

# 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 –20<sup>th</sup> 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<sup>1</sup>:

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

<sup>1</sup>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](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf)

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*<sup>2</sup> 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

<sup>2</sup> *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'<sup>3</sup> 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 the new model of care in a sustainable way.

<sup>3</sup> *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 other 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.

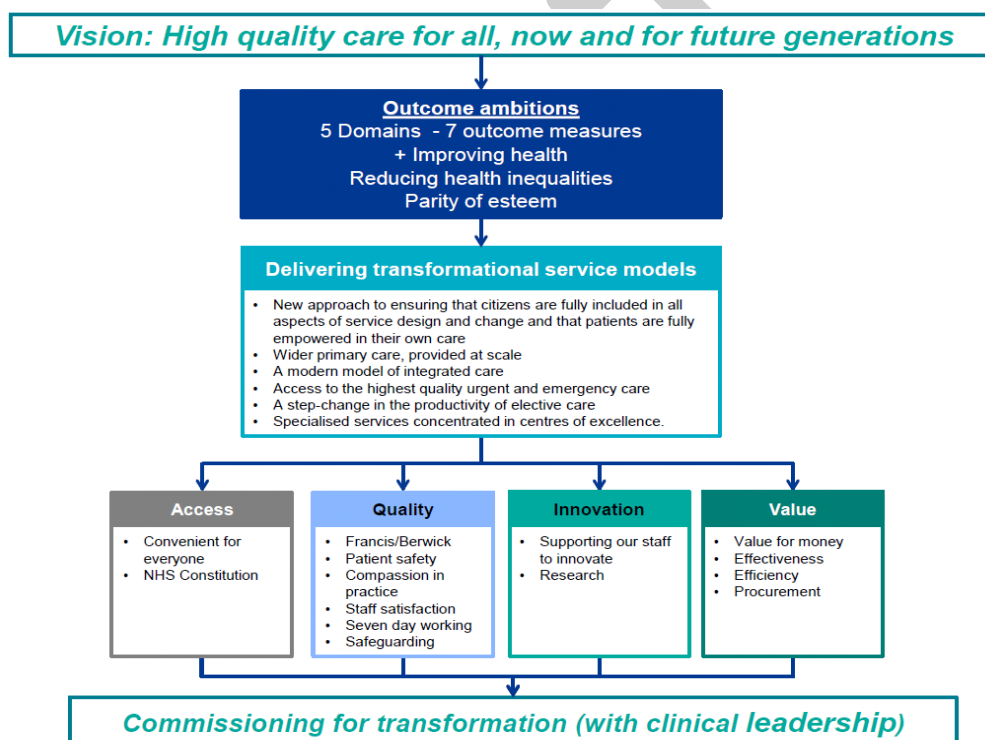
The Plan also articulates how we will work more closely than ever with patients and the public, building on work to embed and sustain co-production as a first principle, and seeking to enable and empower patients to maintain independence and to lead full lives. The Plan builds upon the significant strategic 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*<sup>4</sup>, 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<sup>5</sup>



<sup>4</sup> *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>

<sup>5</sup> 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.midstaffpublicinquiry.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)<sup>6</sup>.

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<sup>7</sup>.

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<sup>8</sup>, are coterminous with the eight local authority boroughs.

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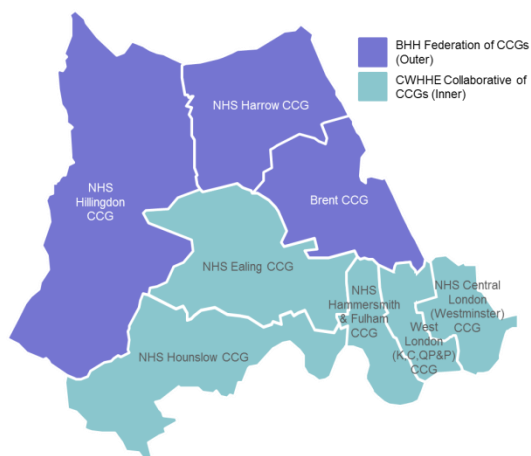
<sup>6</sup> *North West London SPG planning document; Monitor, TDA, NHS England (November 2013), based on GLA 2012 Round Demographic Projections, 2013*

<sup>7</sup> *North West London SPG planning document; Monitor, TDA, NHS England (November 2013)*

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<sup>8</sup> 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.

## 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.

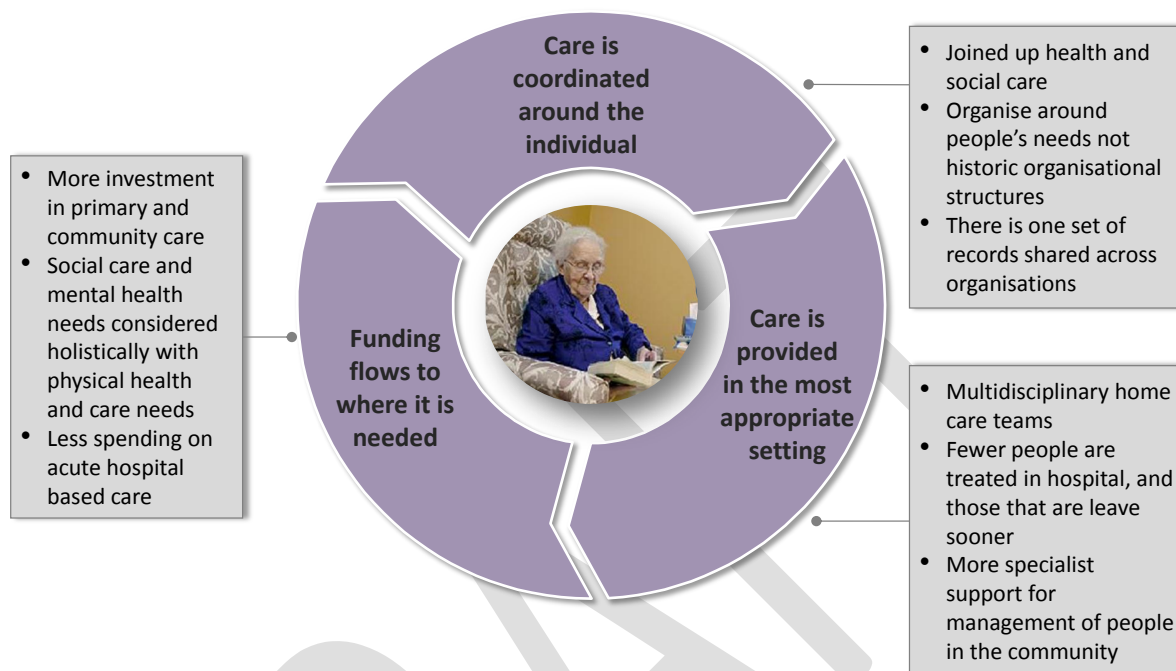


## Our shared vision and outcome ambitions for NWL

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<sup>9</sup>):

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<sup>10</sup>



(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.

<sup>9</sup> *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](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>)

<sup>10</sup> *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<sup>11</sup>:

### 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		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	2,060.8	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
<b>Aggregated</b>	<b>16,174</b>			<b>13,743</b>	<b>15.04</b>

[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*.

<sup>11</sup> 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		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	72.9	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
<b>Aggregated</b>	<b>594</b>			<b>616</b>	<b>3.71</b>

*[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		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	2,053.7	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
<b>Aggregated</b>	<b>17,700</b>			<b>16,007</b>	<b>9.6</b>

*[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.

Whilst 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*<sup>12</sup>.

**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
<b>Aggregated</b>	<b>1,307</b>			<b>1,213</b>	<b>7.20</b>

*[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

<sup>12</sup> 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<sup>13</sup>. 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.

<sup>13</sup> North West London SPG planning document, November 2013 (Monitor, TDA, NHS England)

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

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 with 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<sup>14</sup> 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.

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<sup>14</sup> 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](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*'<sup>15</sup> 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

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<sup>15</sup> *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.

### Safeguarding adults

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*'<sup>16</sup>, 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

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<sup>16</sup> *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](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<sup>17</sup>. 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

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<http://ccgtools.england.nhs.uk/innovation/ISCCG/MedTechT22/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.

#### NIHR CLAHRC for North West London

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

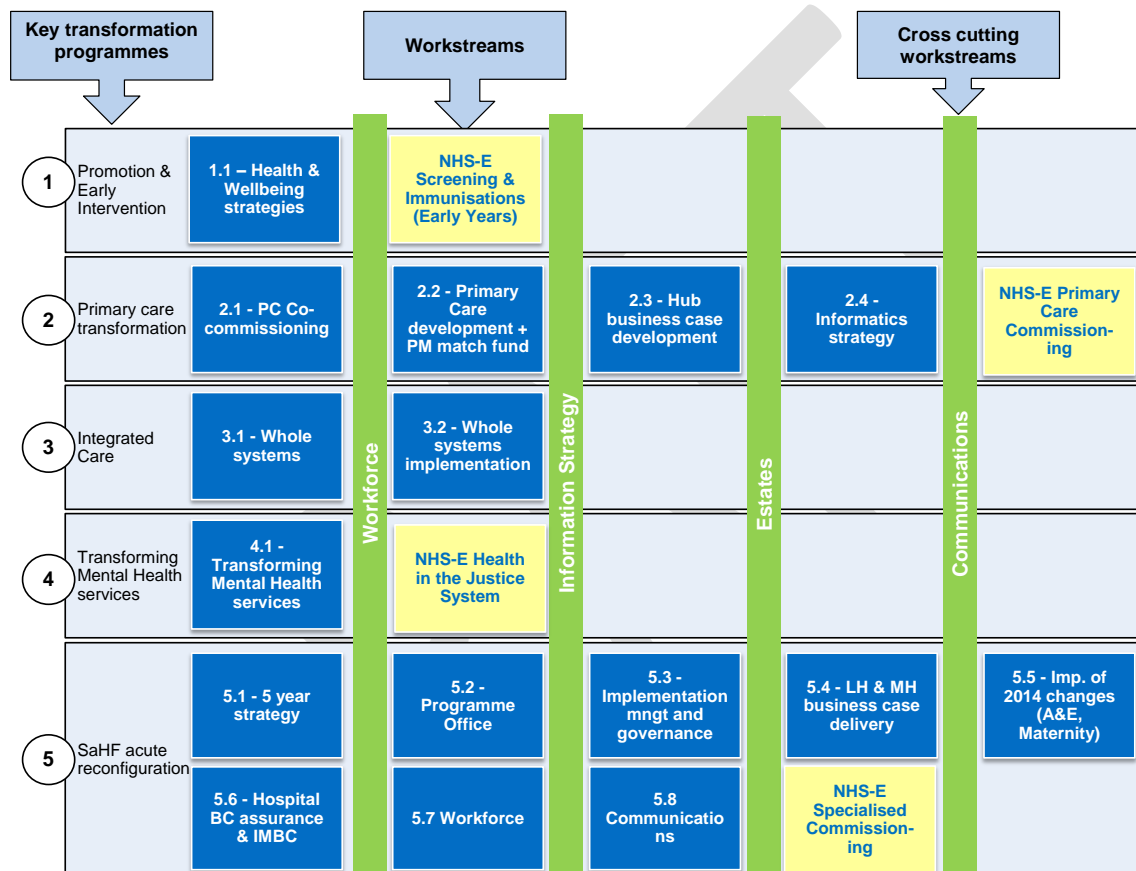
This portfolio of programmes reflects the focus on personalised care for patients and families, and on the level and quality of services provided in the community. The areas of direct NHS England commissioning are also reflected with their related transformation programmes.

## Our key 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).

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## 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<sup>18</sup>

Domain	Out of Hospital Standards
<p><b>A</b> Individual Empowerment &amp; Self Care</p>	<ul style="list-style-type: none"> <li>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</li> </ul>
<p><b>B</b> Access convenience and responsiveness</p>	<ul style="list-style-type: none"> <li>Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:                             <ul style="list-style-type: none"> <li>Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling</li> <li>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</li> </ul> </li> </ul>
<p><b>C</b> Care planning and multi-disciplinary care delivery</p>	<ul style="list-style-type: none"> <li>All individuals who would benefit from a care plan will have one.</li> <li>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</li> <li>GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists</li> </ul>
<p><b>D</b> Information and communications</p>	<ul style="list-style-type: none"> <li>With the individual's consent, relevant information will be visible to health and care professionals involved in providing care</li> <li>Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers</li> <li>Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan</li> </ul>
<p><b>E</b> Population- and prevention-oriented</p>	<ul style="list-style-type: none"> <li>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</li> </ul>
<p><b>F</b> Safe and high quality</p>	<ul style="list-style-type: none"> <li>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</li> </ul>

<sup>18</sup> 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.

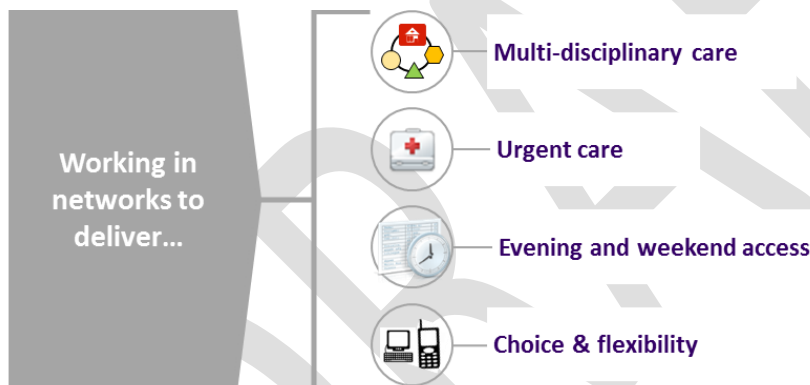
**We have done detailed work to understand General Practice Staff's ambitions for future working** (From *Good to Great* NWL workforce engagement, 2013):

*"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:



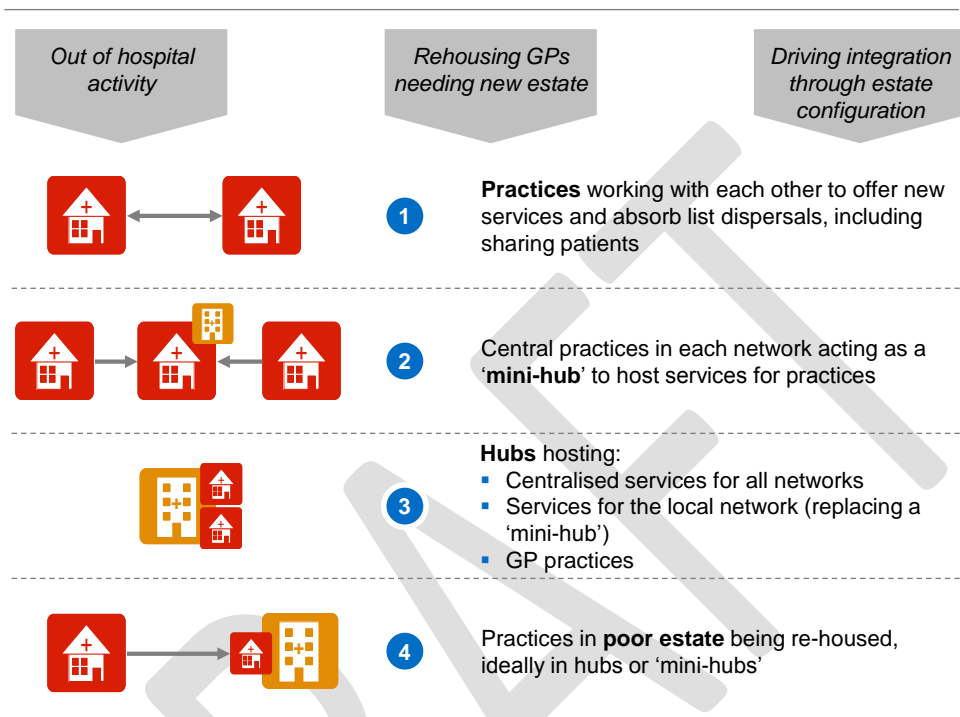
## Out of Hospital Care Settings

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.



## Drivers of out of hospital estates transformation:

- The need to **deliver a new model of out of hospital care**
- The need to **increase capacity** to meet the anticipated 30-35% increase in demand for out of hospital care
- The need to **improve the quality of the estate** in order to meet standards



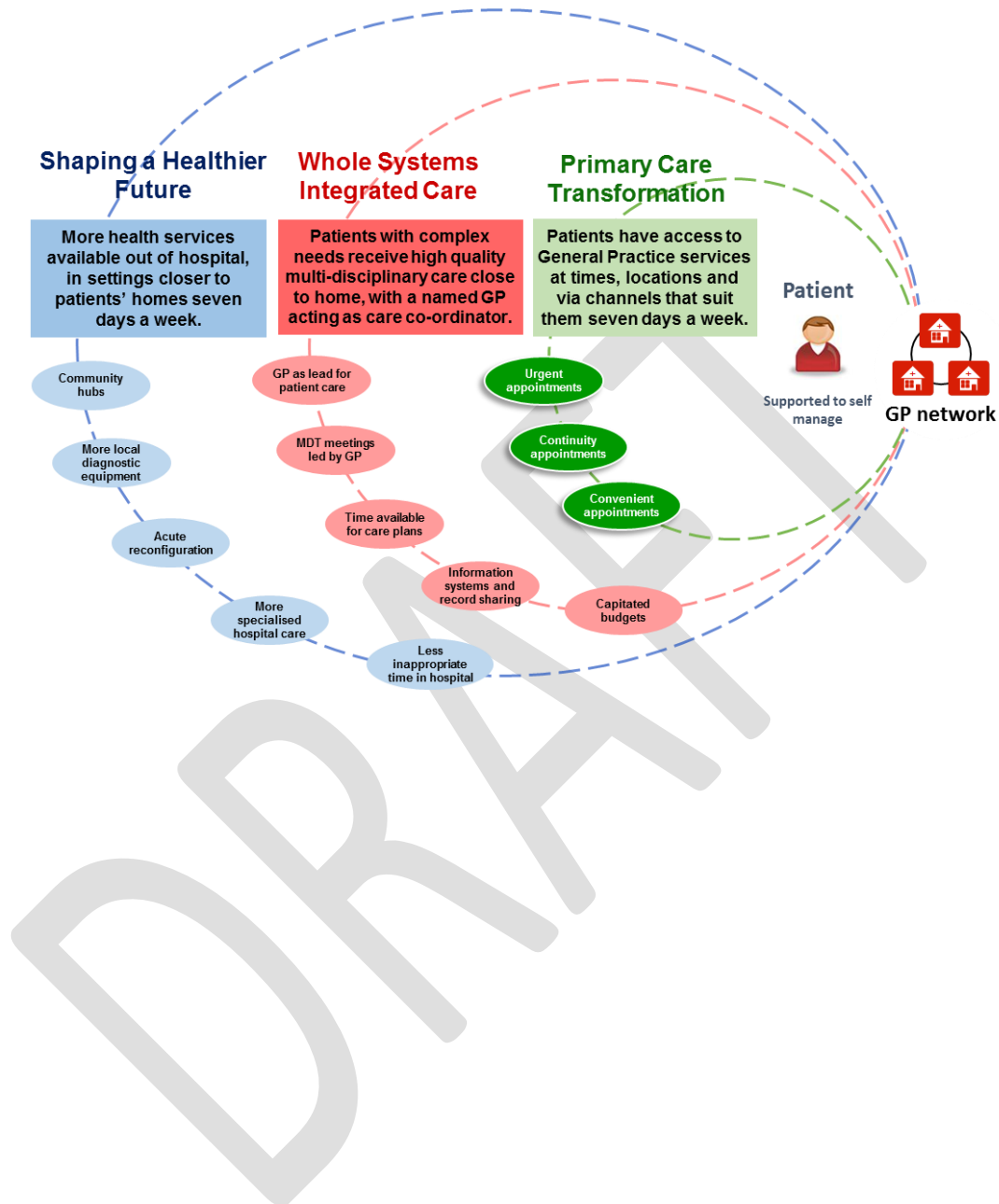
Through our estates transformation will ensure we can:

- **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 care** 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

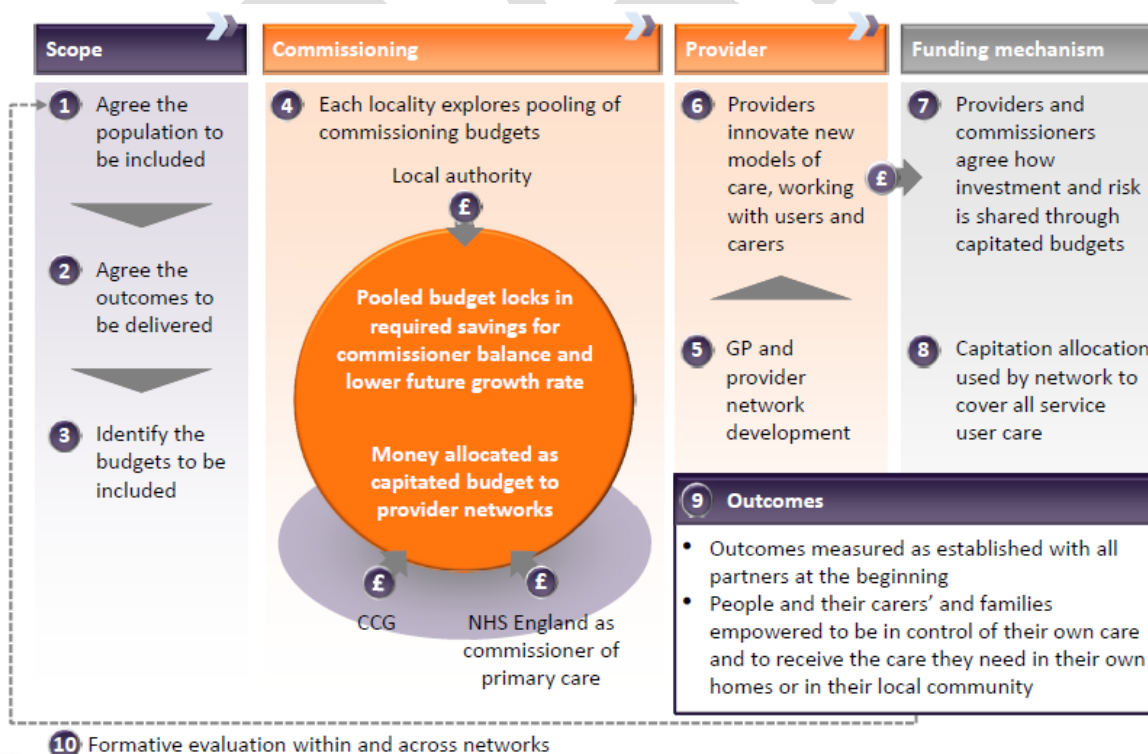
In June 2013, 31 partners across the eight boroughs of North West London submitted a joint pioneer application under a single vision. NWL was one of only 14 areas nationally to be awarded Pioneer site status. Pioneer areas will be provided bespoke and tailored support from government and national partners 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

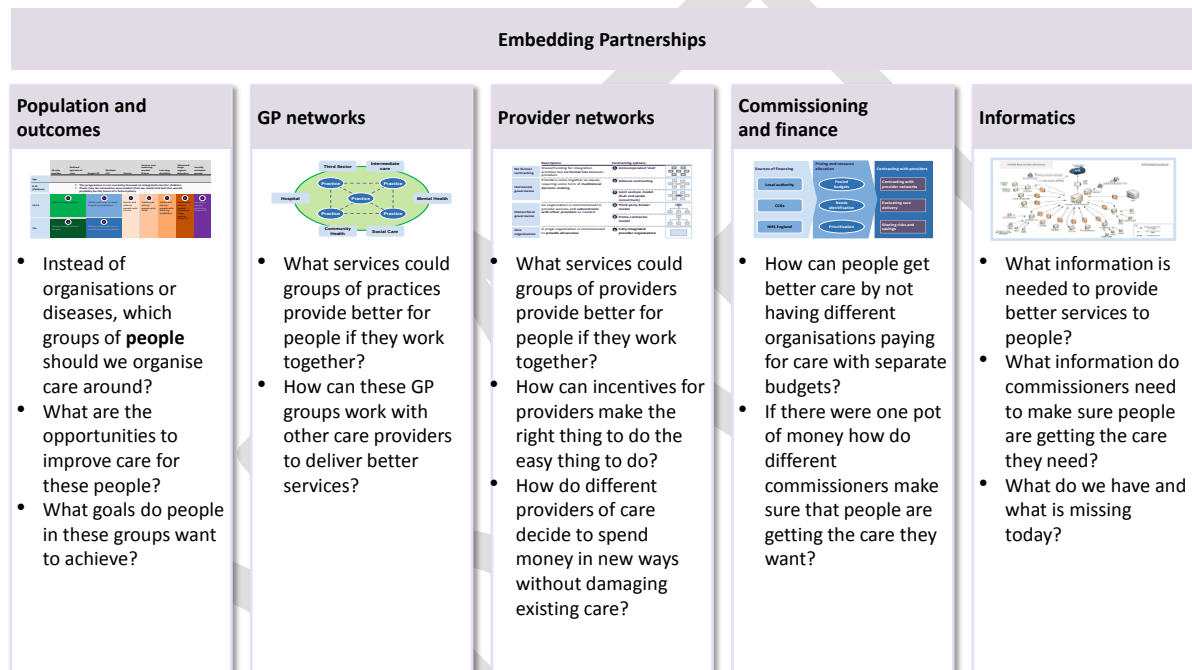


In order to tackle the many difficult questions associated with a number of these steps, NWL has worked together to “co-design common solutions once”. Together with lay partners we have

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'** 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<sup>19</sup>.

*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

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<sup>19</sup> <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. “*

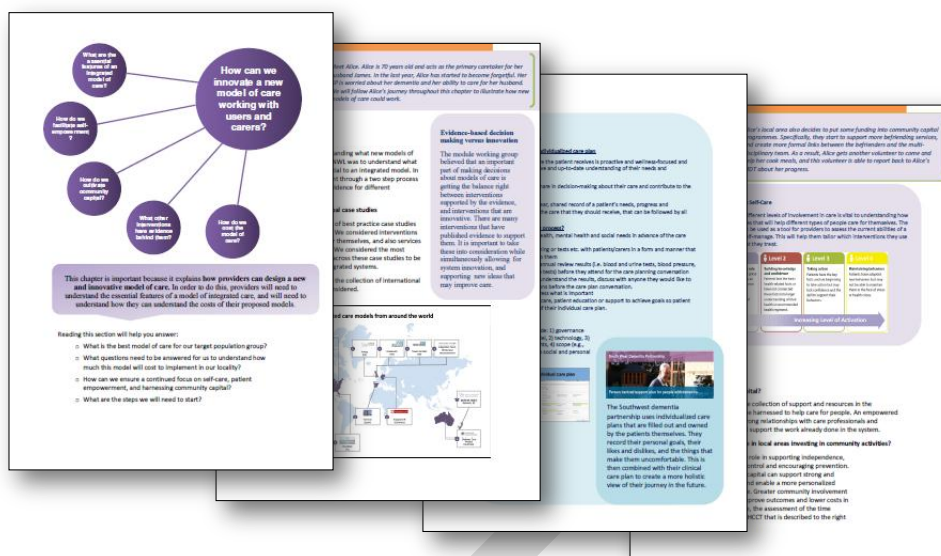
*Lay Partners Advisory Group*

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

<i>Description of group</i>	
<b>1</b> Mostly healthy adults <75	<ul style="list-style-type: none"> <li>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</li> <li>Includes those that have a defined episode of care, e.g. acute illness with full recovery, maternity</li> </ul>
<b>2</b> Mostly healthy elderly (>75) people	<ul style="list-style-type: none"> <li>Same as group 1 but for those that are above the age of 75</li> </ul>
<b>3</b> Adults (<75) with one or more long term conditions	<ul style="list-style-type: none"> <li>People aged between 16-75 that have one or more long-term conditions, e.g. HIV, COPD, diabetes, heart disease</li> <li>Includes common mental illnesses, e.g. depression, anxiety</li> </ul>
<b>4</b> Elderly (>75) with one or more LTCs	<ul style="list-style-type: none"> <li>Same as group 3 but for those that are above the age of 75</li> </ul>
<b>5</b> Adults and elderly people with cancer	<ul style="list-style-type: none"> <li>People aged above 16 that have any form and stage of cancer</li> </ul>
<b>6</b> Adults and elderly people with SEMI	<ul style="list-style-type: none"> <li>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</li> </ul>
<b>7</b> All with advanced stage organic brain disorders	<ul style="list-style-type: none"> <li>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</li> </ul>
<b>8</b> Adults and elderly people with learning disabilities	<ul style="list-style-type: none"> <li>People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills</li> <li>Excludes mild conditions that does have an impact on social relationships or work</li> </ul>
<b>9</b> Adults and elderly people with severe and enduring mental illness	<ul style="list-style-type: none"> <li>People aged above 16 who have a FACS eligible physical disability</li> <li>Excludes physical disabilities, including sensory disabilities, that are not FACS eligible</li> <li>FACS eligibility includes an inability to perform 3 or more household tasks</li> </ul>
<b>10</b> Socially excluded	<ul style="list-style-type: none"> <li>People aged above 16 who have chaotic lifestyles who often have limited access to care</li> <li>Includes the homeless, alcohol and drug dependency</li> </ul>

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.

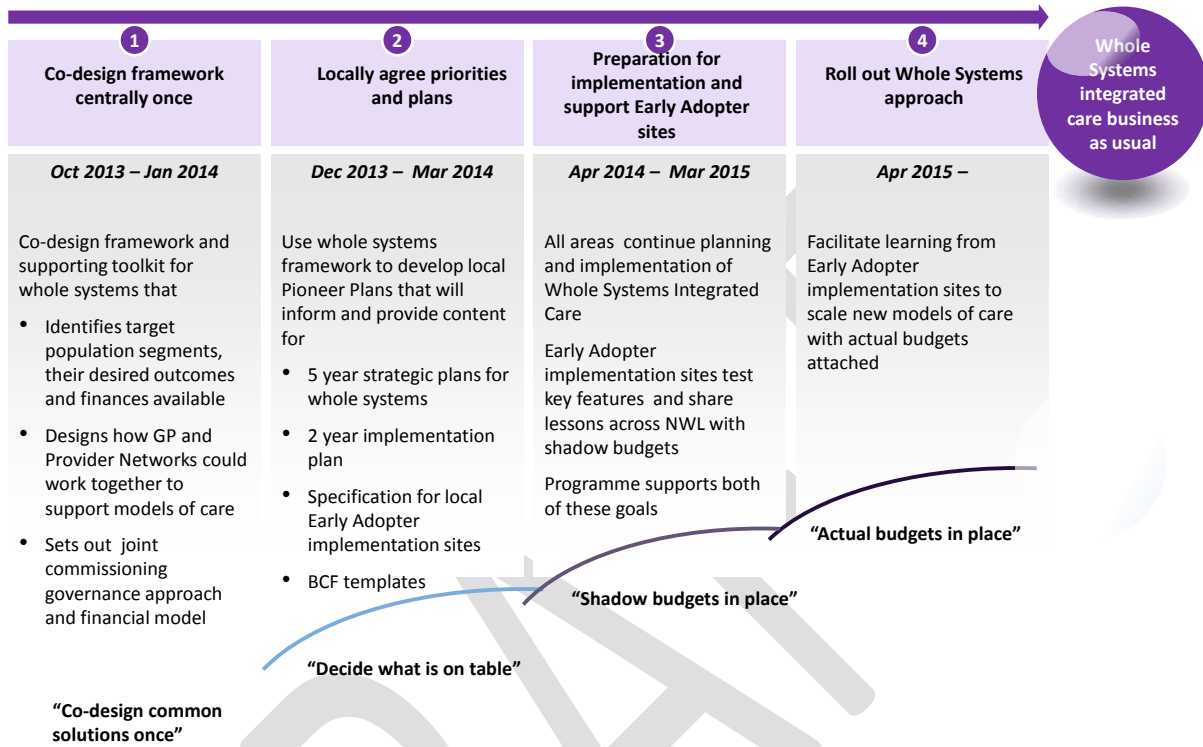
The Whole Systems Integrated Care Toolkit provides further detail on population segmentation, as well as all of the other findings from the co-design process.

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 cohorts of patients – please see the Children's section within the

**Early Adopters**

The first stage of the WSIC programme is complete, as per the implementation timeline below:

### Whole Systems implementation timeline

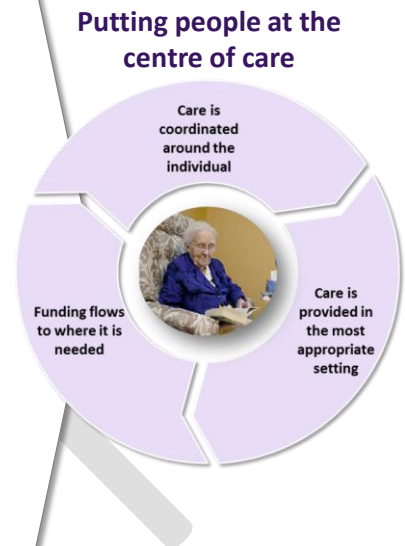


The next step is to work with a number of Early Adopter sites, who will move further and faster and share learning across NWL. Across NWL, groups of commissioners and providers have expressed interest in becoming ‘Early Adopters’ of Whole Systems Integrated Care through defining a segment of their population 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”

Criteria for Whole Systems and “Early Adopters”	
Embedding Partnerships	<ul style="list-style-type: none"> <li>✓ Use co-production to develop plans</li> <li>✓ Commitment to move to personalisation, self care and use of community capital</li> </ul>
Commissioning governance & finance	<ul style="list-style-type: none"> <li>✓ Pool health and social care budgets</li> <li>✓ Operate shadow capitated budgets</li> <li>✓ Generate significant savings to system</li> <li>✓ Agree binding performance management</li> </ul>
Population and Outcomes	<ul style="list-style-type: none"> <li>✓ Organise care models around people with similar needs</li> <li>✓ Identify outcomes to be delivered</li> </ul>
Provider networks	<ul style="list-style-type: none"> <li>✓ Establish governance for networks, bringing together different types of providers around a GP registered population</li> <li>✓ Reallocate money across a care pathway to fund innovative models of care regardless of setting</li> <li>✓ Agree binding performance management</li> </ul>
Information	<ul style="list-style-type: none"> <li>✓ Ensure the flow of information to support care delivery, performance management and payment</li> <li>✓ Information governance to support this across all providers</li> </ul>



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<sup>20</sup>, as well as the key ingredients for integrating care identified by NHS England (see Appendix E).

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<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<sup>21</sup> has developed the following draft vision statement for the development of mental health services across North West London:

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<sup>21</sup> 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 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:

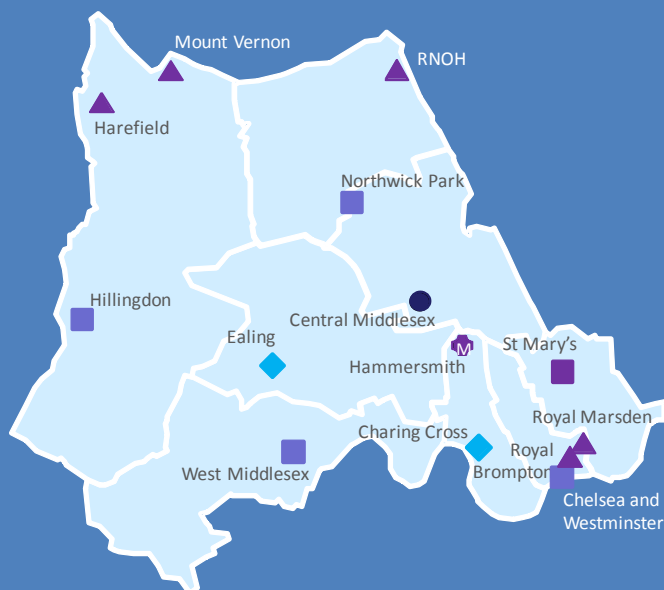
1. **Equivalence and parity of esteem for Mental and Physical Health in NWL strategies by:**
  - Co-commissioning integrated pathways including London s136 protocol and transport, secondary care, and improved access to IAPT.
2. **Reduce re-offending by:**
  - Assuring continuity of care from prisons: 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 rehabilitation
- 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<sup>22</sup>

<sup>22</sup> 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**

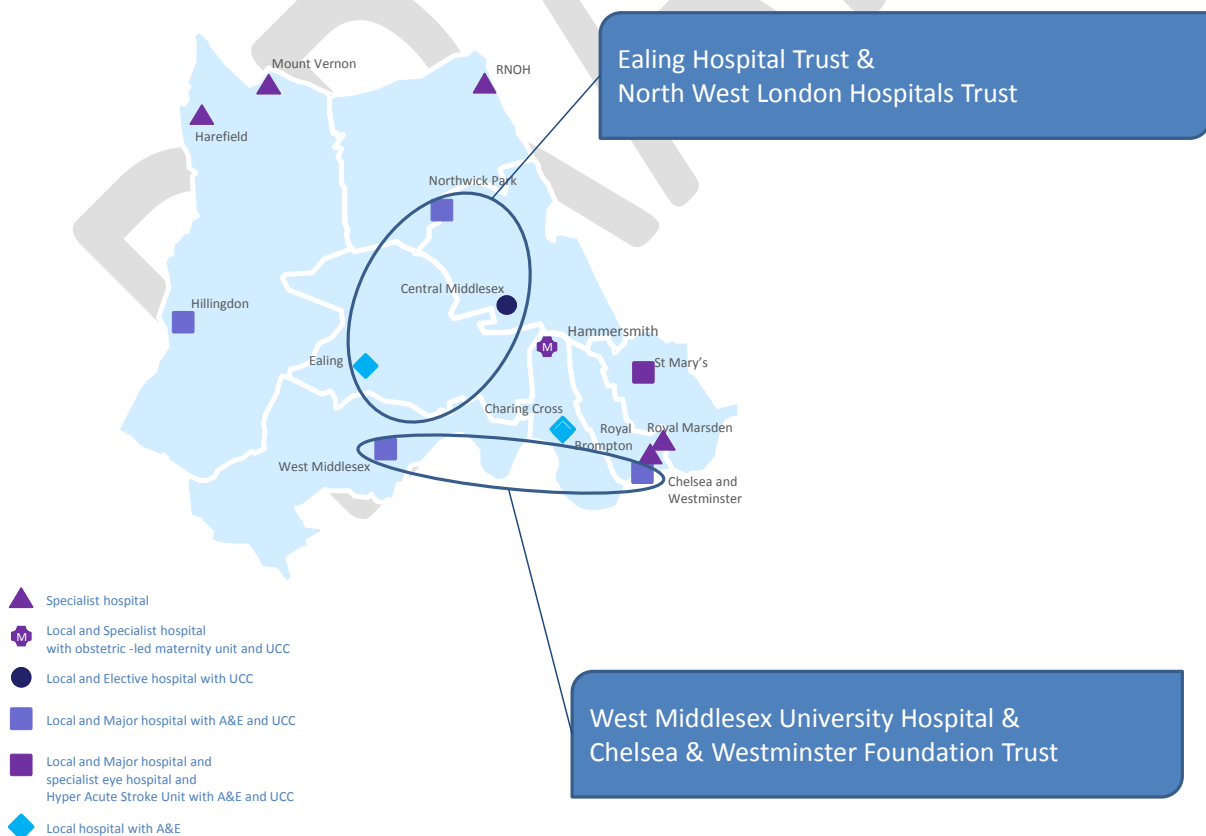
Alongside the pan-NWL acute services reconfiguration, two significant provider transactions are proposed to further strengthen the financial viability of the NWL provider landscape: a merger between North West London Hospitals Trust and Ealing Hospital Trust, and a merger between Chelsea and Westminster 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 to 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.

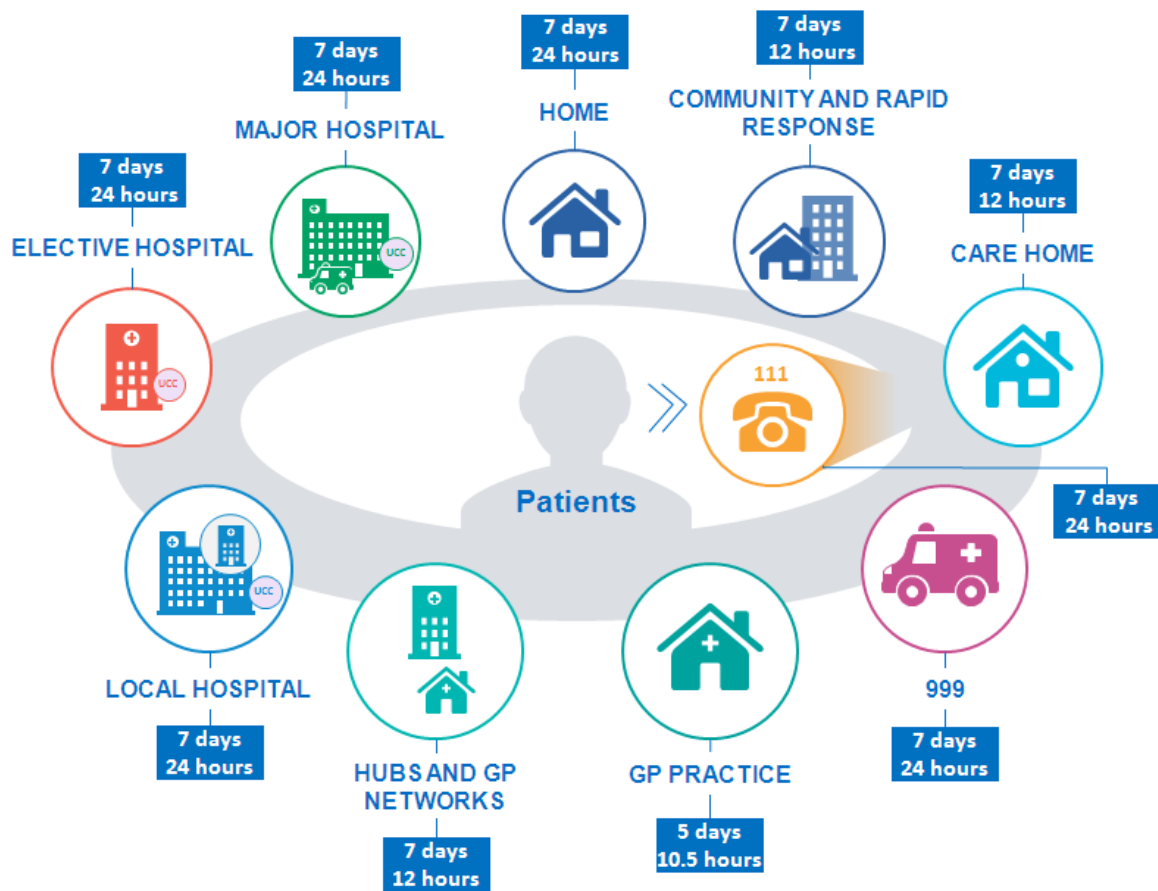
NWL regularly monitors each Trust's progress in achieving the SaHF and London Quality standards, and will be strengthening the support provided to Trusts to achieve these, as well as aligning commissioning processes to achieve them.

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*<sup>23</sup>.

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

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<sup>23</sup> <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

## Cross-cutting plans: Urgent & emergency care, and Cancer services

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

## Cross-cutting plans: Urgent & emergency care, and Cancer services

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 care (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<sup>24</sup>. 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<sup>25</sup>, 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

<sup>24</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213785/dh\\_123394.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf)

<sup>25</sup> <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/01/lon-canc-comm-strat.pdf>

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



## Cross-cutting plans: Urgent & emergency care, and Cancer services

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%
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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'*<sup>26</sup> 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

<sup>26</sup> *Improving Outcomes: A Strategy for Cancer;* Department of Health, 2011 ([http://www.epaac.eu/from\\_heidi\\_wiki/UK\\_Annual\\_Report\\_2011.pdf](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:

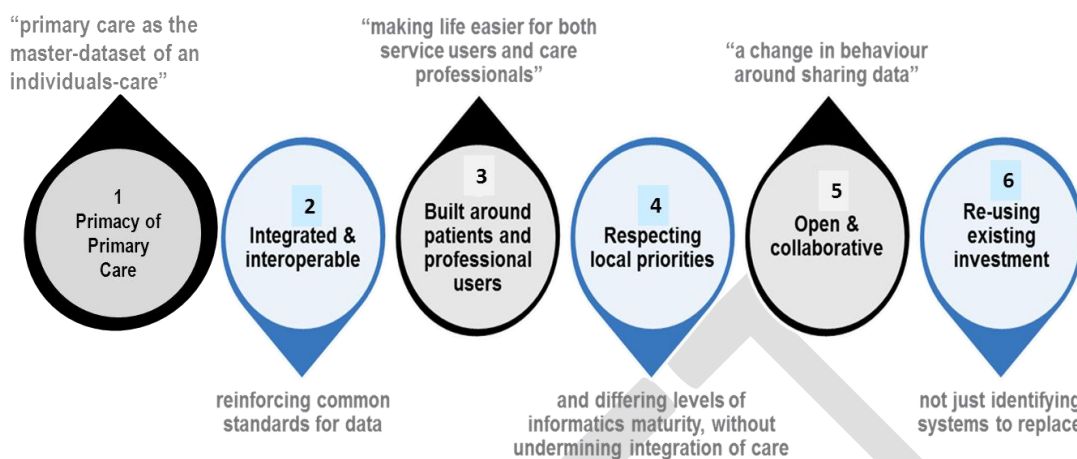
*"Delivering an integrated approach to Informatics across North West London, focussed on:*

- **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<sup>27</sup>.

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

<sup>27</sup> ‘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](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 *Shaping 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.

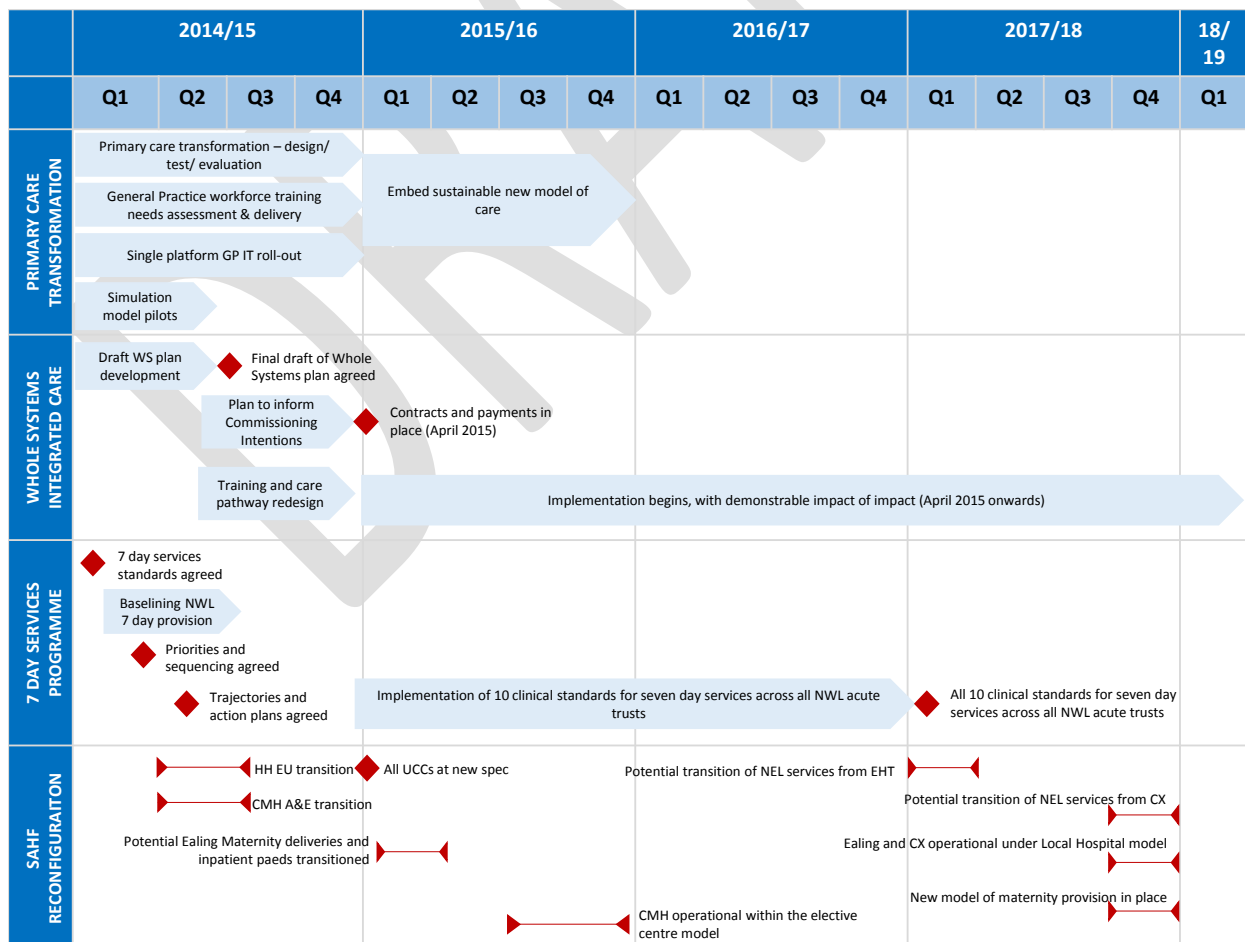
Within this workstream we also track and monitor programme progress using ‘in flight indicators’, such as activity shifts between acute and community settings, changes to the quality of services, and total bed numbers. This enables us to ascertain our progress in implementing the transformation programmes 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.

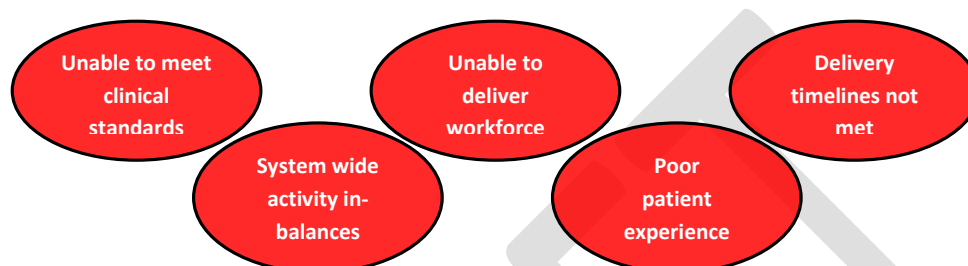
### Programme implementation timeline



### 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.



## How our plans will achieve our vision and strategic objectives

### 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:*

<a href="#">NHS Outcome Framework 5 Domains</a>	7 Outcome ambitions
<a href="#">Domain 1: Preventing people from dying prematurely</a>	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
<a href="#">Domain 2: Enhancing quality of life for people with long-term conditions</a>	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
<a href="#">Domain 3: Helping people to recover from episodes of ill health or following injury</a>	3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
<a href="#">Domain 4: Ensuring that people have a positive experience of care</a>	4: Increasing the proportion of older people living independently at home following discharge from hospital.
<a href="#">Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</a>	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
	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	<i>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 &amp; Wellbeing Board level.</i>	
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	<i>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.</i>	

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.

## How our plans will achieve our vision and strategic objectives

### 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%	<ul style="list-style-type: none"> <li>Health promotion, early diagnosis and early intervention, including integrated approach to screening and symptomatic services</li> <li>London-wide programmes, including the Cancer Commissioning strategy</li> <li>Achieving equivalence and parity of esteem for physical and mental health Screening: integrated approach to screening and symptomatic services</li> <li>Achieving the SaHF, London Quality and 7 Day Services clinical standards</li> </ul>
2	Health related quality of life for people with long term conditions	594	616	3.7%	<ul style="list-style-type: none"> <li>Whole System Integrated Care</li> <li>Primary Care Transformation</li> <li>Transforming Mental Health services</li> </ul>
3	Composite measure on emergency admissions	17,700	15,724	11.16%	<ul style="list-style-type: none"> <li>Whole System Integrated Care</li> <li>Out of Hospital strategies</li> </ul>
5	'Poor' patient experience of inpatient care	1,307	1,213	7.2%	<ul style="list-style-type: none"> <li>Achieving the SaHF clinical standards, including seven day services</li> <li>Quality, Safety and Patient Experience plans</li> </ul>
6	'Poor' patient experience of primary care	69	59	14.2%	<ul style="list-style-type: none"> <li>Whole Systems Integrated Care</li> <li>Out of Hospital strategies, including Primary Care Transformation</li> </ul>

*[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

## How our plans will achieve our vision and strategic objectives

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'<sup>28</sup>:

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.

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<sup>28</sup> '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>



## How we work: Embedding partnerships at every level

- 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 overarching 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.

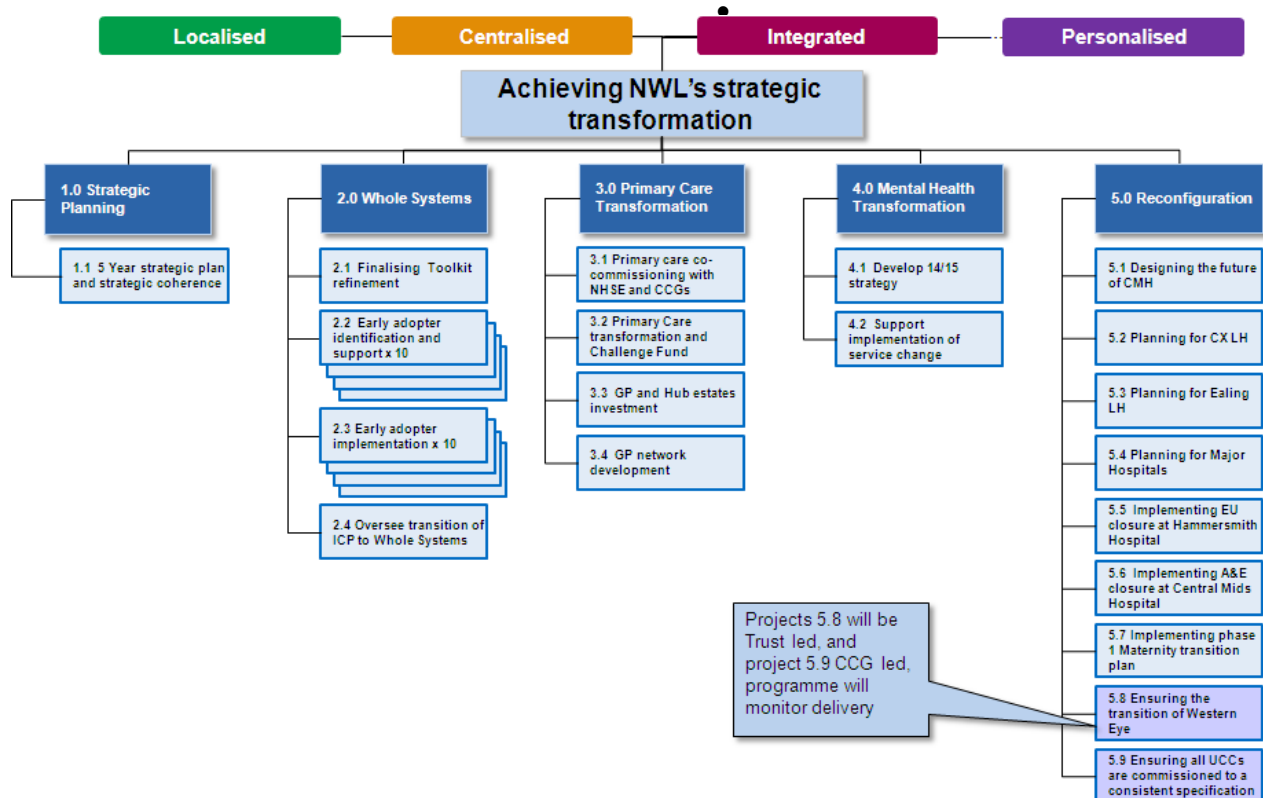
Key joint programme governance structures for the major transformational programmes include:

- *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

## Appendix A – How we have developed our five year plan

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 carers

who use 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

## Appendix A – How we have developed our five year plan

- 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 2<sup>nd</sup> July to 8<sup>th</sup> 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)

## Appendix A – How we have developed our five year plan

- 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

	<b>Model of Care</b>	<b>Alignment to NWL Transformation Programmes</b>
1.	<b>Citizen participation and empowerment</b>	<ul style="list-style-type: none"> <li>• Citizen participation and empowerment is a fundamental tenet of all NWL programmes, and our approach is described in chapter 13.</li> </ul>
2.	<b>Wider primary care, provided at scale</b>	<ul style="list-style-type: none"> <li>• Out of Hospital strategies, including Primary Care Transformation</li> </ul>
3.	<b>A modern model of integrated care</b>	<ul style="list-style-type: none"> <li>• Whole Systems transformation programme</li> </ul>
4.	<b>Access to highest quality urgent and emergency care</b>	<ul style="list-style-type: none"> <li>• Cross-cutting plans – Urgent &amp; Emergency Care</li> </ul>
5.	<b>A step-change in the productivity of elective care</b>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> (SaHF) acute reconfiguration, as well as Planned Care pathway redesign as part of Out of Hospital strategies</li> </ul>
6.	<b>Specialised services concentrated in centres of excellence</b>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> (SaHF) acute reconfiguration</li> </ul>



## 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
<b>Early diagnosis</b>		Planned	Partially met - further plans	Not planned	Planned
<b>Cancer screening programmes</b>		Planned	Partially met - further plans	Not planned	Partially met - further plans
<b>Reducing variability in primary care: <i>referring</i></b>	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>Reducing variability in primary care: <i>prescribing</i></b>	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>GP tele-consultations</b>	Planned	Not planned	Not planned	Planned	Planned
<b>Reducing urgent care demand</b>	Partially met - further plans	Planned	Fully implemented	Fully implemented	Partially met - further plans
<b>Medicines optimisation</b>	Partially met - further plans (BAU)	Partially met - further plans	Fully implemented	Partially met - further plans	Partially met - further plans
<b>Safe and appropriate use of medicines</b>	Partially met - further plans (BAU)	Not planned	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>Self-management: patient-carer communities</b>	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>Service user network</b>	Not planned	Partially met - further plans	Partially met - further plans	Planned	Partially met - further plans
<b>Telehealth/ Telecare</b>	Not planned	Partially – no further plans	Not planned	Not planned	Not planned

## Appendix C – Anytown interventions

	Central	Ealing	H&F	Hounslow	West London
<b>Electronic palliative care coordination systems (EPaCCS)</b>	Partially met - further plans	Planned	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>Case management and coordinated care</b>	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans	Partially met - further plans
<b>Integration of health and social care for older people</b>	Partially met - further plans	Partially met - further plans	Partially met - further plans	Planned	Partially met - further plans
<b>Dementia pathways</b>	Planned	Planned	Planned	Partially met - further plans	Partially met - further plans
<b>24hr asthma services for children</b>	Not planned	Partially met - further plans	Partially met - further plans	Partially met – no further plans	Partially met - further plans
<b>Palliative care</b>	Planned	Fully implemented	Not planned	Fully implemented	Fully implemented
<b>Acute visiting services</b>	Not planned	Partially met - further plans	Planned	Partially met - further plans	Partially met - further plans
<b>Mental Health: Rapid Assessment Interface and Discharge (RAID)</b>	Planned	Partially met - further plans	Not planned	Planned	Partially met - further plans
<b>Acute stroke services</b>	Not planned	Fully implemented	Fully implemented	Fully implemented	Fully implemented
<b>Reducing elective caesareans</b>	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
<b>Alcohol/substance misuse</b>	✓	✓	✓					✓
<b>Cancer</b>					✓		✓	
Supporting parents and the community to protect <b>children</b> and maximise their life chances / <b>Early Years</b> Intervention (0-5 yrs) / Best start in life / <b>Children</b> engaged in risky behaviour / Giving every	✓	✓	✓	✓	✓	✓		✓
<b>Childhood immunisations</b>		✓		✓			✓	✓
<b>Childhood obesity</b>	✓	✓	✓	✓			✓	✓
Empowering <b>Communities</b> to take better care of themselves / fostering social cohesion and reducing isolation	✓	✓		✓				
<b>Dementia</b>		✓			✓	✓		
<b>Dental Health</b> (or Oral Health in Children)	✓	✓		✓		✓	✓	✓
Type 2 <b>Diabetes</b>						✓		
Ensuring Safe and Timely <b>Discharge</b> from Hospital								✓
Tackling <b>domestic abuse</b> through		✓						

Appendix D – Health & Wellbeing Strategies

	Brent	Central	Ealing	H&F	Harrow	Hillingdon	Hounslow	West London
integrated, whole system approaches								
Reducing <b>early death</b> , focusing on the 3 big killers		✓						
Helping vulnerable <b>Families</b>	✓	✓		✓				
Promoting <b>healthy life</b>		✓						
<b>Health Checks</b>							✓	
Better access for vulnerable people to Sheltered <b>Housing</b>				✓				
Improving access to services: <b>information</b> and advice services		✓						
<b>Integrated health and social care services</b>	✓	✓		✓				✓
<b>Long term conditions</b> / reducing impact of disability and long-term conditions		✓			✓		✓	
Increasing Child Population and <b>Maternity</b> Services		✓		✓		✓		✓
<b>Mental health and well-being</b>	✓	✓		✓	✓	✓	✓	✓
<b>Obesity</b>		✓						
<b>Older People</b> including sight loss / Older People and Healthy Ageing			✓			✓		
<b>Out of Hospital</b> Services / Reducing		✓	✓	✓			✓	

## Appendix D – Health and Wellbeing Strategies

	Brent	Central	Ealing	H&F	Harrow	Hillingdon	Hounslow	West London
the use of bed-based care								
<b>Physical activity</b>	✓					✓		
<b>Poverty / improving health and wellbeing through urban renewal</b>		✓		✓	✓			✓
Making better use of <b>resources</b>								✓
<b>Sexual Health</b> services		✓		✓				✓
<b>Smoking cessation</b>							✓	
Delivering the <b>White City Collaborative Care Centre</b>				✓				
<b>Worklessness</b>		✓		✓	✓			
Supporting <b>young people</b> 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:

<b>The Key Ingredients of Integrating Care (NHS England)</b>	
<b>Why</b>	<ul style="list-style-type: none"> <li>• Poor patient experience</li> <li>• Poor outcomes</li> <li>• Increasing demand</li> <li>• Unsustainable models of care</li> <li>• Unprecedented financial challenge</li> </ul>
<b>What</b>	<p><b>Greater integration of services around the person – in NWL, this means:</b></p> <ul style="list-style-type: none"> <li>• See Chapter 6 (Whole Systems Integrated Care)</li> </ul> <p><b>Greater emphasis on self &amp; home care – in NWL, this means:</b></p> <ul style="list-style-type: none"> <li>• Existing Expert Patient Programmes and patient user groups.</li> <li>• The roll-out of Personal Health Budgets from April 2014</li> <li>• Online access to self-management advice, support and service signposting</li> <li>• The roll-out of care plans</li> <li>• 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.</li> </ul> <p><b>Building community capacity to manage demand – in NWL, this means:</b></p> <ul style="list-style-type: none"> <li>• Healthy Living, Early Diagnosis and Early Intervention</li> <li>• Out of Hospital strategies</li> </ul> <p><b>A new primary care offer - in NWL this means:</b></p> <ul style="list-style-type: none"> <li>• Primary Care Transformation, so that primary care: <ul style="list-style-type: none"> <li>○ Accessible</li> <li>○ Proactive</li> <li>○ Coordinated</li> </ul> </li> </ul> <p><b>Reconfiguration of acute services - in NWL this means:</b></p> <ul style="list-style-type: none"> <li>• Acute services that are localised where possible, and centralised where necessary, to be achieved through the <i>Shaping a healthier future</i> acute reconfiguration.</li> </ul>
<b>How</b>	<p><b>Whole health and care system leadership – in NWL this means:</b> see chapter 13 (Governance)</p> <p><b>Three – five year plans signed off by Health &amp; Wellbeing Boards</b></p> <p><b>Local &amp; city-wide coherence</b></p> <p><b>Scale/focus</b></p> <p><b>Commissioning alignment between LA/CCG/NHS England – in NWL this</b></p>



## Appendix E - The Key Ingredients of Integrating Care

	<p><b>means:</b></p> <ul style="list-style-type: none"> <li>• Collaborative commissioning between NWL CCGs and NHS England – see Chapter 7 (Primary Care Co-Commissioning).</li> </ul> <p><b>A way to move around money around the system - in NWL this means:</b></p> <ul style="list-style-type: none"> <li>• NWL’s Medium Term Financial Strategy (MFTS) – see chapter 12 (A financially sustainable health system).</li> <li>• Whole Systems Integrated Care Early Adopter pilots</li> </ul> <p><b>Shared information across agency boundaries- in NWL this means:</b> see chapter 11 (Programme Enablers: Informatics).</p> <p><b>Flexible, engaged workforce and improved training - in NWL this means:</b> see chapter 11 (Programme Enablers: Workforce).</p> <p><b>Transparent measurement of outcomes</b></p> <p><b>A developing evidence base</b></p>
<p><b>Outcomes</b></p>	<p><b>Improved health and care outcomes - in NWL this includes:</b></p> <ul style="list-style-type: none"> <li>• Patient experience</li> <li>• Quality of life</li> <li>• Health outcomes</li> </ul> <p><b>Financial sustainability of the health and care system</b></p>

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?	<ul style="list-style-type: none"> <li>• NHS Brent CCG</li> <li>• NHS Harrow CCG</li> <li>• NHS Hillingdon CCG</li> <li>• NHS Central London CCG</li> <li>• NHS Ealing CCG</li> <li>• NHS Hammersmith &amp; Fulham CCG</li> <li>• NHS Hounslow CCG</li> <li>• NHS West London CCG</li> <li>• NHS England</li> </ul>	
	In case of enquiry, please provide a contact name and contact details	Thirza Sawtell Director of Strategy and Transformation 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?	<p>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”.</p> <p>Four overarching principles support our vision - that health services need to be:</p> <ol style="list-style-type: none"> <li>1. <b>Localised</b> where possible</li> <li>2. <b>Centralised</b> where necessary; and</li> <li>3. In all settings, care should be <b>integrated</b> across health (both physical and mental), social care and local authority providers to improve seamless patient care.</li> <li>4. The system will look and feel from a patient’s perspective that it is <b>personalised</b> - 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.</li> </ol>	<i>The plan on a page</i>



# Appendix F: Signposting to Key Lines of Enquiry

Segment	Key Line of Enquiry	Organisation response	Supported by:
	<p>How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically:</p> <ol style="list-style-type: none"> <li>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</li> <li>2. Wider primary care, provided at scale</li> <li>3. A modern model of integrated care</li> <li>4. Access to the highest quality urgent and emergency care</li> <li>5. A step-change in the productivity of elective care</li> <li>6. Specialised services concentrated in centres of excellence (as relevant to the locality)</li> </ol>	<ol style="list-style-type: none"> <li>1. Citizen empowerment and patient engagement: see page: <a href="#">chapter 13, page 97 (Citizen empowerment and patient engagement)</a></li> <li>2. Wider primary care: <a href="#">chapter 5, page 26 (Primary care transformation)</a></li> <li>3. Modern model of integrated care: <a href="#">chapter 6</a></li> <li>4. Access to high quality urgent and emergency care: <a href="#">chapter 9</a></li> <li>5. Step-change in the productivity of elective care: <a href="#">chapter 8, page 63 (Planned care pathways)</a></li> <li>6. Specialised services concentrated in centres of excellence: <a href="#">chapter 8</a></li> </ol> <p><a href="#">Summarised in Appendix B</a></p>	<p><i>Details provided within the activity and financial templates which will be triangulated.</i></p> <ul style="list-style-type: none"> <li>• <i>Shaping a healthier future Decision-Making Business Case (DMBC)</i></li> <li>• <i>Whole Systems Integrated Care Toolkit</i></li> <li>• <a href="#">CCG Out of Hospital strategies ('Better Care, Closer to Home')</a></li> </ul>

## Appendix F: Signposting to Key Lines of Enquiry

Segment	Key Line of Enquiry	Organisation response	Supported by:
	<p>How does the five year vision address the following aims:</p> <ul style="list-style-type: none"> <li>a) Delivering a sustainable NHS for future generations?</li> <li>b) Improving health outcomes in alignment with the seven ambitions</li> <li>c) Reducing health inequalities?</li> </ul>	<p><i>[Please add your response to the key lines of enquiry here.</i></p> <p>A) <i>From a resources perspective, what will the position be in five years' time? Is this position risk assessed?</i></p> <p><b>Chapter 12, page 92 (Outcome ambitions)</b></p> <p>B) <i>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]</i></p> <p><b>Chapter 12, page 95 (A financially sustainable health system)</b></p>	<p><i>[Please reference additional supporting documentation you feel is helpful]</i></p> <ul style="list-style-type: none"> <li>• <i>Shaping a healthier future Decision-Making Business Case (DMBC)</i></li> </ul>
	<p>Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?</p>	<p><i>[Please provide details of the organisations who have signed up to this vision and the process by which sign up was obtained]</i></p> <p><b>Appendix A</b></p>	
	<p>How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?</p>	<p><b>Chapter 6, page 44 (North West London's Better Care Fund plans)</b></p>	<p>Each of the NWL HWB Better Care Fund plan, submitted on 4<sup>th</sup> April</p>

## 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?	<i>[Please provide details of key feedback from any call to action engagement and confirm how these have been incorporated into the strategic vision? ]</i>  <b>Chapter 2 Appendix A</b>	 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?	<b>Chapter 2 Appendix A</b>	 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?	<b>Chapter 2 Appendix A</b>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> Decision-Making Business Case (DMBC)</li> </ul>
	Do the objectives and interventions identified below take into consideration the current state?	<b>Chapter 2</b>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> Decision-Making Business Case (DMBC)</li> </ul>
	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	<b>Chapter 12 (A financially sustainable health system) 5.1</b>	



## Appendix F: Signposting to Key Lines of Enquiry

Segment	Key Line of Enquiry	Organisation response			Supported by:
b) Improving quality and outcomes	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?	Ambition area	Metric	Proposed attainment in 18/19	
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		<b>Chapter 12 (Outcome ambitions)</b>			
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	<b>See Appendix A</b>			<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> Decision-Making Business Case (DMBC)</li> </ul>
	What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?	<b>See Appendix A</b>			<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future</i> Decision-Making Business Case (DMBC)</li> </ul>
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	<b>See Appendix A</b>			Health & Wellbeing Strategies
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	<b>Chapter 12</b>			

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?	<i>Chapter 12 (A financially sustainable health system)</i>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future Decision-Making Business Case (DMBC)</i></li> </ul>
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	<i>Chapter 12 (A financially sustainable health system)</i>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future Decision-Making Business Case (DMBC)</i></li> </ul>
	Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?	<i>Chapter 12 (A financially sustainable health system)</i>	<ul style="list-style-type: none"> <li>• <i>Shaping a healthier future Decision-Making Business Case (DMBC)</i></li> </ul>

## Appendix F: Signposting to Key Lines of Enquiry

Segment	Key Line of Enquiry	Organisation response	Supported by:
<p>d) Improvement interventions</p>	<p>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 :</p> <ul style="list-style-type: none"> <li>• Overall aims of the intervention and who is likely to be impacted by the intervention</li> <li>• Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have</li> <li>• Investment costs (time, money, workforce)</li> <li>• Implementation timeline</li> <li>• Enablers required for example medicines optimisation</li> <li>• Barriers to success</li> <li>• Confidence levels of implementation</li> </ul> <p>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.</p>	<p><i>See chapters 4 - 10</i></p> <p><b>Intervention One</b>  <u>Overall description</u>            [CCG to comment]</p> <p><u>Expected Outcome</u>            [CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics]</p> <p><u>Investment costs</u></p> <ul style="list-style-type: none"> <li>• Financial costs [CCG to comment]</li> <li>• Non-Financial costs [CCG to comment]</li> </ul> <p><i>See chapter 12</i></p> <p><u>Implementation timeline</u>            [CCG to comment]  <i>See chapter 11</i></p> <p><u>Enablers required</u>            [CCG to comment]  <i>See chapter 11</i></p> <p><u>Barriers to success</u>            [CCG to comment]  <i>See chapter 11</i></p> <p><u>Confidence levels of implementation</u>            [CCG to comment]  <i>See section 4.12</i></p>	<p>143</p>

## 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?	<i>See chapter 13</i>	
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	<i>See chapter 1</i>	

DRAFT

### 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.

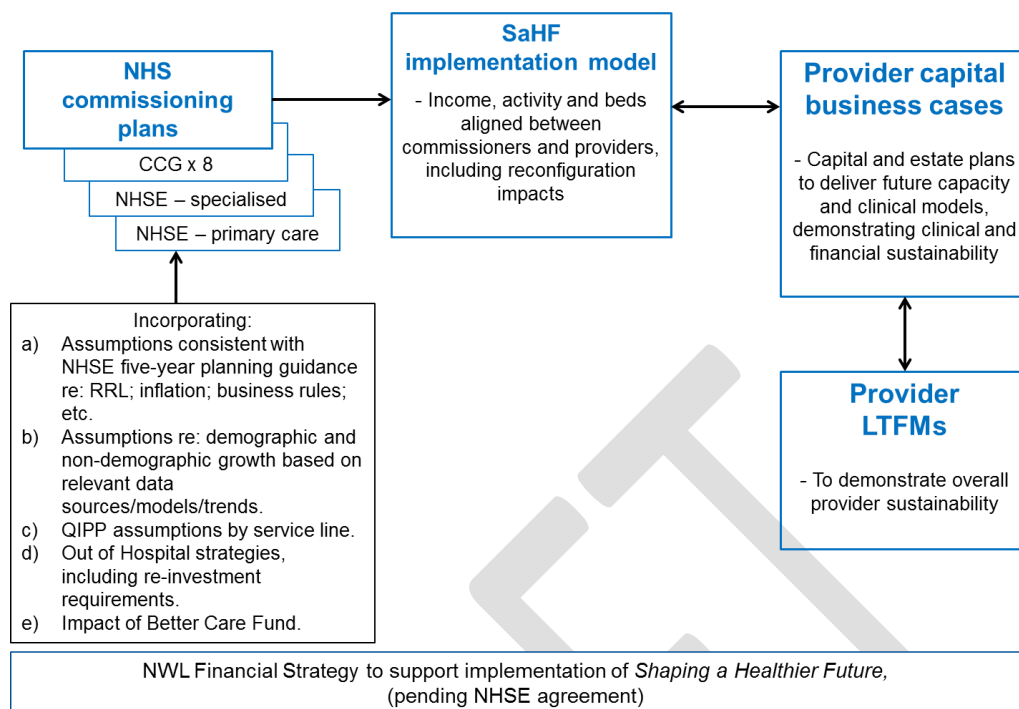
This updated analysis, together with the DMBC, will be known as the *Implementation Business Case (ImBC)* and will form the SOC for NHSE/DH/Treasury approval.

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

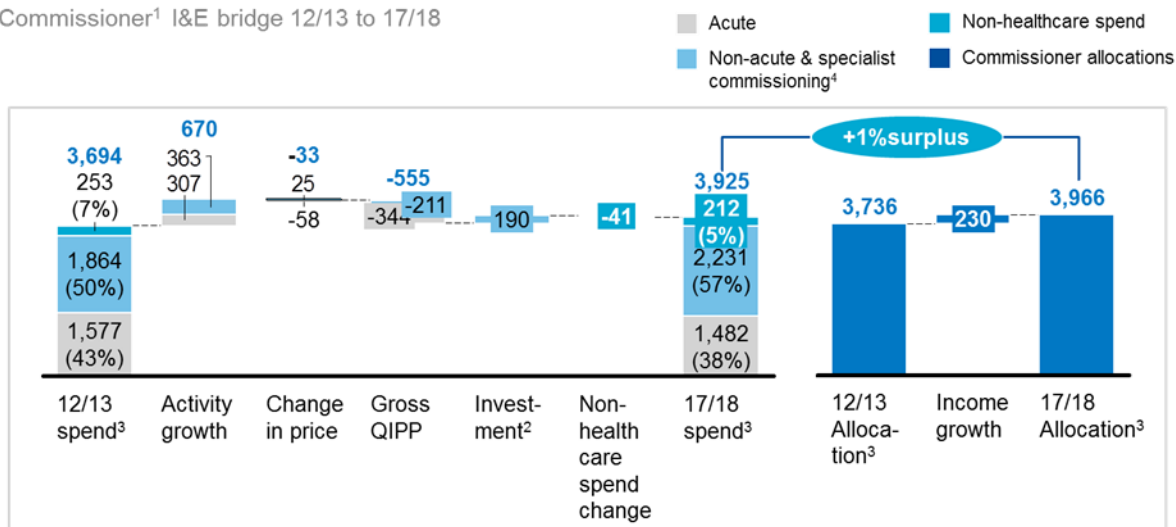
The DMBC overarching commissioner projections covered the period 12/13 – 17/18 and reflected the organisational arrangements at the time (i.e. PCTs).

The graph below shows the Commissioner I&E bridge from 12/13 to 17/18 from the DMBC.



## Appendix G: Financial appendix

Commissioner<sup>1</sup> I&E bridge 12/13 to 17/18



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 re-provision 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.

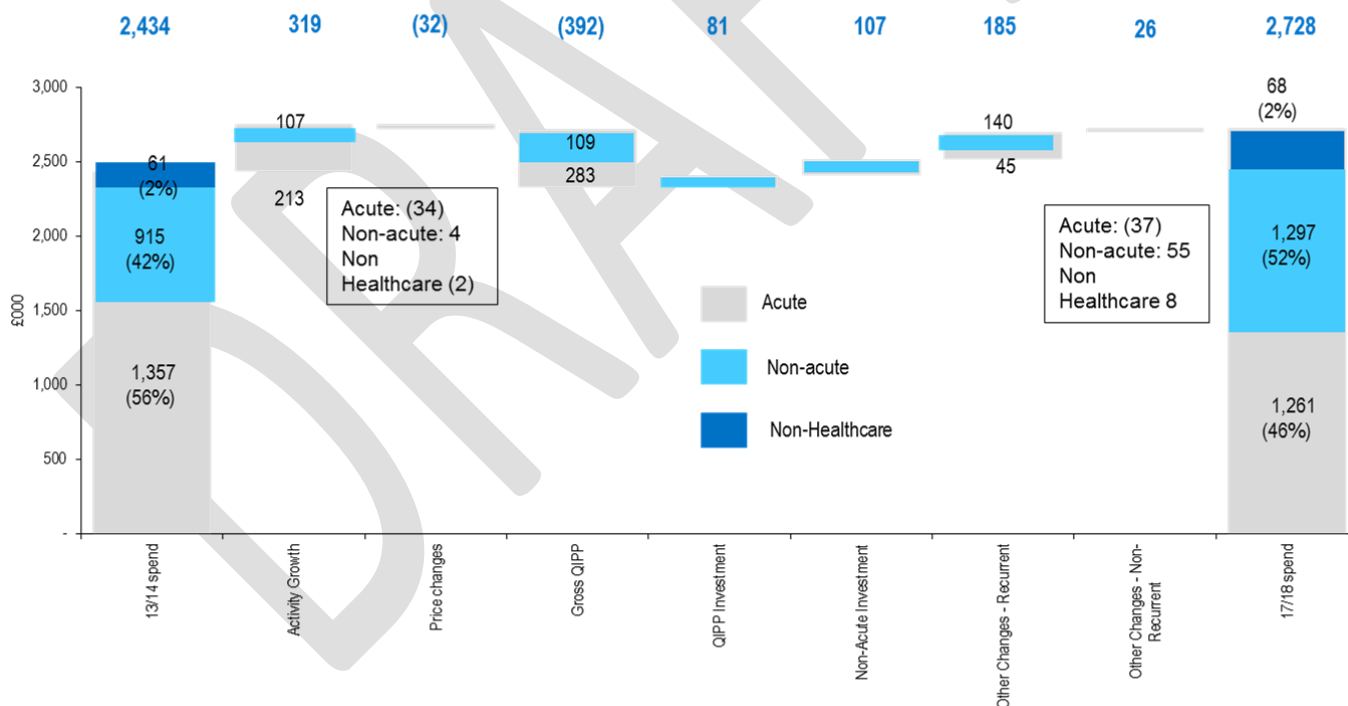
NWL CCGs 2013/14 outturn is an overall surplus of 3.50%, with a range of -4.24% to 8.73%, as shown below. The underlying position reflects the recurrent run-rate (stripping out one-off items), and this is an overall surplus of 3.08%, with a range of -5.92% to 8.67%.

## Appendix G: Financial appendix

	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%
<b>Total NWL CCGs</b>	<b>86,298</b>	<b>3.50%</b>	<b>74,765</b>	<b>3.08%</b>

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 4<sup>th</sup> April (Hounslow and H&F provided an additional update submitted 1<sup>st</sup> 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

## Appendix G: Financial appendix

- 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
<b>Total</b>	<b>-34,064</b>	<b>-34,802</b>	<b>-46,792</b>	<b>-36,345</b>	<b>-21,274</b>	<b>-34,916</b>	<b>-15,838</b>	<b>-26,752</b>	<b>-250,784</b>	<b>154,046</b>
<b>Growth</b>	<b>23,195</b>	<b>15,676</b>	<b>19,328</b>	<b>30,758</b>	<b>11,192</b>	<b>15,865</b>	<b>15,854</b>	<b>22,178</b>	<b>154,046</b>	

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:

## Appendix G: Financial appendix

### Specialised commissioning 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
<b>Sub-total Mental Health</b>	<b>163,662,618</b>	<b>164,018,254</b>	<b>355,636</b>
<b>North West</b>			
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
<b>Sub-total North West</b>	<b>662,924,888</b>	<b>694,158,736</b>	<b>31,233,847</b>
<b>#N/A</b>			
LONDON AMBULANCE NHST	588,155	588,155	0
<b>TOTAL</b>	<b>827,175,661</b>	<b>858,765,145</b>	<b>31,589,483</b>

#### 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	<b>256.3</b>
<b>Dental</b>		<b>84.7</b>
<b>Ophthalmology</b>		<b>18.9</b>
<b>Pharmacy</b>		<b>53.4</b>
<b>TOTAL</b>		<b>413.3</b>

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
<b>Total</b>	<b>-250,784</b>	<b>-61,187</b>	<b>-44,459</b>	<b>-356,430</b>	<b>283,833</b>
<b>Growth</b>	<b>154,046</b>	<b>103,670</b>	<b>26,116</b>	<b>283,832</b>	

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
<b>Total</b>	<b>-28,249</b>	<b>-142,307</b>	<b>-104,653</b>	<b>-11,456</b>	<b>-1,169</b>	<b>-3,986</b>	<b>-64,610</b>	<b>-356,429</b>	<b>283,833</b>
<b>Growth</b>	<b>62,146</b>	<b>60,966</b>	<b>45,824</b>	<b>10,685</b>	<b>13,232</b>	<b>15,331</b>	<b>75,647</b>	<b>283,832</b>	

### 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
<b>Imperial</b>	15,128	20,502
<b>ChelWest</b>	7,409	1,464
<b>West Middlesex</b>	(5,376)	(5,970)
<b>Ealing</b>	220	(8,804)
<b>NWLH</b>	(23,334)	(32,537)
<b>Hillingdon</b>	(744)	194
<b>TOTAL</b>	(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



## Appendix G: Financial appendix

- 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 <sup>1</sup>	135	140	-4	156	155	1
<b>NWL Total<sup>2</sup></b>	<b>1,910</b>	<b>1,910</b>	<b>0</b>	<b>1,897</b>	<b>1,856</b>	<b>42</b>

### 3.3 Capital investment summary

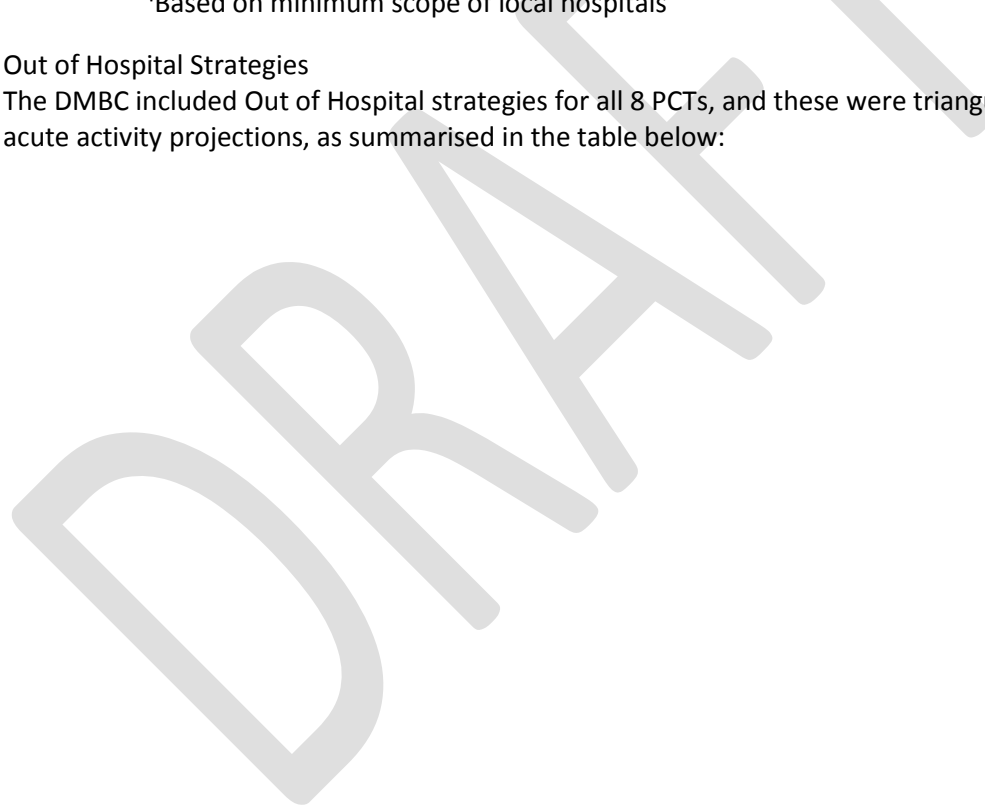
The total DMBC capital requirement (including Out of Hospital / primary care) was therefore as follows:

DMBC	
	Net capital (£m)
Acute (net) <sup>1</sup>	206
Hubs	6-112
Primary Care	32-74
<b>Total</b>	<b>244-392</b>









<sup>1</sup>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

OOH activity increase and annual recurrent investment	Impact of initiatives	Acute activity reduction relative to pre-QIPP baseline <sup>1</sup>
 <ul style="list-style-type: none"> <li>+ 290-300k appointments</li> <li>+ 130-140 Community beds</li> <li>+ £35-38m investment<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>30k spells (equates to 391 beds) equivalent reduction from rapid response teams</li> <li>20k from Integrated Care</li> <li>5k from contractual savings</li> </ul>	<p><b>Non-elective</b></p>  <ul style="list-style-type: none"> <li>55k spells<sup>4</sup></li> <li>391 Acute beds<sup>7</sup></li> </ul>
 <ul style="list-style-type: none"> <li>+ 510-520k appointments</li> <li>+ £35-38m investment<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>300k appts equivalent reduction from re-provision</li> <li>60k from GPs' access to specialists by phone</li> <li>140k from contract renegotiations</li> <li>100k from improved referral mgmt schemes</li> </ul>	<p><b>Outpatients</b></p>  <ul style="list-style-type: none"> <li>600k appt.<sup>4</sup></li> </ul>
 <ul style="list-style-type: none"> <li>+ 60-70k appointments</li> <li>+ £3-5m investment<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>All existing A&amp;Es remain as either A&amp;E or UCC</li> <li>50k spells equivalent reduction from expanded UCC</li> <li>35k spells prevention via 111</li> <li>15k spells from improved primary access</li> </ul>	<p><b>A&amp;E</b></p>  <ul style="list-style-type: none"> <li>100k spells<sup>4</sup></li> </ul>
 <ul style="list-style-type: none"> <li>+ ~10k appointments</li> <li>+ £7-9m investment<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>3k spells equivalent reduction through redirecting minor surgery to primary care</li> <li>7k from contractual and other savings</li> </ul>	<p><b>Elective</b></p>  <ul style="list-style-type: none"> <li>10k spells<sup>4</sup></li> </ul>
<p><b>Total ~£80-90m + ~£25-30m other recurrent investments (see following page) Total = £105-120m</b></p>		<p>The staffing and investment identified in the figures above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.</p> <p>The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling. The 'other investment' estimate covers additional forecast costs to support the delivery of the OOH standards, including increased primary care access, care planning, IT investment, etc.</p>

### 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

## Appendix G: Financial appendix

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:

		Access		Affordability & Value for Money					Deliverability			Research & Education	Total Evaluation		
		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 for costs	Value for Money	Workforce	Expected time to deliver		Co-dependencies with other strategies	Support current and developing research and education delivery
1a	CMH bundle + Willesden bundle	++	+	/	/	--	+	+	/	++	+	--	-	+	<b>+4</b>
1b	CMH bundle + Willesden disposal	++	+	/	/	--	+	+	-	++	+	-	/	+	<b>+5</b>
1c	CMH bundle + partial Willesden disposal	++	+	/	/	-	+	+	-	++	+	-	/	+	<b>+6</b>
2	CMH disposal and dispersal of services	-	/	+	-	--	+	++	--	++	/	-	--	/	<b>-3</b>

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.

## Appendix G: Financial appendix

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 1,033m<sup>2</sup> (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.



## Appendix G: Financial appendix

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

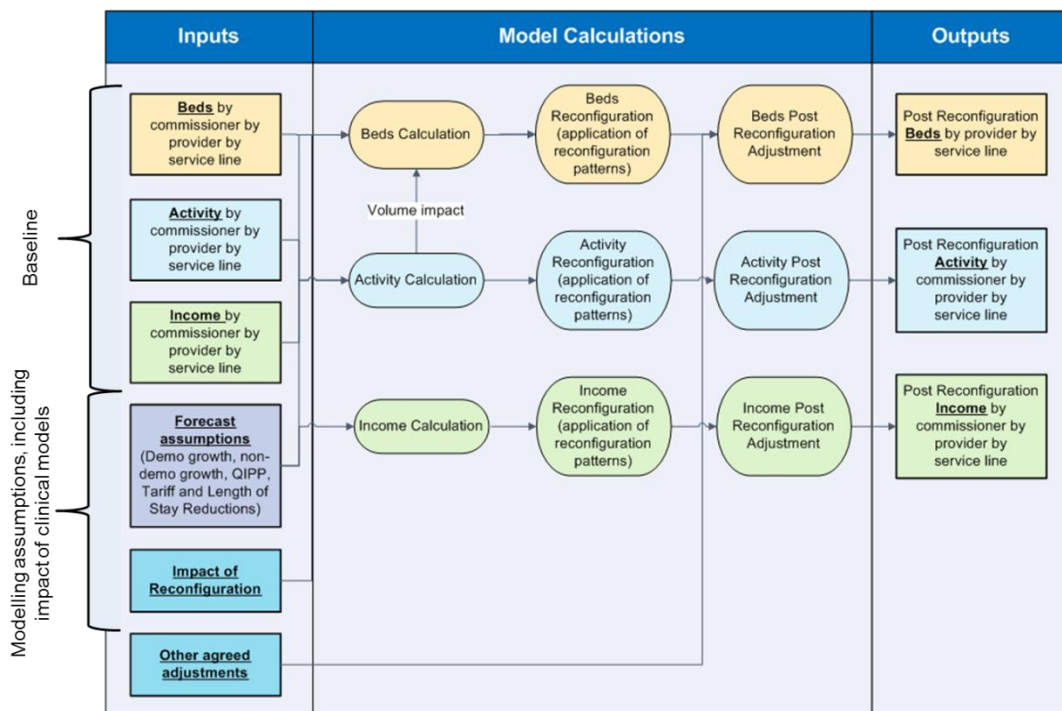
- **Replicate core DMBC modelling** - activity, income and bed forecast by site and by service line, under current configuration and planned reconfiguration. Includes flows of acute activity to Local Hospitals
- **Produce outputs by commissioner and provider** (DMBC outputs only by provider)
- **Take inputs of latest commissioner and provider data in future years**; subsequent years then re-forecasted from that new starting point
- **Model phased implementation plans** to produce year by year forecasts (not yet utilised)
- **Incorporates results of detailed travel time modelling** redone at level of each commissioner and site (DMBC analysis at site level)
- **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
- **Calculates tracking indicators** on latest commissioner and provider data to compare performance versus original plan

### What the model does NOT do

- **Model trust expenditure, estate changes or capital investments** – these will rest with the trust business cases
- **Model comprehensive commissioner I&E** (including allocations, and non-Acute spend) – this will rest with commissioners' strategic plans
- **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
- **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
- **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:

## Appendix G: Financial appendix



### 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:

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Provider	A&E		Critical Care		Elective		Maternity births		Non Elective		Outpatient	
	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
<b>Grand Total</b>	<b>504,602</b>	<b>416,103</b>	<b>62,682</b>	<b>70,704</b>	<b>538,040</b>	<b>584,863</b>	<b>30,208</b>	<b>33,000</b>	<b>187,817</b>	<b>161,019</b>	<b>2,209,296</b>	<b>1,853,060</b>
% 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	
	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%
<b>Grand Total</b>	<b>-16%</b>	<b>-18%</b>	<b>7%</b>	<b>13%</b>	<b>5%</b>	<b>9%</b>	<b>16%</b>	<b>9%</b>	<b>-13%</b>	<b>-14%</b>	<b>-31%</b>	<b>-16%</b>

### 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).

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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	Reconfiguration	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
<b>Total</b>	<b>3,990</b>	<b>-294</b>	<b>-557</b>	<b>132</b>	<b>3,271</b>	<b>0</b>	<b>3,271</b>

### 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
<ul style="list-style-type: none"> <li>Early access to primary care</li> <li>Rapid response to prevent avoidable admissions</li> <li>Integrated care to proactively manage complex patients</li> <li>Planned care pathways</li> <li>Appropriate time in hospital</li> </ul>	<ul style="list-style-type: none"> <li>Reduced emergency admissions</li> <li>Reduced permanent admissions of older people to residential and nursing care homes</li> <li>Increased proportion of older people at home 91 days after discharge from hospital into reablement / rehabilitation services</li> <li>Reduced delayed transfers of care</li> <li>Improved patient &amp; service user experience</li> </ul>

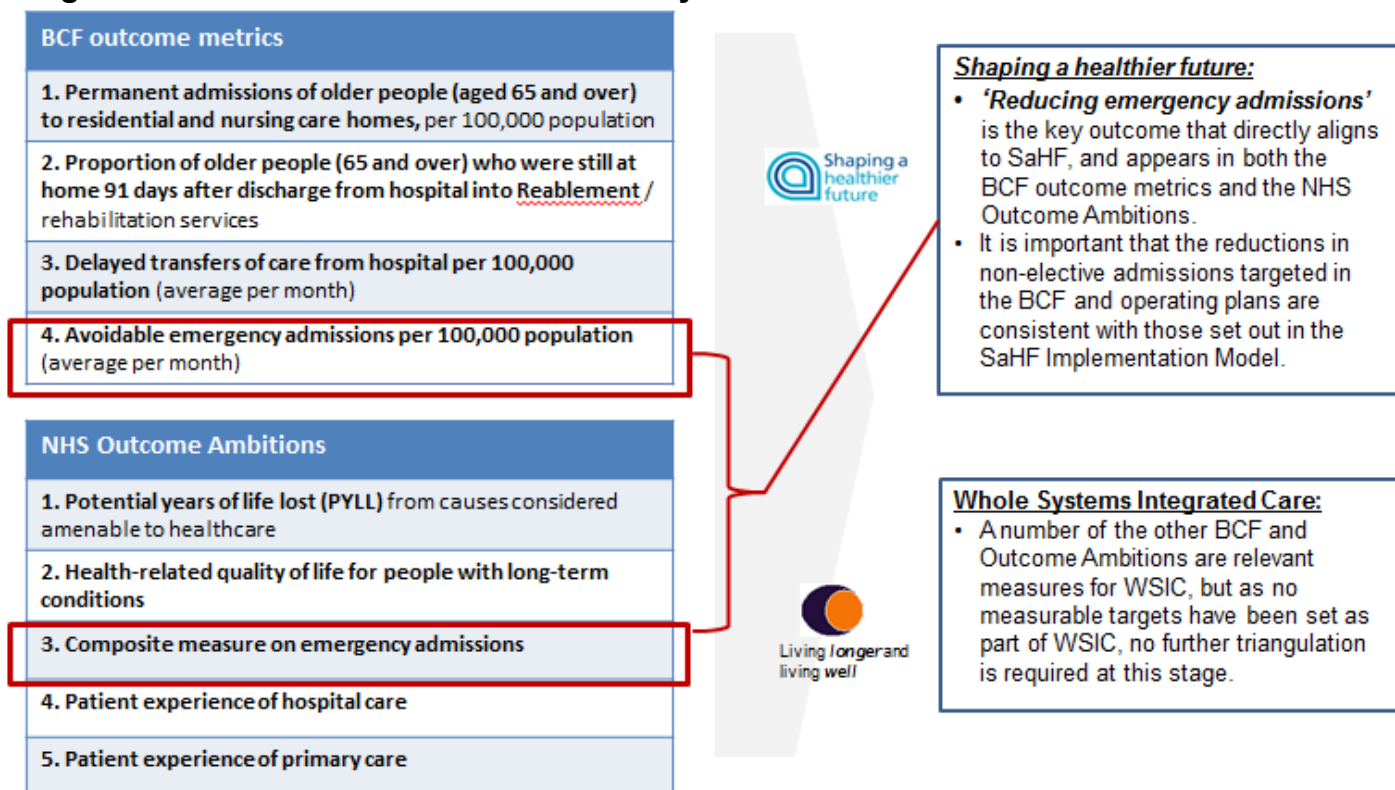
- Delivery of BCF plans is an enabler to the delivery of our Out of Hospital strategies – i.e. they will support the shift of care from acute to community settings, and provider impacts are fully incorporated in CCG QIPP plans set out in section 2.4 above.

### Outcomes and Metrics

There are four standard BCF outcome metrics, one of which relates directly to *Shaping a healthier future*:

## Appendix G: Financial appendix

### 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
<b>BCF Total Ealing</b>	<b>£ 19,830</b>	<b>£ 24,397</b>	<b>£ 24,844</b>
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



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<b>BCF Total Triborough</b>	<b>£ 156,144</b>	<b>£ 47,836</b>	<b>£ 210,495</b>
London Borough of Hounslow	£ 833	£ 1,610	£ 1,610
Hounslow CCG	£ 3,747	£ 15,288	£ 15,288
<b>BCF Total Hounslow</b>	<b>£ 4,580</b>	<b>£ 16,898</b>	<b>£ 16,898</b>
Harrow Council	£ 3,560	£ 1,190	£ 1,190
Harrow CCG	£ 885	£ 13,183	£ 13,183
<b>BCF Total Harrow</b>	<b>£ 4,445</b>	<b>£ 14,373</b>	<b>£ 14,373</b>
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
<b>BCF Total Brent</b>	<b>£ 6,156</b>	<b>£ 22,432</b>	<b>£ 22,456</b>
London Borough of Hillingdon	£ 4,772	£ 2,349	£ 2,349
Hillingdon CCG		£ 15,642	£ 15,642
<b>BCF Total Hillingdon</b>	<b>£ 4,772</b>	<b>£ 17,991</b>	<b>£ 17,991</b>
<b>BCF Total NW London</b>	<b>£ 195,927</b>	<b>£ 143,927</b>	<b>£ 307,057</b>

*NB. Totals may not add due to rounding*

Minimum revenue allocations	£ 40,697	£ 130,759	
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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.

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### 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	Willisden	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	11,500	
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	1,450	Equipment, project costs and temporary accommodation, 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 unknown, this is a holding figure from the PID

<b>Total</b>	<b>47,482</b>
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#### 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 appraisals, 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/m<sup>2</sup>.
- New build is £2,600/m<sup>2</sup> 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. Part A
- 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%.”

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- For 2014/15, contributions at 2.5% are as follows:

	<b>£m</b>
<b>Brent</b>	9.4
<b>Ealing</b>	10.6
<b>Central</b>	6.2
<b>Hammersmith &amp; Fulham</b>	6.1
<b>West</b>	8.4
<b>NHS England</b>	16.3
<b>Total</b>	<b>57.0</b>

Note: Harrow, Hillingdon and Harrow 2.5% retained to support local financial position.

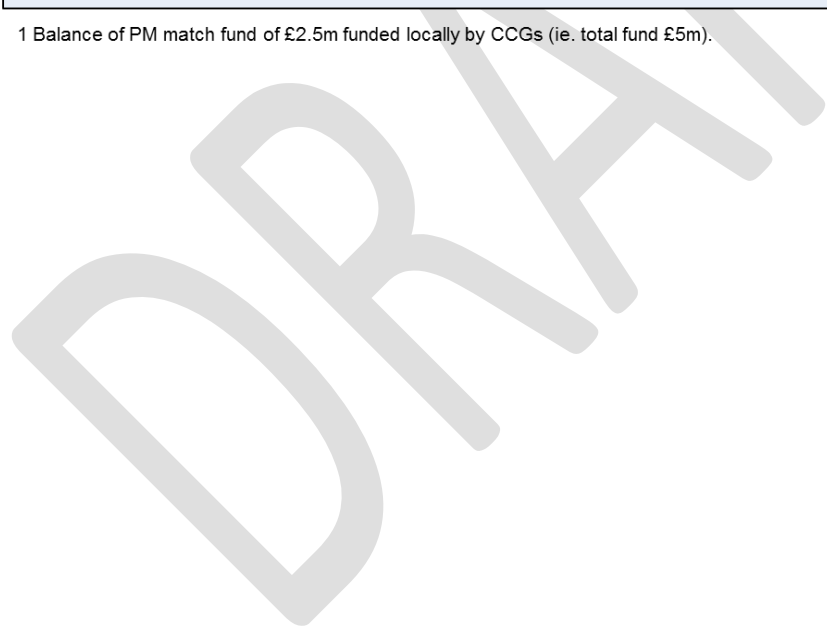
Part A of the fund is being used to support:

- 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:

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1	Enhanced integration	Whole systems	Whole systems implementation				£8.5m	
		£5.0m	£3.5m					
2	Primary care transformation	PC Co-commissioning	Primary Care development + PM match fund	Hub business case development	Informatics strategy			£5.3m
		£1.25m	£2.5m	£1.25m	£0.3m			
3	SaHF implementation	5 year strategy	Programme Office	Implementation mngt and governance	Local H & M.H. business case delivery	Imp. of 2014 changes (A&E, Maternity)	£13.3m	
		£0.2m	£1.5m	£2.6m	£4.0m	£1.0m		
		Hospital BC assurance & IMBC	Workforce	Communications				
		£1.0m	£2.0m	£1.0m				
4	Transforming Mental Health services	Transforming Mental Health services						£2.0m
		£2.0m						
Other costs (core team, non-pay, events)							£2.8m	
1 Balance of PM match fund of £2.5m funded locally by CCGs (ie. total fund £5m).								
<b>Total</b>							<b>£31.9m</b>	
							<b>£30.9m +£1m HENWL</b>	



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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
<b>Total</b>	<b>6,050</b>	<b>16,700</b>	<b>4,350</b>	<b>27,100</b>

### 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.

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- 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
<b>Brent</b>	29.2	40	11.7
<b>Central</b>	16.9	40	6.8
<b>H&amp;F</b>	12.3	40	4.9
<b>West</b>	29.6	40	11.8
<b>Total</b>	<b>88.0</b>	<b>40</b>	<b>35.2</b>

- 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 1% contribution by all CCGs (£23.6m)
  - A further £23.6m contribution from the five CCGs with 13/14 underlying recurrent surpluses, in proportion to 13/14 forecast exit run rates
  - 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



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	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)
<b>Total (excl. NHSE)</b>	<b>47.2</b>	<b>47.2</b>	-
NHSE (1)	TBC	-	
<b>Total</b>	<b>TBC</b>	-	

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) <b>Demand growth I:</b> 1%pt pa higher than plan, trust income allowed to grow	<ul style="list-style-type: none"> <li>▪ Demand is higher than expect leading to increased activity (+1%pt per year)</li> <li>▪ Trusts are reimbursed for this additional activity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Higher income, activity and costs (scaled with increase in activity)</li> <li>▪ More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets</li> </ul>
b) <b>Demand growth II:</b> 1%pt pa higher than plan, trust income fixed as per baseline	<ul style="list-style-type: none"> <li>▪ Same as (a) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts</li> </ul>	<ul style="list-style-type: none"> <li>▪ Same as (a) except income does not increase leading to a worse financial position for the Trusts</li> </ul>
c) <b>QIPP plans I:</b> 60% of plans achieved, trust receive income	<ul style="list-style-type: none"> <li>▪ QIPP initiatives do not deliver the planned level of reduction in acute activity (only 60% achieved)</li> <li>▪ Trusts are reimbursed for this additional activity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Same as (a) except the new activity is focused on services targeted by QIPP initiatives (mainly non-elective and outpatients)</li> </ul>
d) <b>QIPP plans II:</b> 60% of plans achieved, trust income is capped	<ul style="list-style-type: none"> <li>▪ Same as (d) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts</li> </ul>	<ul style="list-style-type: none"> <li>▪ Same as (c) except income does not increase leading to a worse financial position for the Trusts</li> </ul>
e) <b>QIPP plans III:</b> 110% of QIPP achieved (Trusts recover costs)	<ul style="list-style-type: none"> <li>▪ QIPP initiatives deliver 10% more reduction than planned in acute activity (110% achieved), with the associated reduction in income and in activity</li> <li>▪ Trusts adapt by reducing variable and semi-variable costs accordingly</li> </ul>	<ul style="list-style-type: none"> <li>▪ Lower income, activity and costs (scaled with decrease in activity)</li> <li>▪ Less beds needed, leading to lower capital spend and ongoing costs to replace and operate the assets</li> </ul>
f) <b>Tariff efficiency I:</b> Monitor guidance on tariff efficiency, and 90% productivity savings	<ul style="list-style-type: none"> <li>▪ 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%</li> <li>▪ Trusts achieve only 90% planned productivity savings in 12/13-17/18</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased cost inflation, and less cost saving from productivity, leading to a worse financial position</li> </ul>

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Sensitivity tests	Description	High level effect
g) <b>Tariff efficiency II:</b> Monitor downside on tariff efficiency	<ul style="list-style-type: none"> <li>5.5% tariff efficiency in 12/13 and 14/15</li> <li>5% efficiency in 15/16 onwards</li> </ul>	<ul style="list-style-type: none"> <li>Increased costs inflation leading to a worse financial position</li> </ul>
h) <b>LOS reduction I:</b> 10% reduction achieved (instead of 15%)	<ul style="list-style-type: none"> <li>Trusts achieve only 10% reduction in average length of stay, compared to 15% assumed in the main analysis</li> </ul>	<ul style="list-style-type: none"> <li>More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets</li> </ul>
i) <b>LOS reduction II:</b> no ALOS reduction on maternity, paediatrics nor critical care	<ul style="list-style-type: none"> <li>Trusts keep average length of stay for maternity and critical care constant, and achieve 15% reduction for other categories</li> </ul>	<ul style="list-style-type: none"> <li>15% more beds needed in maternity and critical care, leading to higher capital spend and ongoing costs to replace and operate the assets</li> </ul>
j) <b>Transition costs:</b> 20% higher than plan	<ul style="list-style-type: none"> <li>Higher revenue impact from re-configuration (e.g. due to more expensive or extended transition period)</li> </ul>	<ul style="list-style-type: none"> <li>Increased one-off transition costs</li> </ul>
k) <b>Consolidation savings:</b> 50% of the consolidation savings achieved	<ul style="list-style-type: none"> <li>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)</li> </ul>	<ul style="list-style-type: none"> <li>Less cost saving delivered when consolidating services</li> </ul>
l) <b>Higher new build cost:</b> 30% higher than plan	<ul style="list-style-type: none"> <li>Higher capital costs to add new capacity</li> </ul>	<ul style="list-style-type: none"> <li>Increased capital requirements and ongoing costs to operate and replace assets</li> </ul>
m) <b>Lower net land receipts:</b> 30% lower than plan	<ul style="list-style-type: none"> <li>Lower net disposal value for unused land (e.g. due to restrictions or difficulties selling land, or higher exit and demolition costs)</li> </ul>	<ul style="list-style-type: none"> <li>Increase in net capital requirements</li> </ul>
n) <b>Higher cost of capital:</b> NPV discount rate of 4.5% instead of 3.5%	<ul style="list-style-type: none"> <li>Decrease 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</li> </ul>	<ul style="list-style-type: none"> <li>Reduces NPV, particularly for medium-to-long term benefits and costs</li> </ul>

Sensitivity tests	Description	High level effect
o) Time to deliver reconfiguration	<ul style="list-style-type: none"> <li>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)</li> </ul>	<ul style="list-style-type: none"> <li>Extends the time for which current trading deficits need to be covered, and delays the benefit of reconfiguration – reduces the NPV of options</li> </ul>
p) Lower outpatient activity: Local Hospitals retain 40% rather than 85% of outpatient activity	<ul style="list-style-type: none"> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Reduces the contribution margin for Local Hospitals, potentially impacting site viability</li> </ul>
q) Period for NPV assessment	<ul style="list-style-type: none"> <li>Period for NPV assessment increases from 20 years (no terminal value) to 60 years (no terminal value)</li> </ul>	<ul style="list-style-type: none"> <li>Increases the NPV of options</li> </ul>
r) Theatre efficiency	<ul style="list-style-type: none"> <li>Theaters assumed to run 50 hours per week instead of 40 hours</li> </ul>	<ul style="list-style-type: none"> <li>Less new theatres needed, leading to lower capital spend and ongoing costs to replace and operate the assets</li> </ul>
s) Lower new build cost: 30% lower than plan	<ul style="list-style-type: none"> <li>Lower capital costs to add new capacity</li> </ul>	<ul style="list-style-type: none"> <li>Decreased capital requirements and ongoing costs to operate and replace assets</li> </ul>
t) Reduced fixed cost savings at Local Hospitals: Only 75% of net savings delivered	<ul style="list-style-type: none"> <li>Reduced net savings in fixed costs at local hospitals to 75% of modelled savings</li> </ul>	<ul style="list-style-type: none"> <li>Increases cost at Local Hospitals (potentially impacting viability) and reduces cost saving benefit in NPV</li> </ul>
u) Imperial College I: NHS contributes 100% of capital; no net revenue impact	<ul style="list-style-type: none"> <li>Increases NHS capital contribution; no change to on-going revenue cost assuming these costs are already incurred for the existing services</li> </ul>	<ul style="list-style-type: none"> <li>Increases capital cost and reduces VfM NPV. No change to expanded NPV as total capital already included</li> </ul>
v) Imperial College II: NHS contributes 100% of capital; full revenue impact added to ongoing costs (est. 11.5% of capital)	<ul style="list-style-type: none"> <li>Increases NHS capital contribution; on-going revenue costs increased by 11.5% of capital costs</li> </ul>	<ul style="list-style-type: none"> <li>Increases capital and revenue costs, and decreases total VfM and expanded NPV</li> </ul>

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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

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- 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 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 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

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	configuration	
	12. Specialist commissioning planning not integrated with CCGs	a) Further discussion with NHSE

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