led services**

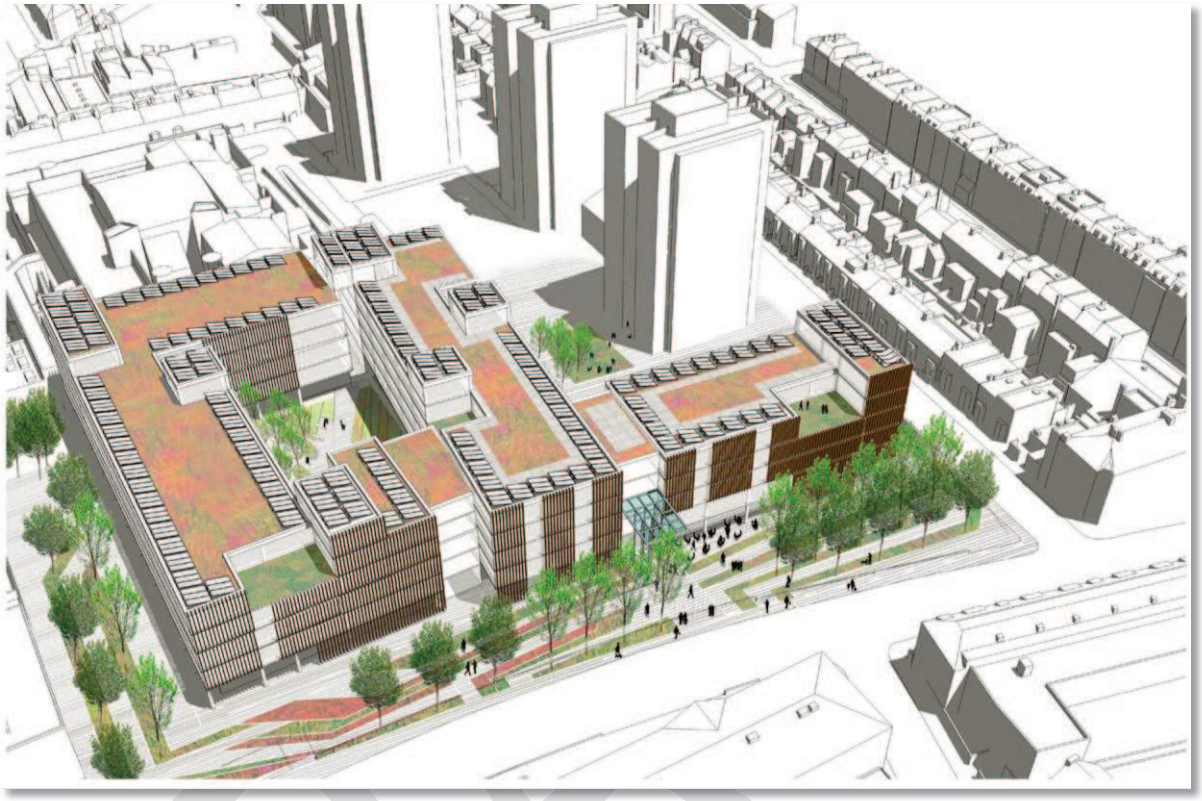
**The Ealing Hospital solution delivers a number of benefits:**

- Reduced morbidity rates
- Reduced admission and readmission rates
- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved care planning that is centred around the patient and carers needs
- Improved clinical outcomes
- Centre of excellence for diabetes and re-ablement
- Improved patient and carer satisfaction
- Improved integration between health, community and mental health services
- Improved health and wellbeing across the Borough

**Services/improvements that Ealing Hospital will offer post reconfiguration:**

- Primary care led services
- 24/7 Urgent Care Centre
- Care assessment, coordination and delivery:
  - Outpatients/ access to specialist opinion and services
  - Diagnostics & Therapies
  - Social care
- Transitional and rehabilitative care:
  - Assessment / observation beds
  - Active post-surgical rehab beds
  - Transfer beds
  - Palliative care beds

**Charing Cross will transform health and care services in the borough as Imperial's new local hospital and centre for non-complex elective surgery**



**The Charing Cross solution delivers a number of benefits:**

- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved care planning that is centred around the patient and carers needs
- Centre of excellence for re-ablement
- Improved patient & carer satisfaction
- Improved integration between health, community and mental health services
- Improved health and wellbeing across the Borough through greater

**Services/improvements that Charing Cross will offer post reconfiguration:**

- Primary care led services
- 24/7 Urgent Care Centre
- Outpatient and diagnostics
- Ambulatory surgery and medicine services (including cancer)
- Access to additional step-up/step down community beds
- Day case/23 hour elective centre for non-complex surgery[22]

[22] Proposals place other post-reconfiguration elective surgery across Imperial's other sites with some orthopaedic elective surgery being undertaken at Central Middlesex Hospital.

## Provider transactions

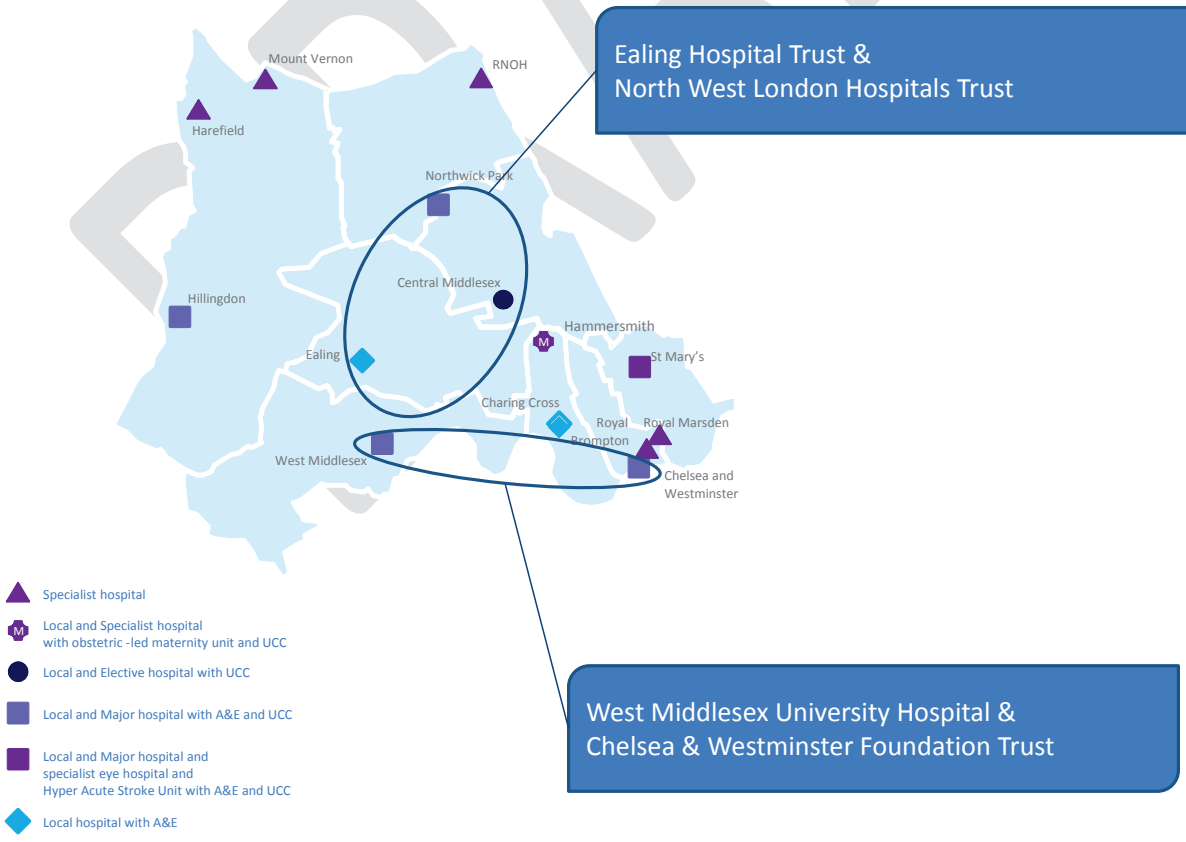
Alongside the pan-NWL acute services reconfiguration, two significant provider transactions are proposed to further strengthen the financial viability of the NWL provider landscape: a merger between North West London Hospitals Trust and Ealing Hospital Trust, and a merger between Chelsea and Westminster Foundation Trust and West Middlesex University Hospital.

### North West London Hospitals Trust & Ealing Hospital Trust

The merged NWLHT/Ealing Trust will be a large scale Integrated Care Organisation with acute and community services co-terminus with its three local authorities. This places it in a unique position to respond to the drive for more streamlined patient pathways with a greater emphasis on local service provision at home and in the community, as well as access to the highest quality acute and specialist in-patient services.

### Chelsea & Westminster Foundation Trust and West Middlesex Hospital Trust

To secure its future financial sustainability West Middlesex Hospital Trust are exploring the opportunities to merge with Chelsea & Westminster Foundation Trust. This would create opportunities for organisational restructuring of services to provide economies of scale and improved quality of care.



### Planned Care Pathways

In addition to the major shared Primary Care Transformation initiative, each NWL CCG is redesigning its local planned care pathways as part of Out of Hospital Strategies. There will be a significant change in that outpatient services are delivered, so that:

- **Services are patient focused**, recognising the cost to the patient of the time and emotion involved in engaging with health services.
- **Clinical decisions are made as quickly** as possible while minimising the time that the patient has to spend in contact with NHS services and the number of times they need to attend a hospital.
- **GPs are able access specialist advice** to enable them to avoid referrals for a second opinion.
- **Hospitals utilise alternatives to outpatient clinics, including technological solutions**, and run one stop shops where patients can have diagnostics and a decision at the same time.
- **Patients are able to book appointments easily** and have a clear point of contact when they have questions.
- **Clinicians in outpatients have full access to the GP patient record** and enter data into it, providing real time updates for the GP.

Improving the planned care pathway – transforming the way in which outpatient services are provided to patients to reduce the number of trips and amount of time that patients spend in contact with secondary care – will lead to step-change in the productivity of elective care and a reduction in the use of acute Outpatient services.

In addition, the strategy to concentrate key elective services onto fewer elective centres of excellence will provide evidence based opportunities for productivity improvements. There are three organisational proposals: the development of a new elective and regional orthopaedic hospital at Central Middlesex; the development of an elective centre for Imperial at the Charing Cross site and Chelsea and Westminster's plans to concentrate certain elective activity at West Middlesex (should the acquisition be successful). The benefits from this concentration of elective work are well recognised; with no unplanned care to cut across planned work there should be fewer cancellations, lower infection rates, enhanced productivity through standardisation, and the concentration of services that supports learning and development, all of which contribute to less waste, reduced length of stay and greater utilisation of facilities.

### NHS England's Specialised Commissioning strategy

Specialised services are those services which are provided from relatively few specialist centres. Conditions treated range from long-term conditions, such as renal (kidney services), mental health care in secure settings and neonatal services, to rarer conditions such as uncommon cancers, burn care, medical genetics, specialised services for children and cardiac surgery.

They are commissioned nationally through 10 of NHS England's 27 area teams, including NHS England (London), and account for approximately 10% of the overall NHS budget.

While NHS England is the direct commissioner for the majority of the services, the delivery of specialised services involves the whole health system, as CCGs and local authorities are also responsible for commissioning parts of the pathway, and delivering, elements of care. Many of the conditions treated in specialised services are highly debilitating, life-long and demand the advice of experts, as well as responsive access to care locally when needed.

The strategic objectives for specialised services in NWL include:

- **Quality** - specialised services will be consistently in the top decile for

outcomes across all providers, including through:
    - Consistent achievement of service specifications
    - Benchmarked outcomes
- **Patient experience** – continuous improvement of patient experience, including through:
    - Engaging patients in service and pathway development
- **Integration** – maintain the integrity of care pathways for patient with specialised services, including through:
    - Co-commissioning with NWL CCGs and Local Authorities
    - Development and implementation of best practice pathways for individual services
- **Value for money** – contain the cost of specialised services, including through:
    - Understanding the cost of services commissioned
    - Convergence of prices
    - Alignment of incentives
    - Contract management

In order to achieve this overall set of objectives, the strategy for specialised commissioning is to provide services from fewer sites, supporting improved quality, patient experience, and value for money, while maintaining integrity of care pathways.

NHS England will work closely with the CCGs of North West London to ensure that any changes to specialised services in NWL are aligned with the *Shaping a healthier future* acute reconfiguration.

*[Placeholder for additional planning detail from NHS England - NHS England and NWL would like to work together with regards to specialised cancer, cardiovascular and children's services, considering their inter-relationships with the plans under Shaping healthier future. NHS England and NWL would also like to further explore how we might better collaboratively commission specialised services].*

National specialised service reviews

There are three specific national reviews which may impact upon specialised services in NWL over the next five years:

- **Children's Congenital and Adult Cardiac services:** this review will be carried out in 2014, and will focus on the number of surgeons and the number of procedures each surgeon undertakes, together with the co-dependencies required on site, e.g. Paediatric Intensive Care Unit (PICU).The review could result in a consolidation of services, with fewer providers nationally and within London.
- **Burn Centre services:** all Burn Centres (treating critically ill children with Burns injuries) must have on-site access to a PICU. NHS England therefore intends to carry out an urgent review of current services prior to the development of long term proposals to address this issue, with a view to moving the small number of children with severe burns who don't currently have access to PICU, to services that provide this facility.
- **Paediatric Oncology Shared Care Units (POSCUs):** NHS England will lead a review of Paediatric Oncology Shared Care Units (POSCUs) in order to develop a new model of care, consolidating existing services to create larger facilities that will enable more shared care to be provided outside of the Principle Treatment Centres. The Principle Treatment Centres (PTCs) are currently based on Great Ormond Street Hospital and the Royal Marsden (the latter of which is in NWL). PTCs are staffed by doctors and nurses with specialist qualifications and training in cancer whereas POSCUs are staff by those with a special interest in cancer. The PTC can deliver a comprehensive service while depending upon the level of care (1-3)

they are designated for deliver some aspects of the service.

This review is intended to be complete by September 2014, with the new model of care becoming operational from April 2015/16.

Cancer services

NWL will develop and implement the following aspects of the London Cancer Commissioning strategy, working collaboratively with NHS England specialised services commissioners:

- chemotherapy commissioning strategy
- radiotherapy commissioning strategy

### Clinical standards, including London Quality Standards and Seven Day services

As part of the original development of NWL's vision, NWL clinicians developed a set of clinical standards covering three service areas:

- Maternity
- Paediatrics
- Urgent and Emergency Care (with a focus on Emergency Departments and Urgent Care Centres)

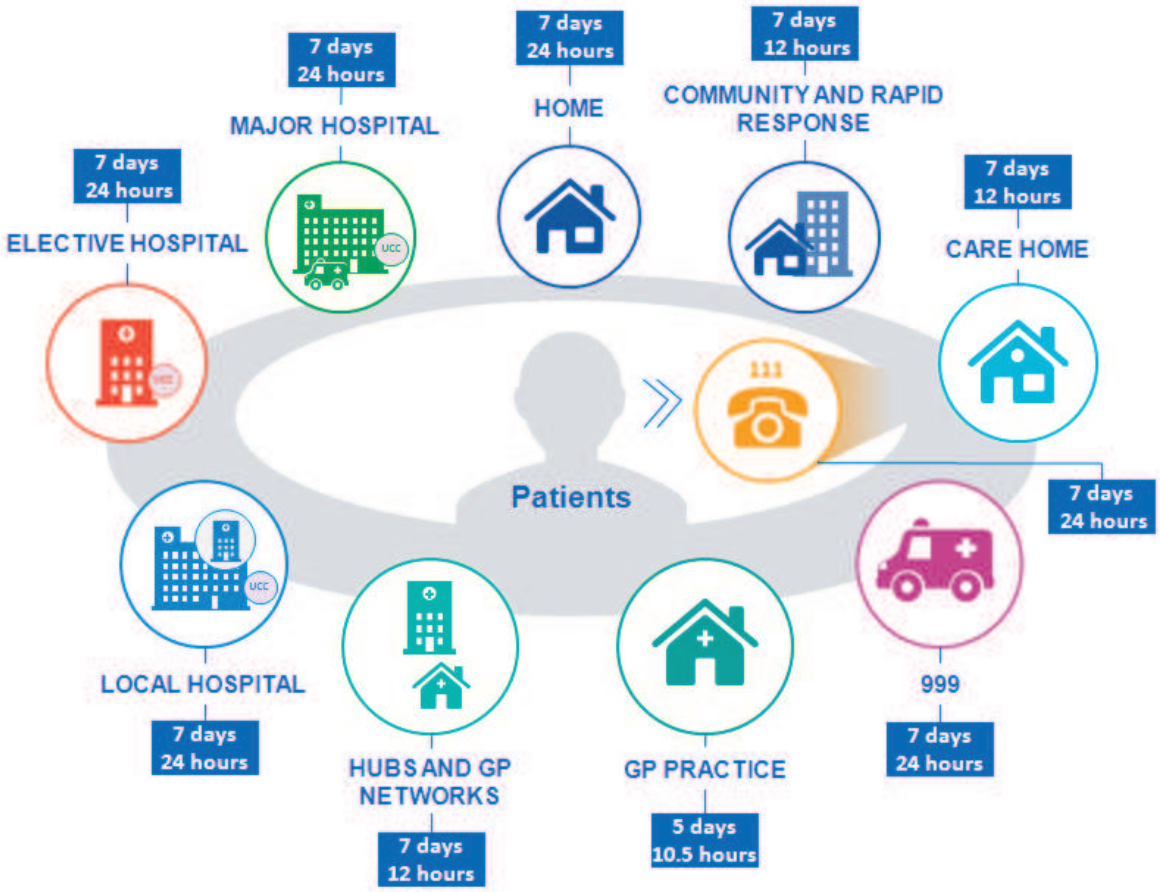
The purpose of these standards is to drive improvements in clinical quality and to reduce variation across NWL's acute trusts. The London Quality Standards were subsequently published in 2013, many of which are consistent with the SaHF clinical standards – these were also adopted by NWL. Together the SaHF standards, London Quality Standards and now the national Seven Day standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway.

NWL regularly monitors each Trust's progress in achieving the SaHF and London Quality standards, and will be strengthening the support provided to Trusts to achieve these, as well as aligning commissioning processes to achieve them.

In November 2013, NWL was selected as one of 13 areas in England to lead the way in delivering seven-day NHS services for patients. Being an Early Adopter of Seven Day Services is important to NWL as it creates the opportunity to accelerate existing commitments to seven day working (through SaHF) and to implement improvements at scale and pace.

Achieving the national clinical standards for seven day services will improve patient care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway. The Seven Day Services programme in NWL is working across the whole health and care system to achieve our shared vision for seven day working:

NWL vision for seven day services




The Seven Day Services programme has two key roles:

- To align, coordinate and support North West London providers, commissioners and other stakeholders to improve the quality, safety, and efficiency of services by collectively achieving agreed standards for seven day services.
- To provide a programme of support for acute providers and other partners to work at pace and scale to implement seven day services and meet the clinical standards, and to learn from and share with NHS colleagues as part of the NHS IQ Seven Day Service Improvement programme.

Acute providers and their partners from across the whole system will be working as part of the NWL Seven Day services programme to develop action plans to achieve all ten of the Seven Day Service Clinical Standards by 2016/17. Better Care Funds include plans for 7 day working in social care by April 2015, and the development of these plans will be done in collaboration with acute and other partners across the emergency care pathway.

### London Children's Strategic Children's Network

Priorities for the London Children's SCN over the next five years include:

- The network is currently developing a proposal to establish **three children's networks** based on the three Local Area Teams/Academic Health Science Networks (AHSN) and Local Education and Training Board (LETB) footprints. Note

that this suggests that a children's network will be established in NWL.

- **Children's healthcare standards**: numerous standards currently exist for children's healthcare, but are located in different organisations such as the Royal College of Paediatrics and Child Health and the National Institute of Health and Care Excellence. The network is gathering these standards together into one cohesive document to enable commissioners to **see all the standards in one place** and to commission against them.

The SaHF clinical standards and London Quality Standards, which include a set of Paediatric standards that the NWL acute trusts are working to implement, will be reviewed once this review of the full set of children's healthcare standards has been gathered together.

### London Maternity Strategic Clinical Network

Priorities for the London Maternity SCN over the next five years include:

- The network is working with CCGs to implement **funded maternity networks** across five areas of London.
- The network will be providing tools and support to enable **reduction in maternal mortality**, a **reduction in still birth rate** and to **improve women's experience of care**. A pan-London commissioning group will be established to enable delivery of these improvements across CCGs.

The SaHF clinical standards and London Quality Standards, which include a set of Maternity standards that the NWL acute trusts are working to implement, will be reviewed by the Maternity Clinical Implementation Group (CIG) once the pan-London commissioning group has published its recommendations with regards to reducing maternal mortality, reducing the still birth rate, and improving women's experience of care.

# 10. Cross-cutting plans: Urgent & Emergency Care, and Cancer Services

*While the key transformation programmes are being implemented on a pan-NWL basis, urgent and emergency care plans are coordinated at a provider level, with local Urgent Care Working Groups overseeing the implementation of changes across the continuum of emergency care*

### Urgent and Emergency Care

Through the *Shaping a healthier future* (SaHF) acute reconfiguration process, North West London has undertaken an intensive review of urgent and emergency care across the health economy, based on the core principles of localisation, centralisation and integration. In addition, each local health economy has developed Urgent Care Improvement Plans in 2013 through their respective urgent care governance structure. Membership of these Working Groups is being refreshed, and the resilience plans will be continue to be reviewed and refined. Urgent Care Working Groups (UCWGs) will also be the vehicle for reaching agreement on the investment plans to be funded by the retained 70 per cent from the application of the marginal rate rule. UCWGs remain a valuable opportunity to bring together local providers and commissioners to deliver practical solutions as NHS services are reconfigured.

The NWL Urgent and Emergency Care plans cross-cut all of the key improvement interventions in NWL, including acute reconfiguration, whole systems integrated care, and primary care transformation, and are consistent with the findings of the phase 1 findings of the *Urgent and Emergency Care Review*[23].

The NWL vision is consistent with the vision set out in the Urgent Care review - i.e. that care be delivered as close to people's homes as possible, and that for those with more serious or life threatening emergency needs that they are treated in centres with the very best expertise and facilities. The NWL plans are also in line with five proposals set out in the Urgent and Emergency Review Phase One Report.

### Alignment to the vision set out in the Urgent and Emergency Care Review

[23] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

The Urgent and Emergency Care Review sets out five proposals for urgent and emergency care in the NHS. These proposals, along with how NWL's plans will deliver them, are set out in this section.

In addition, as a 24/7 pan-London healthcare provider, the London Ambulance Service (LAS) are often the first point of contact for people who want medical help, whether it is an emergency or a less serious condition. Their response may determine whether patients get the right treatment to meet their needs. Over the next five years LAS intends to improve the quality of care in a number of ways.

***Proposal #1: we must provide better support for people to self- care***:

**Self-treatment information**: see chapter 7 (Whole Systems Integrated Care) and chapter 13 (Citizen Empowerment and Patient Engagement section) for details on how NWL CCGs will provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.

**Care planning**: comprehensive and standardised care planning is one of the out-of-hospital standards, and will be achieved through the Whole Systems Integrated Care programme, including supporting initiatives in the Better Care Fund plans.

***Proposal #2: we must help people with urgent care needs to get the right advice in the right place, first time*:**

**NHS 111**: NHS 111 is now nationally available, including across NWL. NHS England will now be revising the NHS 111 specification and core vision ahead of the re-procurement of NHS 111 contracts in 2014/15. London has made twelve recommendations covering proposed changes to 111 contracts across London, including changes to the service operating model. Priorities for 111 in London include:

- A series of pilots are planned within the national Learning & Development programme to test specific elements of 111 service specification and impact across healthcare systems:
  - '111 Smart Call to Make' reviewing the impact of targeted marketing the 111 service on walk-in attendees to UCCs and Emergency Departments
  - Earlier intervention of specialist clinicians, including GPs and specialist nurses within the 111 patient journey for a defined subset of callers e.g. complex callers, children under 5 years old, older callers with Special Patient Notes as crisis records.
  - 111 Digital – building on the successes of Coordinate My Care (CMC) electronic end of life care plans, developing Special Patient Notes as crisis records and sharing across the Urgent and Emergency Care system.
  - 111 Digital – developing online access to 111 assessment and appropriate onward referrals to GPs both in and out of hour GPs.
  - Reviewing **the impact of 111 on GP out of hours (OOH) providers** including direct booking into GP OOH.
  - Reviewing **the impact of 111 on Emergency Departments and UCCs.**
  - Improving **integration and referral mechanisms to community health services.**
  - Reviewing **the impact of 111 on ambulance services.**

  Pilots will report to London and National Programme Boards to influence the final revised specification in September.

The intention is to greatly enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service.

In North West London, there have been other particular concerns, including ensuring the local Directory of Services are regularly maintained and updated, and the need to resolve current Information Governance issues preventing commissioners from

reviewing calls which might have an impact on patient safety.

In addition, NWL CCGs are looking to review how 11 can best be integrated with local plans ahead of the re-procurement.

**Access to data and information about health and services:** NWL, working with national partners, will ensure that the population is well served by access to transparent and accessible data and advice about health and services. This will include a clear avenue for accessing up-to-date local clinical and operational service information for patients, GPs and other providers.

***Proposal #3: we must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E*:**

When individuals have urgent needs, it is important that they can access the advice or care that they need as rapidly as possible. In the new system of out of hospital care, people will be able to access services through a number of routes. These include community pharmacy, extended GP opening hours, such as weekends and evenings (within an individual practice or the practice network), greater availability of telephone advice from the practice or through 111, and GP out-of-hours services. These will be designed to ensure they address equality issues, ensuring that urgent care services meet the needs of all services users, including protected groups.

The CCG Out of Hospital strategies, including Primary Care Transformation, will improve access to primary care, including on weekends, while Rapid Response and Care at Home will reduce demand on A&E services.

Changes in primary care that will help deliver out of hospital urgent and emergency care services include:

- Patients with urgent care needs provided with a timed appointment within 4 hours.
- Access to General Practice 8am-8pm (Mon-Fri) and 6 hours/day during the weekend.
- Access to GP consultation in a time and manner convenient to the patient.
- Online access to self-management advice, support and service signposting.

The Mental Health Urgent Assessment Pathway (part of Transforming Mental Health Services programme) will improve access to local mental health teams, including on weekends.

Commissioners will continue to ensure that Out of Hospital strategies are on the correct trajectory when preparing for acute service changes.

**London Ambulance Service**: LAS recognises that for many of their patients, many can get better, more appropriate care somewhere other than at hospital. People who call LAS will not automatically receive an ambulance response, and those who do will not necessarily be taken to hospital. In their efforts to ensure patients get the right care for their needs, they may refer these patients to their local GP or pharmacist. Alternatively LAS may take or refer them to an urgent care centre or somewhere similar for treatment. If patients call LAS with a minor problem, their specially-trained clinical advisors will provide medical advice over the phone or may refer them to NHS 111 for help. LAS will work more closely with health and social care organisations in London to ensure that there are other places people can go to get medical help. It is also important that LAS staff have the right skills to be able to assess patients with less serious conditions and refer them to the right place for help.

***Proposal #4: we must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery***

As agreed through the SaHF review and consultation, which was informed by working with key partners and informed by a detailed understanding of NWL, the current existing nine acute hospital sites in NW London will

not be able to deliver the desired level of service quality. The SaHF Clinical Board determined that delivering safe and effective A&E services on a 24/7 basis requires rapid access to emergency surgery and expertise for complex medical cases on a 24/7 basis as well as level 3 critical case (intensive care).

Therefore, through the SaHF acute reconfiguration, in NWL there will be:

- **Five Emergency Departments** (EDs) located at Major Acute hospital sites in NWL: Major Acute Hospitals will provide a full range of acute clinical services - they will have sufficient scale to support a range of clinically interdependent services and to provide high quality services for patients with urgent and/or complex needs. At their core they will be equipped and staffed to support a 24/7 A&E with 24/7 urgent surgery and medicine and a level 3 ICU.
- **Nine Urgent Care Centres** (UCCs) in NWL, operating on a 24/7 basis: the UCCs will be fully integrated with the wider integrated and coordinated out-of-hospital system to ensure appropriate follow up. They will have strong links with other related services, including GP practices and pharmacies in the community. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend an UCC with a more severe complaint can quickly receive the most appropriate specialist care at another NWL A&E. As part of SaHF, all Urgent Care Centres in NWL will operate based on a common specification and to a common set of clinical standards. The UCC specification will also ensure that future care meets the needs of all service users but particularly those protected groups and hard to reach communities affected by A&E transition.
- **London Health Programme's London Quality Standards** covering Emergency Surgery and Acute Medicine and UCCs will be adopted across NWL for Major Acute Hospitals.

The London Quality Standards are in line with the national clinical standards, and NWL will be at the forefront of commissioning and providing standards of high quality care, seven days a week. On-going implementation of the London Quality Standards for acute emergency services will be commissioned from April 2014 (see chapter 9 for further details, including about the NWL Seven Day Service programme).

**London Ambulance Service**: LAS has seen major developments in the quality of care that is provided to patients who are critically ill or injured, with patients suffering a heart attack, cardiac arrest, stroke, or life-threatening injuries now taken to specialised centres for treating these conditions, improving chances of survival.

LAS aim to build on this good work so that critically ill and injured patients get the best possible care.

***Proposal #5: we must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts**:*

Building on the success of major trauma networks, we will develop broader emergency care networks. It is essential that GP practices and out-of-hours providers, as well as all those who deliver other community and mental health services, are fully involved.

## Transforming Cancer Services

### Introduction

Alongside the rest of London, NWL aims to achieve significant, measurable improvements in outcomes for patients, including the saving of additional lives currently lost to cancer, improved patient experience and effective use of financial resources. This will be achieved through a collaborative, clinically-led**,** patient-centred approach, maximising the effectiveness of pan-London strategic leadership.

Cancer is one of 4 top priorities for outcome improvement across London and represents one of the top three causes for premature mortality across NWL CCG's. Survival rates, which although are good in places across NWL relative to England, the UK survival rates are still some way behind international and European best[24]. It is the ambition of NWL to achieve European best survival rates equating to 355 lives saved per year.

In London, cancer services are being transformed through work with the London Cancer Alliance and London Cancer – NHS, academic health science centres, the Pan London Transforming Cancer Services Team (TCST) and voluntary sector partnerships – and a Cancer Commissioning Board.

Priorities for the cancer programme in London include localising and supporting the implementation of the Cancer Commissioning Strategy for London 2014/15 – 2019/2020[25], which was produced in partnership between NHS England (London), London's CCGs, Public Health England, the Integrated Cancer systems and charity partners, which sets out a plan to boost cancer services enhance patient experience and raise survival rates.

Key sections within the Cancer Commissioning Strategy include:

- Prevention
- Cancer screening
- Early diagnosis and awareness
- Reducing variation and service consolidation
- Chemotherapy
- Radiotherapy
- Patient experience
- Living with and beyond cancer
- End of life care

Further details about these areas of work in NWL are provided below.

### Prevention

CCGs and Local Authorities will commission well-evidenced prevention programmes to tackle factors such as smoking, unhealthy diets, alcohol and excess weight, which cause one third of all cancers diagnosed in the UK each year.

### Cancer screening

Commissioners will improve the take-up of national screening programmes through closer working with the screening hub. Screening uptake rates across London are all below the England target of 60%. The highest Borough for uptake in London is Harrow at 47%. The lowest uptake across the capital is NWL CCG's. Commissioners, GPs and the screening programmes will all need to work closely together if uptake rates are to improve. Commissioners will also support the roll-out of Bowel Scope – the new bowel cancer screening for those on or around their 55th, and join-up the pathway from screening to treatment. In addition, we will consider potential opportunities over the lifetime of the strategy for the co-commissioning of screening if appropriate.

### Earlier detection of cancer in the community

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf

[25] http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/01/lon-canc-comm-strat.pdf

Implementation of an early detection and population awareness strategy, reducing the number of patients diagnosed when their cancer is at a late stage when successful treatment is less likely as the cancer is more likely to be at an advanced stage. More GPs will be trained to spot the signs of cancer early, for example, using a Macmillan decision support tool that flags up combinations of symptoms that could be caused by cancer. The one year survival for a newly diagnosed cancer patient is significantly reduced if the cancer is diagnosed through an emergency route.

The most recent data from the national cancer intelligence network (NCIN) data demonstrates there is still work to be done across NWL to reduce this cohort.

| CCG | % of new cancer diagnosis through an emergency route Jul-Dec 2012 |
|---|---|
| Ealing | 23.2% |
| West London | 19.6% |
| Hillingdon | 23.1% |
| Harrow | 17.1% |
| Central London | 24% |
| Hounslow | 21.9% |
| Hammersmith & Fulham | 25.6% |
| Brent | 22.9% |
| All England | 20.5% |

*Source: NCIN Cancer commissioning toolkit*

Recently published early detection reports by the Pan London Transforming Cancer Services Team (TCST) for NWL CCG's provide a good baseline for NWL to work with practices to develop plans as part of the NWL early detection & population awareness strategy.

For patients to benefit from the impact of having an earlier stage diagnosis of their cancer, there needs to be a focus on developing prepared patients (aware of the key signs of cancer) and prepared, alert professionals. The community of professionals that can signpost people to their GPs includes nurses, dentists and pharmacists among others.

NWL will aim to build on the Cancer Awareness Measure data of their patient populations, using this information to identify groups and geographies at higher risk. Linking with evidence based national cancer awareness campaigns, local authorities and Public Health colleagues, NWL will aim to target higher risk populations with specific interventions.

Working with NWL Local Education and Training Board, TCST and Cancer Research UK, a professional's cancer learning needs analysis tool will be evaluated. The results will help shape the educational and training needs of NWL front line clinical staff.

**Reducing variation**

There is considerable variation in the management of cancer in NWL. For example, the table below illustrates the level of variation in NWL with regards to the treatment of lung cancer (those in red are below the audit recommendations):

| NWL Trust | % of early stage non small cell lung cancer resected | Lung cancer active treatment rates |
|---|---|---|
| Hillingdon | 46.2% | 46.6% |
| Ealing | 33.3% | 55.2% |
| West Middlesex | 50% | 50% |
| Chelsea and Westminster | 60% | 61.4% |
| Royal Brompton | 75% | 86.4% |
| North West London Hospitals | 76.2% | 54.7% |
| Imperial | 61.3% | 72.9% |

| | | |
|---|---|---|
| National | 52% | 61% |

*Source: The National Lung Cancer Audit 2013 report (2012 patient cohort)*

In order to reduce this variation, commissioners will use provider contracts to improve hospital performance, such as increasing resection rates for lung cancer, and follow best practice on the treatment of lung cancer and bowel cancer in order to reduce variation in outcomes.

NWL will seek to implement the best practice commissioning pathways and clinically agreed protocols, and for providers to demonstrate compliance with NICE Improving Outcomes (IOG) and the requirements of the National Cancer Peer Review programme. NWL will adopt Royal College recommendations on waiting and reporting times for diagnostic tests.

NWL will also ensure that the impact on cancer services is considered when any key strategic changes are planned.

Reducing inequalities

Nationally, the 2011 publication '*Improving Outcomes: A Strategy for Cancer*'[26] states that older people do not always receive the same standard of cancer care as younger people. NWL commissioners, through the integrated cancer system, will look to understand and reduce this variation across their population. NWL commissioners would expect Multi-Disciplinary Team (MDT's) to consider all aspects of an individual when planning treatment decisions (for example, overall health, co-morbidities, quality of life and not just chronological age), demonstrated through audit and the national peer review process.

Improving access to services

In addition to localising and implementing the Cancer Commissioning Strategy for London, NWL will also seek to use contracts to improve access to some cancer services; alongside the rest of London, specifically:

- **Breast Cancer***:* we will adopt the 23 hour pathway as the standard approach for surgery, unless there is clinical reason to justify exception, and ensure that access to reconstructive surgery be provided in a timely manner. This has been seen to have a positive effect on patient experience.
- **Colorectal Cancer***:* we will ensure that the rates of laparoscopic surgery are performed at levels of at least the national average, and that where teams are below average, action plans are provided to commissioners to achieve this. In addition commissioners will monitor length of stay to ensure that trusts are following enhanced recovery programmes where appropriate.
- **Cancer of the Unknown Primary and Acute Oncology Services***:* Commissioners will use contracts to ensure that all trusts with an A&E department have Acute Oncology and Cancer of the Unknown Primary Services that are in line with NICE guidance and peer review. Faster treatment for these patients with significant needs and shorter lengths of hospital stay can be demonstrated. For those who have implemented these services, commissioners would look for a reduction in length of stay for both those newly diagnosed and those with an emergency admission of cancer.

**Living with and beyond cancer**

The numbers of people living with **cancer as a long term condition** is increasing, and is expected to double by 2020. Therefore, we will improve support and care coordination for the NW Londoners living with and beyond cancer.

Commissioners will expand the roll-out of an integrated Recovery Package for all patients at the end of active treatment, which includes a full holistic assessment of their needs, a care

[26] *Improving Outcomes: A Strategy for Cancer;* Department of Health, 2011 (http://www.epaac.eu/from_heidi_wiki/UK_Annual_Report_2011.pdf)

plan, and an education and information event to help people to manage their condition and promote healthier lifestyles, in line with the National Cancer Survivorship initiative (NCSI).

The Whole Systems Integrated Care programme care may be one approach to improving care for people living with and beyond cancer, as people living with cancer are one of the key patient cohort for the Whole Systems Integrated Care programme.

**End of life care**

Commissioners will commission a new proven system that co-ordinates care for people at the end of their life and supports them to die in their chosen place (see chapter 7, 'Transforming end of life care' section) for further details on the NWL End of Life Care plan).

**Improving the cancer patient experience**

We will significantly improve the **patient experience** of all patients living with cancer in London.

# 11. Programme summary, including enablers, investment costs and timelines

*The ambition of the North West London strategic plan is enormous – no other health economy has managed to achieve this level of agreement on the scale of the changes. NWL now faces the equal challenge of implementation.*

## Introduction

The ambition of the North West London strategic plan, including the *Shaping a healthier future* programme, Whole Systems and each CCG's Out of Hospital strategies, is enormous. No other health economy has managed to achieve this level of agreement on the scale of the changes and to deliver this scale of change with their acute providers. A huge amount of work has been carried out to get to the point where commissioners were able to make the necessary decisions on the future of providers in NWL and for this decision to be robust so that it successfully withstood the inevitable legal challenges. Now it has done so, it faces the equal challenge of implementation. This involves creating the design of five major hospitals and nine local hospitals across the area in line with the quality and service intentions of the CCGs. At the same time, the out of hospital services and whole systems integrated care work needs to be delivered to ensure that patients receive high quality care and only go to hospital when they need to.

A number of enabling workstreams have been developed to ensure successful implementation of the transformation programmes, and the realisation of planned benefits, including improved performance against the outcome ambitions.

### Programme Enablers

A number of key enablers are required for the effective implementation of the NWL Strategic Plan, and workstreams have been developed to support each of these:

1. Informatics
2. Workforce
3. Communications
4. Engagement, co-design, travel and equalities
5. Clinical
6. Finance

In addition, there are a number of key dependencies and critical success factors:

7. 'Out of Hospital' strategies and reduction in acute demand
8. Benefits realisation

These have been considered in the sections below:

#### 1. Informatics

The financial and quality challenges facing the NHS, including NWL, require significant improvements in the way that both clinical and financial information is collected, accessed and shared. In addition, patients are expecting more from their healthcare providers in terms of the way they are engaged, often arising from comparison of technologies in other industries.

As part of our collaborative NWL approach, NWL has developed a shared informatics strategy across all organisations, to set out the principles and direction for Informatics in NWL. This strategy articulates a clear vision for informatics focussed on the outcomes required from Informatics by patients, care professionals, commissioners and other professionals:

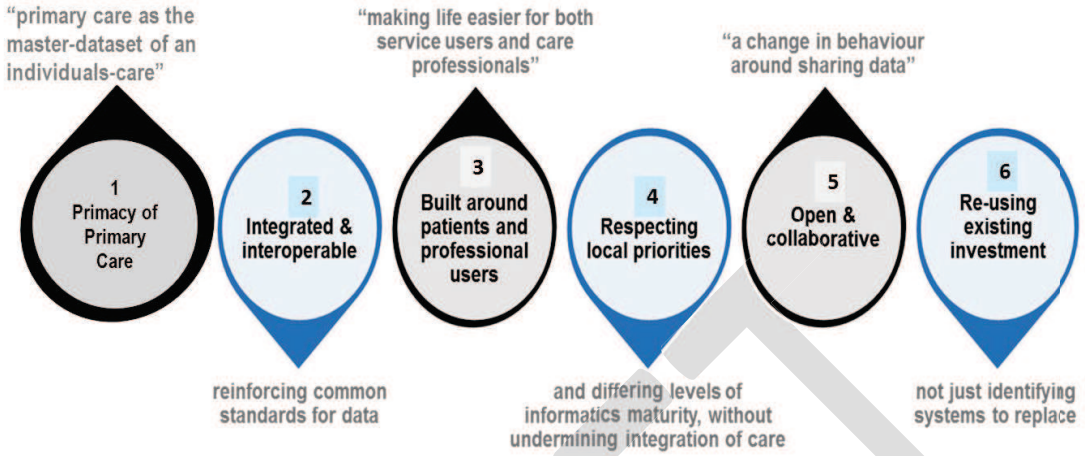
*"Delivering an integrated approach to Informatics across North West London, focussed on:*

- ***Better care for service users** through systems and information that empower them to access services, inform their care and choices*
- ***Better informed and supported professionals** having accurate and timely information available to make better decisions, and technology to support ways of working that deliver higher quality care more efficiently*
- ***Better outcomes** through optimising use of systems and technology; providing access to information to allow commissioners to make more effective procurement and commissioning decisions*
- ***Professional design, delivery and governance** throughout the Informatics estate."*

A set of design principles for Informatics in North West London have been agreed – see figure below. A number of recommendations arising from these principles have been agreed across three categories:

- Develop a number of projects and programmes to improve the quality and efficiency of patient care: e.g. push for a common Patient Identity.
- Invest in informatics solutions that will improve commissioning outcomes: e.g. push to complete a North West London Business Intelligence (BI) solution that meets the needs of users.
- Put in place appropriate informatics governance and leadership: e.g. formalise a collaboration-wide Informatics Lead role.

**Design principles for Informatics in North West London**




Specific Informatics plans to address national priorities over the next five years include:

- All people with a long-term condition will have a personalised care plan that is accessible, available electronically and linked to their GP health record.
- There will be greater use of telehealth and telecare to support people with long-term conditions to manage their own health and care.
- We will make best use of the *care.data* set and any other available national data sets to support our commissioning processes.
- Patients will be able to access their own health information electronically.
- Data from 100% of GP practices in NWL will be linked to hospital data over the course of 2015 - 2018, and will be encouraged earlier through improvement interventions such as integrated care.
- The NHS number will be universally adopted as the primary identifier by all of our providers.
- GP practices will promote and offer to all patients the ability to book appointments, order repeat prescriptions and access their medical notes online. GP practices will upload information about medicines, allergies and adverse reactions onto the Summary Care Record.

**2. Workforce**

Our vision for care in North West London is delivered by a flexible workforce with the right values and skills caring to patients in the setting most appropriate for patients. To support this we want to ensure that workforce planning, training and education support the existing and future workforce and drive sustainable innovation. We also want to liberate the talents and skills of all the workforce so that every patient gets the right care in the right place at the right time[27].

We have therefore established a cross-cutting Workforce Workstream managed jointly between *Shaping a healthier future* and Health Education North West London (HENWL).

All of the work done will need to be underpinned by robust workforce planning and modelling across all teams and settings of

[27] 'Liberating the Talents – Helping Primary Care Trusts and nurses to deliver the *NHS Plan'*, Department of Health, 2002 (http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076250.pdf)

care with recruitment and retention strategies which will ensure that NWL is able to retain its existing highly skilled workforce while continuing to develop it to meet future health and care needs.

Workforce aspects of Whole System Integration

Our model of whole system integrated care will have significant implications for the whole workforce in North West London across health and social care. It will require:

- **Clinical leadership across professions** to ensure the sustainability and effectiveness of care delivery teams. This leadership needs to be visible across all organisations and professions.
- **Development of new roles and enhancement of existing roles,** with community nursing providing a greater range of care in the community and hybrid health and social care workers.
- **Multi-disciplinary care delivery teams** with staff agnostic of organisation with common aligned goals and objectives. This will facilitate a shared understanding across all professionals and organisations to ensure that everyone has the attributes required to enable integrated care and multi-professional collaboration more effective.
- **Facility and organisation independent working**, supported by flexible career paths for both clinical and non-clinical staff to ensure mutual understanding across the multi-professional team and opportunities for staff to move between settings.
- **Service users empowered** to make their own decisions and manage their own care through co-developed care plans owned by the service users.
- **Service users embedded** through co-developing and improving services with lay partners and using patient educators where possible.

A large cultural change programme is planned for the WSIC early adopters to then be rolled out to the wider workforce across NWL. Alongside this, work is underway to understand the implications of the Whole Systems changes for different cohorts of the workforce. Multi-professional education will facilitate the development of mutual understanding across the sector and coordinated working across professions.

Workforce aspects of Primary Care Transformation

GP practices working together more in networks will have a profound impact on the Primary Care team. The changes will bring huge opportunities for the staff to work differently and should identify opportunities for career and skills development. In particular these might include:

- **Practices working collaboratively with other practices** to reduce workloads and share skills enabling enhanced services and greater access out of core hours.
- **Staff developing trust across practices** to offer extended hours and be prepared to share information regarding their patients and adopt new referral patterns.
- **Staff working differently across practice boundaries**, adopting new ways of working and new behaviours to ensure that the benefits of collaboration translate into higher and more consistent standards for care.
- **Clinical staff enhancing their skills** and knowledge to support patients with complex needs. These skills should be deliberately developed in alignment with population needs and offer the opportunity for staff to develop or enhance their scope of practice, with economies of scale enabling more specialist skills in primary care.
- **Non-clinical roles becoming broader** as network managers become integral to the consistent delivery of care across networks, providing more opportunities for career development.

We are currently providing support for our emerging networks and working to model the impact of providing seven-day access to primary care, including impacts on staff numbers. This work will report jointly to our primary care partnership board and the WSIC integration board.

We are also working to increase the provision of education and training in primary care to ensure that we are training the future primary care workforce for North West London.

Workforce aspects of Acute Reconfiguration

The transformation of acute services across North West London will also have wide reaching implications on the acute workforce including:

- A cultural shift, with staff moving to 7 day service delivery with a deeper understanding of the whole patient pathway and more trust in the provision of community care.
- Staff will spend part or all of their time delivering care in the community as care moves to settings most appropriate and convenient for the patient.
- Clinical standards driving the need for more staff across the system in some areas and, in others, requiring new ways of working and collaboration across NWL's providers.

The Workstream is working with the ten trust HR Directors across the sector to develop a set of transition principles which will form the basis for transition plans. Alongside this, the Workstream is creating a best practice approach for NWL to managing staff transition.

Trusts are managing the transition of their staff through projects for service transitions. The Workstream is providing direct support to them to ensure that their plans meet statutory requirements and are coordinated across the patch, working with HENWL to ensure that affected staff have the development support through transition to keep their much needed skills in North West London. HENWL is coordinating the education establishment's response to each service closure.

Investing in the current and future workforce in NWL to support service transformation

HE NWL has an annual budget of £265 million (2013-14 figures), and the majority of funding is invested in future workforce. The 2013/14 expenditure on developing the existing workforce was £12 million, which will be maintained for 2014/15.

Workforce development funds are split across a range of service priorities with Primary Care receiving a specific allocation which will increase year on year. All spend will align to the SaHF vision for care and develop the workforce to deliver the CCGs' out of hospital strategies.

Specific priority areas identified for 2014/15 include:

- Primary Care transformation
- Supporting the implementation of out-of-hospital strategies across NWL
- Emergency medicine and urgent care
- Band 1-4 staff development including apprenticeships

North West London has been piloting innovative models of providing education based around certain conditions and along patient pathways over the last 12 months to enable multi-disciplinary learning across the sector.

Alongside this, we will be developing Community Learning Networks which will provide the education infrastructure in primary and community care to enable integrated learning to support the cross disciplinary, multi-professional team.

Workforce workstream: structure and governance

The workforce workstream is working across six broad areas:

- Acute Reconfiguration implementation
- Acute Reconfiguration planning
- Achieving Clinical Standards

- Primary Care Workforce Transformation
- Integrated Care Workforce Transformation
- Implementing Community Learning Networks

The Joint Workforce Steering Group provides oversight and strategic direction to all workforce related work across the programmes of work.

Workforce is embedded in each programme and work packages will develop as individual programmes of work mature.

This structure enables strategic coherence and oversight while ensuring that there are links made between programmes while maintaining sufficient local detail in each programme.

**3. 'Out of Hospital' strategies and reduction in acute demand**

A key enabler of the successful realisation of the benefits of the SaHF acute reconfiguration, including improved quality and a financially sustainable health system will be the effective implementation of the NWL 'Out of Hospital' strategies, which will deliver the reduction in overall demand for acute services.

**4. Communications**

The scale and complexity of the changes being planned and delivered in North West London necessitate a strategic and structured approach to communications. Through this workstream we ensure greater understanding of the key stakeholder groups and how messages should be shared with these groups. In this way the aim of the workstream is to ensure the right people are aligned to service transformation.

A comprehensive plan has been delivered which includes key messaging across the main sites across North West London as well as timescales for activity. For example, the Central Middlesex and Hammersmith Hospital project plan includes a detailed public information campaign to inform local residents about the key changes to the Accident and Emergency departments prior to transition.

**5. Engagement, co-design, travel and equalities**

Ensuring services are designed 'with users' and not just 'for users', and that travel and equalities considerations and statutory obligations are met are vital to ensuring new services will be fit for purpose. This enabler workstream supports that activity, from the co-design work on Whole Systems to the Travel Advisory Group that advises on the travel implications of the acute reconfiguration. This workstream also works closely with the Communications team to support the behavioural changes required for new systems and services to be successfully adopted.

**6. Clinical**

The Clinical workstream leads the development of clinical solutions underpinning service transformation, manages clinical risk, monitors changes to clinical quality and safety and is responsible for overseeing the clinical subgroups.

The Clinical workstream is aligned with and collaborates with the CWHHE and BHH Quality strategies and governance structures.

**7. Finance**

The enabling workstream works to ensure coherence between the planning assumptions of commissioners and providers and the overarching financial strategy in North West London. To this end the workstream seeks assurance that transformation solutions are financially viable from both an individual and system wide perspective within the overarching framework of the financial strategies.

**8. Benefits realisation**

This enabling workstream tracks and monitors delivery of the benefits of delivering S*haping a healthier future* and the wider transformation programme. The DMBC

described twenty benefits, including better outcomes for patients and carers, reduced avoidable mortality, and improved patient experience. These have now been mapped to the NHS Outcome Ambitions. We need to ensure that the changes being designed and implemented over the coming five years actively contribute to the delivery of these benefits and improved outcomes.

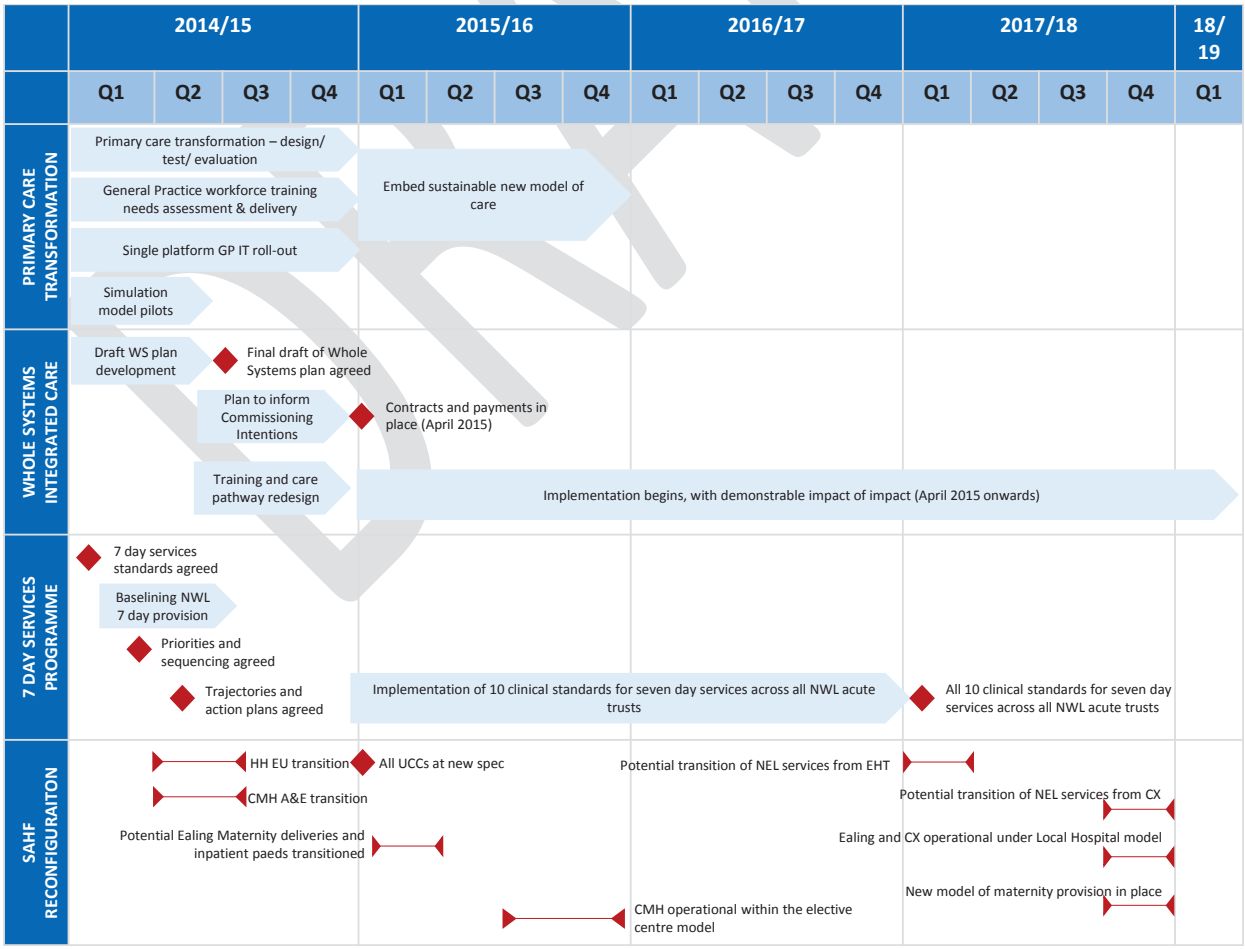
Within this workstream we also track and monitor programme progress using 'in flight indicators', such as activity shifts between acute and community settings, changes to the quality of services, and total bed numbers. This enables us to ascertain our progress in implementing the transformation programmes and the degree to which we can be confident we will deliver the required benefits.

## Programme Implementation Timeline

The high-level programme implementation timeline illustrates the timescales by which each of the programme's key milestones will be achieved, including:

- Sustainable network-based GP model in place by in 2015/16.
- Roll-out of Whole System approaches to commissioning and delivering services from April 2015.
- Consistently high standards of clinical care achieved across all days of week by 2017/18.
- The full transition to the new configuration of acute services complete by the end of 2017/18.

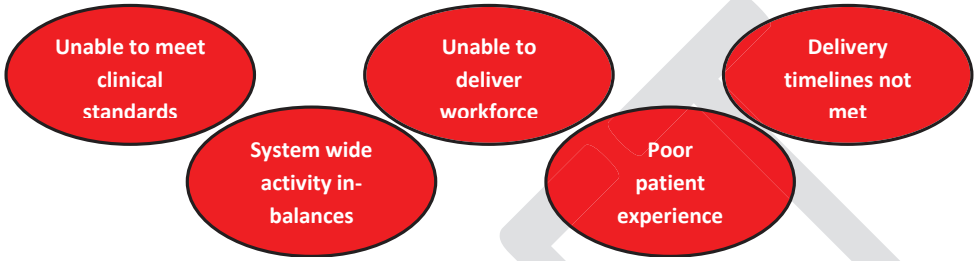
Programme implementation timeline



### Programme – Barriers to Success

A large number of risks to the *Shaping a healthier future* acute reconfiguration programme have been previously identified and developed into a consolidated programme risk register. These risks have been identified from a number of sources, including a series of clinically led Risk Identification workshops.

To provide strategic level oversight and a better sense of the complex interdependencies within the programme strategic level risks have been developed. This was done through a risk mapping exercise, which has led to **5 strategic areas of risk**:




When considered together, these five areas lead to only two risk outcomes. These outcomes form the corner stone of the programme's risk management activities and are what the programme should be designed to avoid. These risks have been captured in the two risk outcomes below, along with the associated mitigation plans. These risks have now been finalised by the Clinical Board and are included in all Organisational Risk Frameworks.

**Risk outcome #1:** through unsustainable demand, uncontrolled delays to the delivery timelines and an inability to deliver the required clinical workforce *Shaping a healthier future* delivers precipitate, poorly planned change, which adversely impacts quality and safety.

***Mitigating Actions***

A programme implementation governance structure has been established to ensure that there is involvement from all major stakeholders and will monitor programme progress:

- *Clinical Board* - brings together all of NWL's medical leaders to ensure transition is being safely planned and managed and will coordinate collective action to address any issues as required. This group will be responsible for leading clinical implementation planning, in particular advising on safe sequencing of change and readiness for change (incorporating the programme four step decision making process). Further scenario testing and readiness exercises are to be carried out.
- *Uncontrolled delays* - dedicated resources have been put in place across all organisations to support the delivery of the programme. These are centrally supported by the programme zones and cross cutting workstreams, which includes the involvement of all major external stakeholders. The SaHF Implementation Programme Board will continue to review the overarching programme progress.
- *Monitoring* - Clinical Board and Programme board continue to review the programme tracker which monitors key metrics on activity, quality and shape change.
- *Travel Advisory Group:* one of the concerns raised through the SaHF consultation process was transport, and how people would travel to and from new health care destinations. The Travel Advisory Group is working to address these concerns by developing mechanisms to assist patients,

carers and relatives to undertake changed patient journeys as a result of reconfiguration. This includes carrying out patient travel surveys to understand the journeys that are currently made, and using the results of these to work with Transport for London (TfL) to look at bus routes and accessibility at tube stations. The delivery of the Out of hospital strategies will also mean that more services are delivered closer to people's homes, and therefore there will be fewer journeys made to major acute hospitals to receive health services.

- *Communications*: there is a risk that patients and the public are not sufficiently aware of the changes taking place, and how they are expected to use services differently. SaHF has developed an extensive Communications strategy to ensure that stakeholder groups are well-understood, and that messages, language and communication media are targeted accordingly, including clear and concise language. Specifically, on the Central Middlesex and Hammersmith Hospital Communications and Engagement Workstream, Lay Members have been helping to advise on putting forward ideas for additional channels as well as ensuring that the messaging is clear and concise.

**Risk outcome #2**: through an inability to meet the clinical standards, deliver the requisite workforce, deliver behavioural change, sustain expected patient experience and an unsustainable demand on the system *Shaping a healthier future* does not deliver the planned benefits to improve quality and safety of health and care across NWL.

***Mitigating Actions***

A programme implementation governance structure has been established to ensure that there is involvement from all major stakeholders and will monitor programme progress:

- *Clinical Standards* – clinical standards were approved and all providers are now creating plans which support the delivery of these standards – this will remain under review by the Implementation Clinical Board.
- *Clinical Workforce* – a steering group for the development of a NW London wide workforce has been implemented, working with HE NWL. A baseline of all acute, community and primary care workers has been defined. A joint workshop is being held to bring together all stakeholders to develop a common view on creating the workforce.
- *Unsustainable demand* – All provider CIP and commissioner QIPP plans have been designed in support of the activity shift and system wide shape change. A finance and activity modelling group consisting of all commissioner and provider Finance Directors has been established to ensure a common view for the creation of all business cases. A programme wide tracker to review activity, quality and shape change is reviewed by the programme quarterly.
- *Benefits framework* –the Decision-Making Business Case (DMBC) included a benefits framework to ensure that the programme was designed to deliver the specified benefits and this will continue to be reviewed.

The five strategic risks and two risk outcomes provide an effective mechanism for coordinated risk management across both providers and commissioners. But it's also vital that we have clarity on the risks that sit beneath this level and manage their mitigation. This is done through a robust risk management process at the project level, with those risks that cannot be managed at this level flowing up to the programme level, which in turn feed the strategic level risks to provide a rich and comprehensive picture of the risks and mitigations.

As an illustration, key programme level risks that we are currently managing include:

- *Unable to maintain quality and safety through transition* – the Clinical Board and associated groups are carefully monitoring quality metrics as we proceed through the transformation to ensure that quality is maintained and in time improved.
- *Not all capital required can be secured* – capital process is being coordinated through the NTDA and DH and work is underway with providers to ensure financial viability of individual business cases and the wider system.
- *Out of hospital strategies do not deliver required reductions in activity in the acute setting*– substantial work underway within CCGs and the wider transformation programmes to deliver improvements in OOH capacity, and benefits already being delivered.
- *Unable to achieve recruitment and retention of workforce in sending and receiving sites* – strong communications and engagement essential, coordinated working with Health Education North West London and various workforce groups working to ensure the workforce of the future is developed.
- *Reduced support of key external stakeholders* – continuing and ongoing engagement with key stakeholders within and out with the health service.

# 12.How our plans will achieve our vision and strategic objectives

*Our five year plan will deliver two key outcomes (1) improved health outcomes and patient experience, as set in our outcome ambitions; and (2) a financially sustainable health system for future generations.*

### Introduction

The NHS is collectively moving towards a more outcomes-based approach to commissioning services, and this is reflected in NWL's developing approach to measurement against our objectives.

NWL has developed a benefits framework that builds on our Case for Change by describing the benefits that are expected to be achieved as a result of implementing the recommendations. The benefits include improvements to patient outcomes and patient experience, as well as improved experiences for staff through advanced patient care, improved ways of working and opportunities to enhance skills.

NWL's five year strategic plan will deliver two key outcomes: (1) improved health outcomes and patient experience; and (2) a financially sustainable health system.

### Outcome Ambitions

As part of the strategic planning process in NWL, a benefits framework was developed to support design and evaluation of the changes. The benefits were developed in line with the clinical standards that underpin the plans for clinical change. The benefits framework was developed by clinicians and tested with patient representatives, including Programme Medical Directors, the SaHF Clinical Board, and CCG Chairs.

Operational benefits in the framework have been informed by Finance and Business Planning group and its sub-groups, Programme Medical Directors, and Out of Hospital Working Group.

The benefits framework has now been mapped where appropriate to the NHS Outcome Ambitions.

**NHS Outcome Ambitions – attainment targets and supporting transformation programmes**

Improving outcomes and securing high quality care is the primary purpose of the NHS in England.

The NHS Outcomes Framework was developed in December 2010, following public consultation, and has been updated every year to ensure that the most appropriate measures are included.

There are five domains in the NHS Outcome Framework:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Seven outcome ambitions have then been developed, each of which maps to one of the domains, as per the figure below:

7 Outcome ambitions mapped to the NHS Outcome Framework domains

*7 Outcome ambitions covers all the NHS Outcome Framework domains:*

| NHS Outcome Framework 5 Domains | 7 Outcome ambitions |
|---|---|
| *Domain 1:* Preventing people from dying prematurely | 1: Securing additional years of life for the people of England with treatable mental and physical health conditions |
| *Domain 2:* Enhancing quality of life for people with long-term conditions | 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions |
| | 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. |
| *Domain 3:* Helping people to recover from episodes of ill health or following injury | 4: Increasing the proportion of older people living independently at home following discharge from hospital. |
| *Domain 4:* Ensuring that people have a positive experience of care | 5: Increasing the number of people having a positive experience of hospital care |
| | 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community |
| *Domain 5:* Treating and caring for people in a safe environment and protecting them from avoidable harm | 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care |

Outcome measures have then in turn been identified for the ambitions, as per the figure below:

The 7 Outcome Ambitions and the baseline measures

| The 7 ambitions | Do I have to submit a 5-year 'quantifiable' ambition figure? | What is the baseline measure to set the quantifiable ambition against? |
|---|---|---|
| 1. Securing additional years of life for your local population with treatable conditions. | ✓ | Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people) |
| 2. Improving the health related quality of life of people with one or more long-term conditions | ✓ | Health-related quality of life for people with long-term conditions |
| 3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital | ✓ | Quality Premium Composite Indicator |
| 4. Increasing the proportion of older people living independently at home following discharge from hospital | *No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health & Wellbeing Board level.* | |
| 5. Increasing the number of people having a positive experience of hospital care | ✓ | Patient experience of hospital care |
| 6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community | ✓ | Patient experience of GP services and GP Out of Hours services |
| 7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care | *Baseline data not yet available at CCG level to set quantifiable level of ambition against. However 'case note review' data will be available to measure progress on local plans in the next few years.* | |

Each CCG has set an attainment target for these measures, to be achieved by 2018/19, in collaboration with partners, including Health and Wellbeing Boards. The aggregated targets for NWL have been set out in the table below, along with the key contributing transformation programmes and other plans.

Summary of NWL Outcome Ambition targets and contributing plans

| Ambition | Outcome Measures | Baseline | 18/19 target | % change | Key programmes and plans |
|---|---|---|---|---|---|
| **1** | Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (adults and children) | 16,174 | 13,741 | 15.04% | • Health promotion, early diagnosis and early intervention, including integrated approach to screening and symptomatic services<br>• London-wide programmes, including the Cancer Commissioning strategy<br>• Achieving equivalence and parity of esteem for physical and mental health Screening: integrated approach to screening and symptomatic services<br>• Achieving the SaHF, London Quality and 7 Day Services clinical standards |
| **2** | Health related quality of life for people with long term conditions | 594 | 616 | 3.7% | • Whole System Integrated Care<br>• Primary Care Transformation<br>• Transforming Mental Health services |
| **3** | Composite measure on emergency admissions | 17,700 | 15,724 | 11.16% | • Whole System Integrated Care<br>• Out of Hospital strategies |
| **5** | 'Poor' patient experience of inpatient care | 1,307 | 1,213 | 7.2% | • Achieving the SaHF clinical standards, including seven day services<br>• Quality, Safety and Patient Experience plans |
| **6** | 'Poor' patient experience of primary care | 69 | 59 | 14.2% | • Whole Systems Integrated Care<br>• Out of Hospital strategies, including Primary Care Transformation |

*[Please note that outcome ambitions are being reviewed and these attainment targets may be updated further]*

Note that there are currently no baseline measures for outcome ambition 4, '*Increasing the proportion of people living independently at home following discharge from hospital'* or for outcome ambition 7, '*Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care'*. However, the former will be supported through Whole Systems Integrated Care and Primary Care Transformation, while the latter will be supported through the Quality, Safety and Patient Experience plans, including achievement of agreed clinical standards for NWL acute trusts.

**Addressing Health Inequalities**

The NHS must place special emphasis on reducing health inequalities. We need to ensure that the most vulnerable in our society get better care and better services, often through integration, in order to accelerate improvement in their health outcomes.

These issues are very pertinent to NWL, which, for example, has a higher proportion of families having children live in poverty than the national average, with higher than

average rate of low birth weight babies and higher levels of obesity, and which serves a diverse population.

Each CCG, in collaboration with local partners through the Health and Wellbeing Board, has identified the groups of people in the area that have a worse outcomes and experience of care, and have developed Health and Wellbeing Strategies to close the gap (see Appendix D for the specific priorities identified by each Health and Wellbeing Board.

In 2013/14, NWL CCGs focused on proactively capturing insight and feedback from BME and other equality groups – for example:

- Central London CCG: commissioned insight work through the BME Health Forum to capture experience and access to A&E by BME communities.
- Hounslow CCG: commissioned Diabetes UK to engage with BME communities on Diabetes.

The feedback received through this work will be used to shape and influence service development, e.g. local Diabetes Service Redesign work.

Equality Delivery System

The Equality Delivery System (EDS) is a toolkit that has been developed to support NHS organisations to drive up equality performance and embed it into mainstream business. The NWL CCGs are committed to embedding equality and inclusion in everything that we do, and specifically in how we:

- Commission and make accessible services for all the residents of our diverse community.
- Recruit and support the development of our staff.
- Proactively inform, consult, engage and involve all our diverse communities.

Each CCG has agreed its Equality Objectives for 2013 – 2016. These were identified through a series of local processes that involved local people, CCG staff, the CCG Governing Body and other stakeholders. This included reviewing the needs of each population through the Public Health Equalities Profiles and the Joint Strategic Needs Assessments (JSNAs). Equality Objectives were set across in relation to the following national goals:

- National EDS Goal 1: 'Better Health Outcomes for All'
- National EDS Goal 2: Improved Patient Experience and Access
- National EDS Goal 3: Empowered, Engaged and Well Supported Staff
- National EDS Goal 4: Inclusive Leadership At All Levels

### A financially sustainable health system

The future pressures on the health service identified in a *Call to Action* include*:*

- Demand for health services:
  - Ageing society
  - Rise of long-term conditions
  - Increasing expectations
- Supply of health services:
  - Increasing costs of providing care
  - Limited productivity gains
  - Constrained public resources

The assumptions made by NWL CCGs are consistent with the challenges identified in a *Call to Action*. NWL plans are to improve outcomes whilst maintaining financial stability.

To fulfil its constitution, the NHS must continue to provide a comprehensive, excellent service, available to all. But these trends in funding and demand will create a sizeable funding gap. NWL has projected that without any change, the funding gap for commissioners could grow to £365m. Hospitals in NWL will also face significant financial challenges, even if they become as efficient as they can be. Achieving and then maintaining a higher level of productivity

across care settings will mean making radical changes to the way care is delivered.

*Shaping a healthier future*, the Out of Hospital strategies and the other transformation programmes have been developed in order to address the challenges set out in our Case for Change and to realise our vision for healthcare in NWL, while delivering a sustainable NHS for future generations.

The CCG projections are to ensure a sustainable position is attained, which is consistent with NHS England Business Rules (i.e. a 1% surplus) and includes contingency (at 0.5%) to respond to risks.

The NWL CCGs' financial plans include the outcome ambitions. Non-recurrent implementation costs are assumed to be funded through the NWL financial strategy agreement to pool CCG / NHSE non-recurrent headroom (2.5% in 2014/15).

The plan on a page elements are reflected in the activity and financial projects covered in operational and financial templates, as these templates reflect the anticipated shift in activity from acute to out of hospital settings that will be achieved through implementation of the major NWL transformational programmes, including WSIC, and individual CCG Out of Hospital strategies and other QIPP initiatives. Financial sustainability in NWL will be achieved by providing more integrated community-based services and less inpatient acute care, as described in the key transformation programme section.

All organisations aim to have clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks.

There is a clear link between service plans, financial and activity plans. Please see Appendix G for further detail on the relationship between the financial and activity modelling underpinning the *Shaping a healthier future* programme and Out of Hospital strategies, the CCG's two year operational plans (including QIPP), and the Better Care Fund plans.

# 13. How we work: Embedding partnerships at every level

*A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, service users, families and carers, building on the co-design approach designed through Whole Systems. We will also continue to work collaboratively across the eight CCGs of NWL, and in partnership with NHS England, local authorities and community groups.*

### Introduction

A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, building on the co-design approach designed through Whole Systems. We will also continue to work collaboratively across the eight CCGs of NWL.

### Citizen Empowerment and Patient Engagement

A fundamental element of our NWL Plan is to ensure that we effectively empower citizens and engage with patients, harnessing technology where practical to do so. Patient engagement is a core element of the overall commissioning cycle, and is integrated into each stage. Strengthening our collaborative service development and commissioning approaches with patients will support us to achieve the principle of **personalised care**, which in turn will improve patient experience. See chapter 2 (Patient Experience section) for further details on how NWL CCGs will improve patient experience in acute, community and primary care settings.

There are four aspects to our approach, which is based on the guidance set out in '*Transforming Participation in Health and Care*'[28]:

1. **Patient self-management and self-care**: we have significant local evidence through our patient journey feedback that patients want to be in control of their condition and treatments and this project will support them to do so. Each NWL CCG will ensure that patients and carers are supported to plan manage and make decisions about their care and treatment through the services they commission. This will be achieved through:
    - Existing Expert Patient Programmes and patient user groups.

[28] 'Transforming Participation in Health and Care', NHS England, September 2013: http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- The roll-out of Personal Health Budgets from April 2014 (building on learning from existing users to ensure they are deployed as effectively as possible).
- The roll-out of care plans, as part of Whole Systems Integrated Care.
- Online access to self-management advice, support and service signposting (implemented as part of Primary Care Transformation).
- Self-management initiatives (where appropriate) to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in an out of a hospital setting, where appropriate, including peer mentoring and local champions. These will expand the role of the third sector in supporting patients and carers through peer education, peer support, therapies, advocacy, volunteer co-ordination and befriending services etc.

2. **Public participation in the commissioning process:** each NWL CCG will ensure the effective participation of the public in the commissioning process, so that services reflect the needs of local people.

   Each CCG has a patient and public engagement strategy to involve local representative groups in decision-making and that identifies the best way to engage with hard to reach groups. Our over-arching communications approach is to engage with patients and the public through a range of existing conduits, including community networks, user-led / self-help groups, voluntary sector forums, partnership boards, Patient Public Groups (PPGs), and local community stakeholders.

   NWL has a genuine desire to meaningfully co-design services with patients and the public, and we will continue to strengthen and develop our approach as we implement our plans. This will build on the work of the 'Embedding Partnerships' lay partners supporting our Whole Systems Integrated Care programme. Part of that work included developing a co-production touchstone (see chapter 7 for further details about our approach to co-design). There is a commitment to working co-productively in NWL, which means:

   - **Commitment to agreed ways of working** – everyone is valued as equal partners, we will capitalise on lived experience as well as professional learning.
   - **Supporting development and learning.**
   - **Fostering a supportive environment** – developing collective resilience and acknowledging that mistakes will be made along the journey.
   - **Working towards shared goals** – promoting local voice and enabling people to be involved in the delivery of their care and support.

   Each NWL CCG is able to demonstrate the impact of patient involvement on commissioning priorities and on our discussions with providers.

   NWL is also exploring Promoting an Asset based approach to working with patients, service users, carers and the wider community in some CCGs. Early stages of this approach will include:

   - To identify and map community and citizen assets in selected localities with relation to independence, health and wellbeing.
   - To identify gaps and strengths in community and citizen assets.
   - To mobilise community assets effectively and sustainably to promote health and wellbeing and reduce health inequalities.
   - To identify citizen and community level insights about where social

capital can be strengthened or optimised.

- To design and deliver substantial, innovative interventions and actions which are co-produced with patients, service users and carers.

3. **Access to data and information about health and services:** NWL, working with national partners, will ensure that the population is well served by access to transparent and accessible data and advice about health and services. This will include a clear avenue for accessing up-to-date local clinical and operational service information for patients, GPs and other providers. This will include:
   - NHS Choices and the creation of a digital 'front door', which will help transform the way patients, their families and carers access information about NHS services and will provide self-management materials and information to further empower them to manage their own condition.
   - Up-to-date and accessible Directories of Service available across the health system.
   - Clinicians and other health staff able to provide accurate information about health and services to patients and carers at the point of care, as required.

   While it is recognised that not everyone has equal access to on-line information, and that therefore a wide range of other communication channels must also be used, it is hoped that over the next five years many more people will also become confident internet users.

4. **Delivering better care through the digital revolution - harnessing technology:** we will harness information technology to deliver better care and to make services more convenient for patients. While further detail about our Informatics strategy is available in chapter 11 (Programme Enablers: Informatics), aspects that will support citizen and patient empowerment include:
   - Greater use of telehealth and telecare to support people with long-term conditions to manage their own health and care.
   - Patients will be able to access their own health information electronically.
   - GP practices will promote and offer to all patients the ability to book appointments, order repeat prescriptions and access their medical notes online.

### Partnership working

There are a number of other partners across the health and care system, and it is critical that commissioners, both CCGs and NHS England, work effectively within these partnerships, including with local authorities and community groups, including through the Health & Wellbeing Boards. It will not be possible to achieve our outcome ambitions, including improving life expectancy and quality of life, without addressing the wider determinants of health, and this will require a pan-NWL approach across all major transformation programmes. This will require a concerted programme of change with our statutory and community partners to reduce demand on the NHS by enabling residents to manage their own health, support one another, and improve their health and wellbeing in the community.

### Governance Overview

Robust governance processes are in place to ensure that future plans are developed in collaboration with key stakeholders, including the local community (as per our Whole Systems approach to co-design and embedding partnerships).

The CCG Collaboration Board, a CCG-led governance structure, monitors and oversees delivery of the entire NWL strategic plan, from the acute reconfiguration to the delivery of supporting out of hospital strategies, including Whole Systems Integrated Care.

See the following page for an overview of the programme governance structure in NWL.

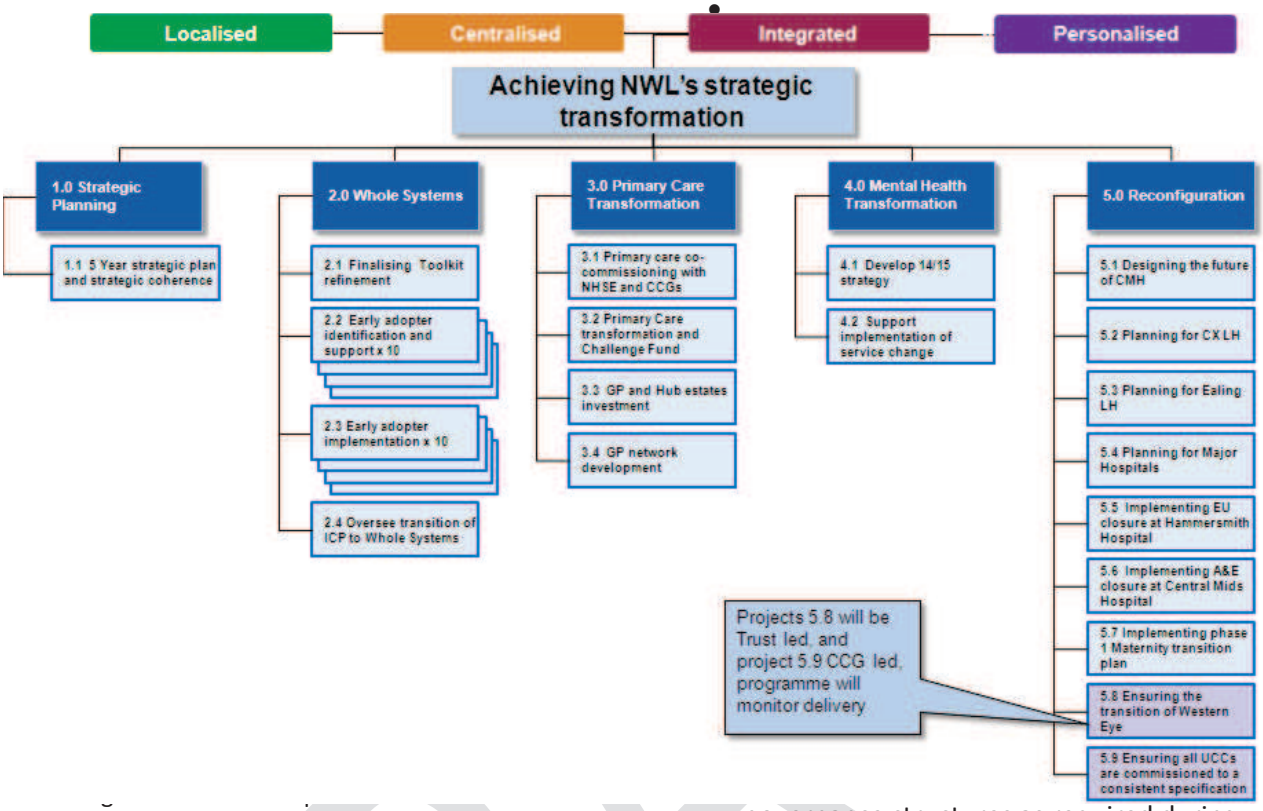
Key joint programme governance structures for the major transformational programmes include:

- *Shaping a healthier future* programme: SaHF Implementation Programme Board
- Enhancing integrated care: WSIC Programme Board
- Primary care transformation: Primary Care Partnership Board
- Mental health transformation: Mental Health Programme Board

Each of these key joint programme boards include lay partners/lay people, whose role includes ensuring that all service developments remain focused on benefiting patients, and that services are wrapped around the individual patient or carer.

While there is robust governance process in place to oversee implementation of the NWL 5 Year Strategic Plan, responsibility for delivery ultimately lies with CCG Governing Bodies and Health & Wellbeing Boards. Each of these programme Boards therefore report to the CCG Collaboration.

Programme governance structure*




programmes, and does not represent the full governance structure across the 8 CCGs or all of the other projects and programmes underway, e.g. CCG QIPP plans, etc.

CCG Collaboration Board

The Board will address issues across the eight North West London CCGs. The eight CCGs in NWL have agreed a Memorandum of Understanding (MOU) setting out how they will work together in a collective way to successfully implement the 'Shaping a Healthier Future' strategy whilst recognising each CCG's individual sovereignty and the need for decision making to be made at a local level.

The main tasks of the Board include:

- Take responsibility for leading the *Shaping a healthier future* Reconfiguration Programme Implementation, including receiving regular reports from the *Shaping a healthier future* Implementation Board governance structures as required during the implementation process.
- Oversee Out of Hospital (OOH) Strategy Implementation, working collaboratively where it is agreed by members to be appropriate in relation to major OOH transformation programmes and evaluation of benefits.
- Take responsibility for ensuring delivery of major transformation programmes established across the CCGs including decisions regarding programme design, resource allocation (including recommendations regarding shared procurements), overseeing progress and benefits realisation.
- Financial risk management across NW London CCGs and other commissioners, in particular the NHS Commissioning Board.
- Collaborative approach to research and education.

# Appendices

# Appendix A – How we have developed our five year plan

## Information sources used to develop our plan

As part of the original strategic planning process, NWL clinicians developed a Case for Change, with involvement from providers, CCGs and representatives of patient groups and the public. The strategic plans for NWL have evolved further based on the initial patient and public consultation that focused on the future of acute services in NWL, the thorough engagement that has taken place with regards to whole system working and the delivery of integrated and out of hospital care, collaborative working across commissioners and providers, and based on a wide range of qualitative and quantitative data, including financial projections, current performance indicators, and local and national benchmarks.

As part of refreshing NWL's strategic plan in line with *Everyone Counts* planning guidance, the following sources of data, intelligence and local analysis were also explored:

- London Data Packs, including the North West London pack which suggests that NWL that three particular challenges to address: (1) improving support for early years (e.g. low immunisation rates and high levels of child obesity); (2) Enhancing support for LTCs (reducing the usage rate of acute services by patients with LTCs); and (3) meeting the needs of the frail elderly population.
- JSNAs: each borough has a JSNA that sets out the health needs of its population, and which supports the commissioning of health, well-being and social care services within the locality, including the local priorities set out in the Health & Wellbeing strategies and reflected in the pan-NWL transformation programmes.
- Atlas tools, including 'CCG Outcomes', 'Levels of Ambition Atlas', and 'Operational Planning Atlas'.
- Commissioning for Value insight packs.
- The 'Any town' toolkit (see Appendix C for current status across the NWL CCGS with regards to the High Impact and Early Adopter interventions described in 'Any town'): this has helped to assure and develop the CCG QIPP plans and other initiatives.

All of these inputs have supported NWL CCGs and NHS England partners in developing the vision, key transformation programmes, and other plans that are set out in our five year plan, including the Health and Wellbeing strategies. There has been a genuine change in recent years in the way that NWL commissioners work with lay partners and other stakeholders, as we increasingly focus on citizen empowerment and patient engagement, and this change is reflected in the language used to articulate this shared five year plan.

## What do the NWL Case for Change, including our current and targeted performance against the NHS Outcome ambitions, and the 'Call to Action', mean for both health services and for local people?

The messages within a 'Call to Action' resonate closely with NWL's ambitious plans to transform and improve our hospital services and bring care closer to patients.

On 2 July 2012, NWL launched a public consultation on the plans for reconfiguration of services. We consulted on a set of proposed clinical standards, clinical service delivery models and options for location of services. The consultation period ran for 14 weeks and ended on 8 October 2012. The feedback from consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism. We responded to this feedback, carrying out significant additional work on the analysis, in particular the clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning. The

outcome of the public consultation is eight settings of care in NWL to deliver the SaHF clinical vision and standards.

The clinical case for change and the acute reconfiguration consultation feedback provide a valuable resource to call upon, as they seek to have an honest and realistic debate about how the NHS can be shaped to meet future demand and tackle funding gap through 'honest and realistic' debate.

Other key themes that have been identified through to 'call to action' engagement events in NWL include:

- Care centred around patient – enabled by IT and shared records (see chapter 7 for Whole Systems and chapter 11 for Informatics).
- People really value access to healthcare professionals who speak their language.
- Flexibility of services (after-hours appointments, phone appointments, GP home visits) (see chapter 6 for Primary Care Transformation).
- Importance of better communication and data sharing, keeping care in the home or community and the role of signposting and care navigation (see chapter 13 for Citizen Empowerment and Patient Engagement).
- Participants expressed a strong desire to be included in the co-design of integrated care, moving beyond traditional forms of engagement and consultation to being involved at every stage of the process from ideas to implementation (see chapter 7 for Whole Systems and chapter 13 for Citizen Empowerment and Patient Engagement).

The key themes that emerged in NWL were consistent with those emerging across London, i.e.:

- Information, communication and education
- Focus on prevention and management of care
- Improving access, partnership working and integration of services

Key feedback from this level of public engagement (our NWL 'call to action' programme) has been fundamental to agreeing the programme of acute service changes in NWL, and to developing our major supporting workstreams, including Integrated Care.

In response to the compelling Case for Change and the public engagement related to the acute reconfiguration and the 'Call to Action', the NHS in NWL must:

- Support its residents to lead healthy lives and offer safe, high quality care to all
- Increase proactive care with more people being screened for preventable diseases and early detection of abnormalities, and with more people immunised against preventable diseases
- Empower patients to make informed choices about their care and help ensure they do not go into hospital unnecessarily
- Provide more specialist hospitals on fewer sites to treat patients with the most complex illnesses, with round-the-clock professional expertise on call
- Integrate the services provided by those delivering care and support – GPs, community services, hospitals, local councils and social care
- Make it easier for more patients to be treated in their community and focus future investment more in these services
- Get the best value from all NHS spending

### How community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions

Public and patient engagement is a core principle of NWL's planning processes, and has underpinned development of our key improvement interventions, both at a CCG and NWL-wide level. The stakeholder engagement associated with key NWL transformation interventions is described in further detail below.

# Appendix A – How we have developed our five year plan

**Health & Wellbeing strategies**

- Significant public consultation has taken place in each Borough to develop the Health & Wellbeing Strategies.

**Whole Systems**

- Through patient and service user workshops, interviews and surveys across North West London, we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.
- Integrated care is what people who use services want, what professionals aspire to deliver, and what commissioners want to pay for:
    - *"I know who is the main person in charge of my care. I have one first point of contact. They understand both me and my condition."*
    - *"The professionals involved with me talk to each other. I can see that they work as a team."*
    - *"There are no big gaps between seeing the doctor, going for tests and getting the results."*
    - *"I am as involved in decision making as I wish to be."*
- One of the core working groups within NWL's programme to implement a modern model of integrated care (see Improvement Intervention #3 – Enhancing the integration of care), is 'Embedding Partnerships'. This working group has a mandate to ensure the person voice is at the heart of shaping Whole Systems Integrated Care through co-design and implementation.
- Both a Lay Partners Forum and a Lay Partners Advisory Group provide input, challenge and debate from the perspective of patients, people and cares who user services across the whole programme.
- In addition to the central role of the patient and carer voice in the design of modern models of integrated care in NWL, the existing Integrated Care Programme (ICP) holds regular patient reference group meetings; members of the patient reference groups have been trained.

**Transforming Mental Health Services**

- In 2011, NWL worked with local Mental Health Trusts, GPs and other stakeholders on how to improve mental health care across the region.
- This work explored the potential for integrated care approach to mental health, and involved a range of stakeholders in the discussions and meetings.
- Feedback from service users on the key themes of the Mental Health strategy were then used to refine the strategy.

**Out of Hospital strategies, including Primary Care transformation**

We know that successful delivery of our Primary Care transformation project depends on active engagement with the people who use our services, their families and carers. Our eight CCGs commissioned a comprehensive review of patient priorities for primary care in North West London in 2012, including a survey of over 1000 residents, and consultations with BME groups, non-English speakers and patients with learning disabilities.

The survey confirmed that, of the top ten patient priorities, seven related to better access, including:

- Being able to easily access an emergency appointment
- Having a continuing, trusted relationship with a named health professional

- Being able to easily get through on the phone to make an appointment or seek advice
- Having access to a variety of appointment types

We therefore already have good insight into the differentiated appointment types that patients in North West London want – urgent, continuity and convenient appointments, available via a range of channels. This is the foundation of our model for future General Practice in North West London.

***Shaping a healthier future*** **– acute reconfiguration**

- The design of the acute reconfiguration was supported by one of the largest NHS public consultations ever undertaken. *The Shaping a healthier future* acute reconfiguration ran a public consultation process which received some 17,022 responses over 14 weeks in summer of 2012, from the 2nd July to 8th October.
- Over 200 meetings were held, engaging with over 5,000 people to consult on:
    - Proposed clinical standards
    - Clinical service delivery models
    - Three potential options (referred to as A, B and C) for the location of acute hospital services
    - Out of hospital services
- NWL agreed the duration and method of the consultation with the JHOSC, and the consultation approach was endorsed by the Consultation Institute. The outcome of the public consultation is eight settings of care in NWL to deliver the SaHF clinical vision and standards.
- A Patient Public Reference Group (PPRG) continues to meet monthly to support implementation of the SaHF plans.

## Who has signed up to the strategic vision, and how have the health and wellbeing boards been involved in developing and signing off the plan

- NWL has engaged in a major strategic planning process across the 8 CCGs of Brent, Ealing, Central London, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow and West London, which has led to the development of the *Shaping a healthier future* programme, including supporting workstreams.
- The *Shaping a healthier future* strategic planning process, and the development of the major transformational programmes of work, have included acute, community, and mental health providers, along with commissioners, Local Authorities, Public Health, Health Education England, and lay members.
- The 5 Year Strategic Plan set out within this document has been developed through the following process:
    a) Initial development of core content from existing strategic and other planning documents
    b) Bi-lateral planning meetings with NHS England Direct Commissioners
    c) Review of key messages with constituent CCG Chairs and Chief Operating Officers/Managing Directors
    d) Agreement of key messages within the Strategic Planning Group
    e) Review and update of individual sections as required with respective leads within all constituent CCGs
    f) Contributions and sign-up from:
        - Patients & carers (pan-NWL stakeholder event held in June 2014)
        - Healthwatch/Patient Public Representative Groups (PPRG)

  - CCGs
- Providers
- Health and Well-being Boards
- Local Authorities (through the Strategic Planning Group)
- NHS England Area Team
- Health Education England (NWL)
- Local Education and Training Board (LETB)

### How the Health and well-being boards have been involved in setting the plans for improving outcomes

- NWL CCGs are reviewing proposed Outcome Ambition attainment targets with their respective Health & Wellbeing Board.

### How two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here

- A necessary foundation of the NWL strategic vision is achievement of the CCG Out of Hospital strategies, and the associated shift in activity from acute settings to community settings.
- This activity shift is reflected in the activity and financial trajectories set out in the detailed two year operational plans. It is also consistent with the anticipated activity levels used to support SaHF acute reconfiguration business cases.

# Appendix B – How our Five Year Plan aligns with NHS England planning guidance

The NWL transformation programmes and cross-cutting plans reflect the three facets of care identified in the NWL Area Deck, i.e.: Care close to home; Hospital Care; and Integrated care. They also reflect the six models of care outlined in *Everyone Counts*, as per the table below:

Relationship between NHS England's 'models of care' and the NWL initiatives

| | Model of Care | Alignment to NWL Transformation Programmes |
|---|---|---|
| **1.** | **Citizen participation and empowerment** | • Citizen participation and empowerment is a fundamental tenet of all NWL programmes, and our approach is described in chapter 13. |
| **2.** | **Wider primary care, provided at scale** | • Out of Hospital strategies, including Primary Care Transformation |
| **3.** | **A modern model of integrated care** | • Whole Systems transformation programme |
| **4.** | **Access to highest quality urgent and emergency care** | • Cross-cutting plans – Urgent & Emergency Care |
| **5.** | **A step-change in the productivity of elective care** | • *Shaping a healthier future* (SaHF) acute reconfiguration, as well as Planned Care pathway redesign as part of Out of Hospital strategies |
| **6.** | **Specialised services concentrated in centres of excellence** | • *Shaping a healthier future* (SaHF) acute reconfiguration |

# Appendix C – Anytown interventions

NHS England has produced a toolkit called 'Any town', which using high level health system modelling, allows CCGs to map how interventions could improve local health services and close the financial gap. It is an additional guide to help commissioners with their five-year strategic plans, showing how a typical CCG could achieve financial balance over the strategic period up to 2018/19.

The NWL CCGs have analysed the proposed 'Anytown' interventions, and a summary of the status of each intervention in each CCG is summarised in the table below:

Anytown intervention status by CCG

| | Central | Ealing | H&F | Hounslow | West London |
|---|---|---|---|---|---|
| **Early diagnosis** | | Planned | Partially met - further plans | Not planned | Planned |
| **Cancer screening programmes** | | Planned | Partially met - further plans | Not planned | Partially met - further plans |
| **Reducing variability in primary care: *referring*** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Reducing variability in primary care: *prescribing*** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **GP tele-consultations** | Planned | Not planned | Not planned | Planned | Planned |
| **Reducing urgent care demand** | Partially met - further plans | Planned | Fully implemented | Fully implemented | Partially met - further plans |
| **Medicines optimisation** | Partially met - further plans (BAU) | Partially met - further plans | Fully implemented | Partially met - further plans | Partially met - further plans |
| **Safe and appropriate use of medicines** | Partially met - further plans (BAU) | Not planned | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Self-management: patient-carer communities** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Service user network** | Not planned | Partially met - further plans | Partially met - further plans | Planned | Partially met - further plans |
| **Telehealth/ Telecare** | Not planned | Partially – no further plans | Not planned | Not planned | Not planned |

# Appendix C – Anytown interventions

| | Central | Ealing | H&F | Hounslow | West London |
|---|---|---|---|---|---|
| **Electronic palliative care coordination systems (EPaCCS)** | Partially met - further plans | Planned | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Case management and coordinated care** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Integration of health and social care for older people** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Planned | Partially met - further plans |
| **Dementia pathways** | Planned | Planned | Planned | Partially met - further plans | Partially met - further plans |
| **24hr asthma services for children** | Not planned | Partially met - further plans | Partially met - further plans | Partially met – no further plans | Partially met - further plans |
| **Palliative care** | Planned | Fully implemented | Not planned | Fully implemented | Fully implemented |
| **Acute visiting services** | Not planned | Partially met - further plans | Planned | Partially met - further plans | Partially met - further plans |
| **Mental Health: Rapid Assessment Interface and Discharge (RAID)** | Planned | Partially met - further plans | Not planned | Planned | Partially met - further plans |
| **Acute stroke services** | Not planned | Fully implemented | Fully implemented | Fully implemented | Fully implemented |
| **Reducing elective caesareans** | Not planned | Not planned | Partially met - further plans | Fully implemented | Partially met - further plans |

# Appendix D – Health and Wellbeing Strategies

A key element of the NWL plans, including of where the local focus is in each CCG in terms of health promotion, early diagnosis and early intervention, is the Health and Wellbeing Strategies. The priorities identified in each of the CCG's Health and Wellbeing Strategy are captured in the table below.

| | Brent | Central | Ealing | H&F | Harrow | Hillingdon | Hounslow | West London |
|---|---|---|---|---|---|---|---|---|
| **Alcohol/substance misuse** | ✓ | ✓ | ✓ | | | | | ✓ |
| **Cancer** | | | | | ✓ | | ✓ | |
| Supporting parents and the community to protect **children** and maximise their life chances / **Early Years** Intervention (0-5 yrs) / Best start in life / **Children** engaged in risky behaviour / Giving every | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| **Childhood immunisations** | | ✓ | | ✓ | | | ✓ | ✓ |
| **Childhood obesity** | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| Empowering **Communities** to take better care of themselves / fostering social cohesion and reducing isolation | ✓ | ✓ | | ✓ | | | | |
| **Dementia** | | ✓ | | | ✓ | ✓ | | |
| **Dental Health** (or Oral Health in Children) | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ |
| Type 2 **Diabetes** | | | | | | ✓ | | |
| Ensuring Safe and Timely **Discharge** from Hospital | | | | | | | | ✓ |
| Tackling **domestic abuse** through | | ✓ | | | | | | |

# Appendix D – Health & Wellbeing Strategies

| | Brent | Central | Ealing | H&F | Harrow | Hillingdon | Hounslow | West London |
|---|---|---|---|---|---|---|---|---|
| integrated, whole system approaches | | | | | | | | |
| Reducing **early death**, focusing on the 3 big killers | | ✓ | | | | | | |
| Helping vulnerable **Families** | ✓ | ✓ | | ✓ | | | | |
| Promoting **healthy life** | | ✓ | | | | | | |
| **Health Checks** | | | | | | | ✓ | |
| Better access for vulnerable people to Sheltered **Housing** | | | | ✓ | | | | |
| Improving access to services: **information** and advice services | | ✓ | | | | | | |
| **Integrated health and social care services** | ✓ | ✓ | | ✓ | | | | ✓ |
| **Long term conditions /** reducing impact of disability and long-term conditions | | ✓ | | | ✓ | | ✓ | |
| Increasing Child Population and **Maternity** Services | | ✓ | | ✓ | | ✓ | | ✓ |
| **Mental health and well-being** | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Obesity** | | ✓ | | | | | | |
| **Older People** including sight loss / Older People and Healthy Ageing | | | ✓ | | | ✓ | | |
| **Out of Hospital** Services / Reducing | | ✓ | ✓ | ✓ | | | ✓ | |

## Appendix D – Health and Wellbeing Strategies

| | Brent | Central | Ealing | H&F | Harrow | Hillingdon | Hounslow | West London |
|---|---|---|---|---|---|---|---|---|
| the use of bed-based care | | | | | | | | |
| **Physical activity** | ✓ | | | | | ✓ | | |
| **Poverty / improving health and wellbeing through urban renewal** | | ✓ | | ✓ | ✓ | | | ✓ |
| Making better use of **resources** | | | | | | | | ✓ |
| **Sexual Health** services | | ✓ | | ✓ | | | | ✓ |
| **Smoking cessation** | | | | | | | ✓ | |
| Delivering the **White City Collaborative Care Centre** | | | | ✓ | | | | |
| **Worklessness** | | ✓ | | ✓ | ✓ | | | |
| Supporting **young people** into Healthy Adulthood | | ✓ | | ✓ | | | | |

# Appendix E - The Key Ingredients of Integrating Care

NHS England has identified the "key ingredients" for integrating care, which also represents a useful framework for summarising the NWL case for change, and the key transformation programmes developed in response:

| The Key Ingredients of Integrating Care (NHS England) | |
|---|---|
| **Why** | • Poor patient experience<br>• Poor outcomes<br>• Increasing demand<br>• Unsustainable models of care<br>• Unprecedented financial challenge |
| **What** | **Greater integration of services around the person – *in NWL, this means***:<br>• See Chapter 6 (Whole Systems Integrated Care)<br>**Greater emphasis on self & home care – *in NWL, this means***:<br>• Existing Expert Patient Programmes and patient user groups.<br>• The roll-out of Personal Health Budgets from April 2014<br>• Online access to self-management advice, support and service signposting<br>• The roll-out of care plans<br>• Self-management initiatives to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in an out of a hospital setting, including peer mentoring and local champions.<br>**Building community capacity to manage demand – *in NWL, this means*:**<br>• Healthy Living, Early Diagnosis and Early Intervention<br>• Out of Hospital strategies<br>**A new primary care offer - *in NWL this means***:<br>• Primary Care Transformation, so that primary care:<br>  ○ Accessible<br>  ○ Proactive<br>  ○ Coordinated<br>**Reconfiguration of acute services - *in NWL this means***:<br>• Acute services that are localised where possible, and centralised where necessary, to be achieved through the *Shaping a healthier future* acute reconfiguration. |
| **How** | **Whole health and care system leadership – *in NWL this means***: see chapter 13 (Governance)<br>**Three – five year plans signed off by Health & Wellbeing Boards**<br>**Local & city-wide coherence**<br>**Scale/focus**<br>**Commissioning alignment between LA/CCG/NHS England – *in NWL this*** |

## Appendix E - The Key Ingredients of Integrating Care

| | |
|---|---|
| | ***means:***<br>• Collaborative commissioning between NWL CCGs and NHS England – see Chapter 7 (Primary Care Co-Commissioning).<br>**A way to move around money around the system - *in NWL this means*:**<br>• NWL's Medium Term Financial Strategy (MFTS) – see chapter 12 (A financially sustainable health system).<br>• Whole Systems Integrated Care Early Adopter pilots<br>**Shared information across agency boundaries- *in NWL this means***: see chapter 11 (Programme Enablers: Informatics).<br>**Flexible, engaged workforce and improved training - *in NWL this means***: see chapter 11 (Programme Enablers: Workforce).<br>**Transparent measurement of outcomes**<br>**A developing evidence base** |
| **Outcomes** | **Improved health and care outcomes** - ***in NWL this includes***:<br>• Patient experience<br>• Quality of life<br>• Health outcomes<br>**Financial sustainability of the health and care system** |

As the table above suggests, NWL's five year Strategic Plan will deliver the key ingredients required to provide integrated care.

# Appendix F: Signposting to Key Lines of Enquiry

This plan was developed to response to the Key Lines of Enquiry set out by NHS England in the strategic plan templates. Signposting to each answer within the document is provided below.

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| Submission details | Which organisation(s) are completing this submission? | • NHS Brent CCG<br>• NHS Harrow CCG<br>• NHS Hillingdon CCG<br>• NHS Central London CCG<br>• NHS Ealing CCG<br>• NHS Hammersmith & Fulham CCG<br>• NHS Hounslow CCG<br>• NHS West London CCG<br>• NHS England | |
| | In case of enquiry, please provide a contact name and contact details | Thirza Sawtell<br>Director of Strategy and Transformation<br>NHS North West London Collaboration of CCGs | |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| a) System vision | What is the vision for the system in five years' time? | Our vision is "To improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community".<br><br>Four overarching principles support our vision - that health services need to be:<br><br>1. **Localised** where possible<br>2. **Centralised** where necessary; and<br>3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless patient care.<br>4. The system will look and feel from a patient's perspective that it is **personalised** - empowering and supporting individuals to live longer and live well. The system will enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs. | *The plan on a page* |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically:<br>1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care<br>2. Wider primary care, provided at scale<br>3. A modern model of integrated care<br>4. Access to the highest quality urgent and emergency care<br>5. A step-change in the productivity of elective care<br>6. Specialised services concentrated in centres of excellence (as relevant to the locality) | ***1.*** Citizen empowerment and patient engagement: see page: ***chapter 13, page 97 (Citizen empowerment and patient engagement)***<br>2. Wider primary care: ***chapter 5, page 26 (Primary care transformation)***<br>***3.*** Modern model of integrated care: ***chapter 6***<br>***4.*** Access to high quality urgent and emergency care: ***chapter 9***<br>***5.*** Step-change in the productivity of elective care: ***chapter 8, page 63 (Planned care pathways)***<br>6. Specialised services concentrated in centres of excellence: ***chapter 8***<br><br>***Summarised in Appendix B*** | *Details provided within the activity and financial templates which will be triangulated.*<br><br>• *Shaping a healthier future* Decision-Making Business Case (DMBC)<br><br>• Whole Systems Integrated Care Toolkit<br><br>• CCG Out of Hospital strategies ('Better Care, Closer to Home') |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | How does the five year vision address the following aims:<br>a) Delivering a sustainable NHS for future generations?<br>b) Improving health outcomes in alignment with the seven ambitions<br>c) Reducing health inequalities? | [*Please add your response to the key lines of enquiry here.*<br><br>*A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?*<br><br>***Chapter 12, page 92 (Outcome ambitions)***<br><br>B) *You should explain how your five year strategic plan will improve outcomes in the seven areas identified, within the context of the needs of your local population and what quantifiable level of improvement you are aiming to achieve*]<br><br>***Chapter 12, page 95 (A financially sustainable health system)*** | [*Please reference additional supporting documentation you feel is helpful*]<br><br>• *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan? | [*Please provide details of the organisations who have signed up to this vision and the process by which sign up was obtained*]<br><br>***Appendix A*** | |
| | How does your plan for the Better Care Fund align/fit with your 5 year strategic vision? | ***Chapter 6, page 44 (North West London's Better Care Fund plans*** | Each of the NWL HWB Better Care Fund plan, submitted on 4th April |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | What key themes arose from the Call to Action engagement programme that have been used to shape the vision? | [*Please provide details of key feedback from any call to action engagement and confirm how these have been incorporated into the strategic vision? ]*<br><br>***Chapter 2***<br>***Appendix A*** | NWL CCG Call to action activity submis |
| | Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included? | ***Chapter 2***<br>***Appendix A*** | NWL CCG Call to action activity submis |
| a) Current position | Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials? | ***Chapter 2***<br>***Appendix A*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Do the objectives and interventions identified below take into consideration the current state? | ***Chapter 2*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here? | ***Chapter 12 (A financially sustainable health system) 5.1*** | |

## Appendix F: Signposting to Key Lines of Enquiry

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td rowspan="5">b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td><table><tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr><tr><td>1</td><td></td><td></td></tr><tr><td>2</td><td></td><td></td></tr><tr><td>3</td><td></td><td></td></tr><tr><td>4</td><td></td><td></td></tr><tr><td>5</td><td></td><td></td></tr><tr><td>6</td><td></td><td></td></tr><tr><td>7</td><td></td><td></td></tr><tr><td colspan="3">Chapter 12 (Outcome ambitions)</td></tr></table></td><td></td></tr>
<tr><td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td><td>See Appendix A</td><td>• Shaping a healthier future Decision-Making Business Case (DMBC)</td></tr>
<tr><td>What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?</td><td>See Appendix A</td><td>• Shaping a healthier future Decision-Making Business Case (DMBC)</td></tr>
<tr><td>How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?</td><td>See Appendix A</td><td>Health & Wellbeing Strategies</td></tr>
<tr><td>How have the Health and well-being boards been involved in setting the plans for improving outcomes?</td><td>Chapter 12</td><td></td></tr>
</table>

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| c) Sustainability | Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Are assumptions made by the health economy consistent with the challenges identified in a Call to Action? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| d) Improvement interventions | Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the :<br>• Overall aims of the intervention and who is likely to be impacted by the intervention<br>• Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have<br>• Investment costs (time, money, workforce)<br>• Implementation timeline<br>• Enablers required for example medicines optimisation<br>• Barriers to success<br>• Confidence levels of implementation<br><br>The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit. | ***See chapters 4 - 10***<br><br>**Intervention One**<br>Overall description<br>[CCG to comment]<br><br>Expected Outcome<br>[CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics]<br><br>Investment costs<br>• Financial costs<br>[CCG to comment]<br><br>• Non-Financial costs<br>[CCG to comment]<br><br>***See chapter 12***<br><br>Implementation timeline<br>[CCG to comment]<br>***See chapter 11***<br><br>Enablers required<br>[CCG to comment]<br>***See chapter 11***<br><br>Barriers to success<br>[CCG to comment]<br>***See chapter 11***<br><br>Confidence levels of implementation<br>[CCG to comment]<br>***See section 4.12*** | |

## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| e) Governance overview | What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community? | ***See chapter 13*** | |
| f) Values and principles | Please outline how the values and principles are embedded in the planned implementation of the interventions | ***See chapter 1*** | |

# 1. Introduction

1.1 The *Shaping a healthier future* Decision Making Business Case (DMBC) (February 2013) outlined the financial and activity strategic plan for North West London.

The DMBC outlined how Commissioner and Provider plans were aligned including:

- Commissioner financial model consistent with NHS London guidance/business rules
- Shift in activity and investment in Out of Hospital services
- Provider efficiency gains (including length of stay)
- Reduction of c£40m in provider cost base contributing to sustainable provider landscape

The continued alignment of NWL-wide commissioner and provider finance and activity plans is being maintained through a SaHF Implementation Model and coordination and alignment of Provider Business Cases/LTFMs with the NWL-wide model.

1.2 The full DMBC economic and financial analyses are due to be refreshed later in 2014, alongside a joint SaHF/NHSE/TDA assurance process of Trust Outline Business Cases, and incorporating the latest Out of Hospital plans.

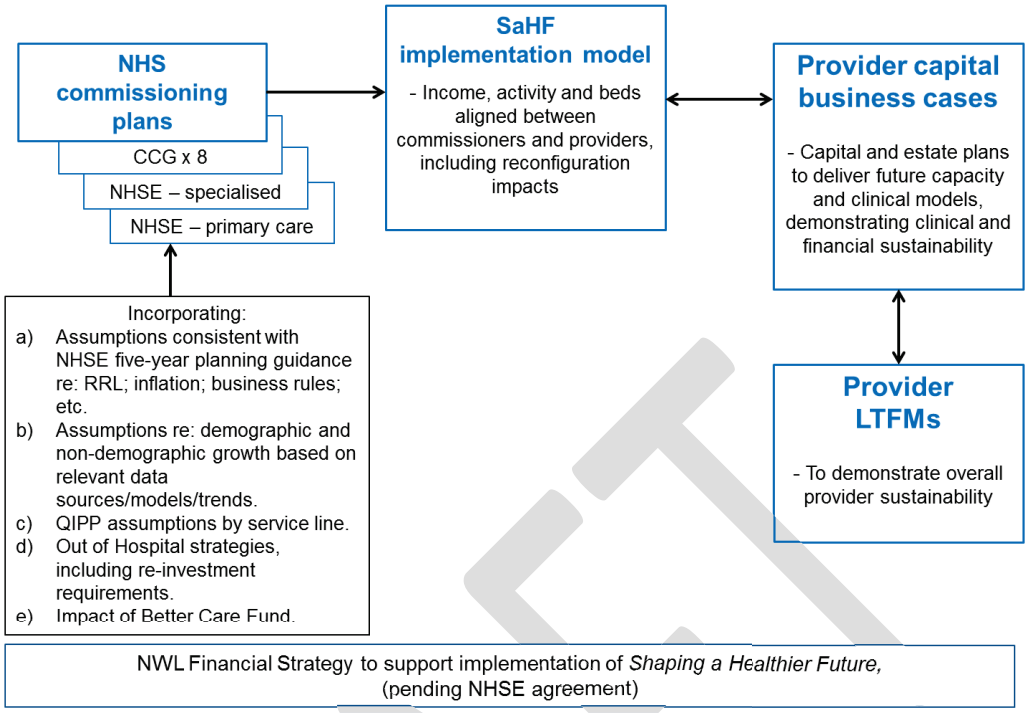
This updated analysis, together with the DMBC, will be known as the *Implementation Business Case (ImBC)* and will form the SOC for NHSE/DH/Treasury approval.

As part of this process we will be assessing the impact of any changes in capital forecasts with particular reference to:

- DMBC value for money scoring
- Affordability to providers and overall sustainability
- Affordability to commissioners
- Capital availability (including access to Public Dividend Capital [PDC])
- Overall economic and financial case
- Level of transitional support required to support the reconfiguration

1.3 For the purposes of this five year strategy submission, a combination of latest information from the SaHF Implementation Model, together with the original DMBC capital estimates have been used (updated provider capital estimates have not been used as the draft Trust Outline Business Cases (OBCs) are yet to go through the assurance process). As noted above, this assurance process is due to take place in the second half of 2014, which will lead to the production of the Implementation Business Case (ImBC).

1.4 The schematic below provides an overview of how Commissioner and Provider finance and activity plans are aligned on an ongoing basis within NW London:




1.5 Within this context, the remainder of this section sets out:

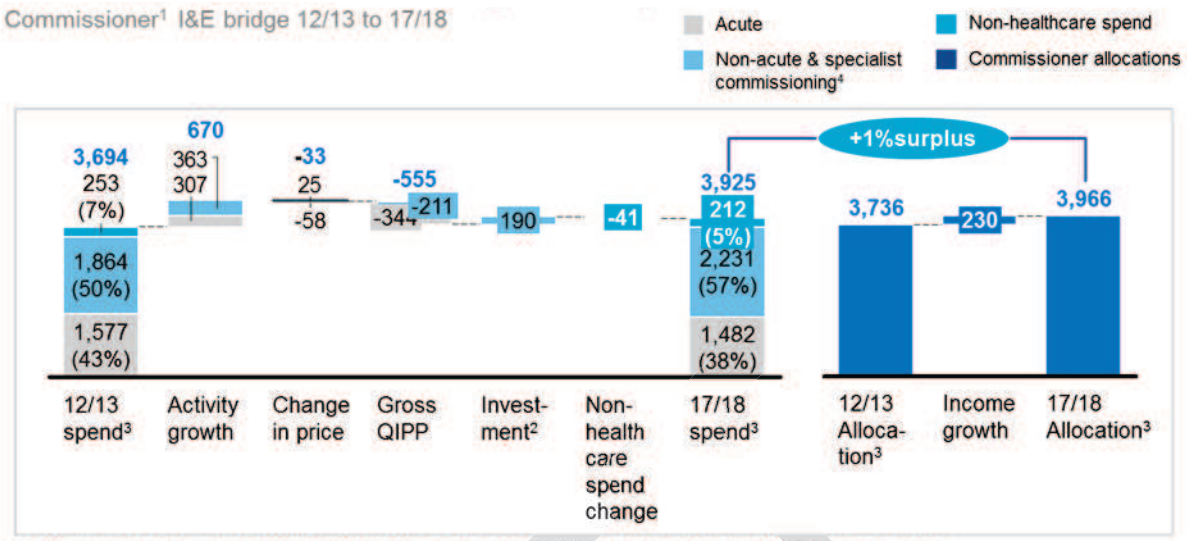
- The financial challenge facing NW London commissioners and providers
- The strategic response
- Five-year finance and activity modelling to 18/19
- Two-year operational plans (14/15 – 15/16), including Better Care Fund
- Capital investment
- Supporting implementation – NWL Financial Strategy
- Financial risk assessment and sensitivity analysis

## 2. Financial challenge

2.1 Commissioners

The DMBC overarching commissioner projections covered the period 12/13 – 17/18 and reflected the organisational arrangements at the time (i.e. PCTs).

The graph below shows the Commissioner I&E bridge from 12/13 to 17/18 from the DMBC.




Note: Commissioner forecast assumptions and plans developed for modelling purposes based on extrapolation from existing OOH plans. High level findings agreed with CCG finance leads as representing the best available estimates at the time of the analysis

1 Commissioner model based on PCT unified allocations/expenditure. From 2013/14 the split of commissioning responsibilities and allocations between CCGs/NCB/PHE, etc., is not expected to change the strategic intention of rebalancing acute and out of hospital services, nor the QIPP impact on acute Trusts and re-investment in OOH services modelled here

2 The £190m covers reprovision of all QIPP , as well as the £0.5m recurrent spend required to fund the 10 additional paramedics for the London Ambulance Service; For modelling purposes, none of this investment is assumed within acute Trusts income

3 Surplus is carried forward but not included in the spend

4 Trusts I&E models include acute and Trust –specific proportion of specialist commissioning

Source: NWL Commissioner forecast model

2.2 The Commissioner analysis has subsequently been updated to reflect a) CCG/NHSE split of commissioning responsibilities, b) 13/14 outturn and c) the five year financial plans for 14/15 – 18/19.

The updated CCG five year financial plans for 14/15-18/19 are consistent with NHS England planning guidelines, as follows:

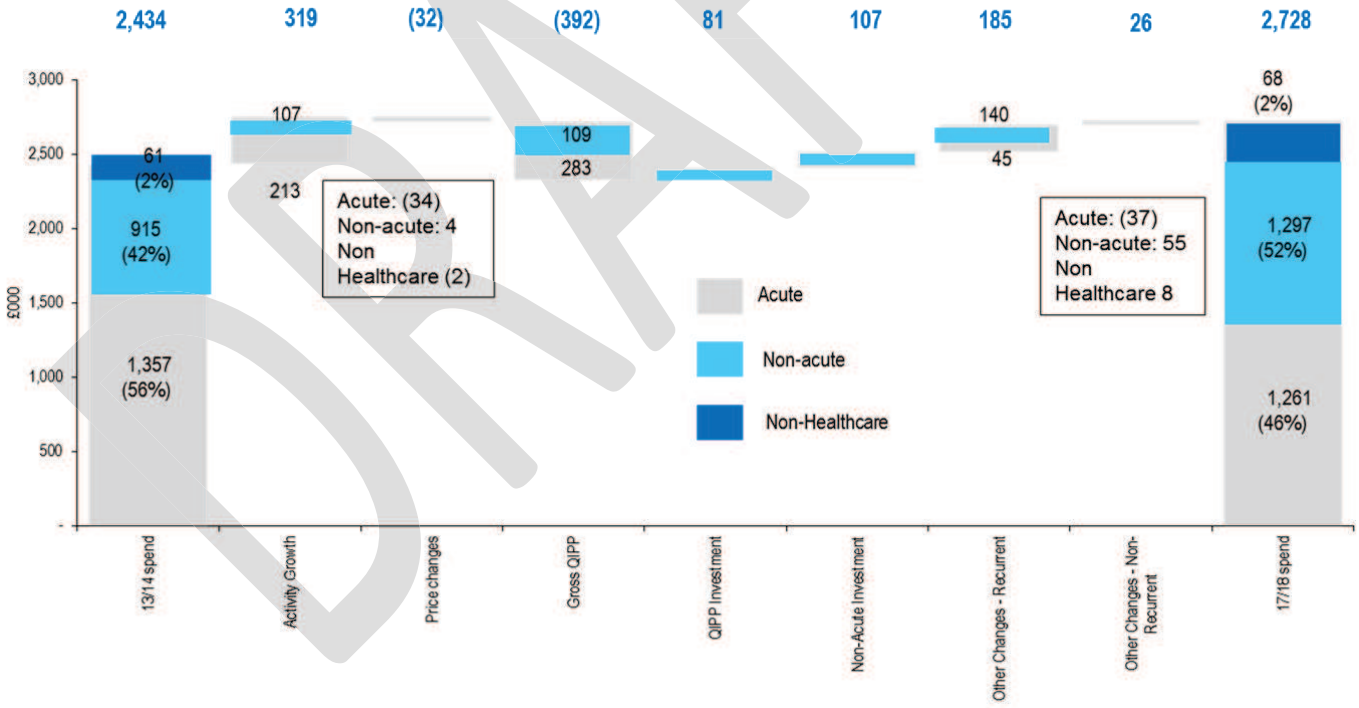
| **Consistency with NHSE Five-Year Planning Guidelines** | |
|---|---|
| a) RRL growth assumptions | Allocation growth as confirmed for 14/15 – 15/16, plus projections for 16/17 – 18/19 |
| b) Inflation assumptions | Reflect national tariff uplifts and NHSE guidance |
| c) Efficiency assumptions | Plans incorporate QIPP (see below) |
| d) Running costs including required reductions | The business case for CSU changes demonstrates how the reduction in running costs will be achieved |
| e) Annual in year surplus requirement of at least 1% | Yes – see bridge analysis below |
| f) Business rules – non-recurrent head room | The NWL financial strategy (see section 7 below) incorporates this. |

NWL CCGs 2013/14 outturn is an overall surplus of 3.50%, with a range of -4.24% to 8.73%, as shown below. The underlying position reflects the recurrent run-rate (stripping out one-off items), and this is an overall surplus of 3.08%, with a range of -5.92% to 8.67%.

| | 2013/14 FOT surplus/(deficit) | | 2013/14 Underlying surplus/(deficit) | |
|---|---|---|---|---|
| | £000s | % | £000s | % |
| Brent | 33,644 | 8.39% | 30,017 | 8.11% |
| Ealing | 6,900 | 1.67% | 9,124 | 2.20% |
| Harrow | (10,049) | (4.24%) | (13,639) | (5.92%) |
| Hillingdon | (5,007) | (1.7%) | (7,765) | (2.75%) |
| Central London | 16,938 | 4.60% | 11,990 | 4.60% |
| Hammersmith & Fulham | 12,327 | 5.08% | 15,083 | 6.22% |
| Hounslow | 1,932 | 0.68% | 552 | 0.19% |
| West London | 29,613 | 8.73% | 29,403 | 8.67% |
| **Total NWL CCGs** | **86,298** | 3.50% | **74,765** | 3.08% |

2.3 CCG Commissioner bridge – the chart below summarises the forecast movements between 13/14 and 17/18. (17/18 is presented in order to maintain consistency with DMBC timelines and modelling – this modelling will be extended to 18/19 for the ImBC analysis).

**CCG Commissioner Bridge – April 2014**




Notes:

- The bridge information is drawn directly from the eight NHSE plans submitted on 4th April (Hounslow and H&F provided an additional update submitted 1st May)
- From the NHSE submissions Non-Acute includes Mental Health Services, Community Services, Continuing Care, Primary Care Services and Other Programme Services
- The Non-Healthcare is Running Costs and Contingency

- QIPP investment links directly to QIPP investment on the NHSE submission
- Non-Acute Investment links to Investment on the NHSE submission
- Other Changes Recurrent links to Other FYE Impact and Other Recurrent Cost Pressures in the NHSE Submission

2.4 The total CCG QIPP and growth is analysed between acute and non-acute, and the gross acute QIPP and growth in 2014/15 to 2017/18 by NWL CCG and provider. The NWL gross acute QIPP of £251m and growth of £154m is expected to impact on Trusts as follows:

| £'000 | Brent CCG | Harrow CCG | Hillingdon CCG | Ealing CCG | Central London CCG | West London CCG | H&F CCG | Hounslow CCG | Total | | Growth |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Central Middlesex | -8,606 | -3,151 | -125 | -1,030 | 0 | -8 | 0 | 0 | -12,920 | | 8,179 |
| Charing Cross | -1,547 | -378 | -194 | -2,922 | -1,877 | -4,036 | -6,336 | -1,792 | -19,082 | | 16,069 |
| Chelsea & Westminster | 0 | -296 | 0 | 0 | -6,660 | -13,911 | -3,736 | 0 | -24,603 | | 16,206 |
| Ealing | 0 | -268 | 0 | -23,159 | 0 | -4 | 0 | 0 | -23,431 | | 14,874 |
| Hammersmith | -2,731 | -1,160 | -339 | -4,162 | -1,942 | -4,571 | -4,229 | -1,251 | -20,385 | | 16,631 |
| Hillingdon | 0 | -1,399 | -45,026 | -636 | 0 | -6 | 0 | 0 | -47,067 | | 18,375 |
| Northwick Park & St. Mark's | -14,511 | -27,265 | -839 | -2,805 | 0 | -12 | 0 | 0 | -45,431 | | 26,052 |
| St. Mary's | -6,669 | -871 | -269 | -1,631 | -10,796 | -12,365 | -1,538 | -591 | -34,730 | | 21,080 |
| West Middlesex | 0 | -13 | 0 | 0 | 0 | -2 | 0 | -23,118 | -23,133 | | 16,581 |
| Total | -34,064 | -34,802 | -46,792 | -36,345 | -21,274 | -34,916 | -15,838 | -26,752 | -250,784 | | 154,046 |
| Growth | 23,195 | 15,676 | 19,328 | 30,758 | 11,192 | 15,865 | 15,854 | 22,178 | 154,046 | | |

Note: the above represents the elements of CCG QIPP and growth applied to NWL providers (the balance is non-NWL providers).

2.5 NHS England commissioning comprises two main elements:

a) Specialised commissioning

Specialised commissioning is commissioned on a provider basis, as opposed to population based. The 13/14 outturn for NWL providers is set out in the table below:

### Specialised commisisonig 13/14 outturn: NWL providers

In terms of future year projections, NHSE have advised to assume growth of 5% and QIPP of 3%. These projections are incorporated in the total acute provider projections (see below). However, it should be noted that these projections are subject to change (as a result of affordability, revision to specialised commissioning scope etc.).

| Mental Health | Budget | Outturn | (underspend)/overspend |
|---|---|---|---|
| C & NW LONDON NHSFT | 39,813,484 | 40,296,120 | 482,636 |
| W LONDON MH NHST | 123,849,134 | 123,722,134 | -127,000 |
| **Sub-total Mental Health** | **163,662,618** | **164,018,254** | **355,636** |
| **North West** | | | |
| CHEL WESTMS HOSP NHS FT | 102,815,486 | 107,434,306 | 4,618,820 |
| EALING HOSP NHS TRUST | 9,727,150 | 9,290,620 | -436,530 |
| IMP COLLEGE HC NFT | 267,773,713 | 285,411,651 | 17,637,938 |
| NW LONDON HOSP NHST | 60,295,337 | 60,287,274 | -8,063 |
| ROY BROMP HARE NHSFT | 202,552,047 | 211,248,397 | 8,696,350 |
| THE HILLINGDON HOSP NHS FT | 12,583,425 | 12,909,608 | 326,183 |
| WEST MIDDLESEX UNIV NHS TRUST | 7,177,730 | 7,576,880 | 399,149 |
| **Sub-total North West** | **662,924,888** | **694,158,736** | **31,233,847** |
| **#N/A** | | | |
| LONDON AMBULANCE NHST | 588,155 | 588,155 | 0 |
| **TOTAL** | **827,175,661** | **858,765,145** | **31,589,483** |

b) Primary care

The 14/15 budget for primary care in NW London totals £413.3m, as per the table below:

| **GP services** | £m | £m |
|---|---|---|
| Brent | 38.0 | |
| Ealing | 42.1 | |
| Hammersmith & Fulham | 22.6 | |
| Harrow | 26.5 | |
| Hillingdon | 30.8 | |
| Hounslow | 34.6 | |
| Kensington & Chelsea | 27.7 | |
| West | 33.9 | **256.3** |
| **Dental** | | **84.7** |
| **Ophthalmology** | | **18.9** |
| **Pharmacy** | | **53.4** |
| **TOTAL** | | **413.3** |

NWL CCGs are currently exploring with NHSE options for potential co-commissioning of some of the above services.

2.6 The combined CCG and NHSE QIPP/growth for 14/15 – 17/18 by Commissioner and Provider is summarised in the table below.

## Appendix G: Financial appendix

Applying QIPP and Growth for NHSE and non NWL CCGs (this is based on DMBC proportions however individual Trusts will make their own assumptions in OBCs based on local discussions with relevant CCGs) to the totals for NWL CCGs, the table below shows that total QIPP applied to Trusts is £356m with growth of £284m:

| £'000 | CCG Total | NHS England | Non-NWL CCG / Other | Total | | Growth |
|---|---|---|---|---|---|---|
| Central Middlesex | -12,920 | -500 | -1,528 | -14,948 | | 9,851 |
| Charing Cross | -19,082 | -9,046 | -4,208 | -32,336 | | 33,837 |
| Chelsea & Westminster | -24,603 | -13,585 | -13,185 | -51,373 | | 46,217 |
| Ealing | -23,431 | -1,187 | -47 | -24,665 | | 17,192 |
| Hammersmith | -20,385 | -16,680 | -3,098 | -40,163 | | 47,108 |
| Hillingdon | -47,067 | -1,147 | -2,116 | -50,330 | | 21,641 |
| Northwick Park & St. Mark's | -45,431 | -8,645 | -7,310 | -61,386 | | 45,779 |
| St. Mary's | -34,730 | -9,255 | -5,820 | -49,805 | | 39,867 |
| West Middlesex | -23,133 | -1,142 | -7,147 | -31,422 | | 22,342 |
| Total | -250,784 | -61,187 | -44,459 | -356,430 | | 283,833 |
| Growth | 154,046 | 103,670 | 26,116 | 283,832 | | |

The total 14/15 to 17/18 QIPP and Growth by Provider and POD (all Commissioners) is shown in the table below and summarises the £356m QIPP and £284m Growth by provider and POD:

| £'000 | Elective | Non-Elective | Outpatients | A&E | Maternity | Critical Care | Other | Total | | Growth |
|---|---|---|---|---|---|---|---|---|---|---|
| Central Middlesex | -1,681 | -4,968 | -5,360 | -253 | 0 | 0 | -2,010 | -14,271 | | 9,851 |
| Charing Cross | -4,153 | -14,893 | -10,960 | -904 | 0 | -395 | -5,627 | -36,931 | | 33,837 |
| Chelsea & Westminster | -2,430 | -16,489 | -18,028 | -793 | -142 | -692 | -12,799 | -51,373 | | 46,217 |
| Ealing | -87 | -6,503 | -15,350 | -3 | -229 | 0 | -2,492 | -24,665 | | 17,192 |
| Hammersmith | -8,819 | -14,055 | -8,653 | -463 | -239 | -1,521 | -7,805 | -41,555 | | 47,108 |
| Hillingdon | -5,270 | -18,535 | -13,655 | -3,602 | -232 | -32 | -9,005 | -50,330 | | 21,641 |
| Northwick Park & St. Mark's | -3,562 | -24,200 | -16,478 | -2,908 | 0 | 0 | -14,916 | -62,063 | | 45,779 |
| St. Mary's | -1,420 | -16,220 | -14,000 | -1,708 | -98 | -1,346 | -9,027 | -43,819 | | 39,867 |
| West Middlesex | -829 | -26,445 | -2,167 | -823 | -228 | 0 | -930 | -31,422 | | 22,342 |
| Total | -28,249 | -142,307 | -104,653 | -11,456 | -1,169 | -3,986 | -64,610 | -356,429 | | 283,833 |
| Growth | 62,146 | 60,966 | 45,824 | 10,685 | 13,232 | 15,331 | 75,647 | 283,832 | | |

**a) Providers**

The 13/14 outturn of the acute providers is shown in the table below. Both reported surplus/deficit and normalised (excluding non-recurrent items) are shown.

| | Surplus/(deficit) (£000s) | |
|---|---|---|
| | Reported | Normalised |
| **Imperial** | 15,128 | 20,502 |
| **ChelWest** | 7,409 | 1,464 |
| **West Middlesex** | (5,376) | (5,970) |
| **Ealing** | 220 | (8,804) |
| **NWLH** | (23,334) | (32,537) |
| **Hillingdon** | (744) | 194 |
| **TOTAL** | (6,697) | (25,151) |

Trust Plans for 14/15-18/19 are not reflected here as they are being submitted to TDA on the 20th June.

## 3. Strategic response

3.1 The DMBC financial and activity modelling provided a comprehensive analysis of the affordability and value for money of SaHF, building upon that in the Pre-Consultation Business Case (PCBC). The key features included:

a) **Confirmation of the preferred option**, based on NPV analyses, the value for money assessment of the options and the sensitivity analysis supporting this conclusion.

b) **Support for further consideration of alternative developments at the Local Hospitals**. (Noting the nature and amount of services should be explored further to test and demonstrate affordability and on-going viability).

c) **Support strategic outline case proposals for capital investment in out-of-hospital** estate to support the reconfiguration including:

i. Capital investment in hubs

ii. Capital investment in GP premises

As part of DMBC development the Finance and Business Planning (F&BP) group was tasked with overseeing the evaluation of the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The group was tasked with advising on the value for money of the options consulted upon both relative to each other, and compared to the 'do nothing' (i.e. current configuration) situation.

The analysis indicated that:

- Commissioner forecasts over the five years involve gross QIPP of £550m with reinvestment in out of hospital services of £190m.
- The acute trust I&E forecast in the 'do nothing' was that most sites would move into deficit with no overall net surplus. In the downside scenario there would be an overall deficit of £89m with all bar one acute site in deficit.

The value for money evaluation criteria used to assess the options were:

- Capital costs
- Transition costs

- Site viability
- Total trust surplus/deficit
- Net present value.

The preferred option required net capital investment of £206m to implement the major hospital model, resulting in a positive I&E position of £42m for the acute sector and had a positive net present value. For all options, the capital investment in out of hospital estates required to deliver the required changes was assessed at £6m-112m for hubs and up to £74m for GP premises.

3.2 The DMBC model suggested remaining provider sites would be viable with the exception of CMH.

The DMBC identified a £42m net improvement in provider positions as a result of the reconfiguration changes, as shown in the table below:

**Net surplus/(deficit) at site level in 17/18**

| Site | Do nothing | | | Option A | | |
|---|---|---|---|---|---|---|
| | I | C | S/D | I | C | S/D |
| St Mary's | 326 | 320 | 6 | 427 | 415 | 12 |
| Hammersmith | 327 | 325 | 2 | 361 | 353 | 7 |
| Charing Cross | 245 | 231 | 14 | 17 | 16 | 1 |
| Chelsea & Westminster | 332 | 323 | 8 | 417 | 390 | 27 |
| West Middlesex | 122 | 130 | -8 | 180 | 178 | 2 |
| Ealing | 110 | 111 | -1 | 15 | 15 | 0 |
| Central Middlesex | 65 | 76 | -10 | 31 | 41 | -11 |
| Northwick Park & St. Mark's | 247 | 255 | -8 | 294 | 293 | 1 |
| Hillingdon[1] | 135 | 140 | -4 | 156 | 155 | 1 |
| NWL Total[2] | 1,910 | 1,910 | 0 | 1,897 | 1,856 | 42 |

3.3 Capital investment summary

The total DMBC capital requirement (including Out of Hospital / primary care) was therefore as follows:

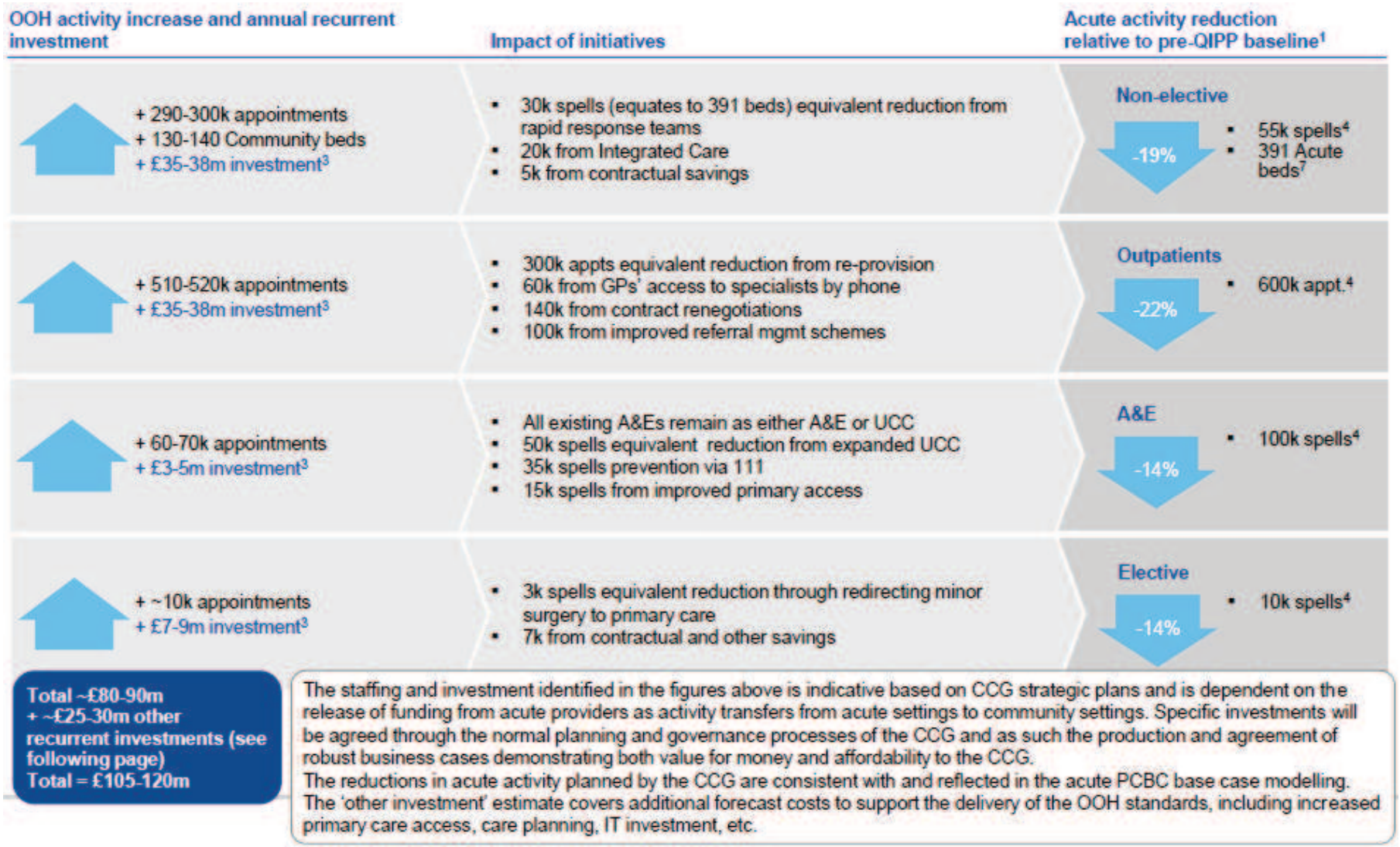
| DMBC | |
|---|---|
| | Net capital (£m) |
| Acute (net)[1] | 206 |
| Hubs | 6-112 |
| Primary Care | 32-74 |
| **Total** | **244-392** |

[1]Based on minimum scope of local hospitals

3.4 Out of Hospital Strategies

The DMBC included Out of Hospital strategies for all 8 PCTs, and these were triangulated with acute activity projections, as summarised in the table below:

## Appendix G: Financial appendix



3.5 Central Middlesex Hospital (CMH)

Further to the DMBC analysis, which identified that CMH remained unviable, a dedicated programme was established to review options for the future of CMH.

This resulted in the agreement of a Strategic Outline Case (SOC); the key features of which are as follows:

a) Background

- The hospital site currently operates at an £11m deficit each year and is a major contributor to the overall deficit for North West London Hospitals NHS Trust.
- One of the decisions made as part of Shaping a Healthier Future was "that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week".
- The Brent out of hospital strategy, which was also agreed as part of Shaping a Healthier Future, set out a range of primary and community care services that will also be provided at Central Middlesex Hospital, as it becomes one of the local primary care hubs.
- However, under these agreed plans for Shaping a Healthier Future, Central Middlesex Hospital remains an underutilised site and will produce a financial deficit indefinitely if steps are not taken to resolve this.
- Extensive engagement was undertaken as part of the Shaping a Healthier Future consultation and feedback showed that stakeholders expressed opposition to any closure of the site. Further engagement has been undertaken during the development of this Strategic Outline Case.

b) Options development and evaluation

- It was agreed that Shaping a Healthier Future plans would be the starting point for the work –the baseline – as this is the service specification that has been consulted on.
- Options for the future of the Central Middlesex Hospital site were developed and evaluated.
- Sensitivity analysis was used to test the options before a final recommendation was made. A programme of workshops and interviews supported this work.

Two options were proposed:

- Option 1 – Optimise services at Central Middlesex Hospital
- Option 2 – Remove all services and dispose of the site

Further detailed work was done to develop proposals for Option 1 and then evaluate these using a set of hurdle criteria and the Shaping a Healthier Future evaluation criteria (clinical quality, access, value for money, deliverability, research and education). This evaluation was done in two phases, first by an Independent Clinical Panel and then a review of the impact on access.

Four proposals were adopted for Option 1:

A. Hub plus for Brent

B. Orthopaedic elective centre

C. Re-house mental health services from Park Royal Centre for Mental Health

D. Relocate regional genetics service from Northwick Park Hospital

Proposals to relocate specialist rehabilitation services from Northwick Park Hospital and to move some or all of St Mark's Hospital were rejected mainly because of their co-dependencies with service on the Northwick Park Hospital site.

Proposal A (Hub plus for Brent) has an impact on the Willesden Centre for Health and Care as it proposes moving 41 rehabilitation beds from Willesden Centre for Health and Care to Central Middlesex Hospital. This resulted in three sub-options for Option 1:

1A. Back-fill Willesden Centre for Health and Care

1B. Close Willesden Centre for Health and Care

1C. Partially close Willesden Centre for Health and Care

The four options (1A, 1B, 1C and 2) were evaluated using the *Shaping a healthier future* evaluation criteria including a value for money analysis, as follows:

## Evaluation of Options

| | | Access | | | Affordability & Value for Money | | | | Deliverability | | | Research & Education | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Clinical quality | Patient experience | Distance and time to access services | Patient choice | Capital cost to the system | Site viability | Surplus for the health economy | Transition costs | Value for Money | Work-force | Expect-ed time to deliver | Co-depend-encies with other strategies | Support current and developing research and education delivery | Total Evaluation |
| 1a | CMH bundle + Willesden bundle | ++ | + | / | / | - - | + | + | / | ++ | + | -- | - | + | +4 |
| 1b | CMH bundle + Willesden disposal | ++ | + | / | / | - - | + | + | - | ++ | + | - | / | + | +5 |
| 1c | CMH bundle + partial Willesden disposal | ++ | + | / | / | - | + | + | - | ++ | + | - | / | + | +6 |
| 2 | CMH disposal and dispersal of services | - | / | + | - | - - | + | + + | - - | ++ | / | - | - - | / | -3 |

The evaluation of the options showed that Option 1c optimise services at Central Middlesex Hospital and partially dispose of Willesden Centre for Health & Care is the preferred option as it improves clinical quality, patient experience, site viability, health economy surplus, workforce and supporting R&D compared to the Shaping a Healthier Future proposal. It compares better to the other options for Willesden Centre for Health and Care. The financial analysis for option 1a, assumes that the space at Willesden is fully utilised by moving services from elsewhere and releasing costs in other sites.

However, following work on options to fill this space, it appears to be highly unlikely that the space could be filled and costs released, this is reflected in the deliverability evaluation for Option 1a.

Additional capital investment is required under all options at Central Middlesex Hospital, the Willesden Centre for Health & Care and at other sites depending on the option under consideration.

Option 2, to remove all services from Central Middlesex Hospital and dispose of the site, was evaluated as being worse than, or the same as, Option 1 on all criteria except access (because some people currently go to Central Middlesex for elective care even though it is not their nearest hospital) and health economy surplus (because Central Middlesex is a relatively expensive building). Option 2 was evaluated as being significantly worse than Option 1 for clinical quality (it would prevent the development of an elective centre) and co-dependencies with other strategies (because it directly contradicts what was agreed in Shaping a Healthier Future and confirmed by the Secretary of State).

c) Conclusion

The final recommendation therefore was to optimise services at Central Middlesex Hospital so that Central Middlesex Hospital will provide:

- Urgent care, via an urgent care centre
- 167,000 Outpatient appointments, with access to specialists
- Orthopaedics elective centre for North West London with activity moving from Northwick Park Hospital, Ealing Hospital and Imperial Hospitals NHS Trust, supported by a Level 2 ITU
- Other elective care (which is currently provided by North West London Hospitals NHS Trust and Ealing Hospital NHS Trust at other sites).
- Simple diagnostics (X-ray and ultrasound)
- GP and nurse appointments
- High risk primary care patients
- Extra hours including out of hours
- Community therapies
- 24/7 psychiatric liaison service
- 41 rehabilitation beds (moved from Willesden Centre for Health & Care)
- Mental health services including a mother and baby unit, an acute assessment service, treatment wards
- Central pharmacy service for Central North West London NHS Foundation Trust (and servicing the Central Middlesex Hospital site).
- Regional genetics services for North West London and surrounding counties

This will leave Central Middlesex Hospital with an on-going deficit of c. £3.3m and vacant space of 1,033m2 (less than 5% of available space). This is based on the assumption that all of the costs are met by the occupiers of the site, which has yet to be agreed.

It was noted that Willesden Centre for Health & Care would be likely to provide services including GP practices, child & adolescent mental health services (CAMHS) and the static breast-screening unit consolidated onto the Willesden Centre for Health & Care site. This would not use all the space at Willesden Centre for Health & Care and would require estimated capital investment of £0.6m for refurbishment, together with the cost associated with the partial disposal of the PFI building.

The site at Park Royal Centre for Mental Health will be closed. Central and North West London NHS Foundation Trust (who own the site) were working through options for relocating the Low Secure Unit currently at Park Royal Centre for Mental Health.

A number of scenarios were modelled to test the sensitivity of the options to changes in key assumptions:

1. 20% reduction in net capital costs for each option
2. 50% reduction in the value achieved by backfilling Willesden Health & Care Centre under Option 1a
3. Central support amounting to £3.5m added to cover the excess PFI costs at Central Middlesex Hospital
4. Other users of Central Middlesex Hospital pay only their current costs for occupation of the site
5. The refurbishment of Central Middlesex Hospital is funded by NHS capital

Under all these scenarios Option 1c remained the best option except for Scenario 4 where Option 2 was viewed to be the best overall option. This was because in Scenario 4, the deficit at Central Middlesex Hospital was £12.1m under Option 1c compared to £1.7m for Option 2.

d) Next steps

The implementation of the Strategic Outline Case anticipated the development of an Outline Business Case Business by the end of June 2014, a Full Business Case by the end of 2014, with the planned movement of services starting during 2015. Changes will be progressed subject to any necessary or appropriate consultation. Central North West London NHS Foundation Trust will need to develop its own business case for the movement of services from the Park Royal Centre for Mental Health.

There will be continuing public engagement and engagement with partner organisations such as the local authority and the Health Overview and Scrutiny Committee (HOSC).

## 4. Finance and Activity Modelling

4.1 The DMBC underpinning financial and activity modelling was overseen and agreed by a working group comprising the Finance Directors of all provider and commissioner organisations in North West London. This group was known as the Finance and Business Planning (F&BP) group.

The DMBC analysis was structured to provide a financial and economic analysis of alternative reconfiguration options against a base case. In order to maintain a macro financial overview and to support the alignment of Commissioner / Provider planning parameters during implementation, an Implementation Model has been developed.

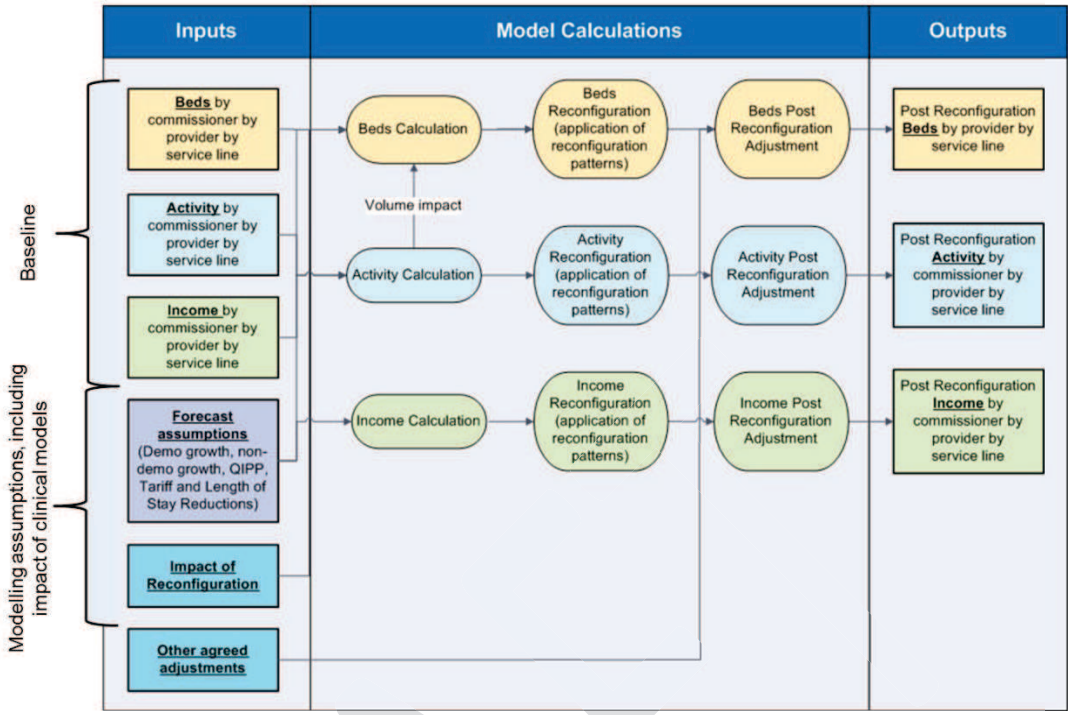
4.2 Following the approval of the JCPCT to proceed, a Finance and Activity Modelling (FAM) group was established, with membership largely common to the F&BP group, tasked with taking the work forward and ensuring the overall alignment of Trust Outline Business Cases (OBCs) with the overall Implementation Model.

The Implementation model is also being used to ensure alignment with other strategic plans e.g. FT applications, merger Business Cases etc.

4.3 The functionality of SaHF implementation Finance and Activity Model is summarised below:

| What the model does | What the model does NOT do |
|---|---|
| • **Replicate core DMBC modelling** - activity, income and bed forecast by site and by service line, under current configuration and planned reconfiguration. Includes flows of acute activity to Local Hospitals<br>• **Produce outputs by commissioner and provider** (DMBC outputs only by provider)<br>• **Take inputs of latest commissioner and provider data in future years**; subsequent years then re-forecasted from that new starting point<br>• **Model phased implementation plans** to produce year by year forecasts (not yet utilised)<br>• **Incorporates results of detailed travel time modelling** redone at level of each commissioner and site (DMBC analysis at site level)<br>• **Allow users to adjust assumptions at the most granular level** (e.g. demand growth, price change, QIPP, ALOS, patient flows) and model dynamically refreshes outputs<br>• **Calculates tracking indicators** on latest commissioner and provider data to compare performance versus original plan | • **Model trust expenditure, estate changes or capital investments** – these will rest with the trust business cases<br>• **Model comprehensive commissioner I&E** (including allocations, and non-Acute spend) – this will rest with commissioners' strategic plans<br>• **Model at more detail than the >7,000 lines** representing every combination of service lines (35 lines), commissioners (12 commissioners), and sites (17 sites) - however, the definition of these lines can be altered if base data and assumptions are also refreshed. In particular, the model is not at specialty or HRG level – more detailed side analyses can be done outside of the model, and then applied to the service line figures output by the model<br>• **Include integrated travel time model** – however, the model will be populated with the results of travel time analysis, and users can refine assumptions on patient flows at the most granular level<br>• **Forecast beyond 5 years** – current forecast period is the 5 years from 12/13 to 17/18 |

The schematic below shows the structure and configuration of the model:




4.4 Running the Model for 2017/18 Income, Activity and Beds

Based on a) 2013/14 forecast outturn data, b) the refreshed commissioner growth / QIPP forecasts and c) other key planning assumptions (below), the Implementation Model has been updated over the period December 2013 – June 2014 to calculate updated forecasts of Trust Income, Activity and Beds.

The other key assumptions that, pending the ImBC refresh, are currently largely unchanged from the DMBC are:

- Length of stay (at 15% over 3 years) offset by headroom (5%)
- Reconfiguration impact – some changes to transition tables to ensure a consistent approach to the DMBC
- All QIPP re-provision assumed to be in non-acute settings

4.5 The key outputs are as follows:

a) Activity

- Activity for 2017/18 is planned overall to increase for critical care, elective and maternity, and to reduce for A&E, non-elective and outpatients.
- The table below summarises the changes to activity at a POD level between 2013/14 (based on month 6 forecasts) and 2017/18. The table includes the movements between sites as a result of the planned reconfigurations:

| | A&E | | Critical Care | | Elective | | Maternity births | | Non Elective | | Outpatient | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 |
| Central Middlesex | 15,075 | 1,714 | 1,695 | 0 | 15,534 | 20,224 | 0 | 0 | 7,481 | 0 | 119,906 | 78,570 |
| Charing Cross | 36,031 | 7,726 | 9,718 | 0 | 45,120 | 120 | 0 | 0 | 19,833 | 55 | 214,280 | 170,346 |
| Chelsea & Westminster | 42,130 | 57,090 | 4,166 | 6,518 | 43,876 | 53,478 | 5,307 | 6,000 | 20,789 | 27,518 | 521,767 | 484,843 |
| Ealing | 40,593 | 14,890 | 3,116 | 0 | 12,687 | 0 | 2,454 | 0 | 21,264 | 0 | 134,977 | 102,343 |
| Hammersmith | 22,918 | 21,200 | 17,082 | 24,604 | 325,169 | 354,839 | 4,915 | 6,000 | 13,328 | 14,476 | 149,009 | 135,200 |
| Hillingdon | 87,494 | 54,735 | 4,028 | 5,205 | 16,456 | 20,311 | 4,033 | 6,000 | 23,724 | 22,165 | 295,174 | 232,250 |
| Northwick Park & St. Mark's | 86,645 | 79,307 | 6,716 | 10,141 | 34,924 | 40,855 | 4,901 | 6,000 | 42,092 | 46,439 | 326,462 | 265,059 |
| St. Mary's | 118,542 | 110,865 | 13,183 | 18,515 | 30,356 | 72,350 | 3,600 | 3,000 | 17,932 | 19,035 | 277,307 | 230,668 |
| West Middlesex | 55,174 | 68,575 | 2,978 | 5,722 | 13,918 | 22,686 | 4,998 | 6,000 | 21,374 | 31,331 | 170,414 | 153,780 |
| Grand Total | 504,602 | 416,103 | 62,682 | 70,704 | 538,040 | 584,863 | 30,208 | 33,000 | 187,817 | 161,019 | 2,209,296 | 1,853,060 |
| % Change | | -18% | | 13% | | 9% | | 9% | | -14% | | -16% |

The table below compares the percentage activity changes between the DMBC (13/14 to 17/18) and the refresh (14/15 to 17/18):

| % MOVEMENT | A&E | | Critical Care | | Elective | | Maternity | | Non Elective | | Outpatient | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement |
| Central Middlesex | -86% | -89% | -100% | -100% | 110% | 30% | -100% | -100% | -100% | -100% | -57% | -34% |
| Charing Cross | -77% | -79% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -47% | -21% |
| Chelsea & Westminster | 42% | 36% | 45% | 56% | 20% | 22% | 16% | 13% | 4% | 32% | -19% | -7% |
| Ealing | -64% | -63% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -40% | -24% |
| Hammersmith | -2% | -7% | 1% | 44% | 5% | 9% | 20% | 22% | 6% | 9% | -9% | -9% |
| Hillingdon | -10% | -37% | 86% | 29% | 32% | 23% | 95% | 49% | -26% | -7% | -39% | -21% |
| Northwick Park & St. Mark's | -24% | -8% | 42% | 51% | 8% | 17% | 26% | 22% | -5% | 10% | -55% | -19% |
| St. Mary's | 0% | -6% | 19% | 40% | 89% | 138% | 16% | -17% | 17% | 6% | -17% | -17% |
| West Middlesex | -9% | 24% | 68% | 92% | 69% | 63% | 42% | 20% | 17% | 47% | -19% | -10% |
| Grand Total | -16% | -18% | 7% | 13% | 5% | 9% | 16% | 9% | -13% | -14% | -31% | -16% |

b) Beds

Beds Bridge DMBC v Refresh (13/14-17/18)

The DMBC projected a reduction in acute beds (from 3908 to 3160) predominantly as a result of net QIPP impacts plus length of stay reductions. In March, the projections were updated to reflect updated baseline information, plus revised activity projections. This showed a similar scale of change (see table below).

The movements between 3,990 in 2013/14 and 3,271 in 2017/18 are analysed below in respect of the breakdown between volume changes, average length of stay (reduction of 15%) and headroom (increase of 5%). These assumptions mirror the DMBC.

The table also shows the movements between sites as part of the reconfiguration:

| | Opening Beds | Volume Change | Reduction in average LOS | Headroom | Closing Beds | Reconfigur-ation | Closing Beds after Reconfig |
|---|---|---|---|---|---|---|---|
| St. Mary's | 435 | -38 | -59 | 15 | 353 | 151 | 504 |
| Hammersmith | 413 | -5 | -61 | 15 | 362 | 35 | 398 |
| Charing Cross | 484 | -26 | -71 | 19 | 406 | -394 | 12 |
| Chelsea & Westminster | 525 | -37 | -73 | 17 | 431 | 185 | 617 |
| West Middlesex | 468 | -43 | -64 | 15 | 377 | 185 | 562 |
| Ealing | 348 | -13 | -50 | 13 | 297 | -297 | 0 |
| Central Middlesex | 180 | -18 | -24 | 0 | 138 | -112 | 26 |
| Northwick Park & St. Mark's | 707 | -63 | -97 | 24 | 572 | 157 | 729 |
| Hillingdon | 430 | -52 | -57 | 14 | 335 | 58 | 393 |
| Acute Site/s - OTHER | 0 | 0 | 0 | 0 | 0 | 32 | 32 |
| **Total** | 3,990 | -294 | -557 | 132 | 3,271 | 0 | 3,271 |

Bed Bridge Comparison – DMBC v Refresh

The bed bridge from the DMBC to the refreshed model is compared below. This shows that Length of Stay and Headroom are broadly similar with the major movements driven by changes to activity volume:

| | DMBC | Revised | Variance |
|---|---|---|---|
| Opening Beds | 3,908 | 3,990 | 82 |
| Volume Change | -333 | -294 | 39 |
| Reduction in average LOS | -538 | -557 | -19 |
| Headroom | 124 | 132 | 8 |
| Closing Beds | 3,160 | 3,271 | 111 |
| Reconfiguration | 0 | 0 | 0 |
| Closing Bed after Reconfig | 3,160 | 3,271 | 111 |
| Net Reduction | (748) | (719) | 29 |

Of the total increase of 148 closing beds, 82 is due to a higher start point and 66 due to a lower net forecast reduction, the latter largely due to a reduction in the volume change.

The bed projections in March, and in particular the new build beds, have been used to inform Trust OBCs.

As part of the forthcoming OBC assurance process, and ImBC analysis, the bed projections will be reviewed against bottom-up Trust estimates.

## 5. 2-year operational plans 14/15 – 15/16, including Better Care Fund

5.1. CCGs and Trusts in NW London have submitted operating plans to NHSE/TDA/Monitor as appropriate. All 14/15 contracts between NW London bodies are agreed, with the exception of CNWL Mental Health and Ealing Hospital.

5.2. A key element of 14/15 operating plans is the Better Care Fund. CCG Out of Hospital plans align with Better Care Fund plans as follows:

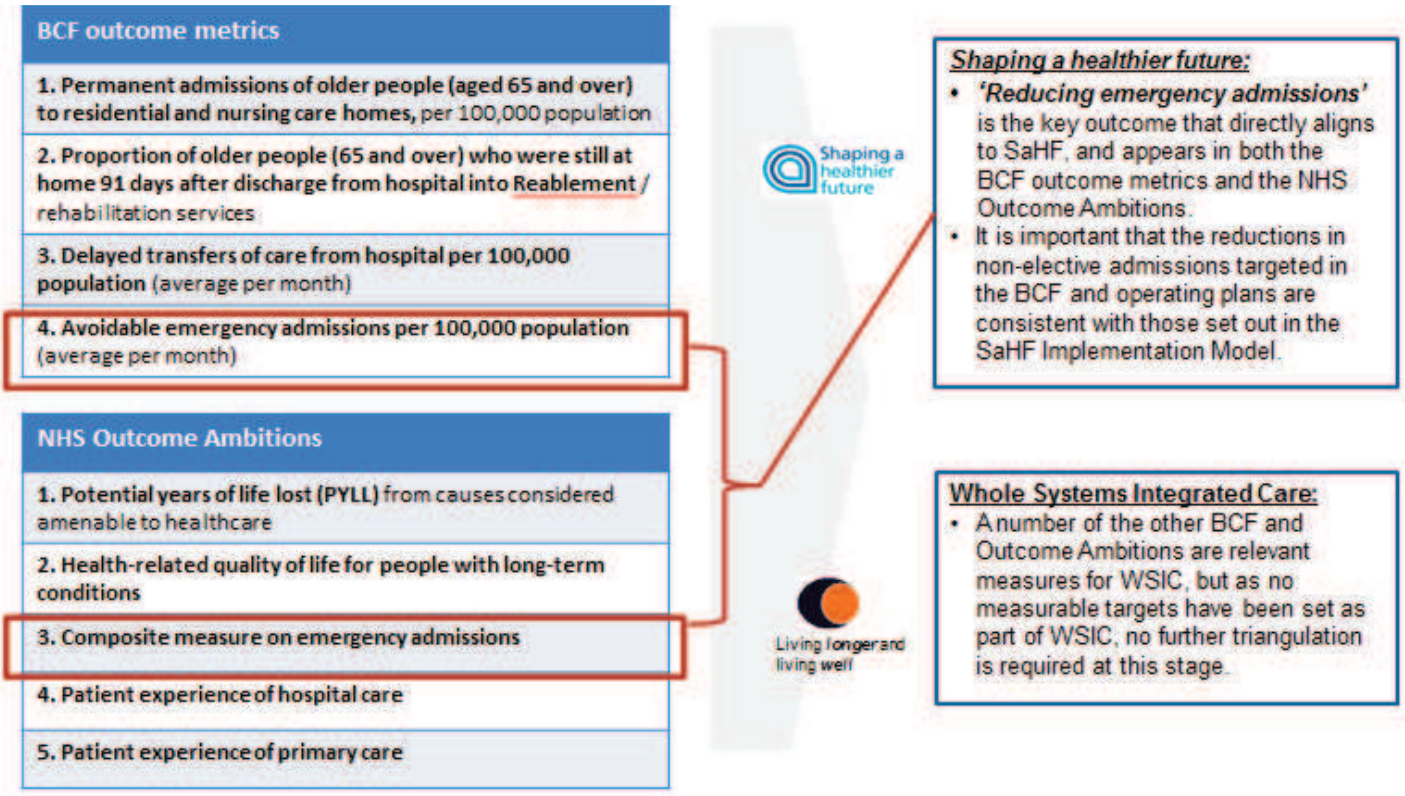
| Out of Hospital strategies | Better Care Fund plans |
|---|---|
| • Early access to primary care<br>• Rapid response to prevent avoidable admissions<br>• Integrated care to proactively manage complex patients<br>• Planned care pathways<br>• Appropriate time in hospital | • Reduced emergency admissions<br>• Reduced permanent admissions of older people to residential and nursing care homes<br>• Increased proportion of older people at home 91 days after discharge from hospital into reablement / rehabilitation services<br>• Reduced delayed transfers of care<br>• Improved patient & service user experience |

- Delivery of BCF plans is an enabler to the delivery of our Out of Hospital strategies – i.e. they will support the shift of care from acute to community settings, and provider impacts are fully incorporated in CCG QIPP plans set out in section 2.4 above.

Outcomes and Metrics

There are four standard BCF outcome metrics, one of which relates directly to *Shaping a healthier future:*

## Alignment of BCF to the NWL vision and key interventions




The Better Care Fund allocations within North West London total £40m for 2014/15, with a further £90m in 2015/16 (the latter contribution from core CCG funding), making a minimum revenue allocation of £130m.

The tri-borough BCF contributions are significantly higher than the mandated minimum allocations, mainly due to the fact that the full section 75 arrangements have been reflected.

The Acute provider impact of the BCF is incorporated in the CCG QIPP plans outlined in section 2.4.

| Organisation | Spending on BCF schemes in 14/15 /£000s | Minimum contribution (15/16) /£000s | Actual contribution (15/16) /£000s |
|---|---|---|---|
| London Borough of Ealing | £ 6,481 | £ 2,114 | £ 2,114 |
| Ealing CCG | £ 13,349 | £ 22,283 | £ 22,730 |
| **BCF Total Ealing** | **£ 19,830** | **£ 24,397** | **£ 24,844** |
| Westminster City Council | £ 28,766 | £ 1,379 | £ 26,252 |
| Royal Borough of Kensington and Chelsea | £ 22,946 | £ 874 | £ 22,004 |
| London Borough of Hammersmith and Fulham | 49,720 | £ 1,052 | £ 47,781 |
| Central London CCG | £ 26,171 | £ 13,553 | £ 42,788 |
| West London CCG | £ 15,911 | £ 17,830 | £ 39,746 |
| Hammersmith and Fulham CCG | £ 12,630 | £ 13,148 | £ 31,923 |

| | | | |
|---|---|---|---|
| **BCF Total Triborough** | **£ 156,144** | **£ 47,836** | **£ 210,495** |
| London Borough of Hounslow | £ 833 | £ 1,610 | £ 1,610 |
| Hounslow CCG | £ 3,747 | £ 15,288 | £ 15,288 |
| **BCF Total Hounslow** | **£ 4,580** | **£ 16,898** | **£ 16,898** |
| Harrow Council | £ 3,560 | £ 1,190 | £ 1,190 |
| Harrow CCG | £ 885 | £ 13,183 | £ 13,183 |
| **BCF Total Harrow** | **£ 4,445** | **£ 14,373** | **£ 14,373** |
| Brent Local Authority | £ 6,156 | £ 6,156 | £ 6,156 |
| Brent Local Authority Disability Facilities Grant | | £ 1,852 | £ 1,852 |
| Brent Local Authority Social Care Capital Grant | | £ 748 | £ 748 |
| Brent CCG | | £ 13,676 | £ 13,700 |
| **BCF Total Brent** | **£ 6,156** | **£ 22,432** | **£ 22,456** |
| London Borough of Hillingdon | £ 4,772 | £ 2,349 | £ 2,349 |
| Hillingdon CCG | | £ 15,642 | £ 15,642 |
| **BCF Total Hillingdon** | **£ 4,772** | **£ 17,991** | **£ 17,991** |
| **BCF Total NW London** | **£ 195,927** | **£ 143,927** | **£ 307,057** |

*NB. Totals may not add due to rounding*

| | | | |
|---|---|---|---|
| Minimum revenue allocations | £ 40,697 | £ 130,759 | |

As a result of the NHSE/local government assurance process, further work is required on many local plans, particularly around the metrics and finance data, and on the extent of provider engagement in the planning process. BCF plans have therefore yet to be formally signed off.

NHSE stated that in addition to resolving issues with the completeness and robustness of data submitted, there are a number of areas on which further information is required from CCGs and Health and Wellbeing Boards in order to ensure a rigorous assurance process ahead of any plans being recommended for sign-off. CCGs and HWBs are being asked to provide a more detailed breakdown of planned investments and savings, clarification on the impact of the BCF on the total emergency admissions, and agreement on the consequential impact on the acute sector.

This further work will be incorporated with further iterations of the Strategic Plan.

## 6. Capital Investment

a) DMBC summary

As described earlier in section 3, the net capital investments in the DMBC were £206m Acute, £6-112m Out of Hospital hubs and £32-74m Primary Care (totalling (£244-392m).

b) Latest position

Acute

Trusts are in the process of producing OBCs and these are due to go through the assurance process described in section 1.1 over the coming months.

Out of Hospital Hubs

The estimated capital value of hub cases in development (as at 16/06/14) is set out in the table below:

| CCG | Description | Stage | Estimated Capital Value £'000 | Commentary |
|---|---|---|---|---|
| Brent | Wembley | OBC in development | 500 | |
| Brent | Willesden | PID not yet started | 1,908 | |
| Brent | CMH Hub Plus | OBC in development | TBC | Part of Local Hospital design |
| Central | Fitzrovia | OBC submitted | 424 | SDLT, equipment, project costs (all incl VAT) and lease exit costs |
| Central | Church St | OBC in development | 6,900 | |
| Central/West | St Mary's | OBC in development | TBC | |
| Ealing | Ealing East Hub | OBC in development | 6,000 | Latest estimate is £4-8m |
| Ealing | Ealing Hospital Hub | OBC in development | TBC | Part of Local Hospital design |
| Ealing | Ealing North Hub | OBC in development | 6,000 | Latest estimate is £4-8m |
| H&F | Charing Cross | OBC in development | TBC | Part of Local Hospital design |
| Harrow | NE Locality Belmont/Kenmore | OBC in development | 12,500 | |
| Hillingdon | Uxbridge and West Drayton Local | PID in development | TBC | SSDP estimates are no longer valid as the preferred site is no longer viable |
| Hounslow | Heston | OBC submitted | 1,480 | Equipment, project costs and temporary accomodation, all incl VAT |
| West | St Charles | OBC in development | 5,800 | This was the estimate in the previous St Charles OBC and is now being reworked due to changes in the phased approach being taken at OBC |
| West | South Locality | OBC in development | 7,000 | As yet unkown, this is a holding figure from the PID |
| | | Total | 47,482 | |

Notes:

1. Values stated are the total of estimated development and associated costs (equipment, project costs etc) for the preferred option. In the case of developed OBCs and options apporaisals, or PID values.
2. Estimated construction costs for new build and refurbishment are included where it is anticipated that an NHS body or bodies will fund the scheme (e.g. DoH, NHS PS, NHSE, CCG) and excluded for schemes expected to be LIFT developments (e.g. Heston) or
3. Costs exclude VAT, other than as indicated in "Commentary".
4. The White City / Park View Collaborative Care Centre, which opened in summer 2014, was a £15m new build developed under LIFT arrangements.

Primary care

The latest position for primary care capital investment, as presented at the SaHF Summit on 17 March 2014, proposes implementing the suggested changes to GP estate (across NWL) requires approximately £49-73m. This comprises £21-34m for refurbishment and £28-39m for re-housing.

The key assumptions in this are:

- No capital receipts are assumed.
- Refurbishment is assumed to require £1,800/m2.
- New build is £2,600/m2 plus land cost. Land cost is estimated based on a plot size three times the GIA (ratio derived from existing estate). Land costs vary by CCG.
- Co-location / re-housing in hub is captured in hub capital.
- Co-location / re-housing in existing sites assumed to have a refurbishment requirement.

c) Process for assuring affordability of recurrent costs

All capital investment will be rigorously assessed for affordability as part of the Business Case process. As well as all individual schemes being assessed as stand-alone Business Cases, the overarching SaHF DMBC economic and financial analysis will be updated as part of the Implementation Business Case.

## 7. NWL Financial Strategy

7.1. The NWL-wide financial strategy encompasses all eight NWL CCGs, plus NHS England and incorporates contributions from all organisations, with the following defined objectives:

- All CCGs need to be in a position to be able to implement their Out-of-Hospital strategies in a consistent manner and timeframe.
- SaHF programme management needs to be adequately resourced.
- Significant investment in primary care (networks, estates etc.) is required to underpin OOH strategies across NWL.
- Transition support for acute providers needs to be explicitly tied to SaHF implementation.
- The investment in NWL-wide S&T programmes (Whole Systems, 7 Day Working, Mental Health Transformation etc.) needed to support SaHF implementation.

7.2. The business rationale for a NWL-wide financial strategy are:

- SaHF is a NWL-wide programme and the probability of successful implementation would be significantly enhanced by a NWL-wide financial strategy.
- Individual CCGs are in radically different financial positions with surpluses/deficits which are predominantly the result of inherited PCT positions, and surpluses/deficits correlate with under/over funding positions.
- If the wide disparity in CCG financial positions is not addressed through a NWL-wide financial strategy, SaHF implementation as a whole could be compromised.
- A NWL-wide financial strategy provides resilience to all CCGs in the light of potential future funding changes, and also in facing provider issues together.

7.3. The NWL Financial Strategy comprises three parts, each part being a component of one integrated fund:

- Part A - Pooling of CCG and NHS England non-recurrent headroom to support non-recurrent SaHF costs.
- Part B - Utilising CCG carry forward surpluses to enable Out-of-Hospital implementation across NWL
- Part C - Creation of SaHF Out-of-Hospital investment fund to support investment in Out-of-Hospital services.

7.4. <u>Part A</u>

- NHSE planning guidance for 2014/15 includes a requirement that:

"Commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. Recognising the need to accelerate efficiencies in 2014/15 both to prepare for the challenges of 15/16 and to create funding for service change, we have increased the level of non-recurrent expenditure in 14/15 to 2.5%."

- For 2014/15, contributions at 2.5% are as follows:

| | £m |
|---|---|
| **Brent** | 9.4 |
| **Ealing** | 10.6 |
| **Central** | 6.2 |
| **Hammersmith & Fulham** | 6.1 |
| **West** | 8.4 |
| **NHS England** | 16.3 |
| **Total** | **57.0** |

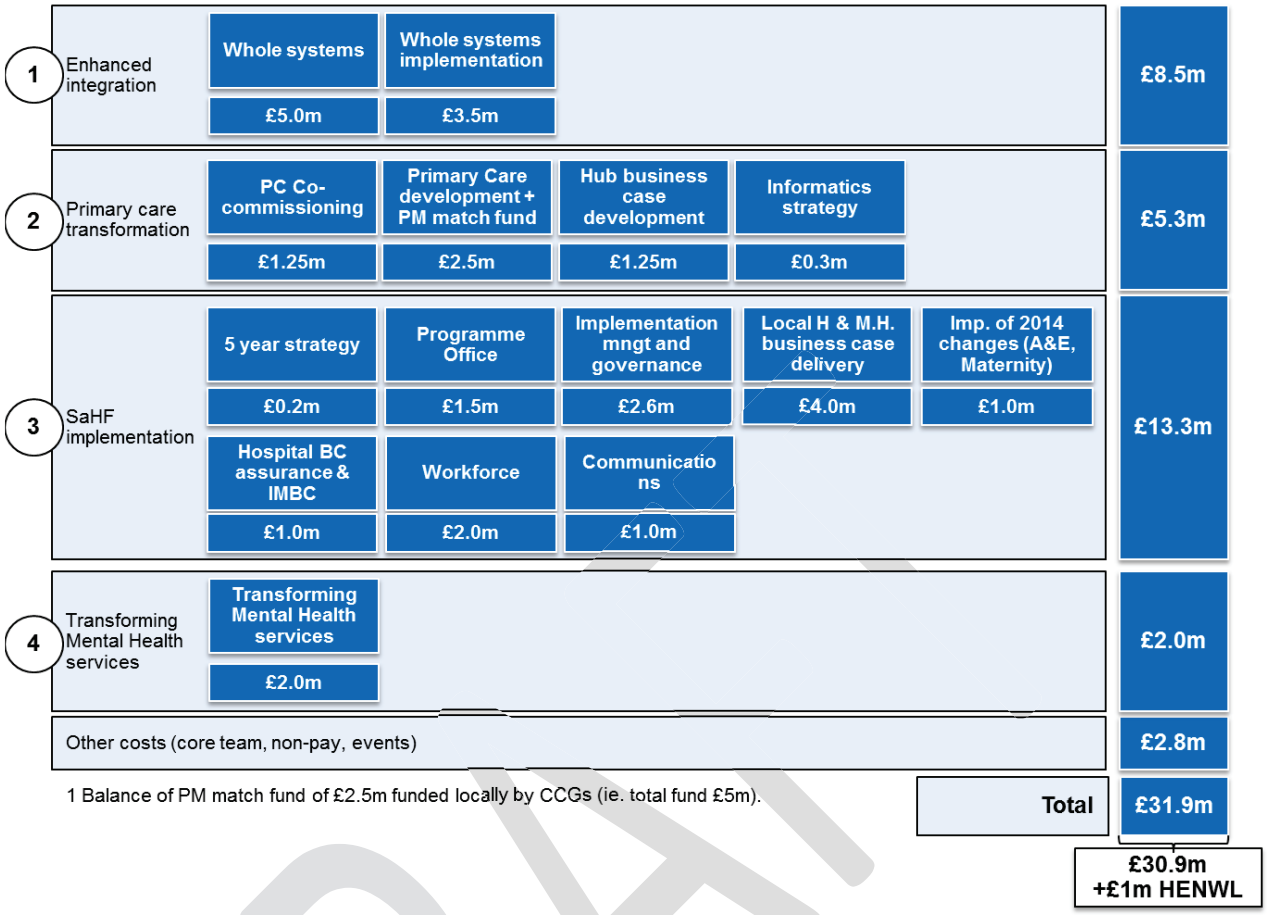
Note: Harrow, Hillingdon and Harrow 2.5% retained to support local financial position.

Part A of the fund is being used to support:

- SaHF programme and implementation costs
- Enhanced integration programme (e.g. Whole Systems)
- Other NWL-wide Strategy & Transformation programmes, including PM challenge fund and mental health transformation
- Acute provider transition, as per the criteria agreed by the SaHF Programme Board

For 2014/15, Part A funding was allocated to the Strategy & Transformation budget as follows:

# Appendix G: Financial appendix




1 Balance of PM match fund of £2.5m funded locally by CCGs (ie. total fund £5m).

For 2014/15, Part A funding was allocated to Providers (for transition costs) as follows:

| | 2014/15 Service Change | Fixed Costs | Transaction Related | Total |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Chelsea & Westminster | 0 | 0 | 0 | 0 |
| Ealing | (a) 1,950 | 0 | 0 | 1,950 |
| Hillingdon | 0 | (c) 3,900 | 0 | 3,900 |
| Imperial | (b) 600 | 0 | 0 | 600 |
| North West London Hospitals | (b) 600 | (d) 11,000 | (e) 2,850 | 14,450 |
| West Mids | (a) 2,900 | (c) 1,800 | (f) 1,500 | 6,200 |
| | | | | |
| **Total** | 6,050 | 16,700 | 4,350 | **27,100** |

**Notes**
(a) Maternity related
(b) A & E related
(c) Fixed cost support in advance of service change
(d) CMH
(e) NWLH/Ealing Merger
(f) ChelWest transaction

7.5. Part B

- The NHSE expectation/requirement is for CCGs to operate with a 1% surplus. In 13/14, four CCGs in NWL had a much larger surplus; two had deficits.
- NHSE planning guidance states that:

"Surpluses and deficits accumulated at 31/03/14 and subsequent years will be carried forward in the following financial years".

- In addition, the planning guidance set out the process to draw-down, or spend, previous years' surpluses, which requires agreement by NHSE.
- In respect of Harrow and Hillingdon, the impact of carried forward 13/14 (and projected 14/15) deficits, would be both to render impossible the implementation of SaHF Out-of-Hospital strategies, and also to impact adversely on outcomes. Furthermore, the deficits are correlated with underfunding indicated by the National Capitation Formula.

- It is therefore proposed that 40% of the carry forward surpluses in the 4 CCGs with large surpluses be pooled, under Part B, to be used to ensure that SaHF OOH strategies are implementable across all 8 CCGs:

| | Total (£m) | % | £m |
|---|---|---|---|
| **Brent** | 29.2 | 40 | 11.7 |
| **Central** | 16.9 | 40 | 6.8 |
| **H&F** | 12.3 | 40 | 4.9 |
| **West** | 29.6 | 40 | 11.8 |
| **Total** | **88.0** | **40** | **35.2** |

- Note: In addition to the above, further contributions to the pool of £5m (£2m from Brent CCG and £3m from CWHHE, split to be agreed) have been identified.
- As noted above, the draw-down and utilisation of carry forward surpluses requires the agreement of NHSE, and this plan reflects NWL CCGs' request to NHSE in this respect.

7.6. Part C

- In order to support the implementation of CCG Out-of-Hospital strategies in a consistent manner and timeframe, Part C of the fund is to focus on SaHF Out of Hospital (OOH) revenue investment. (Note – whilst the investment is predominantly recurrent in nature, NHSE have advised that in-year resource adjustments are required to be non-recurrent).
- Out of Hospital strategies also require capital investment, which is covered in section 6 above.
- Part C contributions to the fund have been calculated as follows:

a) A 1% contribution by all CCGs (£23.6m)

b) A further £23.6m contribution from the five CCGs with 13/14 underlying recurrent surpluses, in proportion to 13/14 forecast exit run rates

c) A contribution (TBC) from NHSE in respect of primary care growth (1)

Note (1) – London has received primary care growth of 1.6% in 14/15. The NWL growth, if utilised as part of the above, will enable NHSE (L) to discharge their responsibility "to account to local stakeholders for how the patterns of deprivation reflected in their allocation have been reflected in their allocation choices."

This would create an investment pool of £47.2m (excl. NHSE), which is proposed to be utilised to deliver SaHF OOH objectives (as set out in the SaHF Decision Making Business Case):

- The Out of Hospital strategies aim to meet people's changing needs by developing:
- Better care, closer to home
- A greater range of well-resourced services in primary and community settings, designed around the needs of individuals

| | Sources (£m) | Application (2) (£m) | Net (£m) |
|---|---|---|---|
| Brent | 12.1 | 5.9 | (6.2) |
| Harrow | 2.2 | 6.5 | 4.3 |
| Hillingdon | 2.8 | 8.1 | 5.3 |
| Ealing | 5.2 | 7.5 | 2.3 |
| Hounslow | 2.7 | 8.1 | 5.4 |
| Central | 5.4 | 3.2 | (2.2) |
| H&F | 6.1 | 3.6 | (2.5) |
| West | 10.6 | 4.2 | (6.4) |
| **Total (excl. NHSE)** | **47.2** | **47.2** | **-** |
| NHSE (1) | TBC | - | |
| **Total** | **TBC** | **-** | |

NB. Totals may not add due to rounding

Note (2) – Applications across CCGs calculated as follows:

a) Return 1% to the three CCGs not in recurrent balance (£7.7m)
b) The remaining £39.5m in proportion to capitation target

7.7. Affordability and future proofing

The principles governing the 5 year strategy have been agreed by CCGs to be:

- Contributions to the financial strategy each year should be determined based on affordability, with the CCGs in the strongest financial position contributing the most. When assessing the financial position of a CCG both the underlying surplus/deficit of the CCG and its distance from target should be considered.
- All CCGs have equal right to draw from, and responsibility to contribute to, the financial strategy, should financial positions of individual CCGs change.
- In acknowledgement that NWL as a whole is £136m above the capitation funding level, all CCGs commit to ensuring that funds are invested in a way that represents value for money and reduces recurrent costs over time while maintaining high quality services.
- All CCGs commit to spending the financial strategy funding to achieve the aims for which the budget is set.

In the current financial scenario, Brent, Central, West and Hammersmith & Fulham CCGs will be significant net contributors in 14/15. In future years, if the allocation model is implemented in full, then other CCGs may well be in this position, and all 8 CCGs need to agree this strategy in acknowledgement of this.

## 8. Financial Risk Assessment and sensitivity analysis

8.1 The DMBC included a comprehensive sensitivity analysis as follows:

| Sensitivity tests | Description | High level effect |
|---|---|---|
| a) **Demand growth I:** 1%pt pa higher than plan, trust income allowed to grow | • Demand is higher than expect leading to increased activity (+1%pt per year)<br>• Trusts are reimbursed for this additional activity | • Higher income, activity and costs (scaled with increase in activity)<br>• More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets |
| b) **Demand growth II:** 1%pt pa higher than plan, trust income fixed as per baseline | • Same as (a) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | • Same as (a) except income does not increase leading to a worse financial position for the Trusts |
| c) **QIPP plans I:** 60% of plans achieved, trust receive income | • QIPP initiatives do not deliver the planned level of reduction in acute activity (only 60% achieved)<br>• Trusts are reimbursed for this additional activity | • Same as (a) except the new activity is focused on services targeted by QIPP initiatives (mainly non-elective and outpatients) |
| d) **QIPP plans II:** 60% of plans achieved, trust income is capped | • Same as (d) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | • Same as (c) except income does not increase leading to a worse financial position for the Trusts |
| e) **QIPP plans III:** 110% of QIPP achieved (Trusts recover costs) | • QIPP initiatives deliver 10% more reduction than planned in acute activity (110% achieved), with the associated reduction in income and in activity<br>• Trusts adapt by reducing variable and semi-variable costs accordingly | • Lower income, activity and costs (scaled with decrease in activity)<br>• Less beds needed, leading to lower capital spend and ongoing costs to replace and operate the assets |
| f) **Tariff efficiency I:** Monitor guidance on tariff efficiency, and 90% productivity savings | • 5% tariff efficiency (i.e. difference between cost inflation and tariff deflator) instead of 4% for 12/13 and 13/14 (modelled by varying cost inflation); 14/15 onwards remains 4.2%<br>• Trusts achieve only 90% planned productivity savings in 12/13-17/18 | • Increased cost inflation, and less cost saving from productivity, leading to a worse financial position |

| Sensitivity tests | Description | High level effect |
|---|---|---|
| g) **Tariff efficiency II:** Monitor downside on tariff efficiency | ▪ 5.5% tariff efficiency in 12/13 and 14/15<br>▪ 5% efficiency in 15/16 onwards | ▪ Increased costs inflation leading to a worse financial position |
| h) **LOS reduction I:** 10% reduction achieved (instead of 15%) | ▪ Trusts achieve only 10% reduction in average length of stay, compared to 15% assumed in the main analysis | ▪ More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets |
| i) **LOS reduction II:** no ALOS reduction on maternity, paediatrics nor critical care | ▪ Trusts keep average length of stay for maternity and critical care constant, and achieve15% reduction for other categories | ▪ 15% more beds needed in maternity and critical care, leading to higher capital spend and ongoing costs to replace and operate the assets |
| j) **Transition costs:** 20% higher than plan | ▪ Higher revenue impact from recon-figuration (e.g. due to more expensive or extended transition period) | ▪ Increased one-off transition costs |
| k) **Consolidation savings:** 50% of the consolidation savings achieved | ▪ Only 50% of the modelled savings in pay costs due to consolidating services are achieved (i.e. 2.5% of pay costs when consolidated on Hammersmith site; 5% for all other sites) | ▪ Less cost saving delivered when consolidating services |
| l) **Higher new build cost:** 30% higher than plan | ▪ Higher capital costs to add new capacity | ▪ Increased capital requirements and ongoing costs to operate and replace assets |
| m) **Lower net land receipts:** 30% lower than plan | ▪ Lower net disposal value for unused land (e.g. due to restrictions or difficulties selling land, or higher exit and demolition costs) | ▪ Increase in net capital requirements |
| n) **Higher cost of capital:** NPV discount rate of 4.5% instead of 3.5% | ▪ Decease the relative value of long term benefits compared to short term costs when evaluating NPV to reflect the cost of up front capital, and the risk of future returns | ▪ Reduces NPV, particularly for medium-to-long term benefits and costs |

| Sensitivity tests | Description | High level effect |
|---|---|---|
| o) **Time to deliver reconfiguration** | • Acute reconfiguration changes take 2 years longer to implement (than originally planned; e.g., delays due to planning or delivering required QIPP or LOS reductions) | • Extends the time for which current trading deficits need to be covered, and delays the benefit of reconfiguration – reduces the NPV of options |
| p) **Lower outpatient activity:** Local Hospitals retain 40% rather than 85% of outpatient activity | • Less outpatient activity retained at Local Hospitals (40% compared to base assumption of 85%) reducing income and variable/semi-variable costs, but with the same fixed costs | • Reduces the contribution margin for Local Hospitals, potentially impacting site viability |
| q) **Period for NPV assessment** | • Period for NPV assessment increases from 20 years (no terminal value) to 60 years (no terminal value) | • Increases the NPV of options |
| r) **Theatre efficiency** | • Theaters assumed to run 50 hours per week instead of 40 hours | • Less new theatres needed, leading to lower capital spend and ongoing costs to replace and operate the assets |
| s) **Lower new build cost:** 30% lower than plan | • Lower capital costs to add new capacity | • Decreased capital requirements and ongoing costs to operate and replace assets |
| t) **Reduced fixed cost savings at Local Hospitals:** Only 75% of net savings delivered | • Reduced net savings in fixed costs at local hospitals to 75% of modelled savings | • Increases cost at Local Hospitals (potentially impacting viability) and reduces cost saving benefit in NPV |
| u) **Imperial College I:** NHS contributes 100% of capital; no net revenue impact | • Increases NHS capital contribution; no change to on-going revenue cost assuming these costs are already incurred for the existing services | • Increases capital cost and reduces VfM NPV. No change to expanded NPV as total capital already included |
| v) **Imperial College II:** NHS contributes 100% of capital; full revenue impact added to ongoing costs (est. 11.5% of capital) | • Increases NHS capital contribution; on-going revenue costs increased by 11.5% of capital costs | • Increases capital and revenue costs, and decreases total VfM and expanded NPV |

The sensitivity analysis supported the conclusion that the preferred option was the leading option in financial terms.

However, as highlighted pre-consultation, it was noted the Programme needs to mitigate against the risk of a number of downside sensitivities happening simultaneously if the overall financial benefits are to be realised. Pre-consultation, a negative NPV over 20 years occurred if the top four sensitivities occurred at the same time. Since this, the analysis above suggested that the top two sensitivities would have this impact. Similarly whilst the preferred option delivered an improved I&E position over 'do-nothing', a combination of the two worst sensitivity impacts would reduce this by approximately 50%.

The highest risk sensitivities are listed below. It was noted in the DMBC that these risks need to be very carefully managed in order for any reconfiguration to be successful and for improvements in acute sector finances to be delivered. Some of these adversely affect the 'do nothing' and all reconfiguration options, whereas others reduce the benefits of all options with respect to 'do nothing' and potentially differentially impact the options relative to each other:

**Sensitivities that affect the 'do nothing' and all reconfiguration options:**

- In the review, -two of the key risks highlighted in the pre-consultation analysis remained significant risks: These both involve higher activity than planned, but where Trusts are not reimbursed for the additional activity
    - Sensitivity B: 1% higher demand, but Trusts not reimbursed
    - Sensitivity D: Only 60% of QIPP delivered, but Trusts not reimbursed
- Two other sensitivities on tariff efficiencies (F and G) were not explicitly tested pre-consultation, but were shown to be high risk through the pre-consultation downside scenario. These demonstrated that higher tariff efficiency (through higher experience cost inflation) or under-delivery of CIP is a significant risk for providers

**Sensitivities that reduce benefits of all options relative to 'do nothing' and potentially differentiate options:**

- Sensitivity T: Reducing fixed costs (defined as establishment, premises & fixed plant, depreciation and PDC) at local hospitals was highlighted as a key sensitivity in the pre-consultation analysis. Failure to reduce these costs (e.g. by retaining more buildings than the estate plans indicate is required) would result in unviable sites and under-delivery of the cost saving analysis through the number of sites in deficit and the reduced NPV, respectively)
- Sensitivities on bed capacity and capital build costs did not have a large impact in the PCBC analysis, but in DMBC analysis emerged as significant risks. These all involved increases to the capital expenditure for adding new capacity, and now have larger impact because of the revisited higher capital costs per bed and because the analysis now accounts for step changes when adding capacity that were identified through the more detailed estates work. It was noted that these sensitivity analyses model the case where all of the additional capacity is built at the Major Hospital sites; the additional capacity could be mitigated through the better use of spare beds at Central Middlesex, or out of hospital capacity.
    - Sensitivity H: Only 10% ALOS reduction achieved
    - Sensitivity I: No ALOS reduction in maternity, paediatrics and critical care (new sensitivity analysis)
    - Sensitivity L: New build capital costs 30% higher than modelled

- Sensitivity K (50% of the consolidation savings through merging into larger clinical teams) has a larger impact on the Value for Money assessment than in the pre-consultation analysis because the preferred option is now closer to the scoring thresholds, particularly on total I&E and Site Viability.

8.2 The NWL strategic planning workshop on 6 May 2014, (comprising NHSE, CCGs, providers and local authorities), reviewed key financial risks (and mitigations) and the following is based on the outcome of the workshop.

| Risk area | Risk | Mitigation |
|---|---|---|
| A. Financial positions | 1. Commissioner funding - NWL CCGs are collectively £136m above fair shares target, with wide variation across CCGs | a) Using NHSE guidelines re future allocation<br>b) NWL financial strategy shares risk across commissioners |
| | 2. Inherited commissioner financial positions vary across CCGs | a) NWL financial strategy shares risk across commissioners |
| | 3. Local authority financial pressures impact on health | a) Joint work through BCF |
| | 4. BCF leads to financial instability in CCGs/acute providers | a) Agreement of BCF by local health community |
| | 5. NHSE position regarding specialist services | a) NHSE to outline impact of recovery plan |
| B. Out of Hospital plans | 6. Shaping a healthier future hospital capacity plans dependent on achievement of Out of Hospital e.g. reducing unavoidable admissions | a) Alignment of Business Case assumptions<br>b) Tracking Out of Hospital schemes |
| | 7. Shaping a healthier future Out of Hospital plans require capital and revenue investment to increase capacity of Out of Hospital services | a) Joint work with NHSE on Business Case development for Out of Hospital Hubs |
| C. Capital | 8. Realigning acute sector capacity also requires significant capital investment (over and above DMBC estimates) | a) Outline business case process in train to determine whether this capital investment is affordable, both to individual organisations and collectively (Implementation Business Case) |
| | 9. Under-utilisation of new Out of Hospital capacity | a) Ensure business cases robustly tested |
| D. Other | 10. Significant challenges in securing and maintaining a viable provider landscape, including performance targets (A&E, 18 weeks, etc.) | a) Alignment of SaHF Implementation Business Case with Trust LTFMs |
| | 11. Transition process – tension between securing service change and supporting current service | a) Targeted application of pooled non-recurrent funds as part of NW London Financial Strategy |

| | | |
|---|---|---|
| | configuration | |
| | 12. Specialist commissioning planning not integrated with CCGs | a) Further discussion with NHSE |

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**North West London – Plan on a Page** (04/04/2014)

1

***Our vision is "To improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community".***

Four overarching principles support our vision - that health services need to be: (1) localised where possible; (2) centralised where necessary; (3) in all settings, care should be integrated across health, social care and local authority providers to improve seamless patient care; and (4) the system will look and feel from a patient's perspective that it is personalised - empowering and supporting individuals to live longer and live well.

2

**System Objective One:** *securing additional years of life for people with treatable conditions*

- To improve clinical outcomes

**System Objective Two:** *increasing the number of people having a positive experience of care, in and out of hospital*

- To improve patient satisfaction, patient experience and confidence

**System Objective Three:** *making significant progress towards eliminating avoidable deaths in our hospitals and outside of hospital*

- To reduce mortality rates

**System Objective Four:** *improving the health related quality of life of the 15 million+ people with one or more long-term conditions*

- To reduce morbidity rates

**System Objective Five:** *reducing the amount of time people spend avoidably in hospital through more integrated care & increasing the proportion of older people living independently at home following discharge from hospital*

- To reduce admission and readmission rates

**System Objective Six:**

To address clinical priorities as set out in local Health & Wellbeing strategies and NHS England direct commissioning strategies.

3

***Shaping a healthier future*** **(SaHF) acute reconfiguration, alongside London, SaHF and 7 day Quality Standards**

Reconfigure acute care and implement clinical standards (emergency, paeds and maternity) and 7 day working so that:

- Safe, high quality, and responsive acute care is delivered consistently 7 days a week from 5 major acute hospitals, with other sites specialising in specific areas (e.g. elective care), and/or providing 24/7 urgent care access and local care.

**Out of Hospital strategies, including Primary Care transformation**

Transform out of hospital care to make it more accessible and responsive to patient needs. This includes new models of primary care (built around networks) and redesigning and shifting the delivery of services, including planned care, from hospitals to community settings, i.e. 'out of hospital'.

**Whole Systems Integrated Care**

Implement population-based models of care that empower patients and have GPs at the centre of coordinating people's care. Develop systems to enable the provision of integrated care. To be developed in line with the Integration Transformation Fund (ITF).

**Transforming Mental Health Services**

Implement/enhance services to support care within community settings, including an enhanced acute psychiatric response and enhanced primary mental health care, as well as more integrated care for people with LTCs and mental health needs.

**Health Promotion, Early Diagnosis and Early Intervention**

Implement health promotion, early diagnosis and early intervention plans in lines with local Health and Wellbeing Boards strategies (HWBS) and NHS England' direct commissioning priorities.

4

**Overseen through the following governance arrangements**

Responsible for delivery:

- Health & Wellbeing Boards
- CCG Governing Bodies

Joint programme governance:

↑ CCG Collaboration Board

↑ SaHF Implementation Programme Board; MH Programme Board; and WSIC Programme Board

5

**Measured using the following success criteria**

- Delivery of the NHS outcome ambition attainment targets
- All organisations within the health economy report a financial surplus in 18/19
- No provider under enhanced regulatory scrutiny due to performance concerns
-

6

**High level risks to be mitigated**

- Unable to meet clinical standards
- Unable to deliver workforce
- Delivery timelines not met
- Unsustainable demand
- Poor patient experience

These key risk areas could lead to two worst case events:

- Precipitate poorly planned change
- Failure to deliver benefits

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# OPERATING PLAN MEDICATION ERROR REPORTING

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Kuldhir Johal |
| **Organisation** | Hillingdon Clinical Commissioning Group |
| **Report author** | Mark Eaton, Hillingdon Clinical Commissioning Group |
| **Papers with report** | Appendix 1: Medication Incident Summary for THH & CNWL |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | Domain 5 of the 2014/15 Quality Premium for the CCG requires Hillingdon CCG to work with named providers to increase medication incident reporting rates. These targets need to be agreed by NHS England and the Health and Wellbeing Board. NHSE has already agreed the targets and this paper is seeking Health and Wellbeing Board agreement. |
| **Contribution to plans and strategies** | This will help deliver the CCG's Quality Premium for 2014/15 and also will impact positively on patient safety. |
| **Financial Cost** | Nil |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**The Health and Wellbeing Board is invited to agree the targets set for improvement within THH and CNWL for reporting Medication Incidents.**

## 3. INFORMATION

This project is being run by Hillingdon CCG in collaboration with both Brent and Harrow CCGs and will affect 3 providers in total: CNWL, THH and NWLHT. Only the first two of these are relevant to Hillingdon. The targets have been agreed by NHS England and the approach is agreed by all three CCGs.

## 4. FINANCIAL IMPLICATIONS

None.

## 5. LEGAL IMPLICATIONS

None.

## 6. BACKGROUND PAPERS

Medication Incident Summary Targets for CNWL and THH are attached.

# Increasing Medication Incident Reporting Rates

## 15% of the Quality Premium

**Carole Mattock, Head of Quality & Safety**
**Mark Eaton, Head of Delivery & Performance**

# Background

Domain 5 of the 14/15 Quality Premium includes an opportunity for Hillingdon CCG to ultimately improve safety by increasing the rate of reporting for medication-related safety incidents within key providers.

The Quality Premiums are dictated to CCGs by NHS England (NHSE) but the mechanism for monitoring performance and demonstrating that the improvements have been delivered is proposed by the local CCG.

To achieve Domain 5 of the Quality Premium the Hillingdon CCG will be working with both Brent and Harrow CCGs to deliver improvements in three specified providers (THH, NWLHT and CNWL). Only CNWL and THH are relevant to the work being undertaken by Hillingdon CCG.

This paper is presented for approval by the HWBB of the targets for CNWL and THH. The targets for these providers has already been agreed by NHS England and also by the Executive Committees of the three BHH CCGs.

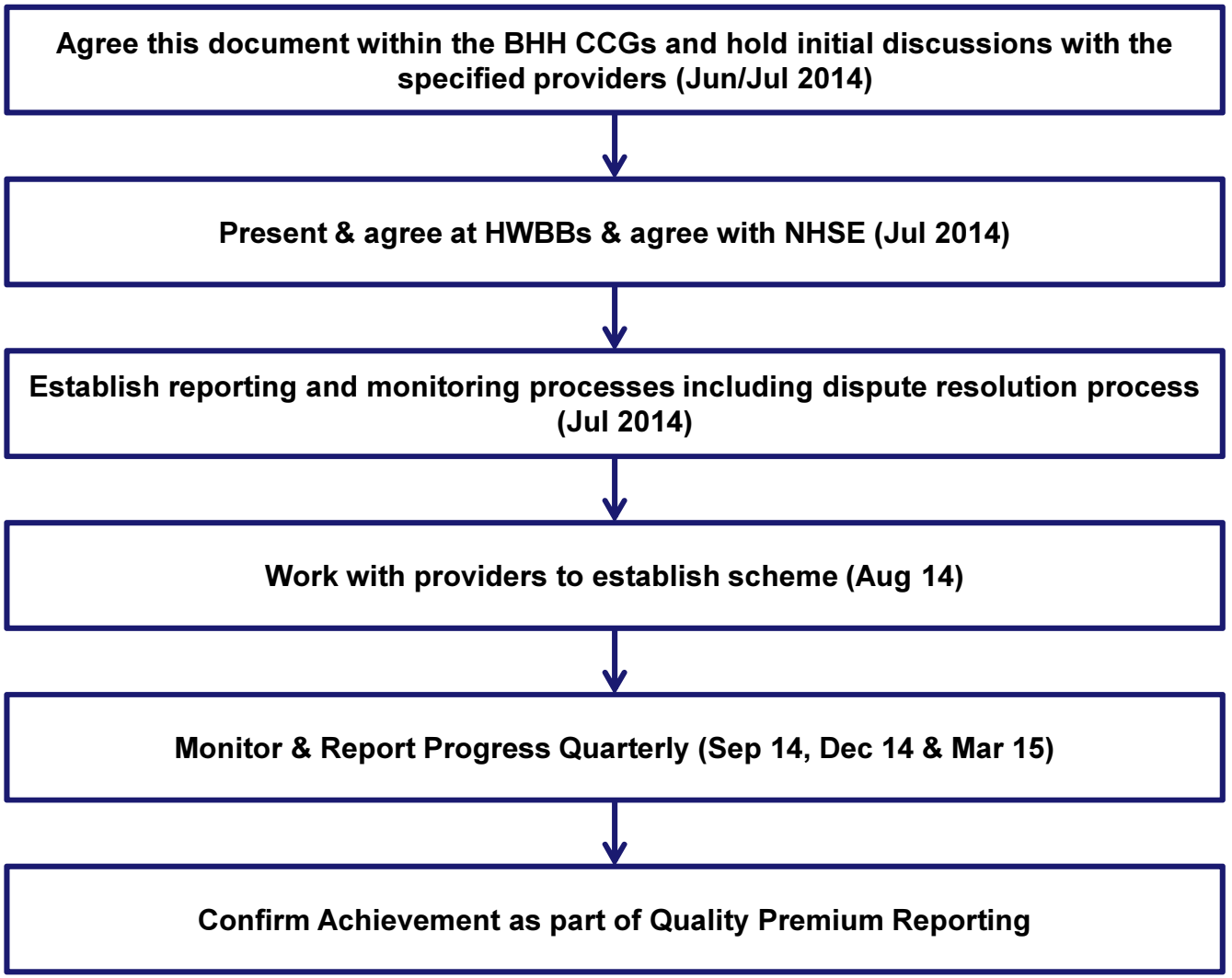
The providers are asked to achieve four things as part of this project:

- Demonstrate that they have a robust reporting process that is compliant with the NHS's NRLS reporting system.
- Put together a communications programme to encourage people to report more of the many unreported incidents that are felt to exist.
- Risk assess three major pathways to identify where medication incidents can occur and to put together plans to improve them.
- Demonstrate an increased reporting rate for medication incidents for Q3 and Q4 of 14/15.

There is a concern by NHSE that areas of poor performance within a provider organisation may be masked by the provider's overall reporting rate. To provide assurance that this is not the case providers are to be asked to produce a quarterly report for presentation at their CQG meetings that demonstrate not only an increase in the rate of reporting but also that the spread of reporting is equitable across the organisation.

This programme will be managed and monitored by Carole Mattock (BHH Quality & Governance Team) and Mark Eaton (Head of QIPP) on behalf of Hillingdon CCG.

# High Level Implementation Plan



# Increasing Medication Incident Reporting Rates at THH

**Carole Mattock, Head of Quality & Safety**
**Mark Eaton, Head of Delivery & Performance**

# THH Targets & Baseline Information

The BHH CCGs propose to work with THH to deliver Domain 5 of the Quality Premium. The following is a summary of the baseline information and proposed improvements in performance.

| THH |
| --- |
| **Baseline Information**<br>(Six Months to Sep 13)<br>- Total Incidents Reported: 2,481<br>- Medication Incidents: 176<br>- Medication Reporting Rate: 7.1% |
| **Comparison To Similar Organisations**<br>The comparison to similar organisations suggests that THH should be reporting medication related incidents at a rate of around 11% of all incidents. Therefore THH are currently reporting at a rate 3.9% below that of comparable organisations. |
| **Proposed Target for December 2014**<br>Increase Medication Related Incidents reporting to more than 270/six months (with approximately 2,400 +/-10% reported incidents overall). This represents a 53% increase in overall reporting rates for THH. |

# Increasing Medication Incident Reporting Rates at CNWL

**Carole Mattock, Head of Quality & Safety**
**Mark Eaton, Head of Delivery & Performance**

# CNWL Targets & Baseline Information

The BHH CCGs propose to work with CNWL to deliver Domain 5 of the Quality Premium. The following is a summary of the baseline information and proposed improvements in performance.

| CNWL |
| --- |
| **Baseline Information**<br>(Six Months to Sep 13)<br>- Total Incidents Reported: 3,660<br>- Medication Incidents: 383<br>- Medication Reporting Rate: 10.5% |
| **Comparison To Similar Organisations**<br>The comparison to similar organisations suggests that CNWL should be reporting medication related incidents at a rate of around 8.8% of all incidents. Therefore they are currently reporting at a rate 1.7% above that of comparable organisations. |
| **Proposed Target for December 2014**<br>Increase Medication Related Incidents reporting to more than 430/six months whilst maintaining this at a rate above 8.8% of all incidents reported. This represents a 12.2% increase in the overall reporting rates. |

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