Joint Health Overview & Scrutiny Committee

Agenda

Wednesday 30 October 2019
2.00 pm
Meeting Room 2 (2nd Floor) - 3 Shortlands, Hammersmith, W6 8DA

MEMBERSHIP

Councillor Mel Collins (LB of Hounslow) – Chairman
Councillor Daniel Crawford (LB of Ealing)
Councillor Lorraine Dean (City of Westminster)
Councillor Robert Freeman (Royal Borough of Kensington & Chelsea)
Councillor Lucy Richardson (LB of Hammersmith & Fulham)
Councillor Monica Saunders (London Borough of Richmond)
Councillor Sachin Shah (London Borough of Harrow)
Councillor Ketan Sheth (LB of Brent)

Substitute Members:

Councillor Neil Nerva (London Borough of Brent)
Councillor Joy Morrisey (LB of Ealing)
Councillor Bora Kwon (LB of Hammersmith & Fulham)
Councillor Vina Mithani (LB of Harrow)
Councillor Shaida Mehrban (LB of Hounslow)
Councillor Max Chauhan (Royal Borough of Kensington & Chelsea)

CONTACT OFFICER: Bathsheba Mall
Committee Co-ordinator
Governance & Scrutiny
☎: 020 8753 5758 / 07776672816
E-mail: bathsheba.mall@lbhf.gov.uk

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Members of the public are welcome to attend and listen to the public discussion. The building is accessible, please report to Shortlands Reception and you will be directed to the meeting room on the 2nd Floor.

Shortlands

3 Shortlands,
Hammersmith,
London W6 8DA

Closest Underground Station
Hammersmith

Closest Bus Stop
Latymer Court (Stop G)

Date Issued: 22 October 2019

London Borough of Hammersmith & Fulham

Joint Health Overview & Scrutiny Committee

Agenda

30 October 2019

Item **Pages**

1. WELCOME AND INTRODUCTIONS

The Chair and the Member from the Host Borough will welcome members and officers to the meeting and make introductions.

2. APOLOGIES FOR ABSENCE

The Chair to note any apologies.

3. DECLARATIONS OF INTEREST

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

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

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

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

4. MINUTES OF THE PREVIOUS MEETING

The Chair to sign the minutes of the last meeting held on Monday, 22 July 2019 as a correct record of proceedings.

5. NORTH WEST LONDON FINANCIAL RECOVERY 4 - 10

This report updates the JHOSC on the North West London CCGs financial recovery plans for the area to date and how they intend to engage with patients, the public and stakeholders.

6. NHS LONG-TERM PLAN SUBMISSION 11 - 157

This report provides an update to the JHOSC on the NHS North West London Long-Term Plan submission and gives examples of key case studies from the plan.

7. JHOSC WORK PROGRAMME 158

For members to note and agree any amendments to the JHOSC Work Programme 2019-20.

8. ANY OTHER BUSINESS

To consider any other business which the Chairman considers urgent.

North West London
Collaboration of
Clinical Commissioning Groups

Joint Health Overview and Scrutiny Committee (JHOSC): NHS North West London financial recovery

18.10.2019

Summary	This document gives the JHOSC an update on our North West London financial recovery plans to date and how we intend to engage with patients, the public and stakeholders.
Date (correct as of)	18 October 2019
Owner	Mark Easton, Accountable Officer, North West London CCGs

North West London financial recovery

The North West London CCGs were set a financial target in 2018-19 (known in the NHS as a "control total") of a deficit no greater than £9.4m. The control total was set as a deficit to recognise the long-standing financial problems in Harrow CCG. In fact the CCGs ended the year with a deficit of £56.7m, a variance to control total of £47.4m. An estimated £10.2m of the deficit related to GP at Hand.

The deficit needs to be seen against total expenditure of £3.5bn, so the deficit represents 1.6% of expenditure.

For the year we are currently in, 2019-20, the CCGs were given a control total of £21.5m deficit, but regulators accepted that the CCGs were unlikely to achieve this and set us a target of a deficit no worse than £50.9m. Included in this position were savings of £98.9m through the CCGs QIPP (quality, innovation, partnership and prevention) programme.

The CCG planned savings for 2019-20 represents £100m out of £3.5bn or 2.8%. There are some national policies which call for greater savings in specific areas. For example the CCGs have to demonstrate a 20% reduction in running costs compared with 2017-18.

In September, four months into the financial year, we recognised that we were in danger of going significantly off plan, and identified a potential additional expenditure of £61.6m, on top of the deficit already in our plans.

At the same time, on the provider side, London North West University Healthcare NHS Trust (LNWUHT) recognised risks to its financial plan of £20m, making the total risk to the system £82m.

Of this potential additional £61.6m variance from plan, £54.6m related additional acute costs. The table shows the breakdown against Points Of Delivery (POD). In addition CCGs are also facing Continuing Healthcare pressures, equating to £7m.

Combined, this equates to a financial challenge which would result in a further deficit of £61.6m above plan.

POD			VARIANCE	
	YTD M4	FOT	Risk Share	Total
	£m	£m	£m	£m
A&E	-£1.67	-£5.70		-£5.70
NEL	-£10.70	-£34.60		-£34.60
Critical Care	£1.30	£1.40		£1.40
OP FA	-£2.50	-£7.00		-£7.00
OP FU	-£2.70	-£7.30		-£7.30
OP Procedures	-£1.00	-£2.90		-£2.90
OP Sub-Total	-£6.20	-£17.20		-£17.20
DC & EI	-£5.30	-£13.20		-£13.20
Direct Access	-£1.40	-£3.00		-£3.00
Maternity	-£0.40	-£2.10		-£2.10
All other	£8.72	-£11.50	£31.20	£19.70
Total	**-£15.65**	**-£85.90**	**£31.20**	**-£54.60**

In response to these pressures we developed a plan to bring our finances back to plan.

It is important to note that no matter what financial challenges we face, as a clinically-led organisation, **the safety of our patients and the quality of our services will always come first.** We will continue to work closely with patients, local residents, NHS staff, our local authority partners, Healthwatch and the voluntary sector as our plans for the next five years take shape.

We continue to abide by NHS constitutional standards, which is to say we are committed to achieving waiting list targets, cancer and mental health waiting times and A&E waiting time targets as set out in our operating plan submission. In addition, we continue to meet the mental health investment standard, that is, additional investment in mental health standards in line with the CCGs overall increase in allocation each year.

Why are we in deficit?

Since 2015, expected growth in our population has been outstripped by increased demand for hospital care. The North West London population has grown by 5%, while acute activity has increased by 18%. In particular, unplanned care has risen by 25%, accounting for over half our increased spending.

Our funding allocations have increased. We have seen a 3.4% budget uplift and continue to achieve our targets with QIPP savings. Some additional investment has been made available for Hillingdon Hospital and St Mary's Hospital in order to address the urgent and longstanding site maintenance issues.

However, while our funding allocations have increased, the rise in demand for health services has outstripped the increases in funding. Lack of standardisation and efficiency in commissioning of clinical and non-clinical services has increased costs and led to variations in the quality and costs of care. Estates and staffing costs have also played a part in the size of our deficit.

Until recently, our financial performance was broadly similar to the NHS in London as a whole. However, our position has worsened over the last year.

North West London CCGs' Financial Allocation from NHS England

NHS England published five year allocations for CCGs in January 2019 covering the period from 2019-20 to 2023-24. These allocations are part of the deployment of NHS England's five-year revenue funding settlement, averaging 3.4% a year in real terms and reaching £20.5bn extra a year by 2023-24.

Overall CCG allocations are being set on the basis of NHS England's five-year real terms revenue funding profile, which has now been set by Government as 3.6%, 3.1%, 3.0%, 3.0% and 4.1%.

Individual CCG allocations are based on historic funding levels uplifted by differential growth rates depending on their relative distance from target allocation, which is based on a national funding formulary.

Our Financial Recovery Plans: four strands

Strand one: same service, lower cost

There are changes we can make which will offer the same services for a lower cost to the NHS through a change in supplier. These will not impact patient care, and although details will be publically available, we do not see any rationale for a public engagement process.

Example: We expect to see savings from the new London-wide procurement of the home oxygen service.

Strand two: Changes to referral behaviour

Strand two of our financial recovery work involves looking at ways we can influence GP behaviours by comparing referral patterns and identifying best practice. By looking at the underlying causes of the different referral patterns we can identify best practice, share learning, and make sure we are always referring patients in the most appropriate way, so they get the right care for their need.

Unwarranted variation in GP referral patterns has already been reduced through practice visits and action plans, which we now have in place with 132 practices across North West London. CCGs have agreed with in-sector providers a standardised approach for consultant-to-consultant referrals, and for follow-up appointments with outpatients. We are working on agreed pathways for same day care, and working with community trusts to agree in common a set of 'out of hospital standards' to safely reduce avoidable and unnecessary admissions, and speed up patient discharge.

CCGs will continue the practice visits where we discuss activity trends against peer comparisons. Feedback from most practices is that this has proved useful and raised awareness of alternative primary and community care pathways that can provide a more convenient and better value care alternative for the patient.

Example: There may be disproportionately high referral rates into acute or specialist services from a particular GP practice because they do not have the right information about alternative community services that are available.

Strand three: enforce existing policies

NHS England has national policies on prescribing medicines which are available over the counter (and in some cases are cheaper over the counter than with a prescription). Compliance with these policies varies across North West London and we are working to understand the reasons for this variation and ensure the policy is fully implemented by all our providers. North West London has previously agreed an approach to consultant to consultant referrals but has not fully implemented it.

Example: Consultant-to-consultant referrals are very high in parts of North West London. It is agreed national best practice that in cases where a patient is referred to a consultant and the consultant believes the patient needs to see a specialist in an unrelated area, the patient be referred back to the GP first.

Strand four: updating eligibility criteria

Although we will prioritise savings from administration and by reforming how we commission care, we will look at all aspects of our spend. This may involve updating the eligibility criteria for some of our Planned Procedures with a Threshold (PPwT) and for our patient transport services to ensure the standardised guidance fully reflects the most up to date evidence, best clinical practice, and value for money.

Example 1: We are in the process of standardising the eligibility criteria for patient transport across North West London, to make sure access is consistent and fair regardless of where a patient lives, and looking at the reasons for variation between contract costs. We evaluate the eligibility criteria on an ongoing basis in partnership with patients as this work develops. We will continue to engage with patients on this work through the patient transport group and other patient groups, through special events, and through written or online feedback submissions, among other channels.

Example 2: We are reviewing our Planned Procedures with a Threshold policies, with a view to updating the eligibility criteria for certain procedures. The current areas of focus are the eligibility thresholds for bariatric surgery, and Smoking Cessation and Pre-operation Weight Management Programme.

This is the area which is likely to be the focus for patient engagement and consultation if necessary.

Stages of implementation

The implementation of this plan has now begun, with some reforms relatively simple to achieve (such as those which are administrative in nature and do not impact patient care)

and others may require wider public engagement and planning before they are taken forward.

There are four strands of work and only the fourth category will require an Equalities Impact Assessment (EQiA) or patient engagement. North West London CCGs will share this information with the JHOSC and other stakeholders as early in the process as possible.

The Financial Recovery Programme is overseen by a North West London Financial Recovery Board. Because the majority of North West London's deficit is centred upon the system surrounding London North West University Hospital Trust, there is a separate recovery board which involves LNWHT together with Brent, Ealing and Harrow CCGs. This is chaired by Lesley Watts, who is the leader of the North West London Health and Care Partnership and also the Chief Executive Officer of Chelsea and Westminster Hospital NHS Trust.

Updates are also presented to local CCGs' Finance, QIPP and Performance Committees as appropriate.

Impact of winter

As we develop our financial recovery plans we will take into account the impact of winter on demand, and on activity performance across North West London. This includes increased emphasis on the urgent care pathway, so that the spike of costs anticipated for winter is minimised.

Impact on provider trusts

Since our recovery plan is aimed at getting the NHS system back to plan, the remedial work on referrals and waiting lists should help hospitals by removing the need to put on additional capacity. We continue to work closely together as a single system.

What does success look like?

We aim to return to our original plan, which was a £51m deficit. No matter how much or little money we have, it is always right and fair that we use the money we do have as efficiently as possible, and put resources where they will do the most good for patient care.

Next year and subsequent years

Our financial planning for next year has already begun. We are anticipating that financial recovery will be a three year programme of getting us back to balance. Our plans for next and subsequent years will be guided by our NHS Long-Term Plan submission, which is already available in draft on our website.

Appendix 1: full list of schemes

Scheme		Opportunity Identified
Additional CCG savings	Fully identified, over 70% now implemented, budgets removed at line level therefore high confidence of delivery.	£16m
Reserves	All fed into forecast outturn. No risk.	£16m
Eliminating CHC (Continuing Healthcare) overspend	Project team and support in place, schemes agreed with management team, implementation underway. Savings from: catching up with the review backlog, invoice scrutiny, use of decision support tool.	£7.9m
Localising Services	Savings based on 15% of out of sector referrals being treated in North West London. Supports local hospitals, takes advantage of North West London marginal rate.	£1.5m
Elective	Agreed that providers will plan activity back down to contract level, unless this puts waiting list commitments at risk (no rise in list compared to March 18 and no +52 week waiters).	£4.6
Referral to Treatment (RTT) reserve	Not all of the waiting list reserve may be required.	£2.9
Emergency pathway	Four elements have been developed: - Improved frailty model on front door - Same day emergency care - Diabetes care - 111 and London Ambulance Service (LAS) dispatch	£4.6

Outpatients	All parts of the system have agreed to a policy on Consultant-to-Consultant referrals and to re-establish thresholds for new follow-ups. All trusts to cap cost at contract level.	£6.0
Management costs	CCGs have agreed the shape of a single operating model that will save £1m in this year.	£1.0
Patient Transport	Standardisation of contracts.	£1.4
Procurement	The project to procure enteral feeds is well-advanced, saving £1m. Awaiting details on the Home Oxygen opportunity.	£1.5
Estates	Further rationalisation of the primary care estate. Projects identified to deliver the savings. There is a risk around ability to exit buildings in time to release sufficient cash in-year.	£1.1
Over the Counter Medicines	CCGs have agreed to implement the national policy in full.	£1.5
TOTAL		**£66m** (Subject to Slippage)

The North West London health and care partnership

Joint Health Overview and Scrutiny Committee (JHOSC): NHS North West London Long-Term Plan

18.10.2019

Summary	This document gives the JHOSC an update on our North West London Long-Term Plan and examples of key case studies from the plan.
Date (correct as of)	18 October 2019

Background

The North West London Health and Care Partnership is a collaboration of over 30 organisations, including NHS commissioners, trusts, local authorities, voluntary sector and Healthwatch. With eight boroughs and a population of 2.4 million we are the largest health and care partnership in the country.

We have been working together to consider what the requirements set out in the NHS Long-Term Plan mean for our residents, staff and health and care partner organisations across all eight boroughs. We have made a collective commitment to deliver changes that will improve the health and wellbeing of residents, and we have listened to what residents told us is important to them.

On 27 September 2019 we published and shared the North West London working draft Long-Term Plan. Over a period of six weeks we have engaged with local partners, residents, patient groups, and other stakeholders. We are now in the process of considering all feedback and evidence that has been shared with us, costing the plans, and preparing to submit a final draft to NHS England in November.

Our draft Long-Term Plan submission

The structure of our draft Long-Term Plan submission is designed to make sure our local plan responds to the requirements set out in **NHS England's Implementation Framework.**

You can view the full draft submission online. This paper sets out four case studies from the plan to give an overview of the work we are doing. This should by no means be considered a comprehensive or exhaustive summary of all the work that is ongoing in North West London and we strongly encourage the JHOSC to review the draft plan in full to gain a clear understanding on the wider picture.

DOWNLOAD OUR DRAFT PLAN: North West London Health and Care Partnership Strategic Delivery Plan for the NHS Long-Term Plan.

The full draft plan has been sent directly to every JHOSC member with details on how to offer feedback. We are now in the process of collating the feedback we have received to

date. We will consider any points arising from the JHOSC meeting on 30 October 2019 in this work.

Case studies

Case study one: North West London diabetes prevention programme

The diabetes prevention programme works by preventing diabetes through managing patients with risk factors that can lead to diabetes, and supporting patients with the condition to improve their health outcomes.

The programme has driven a 50% increase in the past year in the numbers of patients attending an education course to help them better manage their own diabetes, and the growth in hospital admissions for diabetes-related complications has been almost halved to 4.9% in 2018-19 from 8.3% in 2017-18.

Case study two: cancer

Our one-year survival rates are significantly higher than England as a whole. Significantly higher survival rates are also seen in specific tumour groups (breast, colorectal, kidney, lung, myeloma, non-Hodgkin's lymphoma and prostate cancer.

Screening rates are a crucial measure of success on cancer. Early cancer detection saves lives. In North West London we are working to improve our screening rates in a range of ways.

From September 2019, the HPV vaccination programme will be extended to boys aged 12-13. The evidence shows that this will help reduce cancers such as oropharyngeal (head and neck) penile cancer, anal cancer, and conditions such as genital warts. By protecting as many people as possible, the risk is reduced for anyone who is not vaccinated for any reason.

We have achieved some success to date in increasing uptake for bowel, breast and cervical screening during 2018-19, and we will build on this further in the coming years by working closely with screening providers and commissioners to improve our Faster Diagnosis Services (FDS), and by working with primary and community care providers to increase bowel screening uptake by telephoning patients who do not respond to screening invitations, and encouraging them to attend. We are also working to increase access opportunities for cervical screening by providing more flexibility and more convenient appointment times.

With regards to endoscopy, the main challenges are around current and future demand, so we are working with endoscopy units to increase capacity to anticipate and accommodate the need.

Case study three: improving maternity services

North West London was chosen as an early adopter site to improve continuity of care during pregnancy. Our maternity services are recognised nationally for our innovative improvements to care – in particular, through delivering continuity of care, so that new parents see the same midwife throughout and after the pregnancy.

We also launched the North West London 'Mum and baby' app, which includes care plans and information about all aspects of maternity and baby care for new families. This successful app has now been adopted by other health partnerships across the country.

Case study four: population health management (whole systems integrated care)

The Whole Systems Integrated Care Dashboard (WSIC) tools are available to any clinicians or care professionals responsible for providing direct care to patients. These dashboards were pioneered in North West London and are a national exemplar in population health management.

The WSIC dashboards provide a linked summary of patient's health and social care information. This information is used for case-finding and case-management to better support patients who require more targeted and proactive care.

For example, if a patient has a long-term condition and has visited A&E due to a change or flare-up in their condition, or if a patient's test results have changed as a result of the way their long-term condition is being managed, the WSIC dashboards will highlight to the health and care professionals that the patient in question should be proactively supported to manage their condition in the right way.

More data is available to support GP decision-making including activity and quality dashboards for practices and networks to help them track, compare and improve patient outcomes and interventions for urgent care and patients with long-term conditions such as diabetes, asthma, and atrial fibrillation.

Long-Term Plan engagement

Our engagement on the Long-Term Plan is ongoing and we continue to evaluate our progress as we work.

A report summarising the engagement carried out in North West London on our draft plan will be available to download here.

The North West London
health and care partnership

First draft submission
27 September 2019

The North West London Health and Care Partnership

Strategic Delivery Plan for the NHS Long Term Plan

I - Foreword

This North West London (NW London) response to the NHS Long Term Plan marks a new chapter for our health and care partnership, setting out our commitments to each other as members of the partnership, our local communities and patients and those that work across health and care in NW London.

Our partnership has a long history working together and we have made strides in improving health and care services since we formally came together in 2016 including:

- Our maternity services are recognised nationally for developing new ways of working, which have improved care and specifically continuity in the midwives women see. We also launched the NW London 'Mum and baby' app, which includes care plans and information about all aspects of maternity and baby care. This successful app has now been adopted by other health partnerships across the country.

- Using digital tools to improve access to health services – we are leading the way in developing and testing new ways for patients to access health and care services digitally. Online consultations, allow patients to email their GP through a secure form on the GP practice website, removing the need to call or book an appointment to ask for advice. The launch of our self-help and service directory app 'Health help now' has helped over 100,000 people so far. Our 'Whole Systems Integrated Care Dashboard' is recognised nationally as one of the best health data sets available and clinicians are using it to improve the care and treatment.

- Our diabetes programme is starting to see real success with a 50% increase (last year) in the numbers of patients attending an education course to help them better manage their own diabetes. This programme of work is being built on and has already seen the growth in hospital admissions for diabetes-related complications has been almost halved to 4.9% in 2018/19 from 8.3% in 2017-18.

- Care for those with dementia has significantly improved with all areas of NW London exceeding national standards for early diagnosis of the disease. This means more people are getting the right advice and support at the early stages of the disease.

- We have a world-leading reputation for some of our acute hospitals and the research work connected with them, through our Academic Health Science Centre.

The launch of our new five-year plan allows our partnership to build on this success and take a fresh look at how we deliver high quality, best value, and safe care for the residents of NW London. We need to work together to continue to reduce

inequalities for our residents, improve our staff experience and deliver the optimum value for the NHS.

Prevention and supporting our population to start well, live well and age well are also key ambitions for the success of our plan. We want to work ever more closely with local people and across health and social care, building on the successful plans we have put in place.

Clinically safe and sustainable services require financial stability and our plan sets out a suite of ambitions to improve care and services, but there are some real financial challenges we also need to address over the next year, five years and beyond.

In NW London we collectively have an underlying NHS deficit of £324million across our clinical commissioning groups and service providers, with financial challenges also present for our local authorities.

Currently the services we provide cost more than we are allocated to deliver them and we need to address this. We know there is variation in the quality and cost of services we provide across NW London and as a partnership we are committed to improving this.

We will have difficult decisions to make if we want to ensure that we continue to offer world-class care to our residents and aid London to be the healthiest global city.

Led by our clinicians we will work as a system, rather than a series of individual organisations, to reduce the variation in our services, maximise the value and ensure consistent, high quality for our patients. We are committed to engaging with local residents and our stakeholders to ensure the right decisions are made to meet the needs of all who live and work in NW London.

A key focus to ensuring delivery of high quality care whilst also tackling our financial deficit and delivering our ambitions set out in this plan will be the development of our integrated care system (ICS). This will provide opportunities for us to support each other and focus our collective budget to improve outcomes for all residents. NW London has a strong history of working together to improve care for our residents and through our Health and Care Partnership we have established robust governance that brings us together. We will further develop and strengthen this to become an Integrated Care System by April 2021.

Alongside the development of our integrated care system we will, subject to the necessary approvals, move to create a single clinical commissioning group (CCG) for NW London. We see this change to the way our CCGs operate as an opportunity to streamline systems and processes, reduce duplication and improve the consistency in our offer of care to NW London residents. In doing this, we will learn from the experience of previous large-scale operating models, ensuring that we

maintain a strong focus on public and stakeholder engagement in each of our eight boroughs.

Work is also underway to develop integrated care partnerships (ICPs) locally to ensure the right services are available for our specific population needs. Our integrated care partnerships will bring together local GPs through the newly-formed primary care networks, community nurses, therapists, social care and others, working with our residents to improve health and care outcomes for people as a whole, not as separate services provided to someone.

There will be a lot of change to the way health and care is planned, provided and bought in NW London and as a partnership we are looking forward to being able to do things differently and in the process drive out some of the variation that is seen in the services we provide.

This plan summarises the next steps for the development of our health and care partnership and covers a wide range of services and systems we will shape and improve in order to deliver the ambitions set out by NHS England to all of our two million residents in NW London.

Mark Easton
Accountable Officer
NW London Collaboration of CCGs

Lesley Watts
Senior Responsible Officer
NW London Health and Care Partnership

Contents

1.0 Introduction

NHS Long Term Plan says:

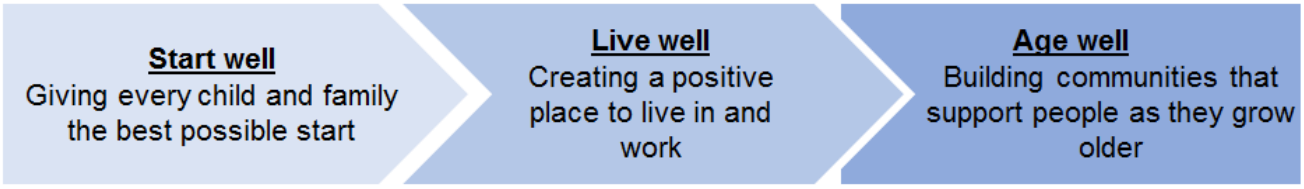
As medicine advances, health needs change and society develops, the NHS has to continually move forward so that in 10 years' time we have a service fit for the future. The NHS Long Term Plan is drawn up by frontline staff, patients groups, and national experts to be ambitious but realistic.

In NW London our health and care partnership is a collaboration of over 30 organisations, including the NHS, local authorities, voluntary sector and Healthwatch. Bringing eight boroughs together, serving a population of 2.4million, makes us the largest health and care partnership in the country.

This is our partnership's plan for the next five years to meet the new national requirements set out in the NHS 'Long Term Plan', to improve the quality of patient care and health outcomes, while focusing on building an NHS fit for the future.

This plan covers a broad range of services and key areas, with a focus on reducing local health inequalities and variation in services across NW London. It also looks at tackling current workforce pressures and using national funding to upgrade technology and digitally enable care across services. Along with these priorities we want to develop services that:

- enable everyone to get the best start in life
- help communities to live well
- help people to age well.



This plan sets out some significant changes in the way we operate as a partnership on a NW London level as an integrated care system and locally as we develop our integrated care partnerships to continue to provide and develop local, place-based care. The recent launch of primary care networks across boroughs will provide local clinical leadership.

In order to deliver the ambitions set out in the long term we are focusing on seven interconnected areas, which we have embedded across our health and care partnership focusing on:

- Healthy communities and prevention
- Maternity, children and young people
- Primary, social and community care
- Urgent and emergency care

- Mental health, including learning disabilities and autism
- Cancer care
- Hospital and specialist care

Through this plan you will find more detail and outcomes from these work areas and their plans for the future to deliver the ambitions of the NHS Long Term Plan and improve care for all NW London residents over the next five years. We have also used NHS England's 'Gold Diagnostic' to help shape priorities in care for NW London.

Our plan also has shared ambitions with our neighbouring partnerships across London to improve health outcomes and reduce variation across all of the capital and:

  - Reduce childhood obesity
  - Improve the emotional wellbeing of children and young people
  - Improve mental health and progress towards zero suicides
  - Improve air quality
  - Improve tobacco control and reduce smoking
  - Reduce the prevalence and impact of violence
  - Improve the health of homeless people
  - Improve services and prevention for HIV and other STIs
  - Support Londoners with dementia to live well
  - Improving care and support at the end of life

Our plan has been developed through many conversations with residents and staff. Nationally, the Long Term Plan was developed through engagement with over 3.5million people from all around the country to set national priorities for change. We have further developed our local plan in partnership with frontline health and care staff, patients and their families through our working groups, boards and local engagement with the public, to ensure we can deliver these priorities in the right way for those that live and work in NW London.

Our engagement and discussions do not end with the publication of this document. We will ensure that as we progress with the implementation of this plan we will continue to engage and incorporate public feedback into our decision making and service development.

We look forward to working with all our partners and communities across NW London to deliver real change, in order to provide services that are fit for purpose now and in the future.

Juliet Brown
Health Care Partnership Director

2.0 Our vision and clinical and care strategy

Across NW London, our health and care partners, residents and patients have come together to describe a vision for care.

We want to create an integrated health and care system that works together to maximise benefits for all residents and staff:

- giving every child and family the best start in life and continuing to support people to deliver healthy lives
- making sure there is care and support when residents need it
- and for those who need to be in hospital ensuring they receive high quality care and spend the appropriate time there.

Through a series of workshops, supported by regular meetings, our senior clinicians – medical directors, CCG Chairs, GP leaders, nursing directors, other professional representatives and service user representatives have articulated our clinical and care strategy to realise this vision.

The clinical and care strategy sets out our expectations of care – as professionals working across the system in London, as stakeholder organisations accountable to our communities, and as patients, carers and residents in our local areas.

This clinical and care strategy supports our commitment to deliver the key national priorities of the NHS Long Term Plan and the London Vision as well as our local strategies for the health and care needs of our population. It also provides the foundations and framework for this strategic delivery plan.

As a health and care partnership, the clinical and care strategy will underpin our operating plans to deliver sustainable improvements to health and wellbeing outcomes and to reduce health and care inequalities.

It is designed to achieve consistency of outcomes and the highest achievable quality of care, for every one of our 2 million-plus residents – along with rewarding working conditions for the thousands of staff working in our health and care services.

Delivering our clinical and care strategy

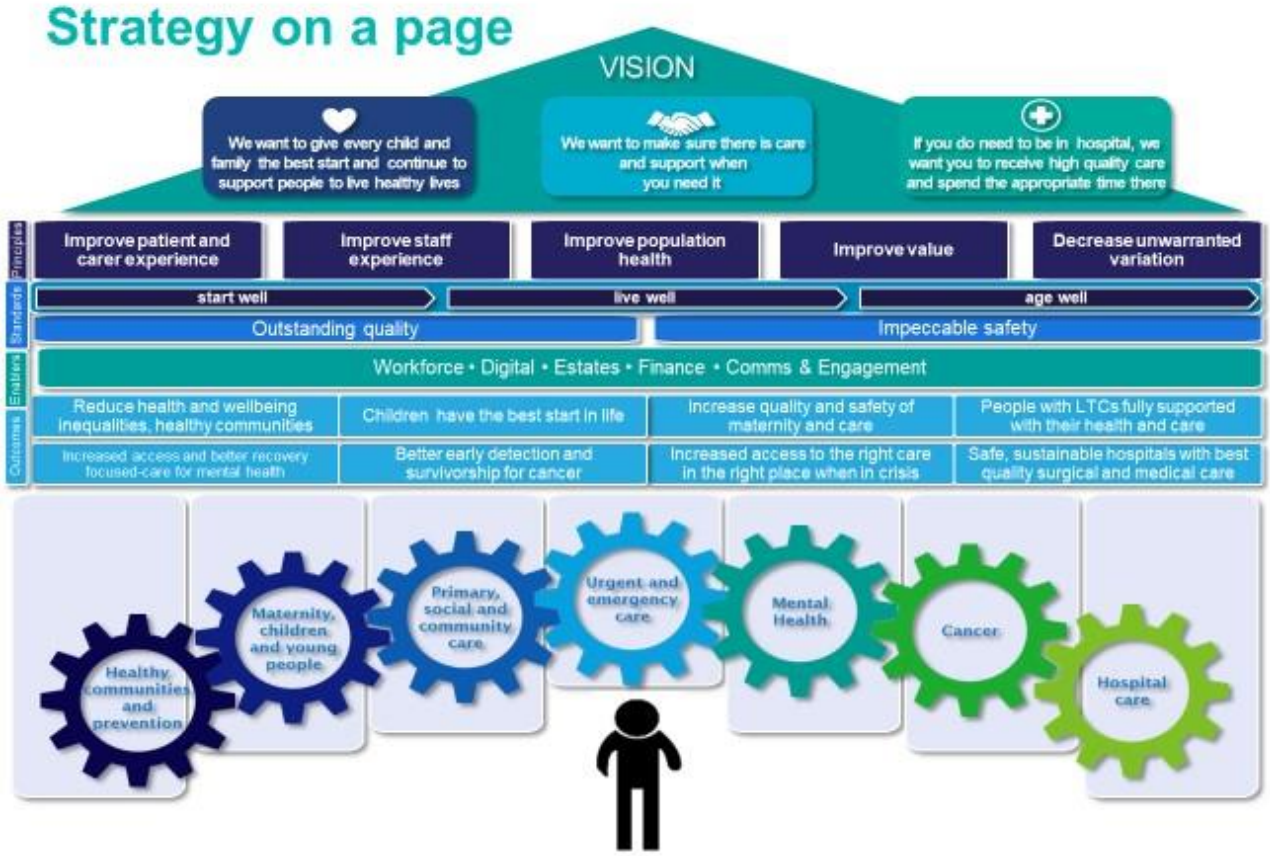
Our clinical and care strategy is developed in seven interconnected programme areas.

1 – Healthy communities and prevention
2 – Maternity, children and young people
3 – Primary, social and community care
4 – Urgent and emergency care
5 – Mental health
6 – Cancer
7 – Hospital care

Our '*strategy on a page'* (below) shows how these programme areas interlink with our enabling strategies, to deliver our key outcomes for our whole population.

To ensure a robust approach to delivering our strategy, we have established system transformation groups for each of the seven delivery areas. Each has a senior responsible officer, a lead clinician, programme lead and resident input. These groups report into our Clinical and Quality Leadership Group and the Parternship Operations Group.

These seven programmes areas are the bedrock to ensure we deliver our long term plan commitments. Throughout this document as we discuss our approach to deliving the specific commitments within the long term plan, each is clearly mapped to these interconnected programme areas.



Ensuring financial sustainability

Our clinical and care strategy needs to ensure that we are able to provide both high quality, clinically sustainable services and financially sustainable services. Currently the services we provide cost more than the resources allocated to us and we need to address this. In NW London as at April 2019 we collectively have an underlying NHS deficit of £324million across our clinical commissioning groups and NHS service providers, with financial challenges also present for our local authorities.

The NW London system now faces some difficult choices as we work to ensure we are able to continue to deliver world-class care and realise the ambition of London being the healthiest global city within the financial and staffing resources available to us. We have to review each one of the Long Term Plan commitments and assess how we are able to deliver it and over what time scale and importantly we have to leverage the synergy of working as a system. We will use the experience and knowledge of our clinicians working together across organisations to standardise and consolidate our services so that all our residents are provided equal opportunity to access high quality care when they need it.

To provide more financially sustainable services each of our interconnected programme areas are working to three key aims as they deliver their programmes:

- ensuring we maximise the amount of money available to spend on direct care delivery through reducing our back office, administration and supplies costs

- maximising value and delivering our services as cost effectively as possible through standardising our approaches, enabling our staff to operate at the top of their licence
- developing more proactive and preventative care thereby managing demand for high-cost hospital services.

Within these broad areas we will specifically focus on the following areas as we work to reduce the gap in our system finances. We believe that these give us the greatest opportunity to reduce expenditure, improve value and increase the quality of care our residents receive. Our approach to these drives our transformation focus and is embedded within our integrated programme areas.

Maximising expenditure available for direct care

- Reducing our back office costs and developing more shared services.
- Moving to the top quartile for procurement.
- Managing the cost of our medicines.
- Assessing and reducing our programme costs.
- Reducing the cost of our estates and maximising the digital opportunity to drive automation and less intensive care models.
- Working as a single CCG to reduce duplication and fragmented commissioning.

Maximising cost effectiveness of services

- Developing consistent and standardised pathways within the community and through our acute providers.
- Enabling our staff to work at the top of their licence, introducing new roles and standardising roles.
- Reducing the number of people staying in hospital for a very long time
- Focussing on how we use our drug budgets.
- Using our clinical expertise and tools such as the GOLD diagnostic to identify services that can be provided across providers.

Managing demand

- Support to GPs and consistent referral arrangements.
- Working with our new primary care networks and integrated care partnership to drive this consistent and proactive approach.
- Developing alternatives to A&E so patients and professionals feel confident being cared for outside hospital.
- Developing a more proactive approach to managing long term conditions.
- Better detection of cancer.

2.1 What people have told us

Both nationally and locally staff and patients have helped develop the NHS Long Term Plan. NHS England shaped the focus of the plan through engagement with over 3.5 million people.

Locally we have spoken to more than 1750 people over the last four months to help form our local response.

NW London Healthwatches held 18 events and spoke with 257 local people, ensuring that local issues, concerns and understanding of what is working well has been captured in our plans for improving health and care services over the next five years.

Engagement teams across the NW London health and care partnership have also asked local people for specific feedback on this plan. The team spoke to people at community events, in shopping centres, A&E and outpatient departments, GP centres and public focus groups. They captured views and used the sessions as a good opportunity to tell people about some of the work that has already been undertaken to improve service access. 500 people have completed written feedback forms on our plan.

On the whole there was support for the aims of our plan, but there are fears about the affordability of the ambitions.

'You said we did'

Feedback from both the Healthwatch events and our health care partnership engagement is reflected throughout this report, under each chapter with the heading:

'What do we know people are concerned about?'

Each chapter then looks at programmes of work over the next five years that will address and improve upon feedback provided.

Full reports of these two engagement exercises can be read here.

Key learning from the Healthwatch engagement report:

Communication – local people would like:

- Good levels of communication.
- Information that is consistent, accurate and up-to-date.
- Clear oral and written language and information in accessible formats.

- Choice of electronic, oral or written communication.
- To be aware of existing services, and advised on which to use.
- Timely information and engagement on service changes.
- Engagement between services and the 'wider community'.

Staffing, training and continuity – local people would like:

- Good working conditions and working environment for staff (example, employers to observe the 'Anchor Organisations' principles).
- Adequate staffing levels and well resourced specialists.
- A well trained workforce (both hard and soft skills).
- Continuity (choice of professional) if required.
- A named contact.

Service access – local people would like:

- Good telephone access.
- Reliable and easy-to-use booking systems.
- Punctuality of services and communication from staff when this is not the case.
- Priority for those with a particular need (such as Autism).

Coordination and consistency – local people would like:

- Consistency across services.
- Services in different localities, and of different specialities to work together.
- Staff to be aware of, and actively utilise Health Passports.

Local people would also like:

- Recognition of their disability, condition or need.
- To be included, involved and respected.
- Good levels of awareness (training for staff).

This, our local response to the NHS Long Term Plan, includes work that is already in motion, that we are looking to further implement and improve. To ensure that we are developing programmes that are right for our local communities, we have an on-going engagement programme, both going out and meeting people and using online surveys to capture views on specific topics. Patients and public representatives also make up the membership of all of our leadership boards and working groups. This plan has been developed using the insight and feedback captured through all of these channels.

The publication of this plan and our priorities for the next five years does not by any means mark the end of our engagement on the areas of work included. This is just the beginning and as we further develop and implement programmes we will continue to work with staff, patients and the public, to ensure we shape and tailor the right support, services and outcomes for people in NW London.

To ensure that more people than ever before can comment regularly on our work, we are developing a citizen's panel that will launch in 2020. This panel will be in addition to our current engagement activities and will be made up of 3000+ patients and public representatives from across all walks of life. We hope this panel will help improve the diversity of our engagement and capture a broader range of views into our work.

Through this plan we want to deliver care and services to all residents of NW London were all interactions generate positive responses like these captured by the Healthwatch report:

"There is a course for informing people about avoiding diabetes – very good for prevention and awareness."

"It's easier to book online or in person (than it was)."

"I got a telephone triage – I phoned, described my symptoms and they were able to tell me if I needed to come in. Very good service."

"My pharmacist gave me a 'My Medication Passport' – excellent idea!

"GP did a good initial assessment and sent to the hospital, where I was diagnosed with a serious condition the next day and operated on."

"I felt listened too and the support I was provided really helped me get back on track."

2.2 The London vision

Working together to make London the healthiest global city, and the best global city in which to receive health and care services.

London is a major global city that is dynamic and diverse. Like many big cities, London offers a wealth of opportunities for people to lead healthy and happy lives, but it also presents issues and challenges to health. In London, where there are significant and persistent inequalities, these issues and challenges are experienced most by those in our most deprived neighbourhoods and communities. That is why concerted and coordinated efforts are needed across public services and wider society to make the most of opportunities for good health, and to tackle the issues that cause poor health.

We are working as part of partnership, which is made up of the Greater London Authority, Public Health England, London Councils and the National Health Service (NHS) in London. It exists to provide coordinated leadership, a shared ambition to make our capital city the world's healthiest global city and the best global city in which to receive health and care services. This is because no single organisation can achieve this alone, and shared action makes us greater than the sum of our parts. We have formed our partnership in order to address priority issues that require pan-London solutions, to support pan-London actions that enable more effective and joined-up working at the level of the neighbourhood, the borough and the sub-regional system, and to make the most of the very direct social, economic and environmental roles we each play as major anchor organisations in London. Initiatives such as the Thrive LDN mental health movement, child mental health trailblazers, school superzones, and the London Estates Strategy show just what can be achieved when we work together.

Building on significant work between our organisations over several years, our London Vision sets out our proposals for the next phase of our joint-working. It reflects the Mayor's Health Inequalities Strategy, London Councils' Pledges to Londoners, the Prevention Green Paper and the NHS Long Term Plan. It highlights ten key areas of focus where we believe partnership action is needed at a pan-London level. This includes issues such as air quality, mental health and child obesity, and we set out our ambition for deeper and stronger local collaboration in neighbourhoods, boroughs and sub-regional systems so that services are genuinely integrated, and Londoners can start well, live well and age well. Our Vision is not a description of the multitude of actions that are taking place locally, nor a population health plan, rather it sets out the areas where our shared endeavours seek to complement and add value to local action.

Areas of focus for pan-London working: summary of commitments

Details of local commitments to each of these actions can be found in chapters 5 and 6.

Area of focus	Commitments
Reduce childhood obesity	• We will achieve a 10% reduction in the proportion of children in reception (age four or five) who are overweight by 2023/24, delivered through bold citywide actions and targeted support for those most at risk
Improve the emotional wellbeing of children and young people	• We will ensure access to high quality mental health support for all children in the places they need it, starting with 41 Mental Health Support Teams in schools, maximising the contribution of the Mayor's/GLA's Healthy Schools London Programme and Healthy Early Years London Programme, and extending the use of digital support technologies.
Improve mental health and progress towards zero suicides	• We will ensure that all Londoners have access to mental health care, support and treatment, especially those experiencing health inequalities
Improve air quality	• We work together to reach legal concentration limits of Nitrogen Dioxide (NO_2) and working towards WHO limits for particulate matter$_{2.5}$ concentrations by 2030.
Improve tobacco control and reduce smoking	• We will speed up a reduction in smoking prevalence in London, especially among groups with the greatest health inequalities
Reduce the prevalence and impact of violence	• We will work collaboratively with the London Violence Reduction Unit to develop and implement effective ways of reducing violence, including addressing its root causes
Improve the health of homeless people	• We commit to drive action to improve, grow and innovate services that improve the health of rough sleepers, including expanding the pan-London rough sleeping services funded by the Mayor, building on existing good practice, piloting new models of care and data collection, and developing plans to build more integrated services in London
Improve services and prevention for HIV and other STIs	• We will broaden partnership working to focus further on tackling health inequality and a wider range of sexually transmitted diseases
Support Londoners with dementia to live well	• We will ensure that Londoners receive a timely diagnosis, ongoing support and are able to live well in their community
Improving care and support at the end of life	• We will ensure that all Londoners in their last year of life have access to personalised care planning and support that enables them to die in their preferred place

3.0 Our population

In NW London we have a population of over 2.4 million people.

Our population is diverse in many ways, both culturally and socially; with significant differences between those living with wealth and in poverty.

We are one of the most multicultural areas of the capital, around half of our population is from a black minority or ethnic background; and across some of our more central boroughs we also have distinct groups with differing health needs, homelessness presents a stark contrast to the large influx of commuters we see during the working week.

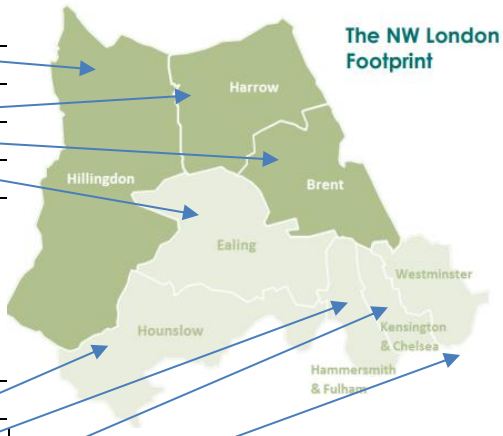
Each borough also has its own unique population profile, but within each of these areas are also many shared health needs. Understanding all these aspects of our population's health is necessary to develop the right services and support for everyone living and working in NW London.

NW London has:

- over £2.4million people
- an annual health spend of over £3bn
- 8 boroughs
- 360 GP practices
- 10 acute specialist hospitals
- 4 community and mental health service providers
- A range of voluntary sector organisations

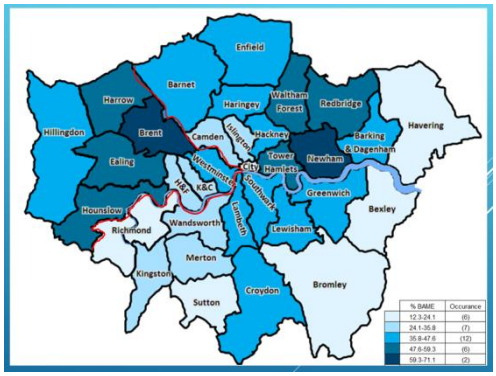
Borough populations

Each of our boroughs supports a different population size, with Brent, Ealing and Hillingdon having populations that are double the size of some of our central London boroughs.



316,000	
254,000	
336,600	
349,000	
	276,000
	182,000
	156,000
	253,000

Black and minority ethnic communities
In NW London we have some of the most multicultural boroughs in the capital.



Overview of poverty and inequalities across NW London

Out of 32 London boroughs all eight of our NW London boroughs have areas of deprivation and inequality that are rated as being the worst in London.

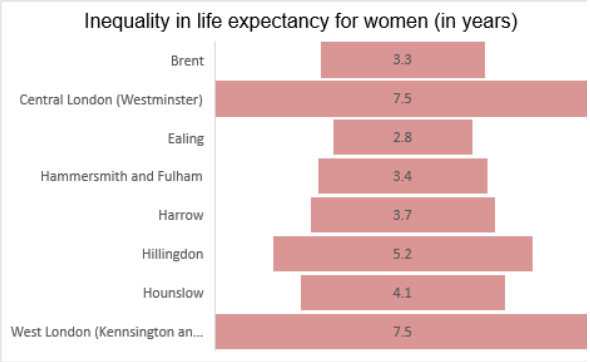
This interactive table compares poverty, child poverty, inequality, homelessness, temporary accommodation, evictions, affordability, unemployment, low pay, benefits, council tax support, GCSE attainment, infant mortality and premature mortality.

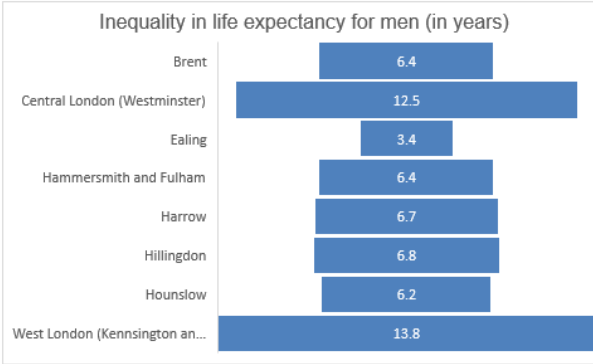
	Poverty rate	Child poverty rate	Income inequality	Pay inequality	Homeless acceptances	Temporary accomodation	Eviction	Housing affordability	Housing delivery	Unemployment ratio	Unemployment change	Low pay	Low pay change	Out-of-work benefits	Council tax support cut	GCSE attainment	Qualifications at 19	Infant mortality	Premature mortality
Brent																			
Ealing																			
Hammersmith & Fulham																			
Harrow																			
Hillingdon																			
Hounslow																			
Kensington and Chelsea																			
Westminster																			

Worst four boroughs
Next four worst boroughs
Next eight worst boroughs
Remaining boroughs

(Data source Trust for London)

The high rates of poverty and inequality are reflected in life expectancy between the most and least deprived communities and highlight dramatic differences across individual boroughs and across gender. Some NW London boroughs have the highest life expectancy differences in England.





Life expectancy compared to the national average

While life expectancy for many is very good, there are still areas we need to improve. The prevalence of cardiovascular disease is still a big killer and suicide rates in our central London boroughs are high compared to the national average.

Indicator	Brent	Ealing	Hounslow	Hammersmith & Fulham	Harrow	Hillingdon	Kensington & Chelsea	Westminster
Life expectancy at birth (male)	80.3	80.9	80	79.5	82.7	80.8	83.2	82.7
Life expectancy at birth (female)	85	84.6	84	84.5	85.9	83.8	86.2	86
Under 75 mortality rate: all causes	317	302	319	347	247	307	247	265
Under 75 mortality rate: from all cardiovascular diseases	91	77.3	83.1	67.7	55.7	73.8	44	60.3
Under 75 mortality rate from cancer	117.5	117.9	113.1	140.3	105	124.1	102.2	102.8
Suicide rate	7.4	9.8	10.6	13.4	8	11.2	9.5	8.3

Worse
Similar
Better

(Data source: Public Health England**)**

Key stats

Use of hospital or acute services

Since 2015, expected growth in our population has been outstripped by increased demand for hospital care. The NW London population has grown by 5%, while the numbers of people needing acute care has increased by 18%. In particular, unplanned care has risen by 25%.

Obesity

- On average a quarter of all our 10-11-year-old school children in NW London are obese and across all boroughs one in five of all children are obese.

- It's not just children across all boroughs we have high incidences 20-30% of obesity in all ages up to 65.

Diabetes

- This is also reflected in the high levels of diabetes also seen across NW London. With around 240,000 people or one in 10 diagnosed with diabetes or non-diabetic hyperglycaemia (NDH).

Smoking

- The number of people who smoke has reduced compared with previous years, but we still have on average more than 13% of our population smoking regularly.
- Smoking attributes to 1500 hospital admissions and over 350 emergency COPD admissions a year.
- The annual cost of smoking in NW London is estimated at more than £450million, including loss in productivity, NHS social care and fire services.

Alcohol

- On average 576 people per 100,000 of the population are admitted to hospital each year, with issues related to alcohol. That's around 14,000 people across NW London.
- More than 7000 children are living with alcohol dependant adults.
- One in five adults drink more than 14 units per week.
- 582 deaths and 7802 years of life are lost due to alcohol related conditions.
- The social economic impact is £3,847,418 a year.

A&E usage

- Over the last year 17/18 to 18/19 there has been a 3.4% increase in the numbers of people attending urgent and emergency (same day) care services. This includes A&E, urgent treatment centres and walk-in services. The total number of people who used these services last year was close to £1.2million people, with 567,000 people visiting an accident and emergency department. 198,000 people were taken to A&E by ambulance but this was a 2.4% reduction on the previous year.

Air pollution

- Urban environment issues such as congestion, air quality and high levels of road traffic accidents. Parts of the City are among the worst performers in air quality tests in Europe.
- In Ealing 7.2% of all deaths are related to long term exposure to particulate air pollution compared to 5.6% across UK.

- Carbon emissions in Hammersmith are the 6th highest in London and the proportion of deaths attributable to air pollution is estimated to be the 7thhighest nationally.

Maternity

- 30,000 babies are born in NW London every year. Giving every baby the best start in life is one of our main priorities.

Mental Health (children and young people (CYP))

- 32,287 CYP aged between 5 and 19 years have a mental health disorder.
- 16,671 females and 6,478 males aged between 5 -19 years show signs of an emotional disorder.

Developing our plan to support local needs

This section sets out key areas of challenge for our local population which have been addressed throughout chapters 5 and 6 of this plan.

4.0 New ways of working

NHS Long Term Plan says:

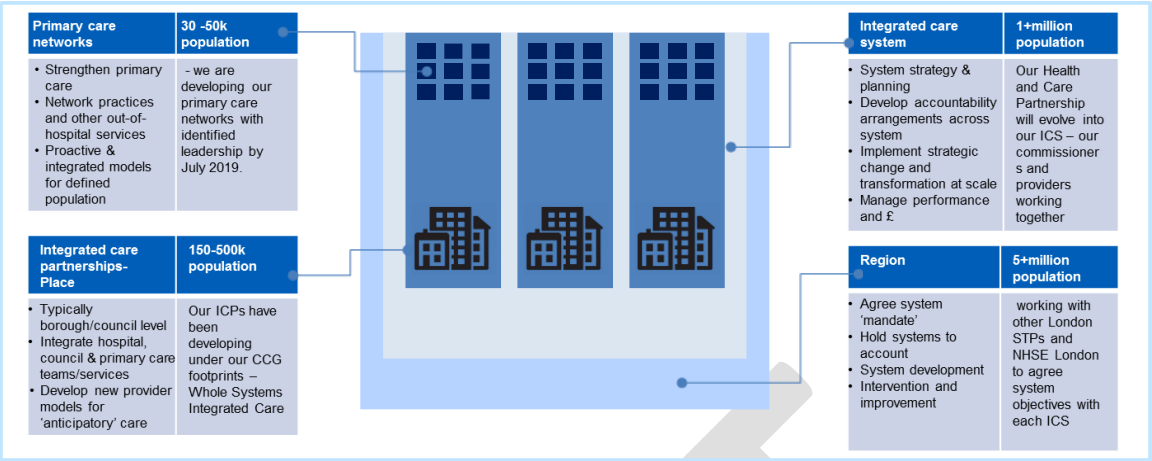
'We will continue to develop Integrated Care Systems (ICS), building on the progress the NHS has already made. By April 2021 ICSs will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships (STPs)….Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.'

As one of the pioneers of integrated care with our Whole Systems Integrated Care (WSIC) programme, health, council and voluntary sector partners have a long history of working together in NW London. We have seen the benefits of investing our energy and passion in co-creating and working with our local communities in a more integrated way for the benefit of all NW London residents and we want to build on this into the future.

Over the past 18 months we have formalised this joint approach as we work through our health and care partnership to become an Integrated Care System (ICS) and deliver our agreed vision of maximising benefits for residents and staff by:

- Giving every child and family the best start in life and continuing to support people to deliver healthy lives.
- Making sure there is care and support when residents need it.
- And for those who need to be in hospital ensuring they receive high quality care and spend the appropriate time there.

To deliver this vision we need to work as an integrated care system across NW London to ensure equity of standards, outcomes and provision for our residents whilst also developing strong place-based teams who are able to understand, adapt to and work with communities to improve the health of their populations. This place-based care is driven by our new groupings of general practices and community providers called Primary Care Networks (PCN), who are brought together into Integrated Care Partnership (ICP) within our boroughs.



Leading our health and care partnership

Effective system leadership is crucial to the success and impact of our partnership. If we are to achieve these new ways of working, we need to reimagine a future health and care system where our relationships across organisations and with our communities and partners are no longer based on delivery of activities and transactional relationships. Instead they need to be based on trust and transparency where we are all able to act and deliver beyond our organisational boundaries for the benefit of our communities and the system.

We have a strong leadership team:

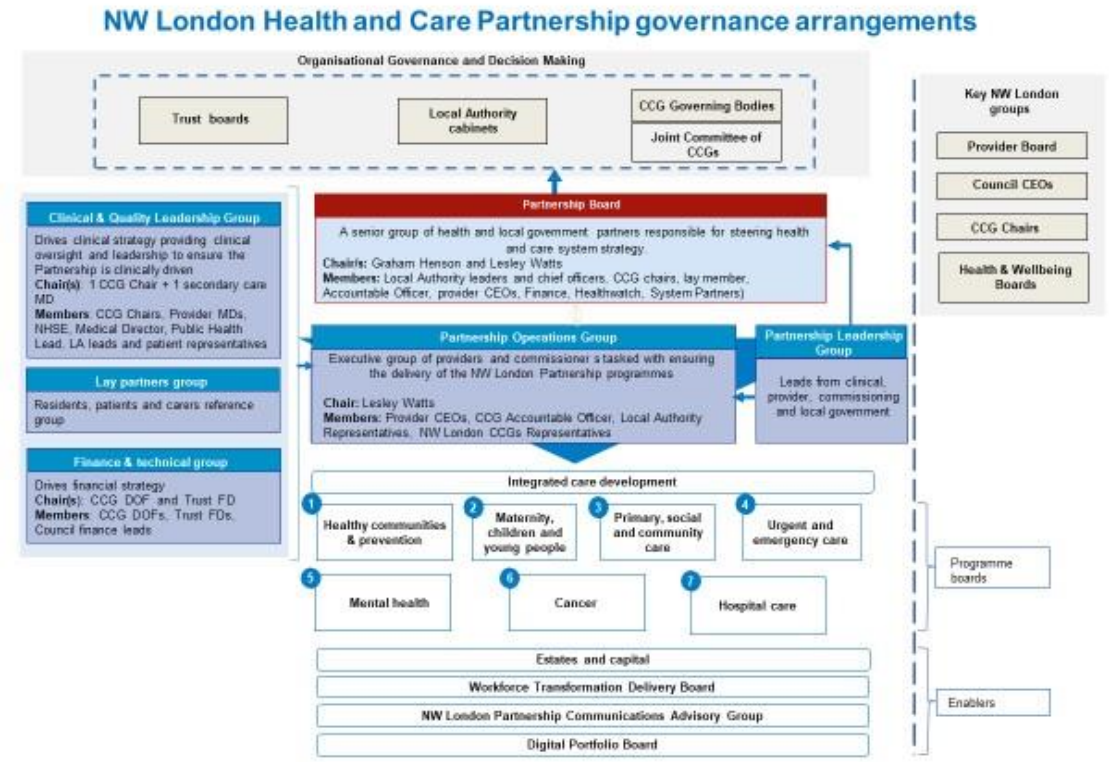
- Lesley Watts, CEO Chelsea and Westminster Hospital and STP Lead
- Mark Easton – CCG Accountable Officer
- Dr Mohini Parmar – Clinical lead
- Sean Harris – CEO Harrow Council and Council lead
- Supported by Juliet Brown – Health and Care Partnership Director
- Currently recruiting an Independent Chair.

We have formalised effective governance arrangements through our Health and Care Partnership Board and Partnership Operations Group. Our Partnership Board enables all partners to develop and inform our strategy whilst the Partnership Operations Group drives the delivery of our strategic priorities by directing our seven interconnected programme boards. These leadership groups are also informed by a series of system wide specialist groups:

- Clinical and quality leadership group that brings together medical directors, GPs, nursing leads, public health and others
- Lay partners group – patients, carers and residents
- Chief finance officers group
- Chief operating officers and managing directors
- Digital board
- Workforce board

- Lay partners group – patients, carers and residents

By bringing our organisational leads together we can pool expertise and best practice to develop and recommend policy and provide a consistent system approach.



Developing further as an Integrated Care System

NW London intends to become an Integrate Care System by April 2021. With a clear vision and robust governance arrangements supported by a well-developed population health approach, we are well on our way to achieving this goal. Working with NHS England/Improvement we have undertaken a maturity assessment to agree further areas to focus and we are now working with the national ICS Accelerator programme. This programme is focussed on realising the benefits of an ICS; promoting financial sustainability and developing clear vision. This will be achieved through the clear alignment of our primary care networks and integrated care partnerships through to our ICS. Promoting and encouraging strong community and place-based care, and by clear areas for system focus so as to ensure equity of provision and experience for all residents in NW London.

Developing a system approach to commissioning

Subject to the necessary approvals we will move to create a single clinical commissioning group (CCG) for NW London from April 2021. We see this change to the way our CCGs operate as an opportunity to streamline systems and processes, reduce duplication and improve the consistency in our offer of care to NW London

residents. In doing this, we will learn from the experience of previous large-scale operating models, ensuring that we maintain a strong focus on public and stakeholder engagement in each of our eight boroughs.

A system of health providers coming together

In NW London we have four acute trusts, two community trusts and two mental health and community trusts all of which offer a wide range of high-quality specialist and more general services. The reputation of our services and clinicians is such that they attract people from all over the world both to work within services and to seek the care that is offered.

However, with increased specialisation, workforce shortages and a challenging financial environment we need to work differently if we are to continue to deliver world class services and achieve the ambition of London being the healthiest global city.

Working as a system affords us opportunities that are not available to us if we work as competing and separate organisations. Working as a system we are able to pool our clinical expertise, share best practice, standardise care pathways, and maximise opportunities from technology so that our population are able to access the same high quality care wherever they live in NW London and that we can continue to attract the highest calibre workforce and build on our reputation as offering international centres of excellence.

Over the past years we have been increasingly developing this way of working. For example:

- community providers are developing common pathways and standards for rapid response services - so people are able to get equal access to crisis care in their homes
- Imperial College Healthcare and Chelsea and Westminster Hospital have brought together clinical leaders to develop HIV services
- all our acute service providers have been working with GPs to develop common guidance for use of outpatient services.

Increasingly we will work across our organisational boundaries to ensure we are harness our optimising and ensuring best value in our specialist services.

Delivering the financial stability required to be a successful Integrated Care System

Working collectively as an integrated care system affords us new models to facilitate the delivery of our challenging transformation agenda to drive improved quality and financial sustainability. Aggregating control totals across our organisations, incentivises partners to work together and release the synergy presented by taking a system approach.

Our aim is to work as two clusters embedded within our ICS and supported by our integrated care partnerships, outer NW London and inner NW London. These clusters bring together providers and commissioners grouped around the common issues that are driving inequality of expenditure and higher demand in the cluster.

4.1 Communities as the building block for integrated care (Developing ICPs)

The majority of services will continue to be planned and coordinated at a borough level where: local health, council, voluntary sector and resident partnerships take shared responsibility to improve the health and care system for their local population - linking health, social care and the wider determinants of health. Through integrated care partnerships and working with their constituent primary care networks, partners will plan, develop and coordinate services based on agreed outcomes.

All areas are actively meeting and working to develop local plans based on local population needs and this section summarises the arrangements, priorities and ambitions of each integrated care partnership.

In this section you will find information on the development of integrated care partnerships in each of the eight boroughs across NW London.

- Brent
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- West London
- Westminster (Central London)

Brent Integrated Care Partnership (ICP) DRAFT

Our partnership

Our partners include:

- Primary Care (10 Primary Care Networks (PCN) and 3 GP Federations)
- Lay Members
- London North West University Hospital Trust
- Imperial College Healthcare Trust
- Royal Free Foundation Hospitals Trust
- Central and North West London Mental Health Trust
- Brent Council
- Voluntary Sector (CVS, Age UK)
- HealthWatch Brent

Our scope

Through engagement with key stakeholders across the health and care system and an analysis of the Brent population, an ICP model of care has been developed to deliver the required care needs to a defined cohorts of patients – complex and 'rising risk' patients aged 18 and above with one or more long term condition.

The ICP will deliver a wide scope of out-of-hospital care, based on a close partnership of organisations working under a single capitated budget and being responsible for locally devised outcomes.

Our vision and values

To build an ICP that will take collective responsibility for the health outcomes and use of resources for the people of Brent.
This means:

- Preventing as much ill health as possible
- Focusing care in the right place and right time
- Treating as much in the community as possible.

This is to be facilitated by:

- More joined up and co-ordinated care achieved through ending the historic divide between acute, community and primary care leading to fully integrated enhanced community teams built around the PCN
- Much greater emphasis on more proactive care - underpinned by population health management.
- Much more tailored and differentiated support for individuals and their health needs giving people more control over their own health, more personalised care and digitally enabling their interactions with services.

Our partnership focus

Through putting patients at the centre of our care we can better support patients to increasingly self-manage their care where possible, avoid unnecessary and inappropriate use of services and improve patient's experience of and engagement in their care – leading to better outcomes.

Our approach is based on the following principles:

- **Collective responsibility** across the system for the health and care and outcomes for a population.
- **Accountability** of all members of the team for the patients and the use of resources
- Treating all resources across the system as **collective assets** to be used for the health of the population.
- **Collective co-ordination** of health and care interventions and pro-active working to prevent need.

Delivering our model of care

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Resources
- Increase in clinical capacity
- Using partners where there will be an impact on NEL
- Maintaining understanding of relevant partner offers and how to use them

Continuity
- Knowing patients well enough to pick up the signs of change
- Improved recruitment and retention

Information
- Communications – live sharing of information
- Responsibility and accountability for acting on shared information

Community
- More engagement of assets in the community needed
- PCNs need to remain connected to other levels (network, borough)

Accessible care
- Facilitating access is a responsibility for all the team (from receptionist through to GP)

Skills
- More flexibility – with the skills for the population needs – people need to be less role bound and have skills to support this
- Learning and development, clinical support, supervision and reflection will all need to support day to day and working differently

Co-ordination
- Always working around the patient (pro-active care plan)
- Part of the same team – alignment to the patient cohorts
- Frequency of MDT involvement

Working culture
- Changed mindset and culture
- Commitment to new ways of working
- Motivation and permission to innovate needed
- Moving away from the current contract drivers– currency of referral and task not care and outcomes (transactional)

Our Model of Care

The model of care is being delivered through:
- Consultant and GP led virtual ward rounds
- Multi-disciplinary case management for up to 6 weeks.
- Comprehensive care planning accessible to community and GP teams
- Community based consultant-led elderly care hot clinics
- Expansion of clinical capacity in the ICP team
- Alignment of District and Specialist Nursing (plans to link in with Practice Nursing)

Achievements 2019-20
- Develop approach to population health management
- New model of care agreed
- Embed communications and engagement strategy
- Pilot ICP model with 4 PCNs

In Progress 2019-20
- Development of outcomes framework
- Development of finance and contracting options
- Brent-wide ICP coverage by November 2019
- Defining the scope of formative evaluation to support continuous improvement

Ealing Integrated Care Partnership (ICP) DRAFT

Our partnership

Ealing Integrated Care Partnership (ICP) is formed of the following organisations all working in the Borough to improve, commission and/or provide care:

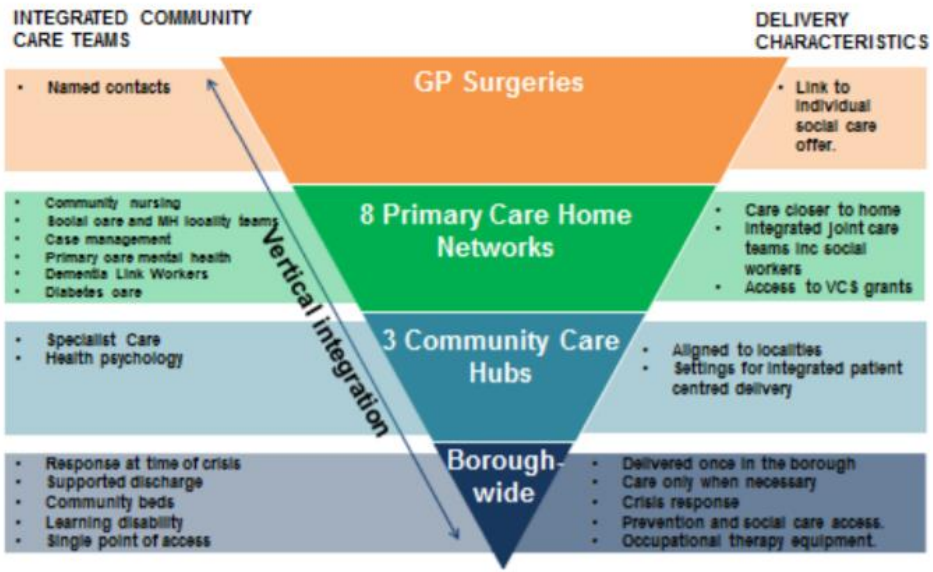
- Ealing CCG
- Ealing Local Authority
- Ealing Community Partners
- West London NHS Trust
- Ealing GP Federation and Primary Care Network Directors
- Central London Community Healthcare NHS Trust
- Ealing Healthwatch
- Voluntary Sector
- Acute partners

Our Acute Partners

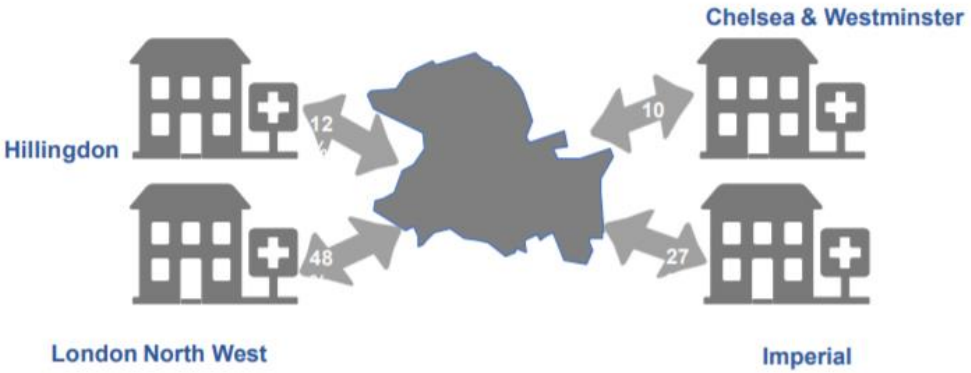
Ealing ICP is committed to working with all our acute partners, recognising that people in Ealing **access hospital care across NW London.**

Ealing ICP will **work through planned care pathways & A&E/urgent care delivery boards for each hospital system** to ensure clear pathways of care are in place to support the needs of patients, to deliver optimum care across the health economy via appropriate demand management and timely discharge from hospital.

Ealing CCG and Ealing local authority is focused on developing a model of care that has been enabling our residents can access the right support, in the right place, at the right time and with the right level of intervention together through the BCF but more broadly through the commissioning each of the organisation's has undertaken.



All partners would recognise this as a developing model of care, for adults which will need further development and iteration. All partners would recognise particular challenges in demographic growth and increasing needs across both children's and adult services.



Our vision and plan

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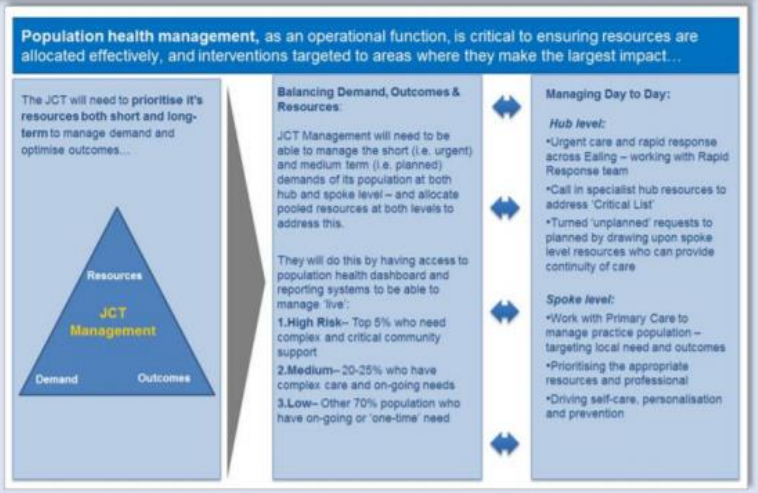
Ealing Integrated Care Partnership is committed to working together to:
- **Improve health, wellbeing and independence, and reduce inequalities** for Ealing Residents through delivering the health and wellbeing strategy
- **Improving the experience** of people accessing health and care in the Borough
- **Delivery of high quality care** across the Partnership
- Creating a **sustainable care system** in Ealing

Our model addresses the health and wellbeing gap: Taking a population health management approach, using tools including the Whole Systems Dashboards and shared analytics: we will identify patients who will most benefit from our intervention, supporting them to maintain independence.

We will support population health management by:
- Work jointly to understand our local population needs via our joint strategic needs assessment (JSNA)
- Risk stratification and predictive modelling
- Enabling access to population health dashboards and reporting systems to 'live-manage' patients, deploying resources to match demand. All partners including the LA contribute data for this purpose
- Focus on inequalities and wider determinants of poor health, and healthy lifestyles by engaging with patients, promoting prevention/self-care and working with local authority/VCSE organisations.



Our areas of focus

Sustainability, improving efficiency and performance
- Including best use of resources and our joint focus on urgent and emergency care system use

Improving service quality
- Ensuring that our out of hospital services deliver the best possible care

Service and system transformation
- Delivery of agreed milestone and transformation plans

Financial Recovery
- Ensuring all organisations deliver budgets to plan

One public estate
- Getting best use of all public estate and minimising void costs
- Working together to address the challenges of increased residential developments.

Our principles of integration

- Collaborative leadership
- Subsidiarity - decision-making as close to communities as possible
- Building on existing, successful local arrangements
- A person-centred and co-productive approach
- A preventative, assets-based and population-health management approach
- Achieving best value
- Equitable.

Hammersmith and Fulham Integrated Care Partners DRAFT

Since an initial integrated care pilot scheme in 2011 health and care partners and local people working together to develop and sustain healthier and happier individuals and communities

Our key values are:

- Coordinating and providing services around people's needs
- Enabling people to look after their own health and wellbeing and to make active and informed choices and decisions
- Focusing on health and wellbeing outcomes at different stages of people's lives
- Taking a proactive and preventative approach to health and wellbeing
- Fostering a culture of open and honest conversation and constructive challenge
- Thinking and acting as a health and care system, not as individual organisations and services
- Sharing resources and assets in the most efficient way to sustain services for future generations.

Local NHS organisations, the local authority and voluntary and community organisations have formed a partnership with the shared aim of working with people to improve:

- Their health and quality of life
- Their experiences of health and care services
- The use of our collective resources and assets to ensure financial sustainability of the system
- Staff wellbeing and fulfilment.

Building on the long history of partnership working six organisations have formally come together through an **Alliance Agreement** covering the registered population of Hammersmith and Fulham.

Formal partners:

- Hammersmith and Fulham GP Federation
- Central London Community Healthcare Trust
- West London Trust
- Imperial College Healthcare Trust
- Chelsea and Westminster Foundation Trust
- Hammersmith and Fulham CCG

Associate partners:

- London Borough of Hammersmith and Fulham
- *Sobus (a community development agency)*

ICP & PCNs will develop outcomes together

We do this by:

- Designing, developing and delivering services with local people, patients and communities
- Developing up-to-date, safe and efficient information and systems, so that knowledge about patients is available in the right place at the right time
- Developing communication and information sharing systems for staff across organisations to improve coordination
- Enabling staff to work in new ways and different care settings, leading to new development opportunities in order to deliver more joined up care.

H&F GP Federation

NHS Central London Community Healthcare NHS Trust

NHS West London NHS Trust

NHS Imperial College Healthcare NHS Trust

NHS Hammersmith and Fulham Clinical Commissioning Group

NHS Chelsea and Westminster Hospital NHS Foundation Trust

Our governance arrangements

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ICP board

Ensures alignment and shared decision making of all parties to the ICP and oversees the work established to deliver the ICP ambitions.

The board is comprised of the individual partners board committees or executives delegated from each partner

It also includes local authority, lay partner and voluntary sector representatives.

ICP management group

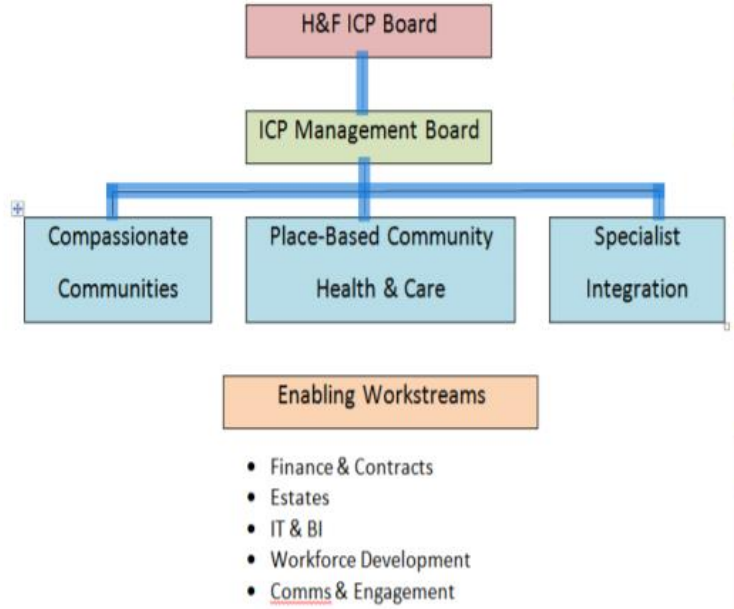
Oversees the operational and clinical workstreams and direct the project groups established for each of the workstreams.

Includes representation from clinical and managerial staff from each of the partners alongside the local authority, lay partners and voluntary sector representatives.

Pooled resources

The partners have pooled resources to joint-fund the ICP manager and administrator posts as well as 'back-filling' GPs for workstream support

H&F ICP GOVERNANCE



Initial areas of focus (2019/20)

Compassionate Communities	•PCN link workers recruited – September 2019 •Borough Level Social Prescribing Architecture – September 2019 •Macmillan Investment Application – October 2019
Integrated Community Teams	•Staff allocation by PCN mapped and agreed – August 2019 •Overarching operating model for the borough developed – September 2019 •PCN Level milestones agreed – September 2019
Integration of Acute Services	•Business case for first PCN developed and approved – September 2019 •Implementation of initial 'priority' pathways – March 2020 •Business case for on-going implementation and expansion to other PCNs – 2020/2021
Integrated Care Champions	•Wormholt Park Summer Fete and Live Well Fair – September 2019 •Champions workshop to develop future plans – September / October 2019

Harrow Integrated Care Partnership (ICP) DRAFT

Our partnership

Our partnership is underpinned by a strong patient, public and wider stakeholder engagement strategy, ensuring that excellent patient experience, equitable access and high quality health and care outcomes for everyone in Harrow.

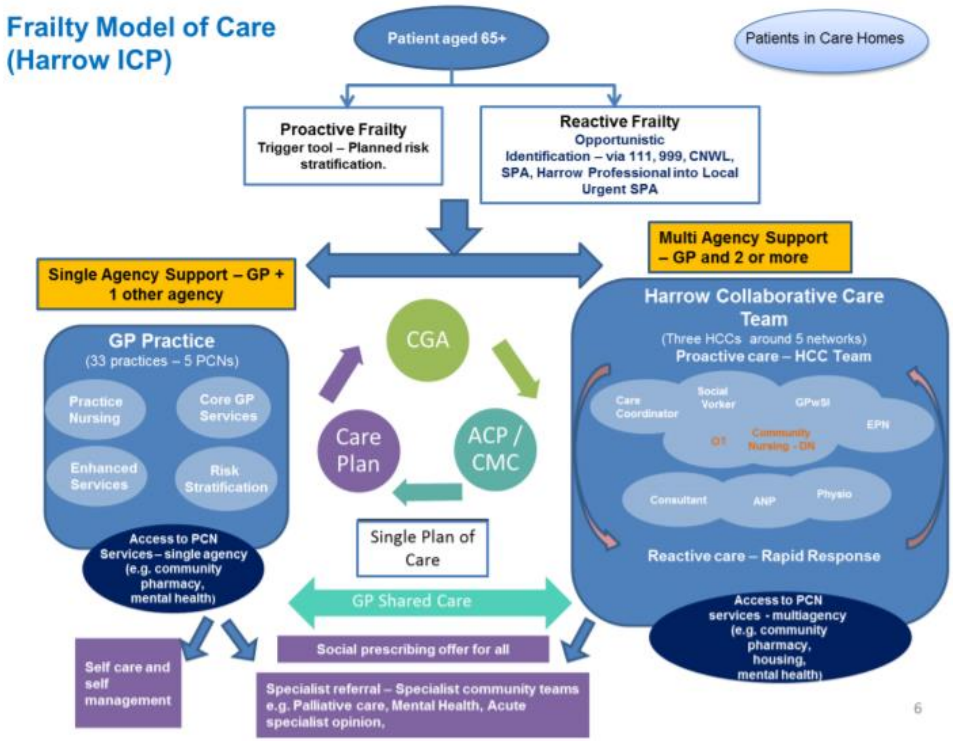
Our partners include:

- CLCH
- CNWL
- Harrow CCG
- Harrow Community Action (Voluntary Sector Consortium)
- Harrow Health CIC
- Harrow Council
- LNWUHT
- St. Luke's Hospice
- Harrow Patient Participation Network – three patient representatives
- 5 Harrow PCNs: engagement started since PCNs were established in July, interface with ICP governance is suggested to be one PCN Clinical Director per governance level representing all PCNs.

Partnership commitment:

- Initial MoU signed: May 2017 for the Integrated Care *Development* Programme
- Understanding and confirmation of provider and commissioner roles within the integrated care partnership has successfully taken place (April – June 2019). A new governance structure has been developed to facilitate the transition from development to delivery, and enable the providers to take ownership for the design and delivery of new models of care
- There has been strong commitment and excellent engagement from all health and care partners across the Harrow system.

Frailty Model of Care (Harrow ICP)



Our priorities

- Prevention
- Early diagnosis and self care
- Primary care management and surveillance
- Crisis management and unplanned care
- Last phase of life

Our scope for 19/20

- 65+ with moderate-severe frailty
- 65+ with dementia
- 65+ in care homes
- 65+ mostly healthy
- 18+ in palliative care
- Adults 18-64 with MH needs (Primary and Community Mental Health Service)

Our vision and plan

DRAFT

As a person, I would like to experience a single seamless service and that helps me to manage my health and wellbeing, recognises that my family and carers matter, and anticipates and responds to my needs from assessment through to support.	**As professionals,** we will work together with pride to deliver a high-quality, value-for-money, joined-up health and care service, that supports our population to manage their health and wellbeing, and anticipates and responds to their needs in the right place and at the right time.
Defining the care model: Dissolving the traditional boundaries between health and care services. Incorporating the wider determinants of health to ensure a quality-driven approach to care delivery focused on prevention, citizen empowerment and support for self-care, to free resources to target those with the most complex needs.	**Securing the delivery infrastructure:** Primary and community workforce will be strengthened and remodelled with multiagency roles working to a new culture delivering care in partnership, digital transformation and estates solutions for both how we work with each other and how we provide care for patients.
Taking a population based approach: To increasingly focus on an outcomes based approach in the commissioning and delivery of out of hospital services across partnerships to align delivery, reduce health inequalities and unwarranted variation in outcomes in the services our local population access.	**Securing the foundations for integrated care:** the development of Primary Care Networks (PCN) as the foundation and bedrock for the development of integrated care. Wrapping extended multi-agency and multidisciplinary team based care around these for their local population and in partnership with local community and care providers.
Provider mobilisation: delivery of a transformation programme to implement a multispecialty community provider (MCP) style model that enables our community providers to provide joined up care services as assessed by the ISAP and Population Health Readiness Tool. Realignment of Community Education Provider Networks (CEPN) to support training and roles for out of hospital services.	**Aligned contracting approach across Harrow (health and care) to deliver integrated care:** To ensure the strong delivery a consistent population health approach through the commissioning of all services in Harrow realising the opportunities presented in development to wider system transformation.

September 2019	October 2019	December 2019	January 2020	March 2020	April 2021
Development of framework to determine RoI and impact of frailty model. System agreement, mandate, accountability and ownership of the integrated care partnership	Agreement of PCN representation in ICP governance Preparation for partners to approve/sign Alliance Agreement in November 2019	Primary and Community Mental Health Teams Go-Live. CCG QIPP confirming 20/21 deliverables for ICP	Dementia post-diagnosis model and care homes improvement model for implementation. Next population segments & service specifications for integrated care models	Frailty trigger tool and frailty model implemented across Harrow for 65+	Harrow Integrated Care Partnership operational (Alliance Agreement signed and functional)

Hillingdon Integrated Care Partnership (ICP) DRAFT

Our partnership

- Hillingdon 4 ALL (H4ALL) – voluntary sector consortium (Full Partner)
- Hillingdon Primary Care Confederation – Primary Care (Full Partner)
- Central North West London NHS Foundation Trust – Community & Mental Health (Full Partner)
- The Hillingdon Hospital NHS Foundation Trust (Full Partner)
- Hillingdon Clinical Commissioning Group (Integrated Planning, Transformation & Delivery)
- London Borough of Hillingdon (Operational Alignment – to be ratified)

Our partnership focus

Our values are based on being **connected, collaborative and open** (as prioritised by our residents and front-line staff)

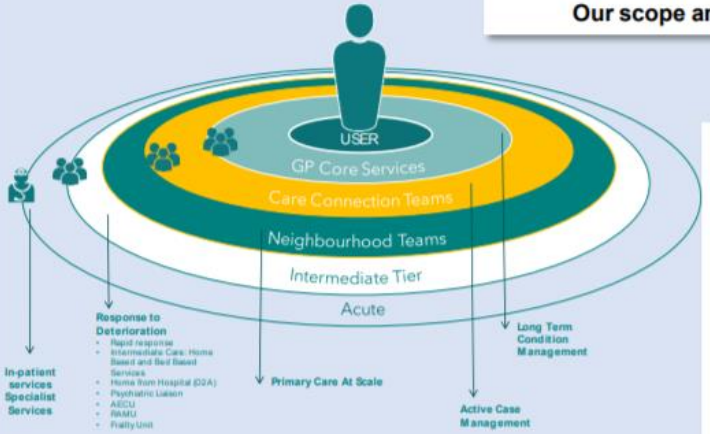
Our overall integrated model of care is based on the delivery of **comprehensive personalised care agenda** – allowing us to support people and their families. This means:

- Our original partnership started in 2017/18 with a focus on **+65 population** and the development of care connection teams and integrated discharge as our priority partnership areas.
- The scope of work for our Integrated Care Partnership (ICP) was extended in 2018/19 to cover all adults in order to further improve **urgent care performance** and flat line non elective growth (in scope services circa £100m).

An Integrated Business Case (IBC) and model of care was co-produced and approved by all sovereign boards in 2018/19 setting out a range of key priorities for the further development of a Hillingdon Integrated Care Partnership (ICP) for 2019/20:

- The implementation of a new target operating model for integrated care based on eight primary care led **neighbourhoods** aligned to PCN's with joined up physical and mental health care and aligned social care;
- The population segmentation and **active case management** of the 5,500 Hillingdon Adults most at risk of a non-elective episode and who drive 50% of all non-elective activity.
- Investing in voluntary sector, primary care and community health services to create the home based alternatives to a hospital admission through both our neighbourhoods and borough-based '**intermediate tier**' configuration which focuses on the '2 hour, 2 day' standard.
- **'System-Based' financial framework** – we are working on a cost-based approach and borough-level deficit reduction for all partners. There is currently a unplanned care risk & gain share agreement in place for 19/20 to further incentivise partnership working and reduce system-based deficit.
- As of September 2019 – we will be extending the scope of our ICP to cover all **planned care, children's and young people (0-25), mental health and learning disabilities** to cover the whole population of our borough.

Our scope and model of care



We are rolling out integrated primary, community and acute care management focused on:

- High intensity users
- Care homes
- Falls and frailty
- End of life care and
- Ambulatory care Sensitive Conditions.

Our collaboration and achievements

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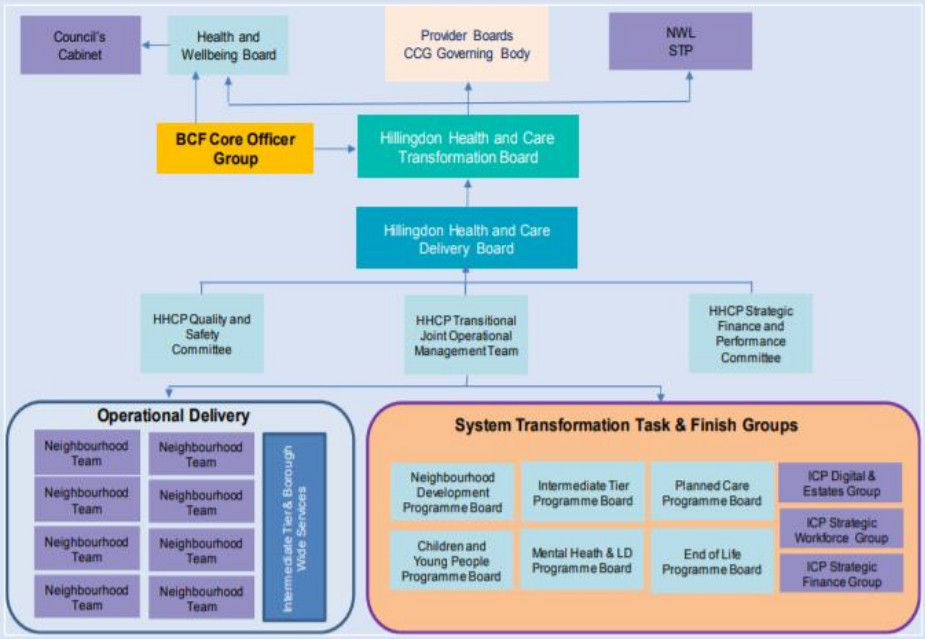


We **collaborate** through:

- Place-based governance – and place-based financial control total starting 20/21
- Alliance agreement – including Integrated Management across providers and CCG
- Integrated management teams at operational and front-line level
- Virtual lead provider contract for 20/21 – and to go live for April 2021
- Joint Commissioning between Hillingdon CCG and London Borough of Hillingdon– working through our Better Care Fund to deliver CYP, MH, LD and Older People care and support.

2017/18

Care Connection Teams have reduced both non-elective admissions (flat lining growth) and A&E attendances (a 35% reduction) for the in-scope 65+ cohort of patients.
The Partnership successfully Implemented 'Discharge to Assess' resulting in a net reduction in the average LOS in THH for the 65+ cohort of 20% (from 10.7 to 8.7 days).

2018/19

Non elective admissions for the Hillingdon registered Adult population (18+) have reduced by 1% at year-end 2018/19 compared to 2017/18.
3% reduction in A&E admission rate for residents aged 75+.

2019/20

30% underperformance of A&E attendances and 8% underperformance on non-elective admissions admissions based on planned year-to-date (YTD) trajectory (based on non-validated month 2 data)

Hounslow Integrated Care Partnership (ICP) DRAFT

Our approach to integration

Joint vision

We want to set out that we work together because…

Shared challenges

Our shared challenges that we can only resolve by working together are….

Framework to work within

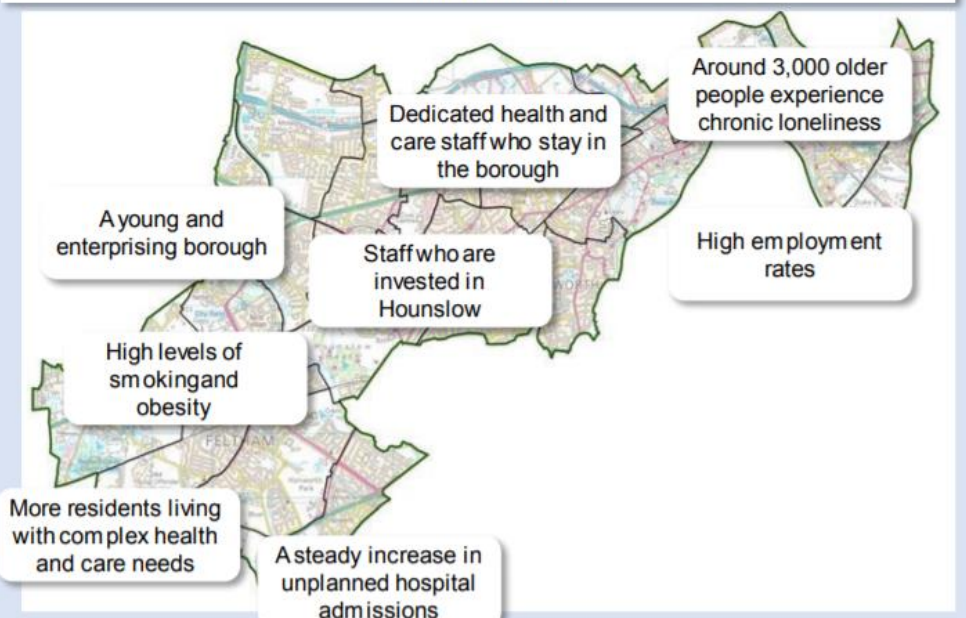
Our framework that enable us to work flexibly to realise our ambitions is…

Capacity

We release the capacity to deliver integration though new ways of working and behaviours that support that

We build on what we do well, release our staff to adopt integrated ways of working and support our residents to co-produce the changes

About Hounslow



Our triple aim

Goal 1
- Improve the care that Hounslow residents receive

Goal 2
- Improve the overall health of people living in Hounslow

Goal 3
- Make sure that we provide better value for money

Our partnership

London Borough of Hounslow

Hounslow Voluntary Sector Support Service

NHS Hounslow

NHS Hounslow and Richmond Community Healthcare NHS Trust

Chelsea and Westminster Hospital NHS Foundation Trust

healthwatch Hounslow

NHS West London NHS Trust

Local patient, service user and carer representatives

Our strengths and our key milestones

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Hounslow has strong foundations of developing the vision for Hounslow health and care system across partners and the public:

- **Principles of integrated care are well embedded in the Hounslow Joint Health and Wellbeing Strategy**

Ensure services are well coordinated within and between partners and that we work in partnership

- **Future-proofing health and social care in Hounslow co-produced and co-designed**

Developed across partners and service users in 2017 provided the strategic intent for integrated care, and sets out the vision for 2022 Hounslow Health System

- **Hounslow outline business case for integrated care shared with CCG Governing Body and all partners**

Outlined four priority areas for development; urgent care, high intensity users, home, preventing deterioration

- **Primary Care Network development**

The 'working together' partnership between HRCH and Hounslow GP consortium is supporting the establishment of primary care networks (PCNs) and primary care at scale.

2019/20	2020/21	2021/22	2022/23	2023/24
• Develop approach to population health management • Implement OD programme • Outcomes, new model of care agreed • Embed comms and engagement strategy	• Alliance agreement live • Further care models delivered • IG framework and agreement implementation	• Next wave of clinical services delivered at PCN level • Place-level ICP working within ICS • Active case management embedded	• Next wave of services developed and delivered at PCN level	• Develop and let alliance contract • Fully integration all services aligned with social care with population health management approach

West London Integrated Care Partnership (ICP) DRAFT

Our partnership

Our ICP will build on the work done by our Alliance to further reshape all care that is currently delivered outside of a specialist hospital, AND including "traditional" hospital outpatients – this is our opportunity to really stretch our ambition

Our Alliance partners include:

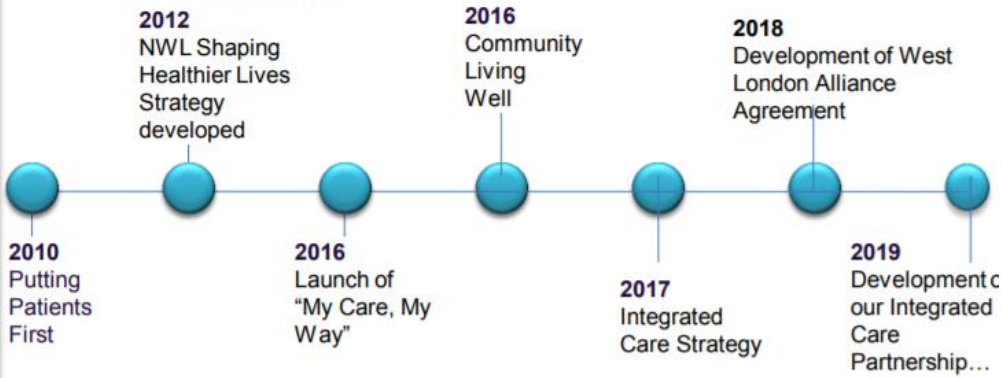
- Patients
- Primary Care
- KCSC
- LCW
- CLCH
- CNWL
- Imperial
- Chelwest
- Local Authority

Partnership commitment:

- Our partner commitment has been demonstrated since we started on our integration journey in 2010 with "Putting Patients First"
- Our third sector colleagues are equal partners, and we will continue to support their proven value interventions
- Scope will include NWL demand management as a priority and support the requirements in the NHS Long-Term Plan
- Public health and local authority will be key in supporting delivery of our ICP
- We will ensure our model is primary care led, responsive, promoting prevention, wellbeing and self- care
- We will focus on Intervening early to minimise deterioration, maintain health, optimising symptom management in line with patient lifestyle and choices.

2016
Community Living Well: Primary care led integrated mental health services, bringing together clinical and wellbeing services to wrap around the service user, with the GP having overall responsibility for care.

2018
Alliance Agreement: Developed with key partners, to support Integrated Community Team governance, management and delivery - testing and supporting new ways of working within our Alliance.



2015-16
My Care My Way: Focus on over 65s, primary care led service, providing case management and health and social care navigation, self care and social prescribing

2017
West London Integrated Care Strategy: co-designed with partners and service users, building "My Care, My Way" and "Community Living Well" to further support patients being proactively supported in the community

Our priorities

- "Get right what we are doing now" – Embed our ICT model for our complex older adult population to ensure full and consistent population overage across our ICP
- Focus on addressing non-elective activity – both attendances and admissions – to continue our support of system recovery
- Develop our mental health pathways such that they are aligned more closely to support unplanned demand
- Support our "at risk" working age adults through our North Kensington recovery work
- Getting the governance right– sharing skills according to need of patient accepting accountability and risk.

Our vision and plan

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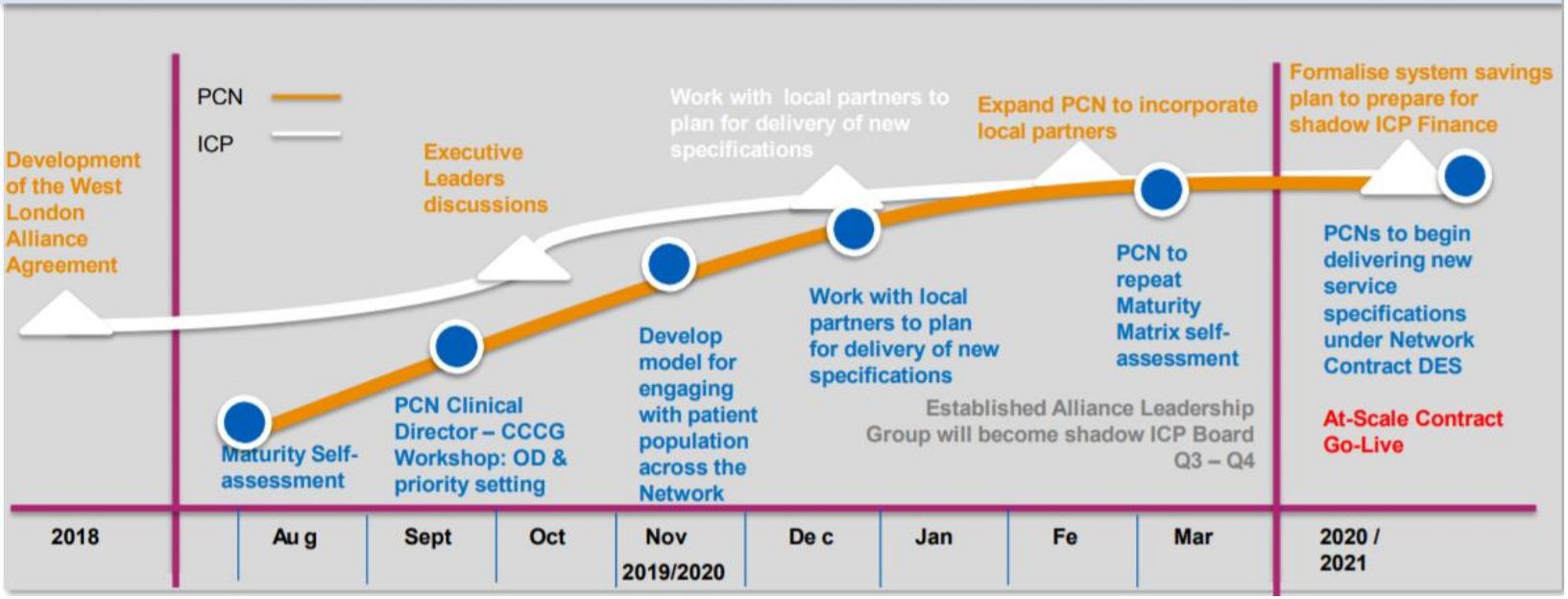
Our ICP will bring about a resolution and reshaping of today's fragmented system, that is expensive, affects quality and creates duplication.	We will reshape primary and community care, "front door" access and "back door" flow from acute services, including revolutionising outpatients
We will do this through patient leadership, clinical discussion and service redesign.	This will deliver our ambition to improve our residents' experience of care, enhance professional experience and support the long-term financial sustainability of our local care system.
A whole population model, one contract, with aligned priorities across organisations, and with an equivalent focus on mental, physical and the wider determinants of health, delivered by one workforce.	We will build on the principles of the "My Care, My Way," including the ICT for patients over 65, and the work already overseen by our Alliance Leadership Group.



Westminster Integrated Care Partnership (ICP) DRAFT

Our vision

Our ICP development is driven by our vision statement which sets out the purpose of the ICP as: *"Developing the best services for Westminster people focussed on providing better outcomes within the available resources."*

In particular this means:

People in Westminster will have tangibly improved clinical and wellbeing outcomes. We will deliver reduced health inequalities, reduced harm faced by patients and the same life chances regardless of location, income. Westminster also has a vision to improve the health of the poorest the fastest. There will be less variation in the care that people receive in Westminster and compared across North West London. People will have increased resilience to feel better able to manage their own care.

Westminster people will have improved access to health and care services, and services will make increased and better use of community assets. The care that people receive will be more holistic, looking beyond simply their health needs. This includes linking in with wider determinants of health such as housing and employment to improve overall wellbeing

We will maximise value – the best possible outcomes for the people of Westminster for every pound spent. This means moving away from looking at short term cost-cutting and to longer term value for money. We want to be financially sustainable across health and social care and make sure we are flexible enough to meet growing demand and demographic challenges within our budget. We will prioritise improved outcomes that are proactive and preventative.

Our challenges

Health and wellbeing in the borough is still characterised by inequality. This includes:

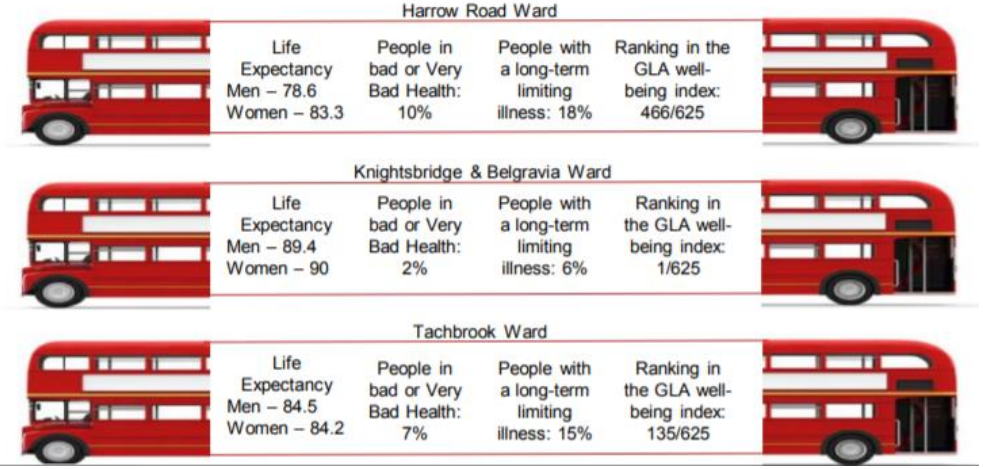
life expectancy – people in the most deprived parts of the borough have shorter lives, by up to 11 years for men and 7 years for women when compared to people in the wealthiest wards;

early deaths – approximately 1,200 residents die before the age of 75 per year, including from cancer, cardiovascular disease, and chronic obstructive pulmonary disease (and not including deaths from accidents and injuries);

quality of life – there is a significant burden of disability on quality of life in Westminster, including from Long Term Conditions, mental disorders, substance misuse, musculoskeletal disorders, and falls; and

the welfare of socially excluded groups – difficulties in accessing and navigating the local care system can be profound for people who are homeless, people with mental health conditions, older people and those from minority backgrounds.

Along the number 36 bus route in Westminster, life expectancy fluctuates. For men, it increases by eleven years between Queen's Park and Knightsbridge and then drops by seven years between Knightsbridge and Vincent Square.



Our scope and Model of Care

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Scope

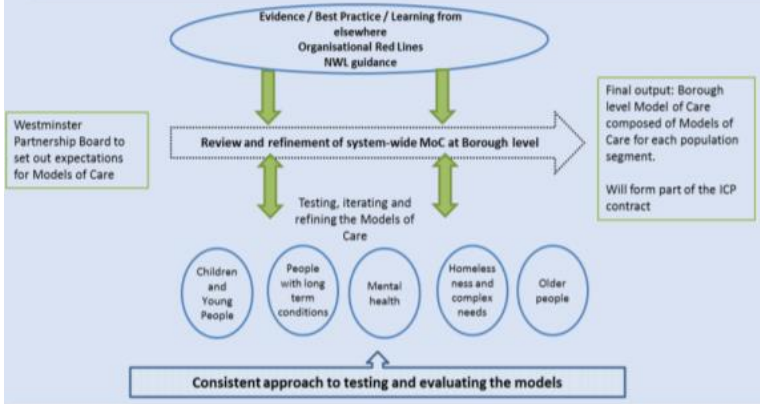
The initial anticipated scope of the ICP will cover:

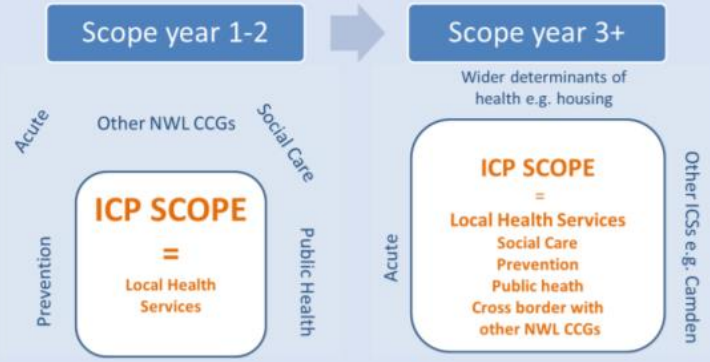
- community based physical health services for adults and children;
- the current Partnership in Practice (PIP) primary care contract
- CCG commissioned community mental health and learning disability services;
- end of life care;
- voluntary and community sector services;
- intermediate care services.

Westminster is ambitious for our population and keen to use the ICP development as a tool to enable genuine innovation and improvements that are future proofed for decades to come.

This means aiming for as wide a scope as possible in the long term, taking into account the national direction of travel and the opportunities created by national guidance and changes to legislation across health and local government.

However, due to complexities of contracts and budgets, our scope will start initially with a focus on health services, moving to include Local Authority services as joint commissioning is made easier in the future.





Models of care

Our ICP will be made up of five models of care that cover the whole population of Westminster. These models of care are based on population segments that are tailored to Westminster but that also take into account good practice in population segmentation and the STP segmentation model in the STP Plan. We have made progress in some areas over the last few years, with each model of care at different stages of the journey.

Each model of care will set out for its population :

- The benefits to be achieved in terms of clinical outcomes, patient experience, improving access, reducing variation, reducing inequalities.
- Benefits that the model will deliver to the workforce such as improved staff satisfaction, reduction of duplication in roles/tasks, meeting recruitment, retention and succession challenges etc.
- Benefits for the 'Westminster pound' such as using more upstream preventative and proactive interventions

The models will link with national guidance and best practice such as the Long Term Plan. Prevention, building patient and staff resilience, developing a learning culture and supporting patient self-management of conditions will be key components of the models of care

Each model of care will have patient and carer engagement embedded from the start and a clear timetable for testing, refining and implementation.

5.0 Delivering the NHS Long Term Plan

This next section looks at all the programmes of work that will be undertaken across NW London to fulfil the priorities of the long term plan for patient care and prevention. These nine sections are supported by the priority work programmes already established to deliver the NW London clinical and care strategy (see chapter 2 for more information on the clinical and care strategy).

- **Transformed 'out-of-hospital care' and fully integrated community-based care**
  - Primary social and community care
- **Reducing pressure on emergency hospital services**
  - Urgent and emergency care
  - Primary social and community care
  - Hospital care
- **Giving people more control over their own health and more personalised care**
  - Healthy communities and prevention
  - Primary social and community care
- **Prevention**
  - Healthy communities and prevention
  - Primary social and community care
- **Digitally-enabling primary care and outpatient care**
  - Healthy communities and prevention
  - Primary social and community care
- **Improving cancer outcomes**
  - Cancer
  - Hospital care
- **Improving mental health services**
  - Primary social and community care
  - Maternity children and young people
  - Healthy communities and prevention
  - Mental Health
  - Urgent and emergency care
- **Shorter waits for planned care**
  - Hospital care
- **Population health**
  - Healthy communities and prevention
  - Primary social and community care

5.1 Transformed 'out-of-hospital care' and fully integrated community-based care

NHS Long Term Plan says:

'People will be empowered, and their experience of health and care will be transformed, by the ability to access, manage and contribute to digital tools, information and services… The NHS App will create a standard online way for people to access the NHS… Support for people with long-term conditions.

'Care will be improved by interoperability of data, mobile monitoring devices and the use of connected home technologies over the next few years… Patients' Personal Health Records will hold a care plan [with] information added by the patient themselves, or their authorised carer.

'We will support the workforce to develop the digital skills they need… and mobile access to digital services to allow health and care workers to work more flexibly.

'Patients, clinicians and the carers working with them will have technology designed to help them... Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a 'virtual' outpatient appointment… Technology will enable the NHS to redesign clinical pathways.

'The use of de-personalised data… will enable more sophisticated population health management approaches and support world-leading research.

'In the coming years Artificial Intelligence will make it possible for many tasks to be automated, quality to increase and staff to focus on the complexity of human interactions that technology will never master.

The four strategic priorities for community health services are:
(i) delivering improved crisis response within two hours, and reablement care within two days
(ii)providing 'anticipatory care' jointly with primary care
(iii) supporting primary care to developed Enhanced Health in Care Homes
(iv) building capacity and workforce to do these three things, including by implementing the Carter report and using digital innovation.

Of these, (ii) and (iii) are a joint enterprise with GP practices as part of PCN delivery.

Our primary care strategy has a strong digital focus, this chapter should be read in conjunction the chapter 'Digitally enabling primary care'.

What do we know people are concerned about?

- NW London residents want to be able to access their GP and practice nurses quickly and through a variety of means including online and over the phone. They want better standards of premises and treatment facilities, delivering high quality care close to home.

- Better coordination of services is also important so you do not have to repeat medical history. Our residents want staff to deliver a personalised service that is not rushed and is sensitive to individual needs, particularly of people with mental health issues.

- They want to know which service to ask for and have a choice of ways to get treatment and advice, receiving information about their condition and choices that is easy to understand.

What progress has been made as a system so far?

- Extended GP access services are now available for all patients in NW London from 8am to 8pm Monday to Sunday. Direct bookings can be made by NHS 111.

- New GP premises have been opened, and a recent stocktake report has been carried out on current planning for new community-based facilities, to assess value for money, accessibility and opportunities to upgrade further.
- Complete population coverage by Primary Care Networks (PCNs), ranging in size from 30,000 to 80,000 people.

- There is improved access to psychological therapies (talking therapies) through primary care, with additional staff trained and in post. See the ‘Improving mental health’ chapter for more information.

- More data is available to support GP decision-making including: activity and quality dashboards for practices and networks to help them track, compare and improve patient outcomes and interventions for urgent care and patients with long-term conditions. (Part of the NW London Whole Systems Integrated Care dashboard.)

- Rapid response services delivered by nurses and therapists are available in every borough, providing a two-hour response time for people experiencing a crisis.

- Our intermediate care services support people to get home from hospital sooner (when they are clinically ready), with care provided in peoples' homes to get them back to their usual selves after an unexpected admission. 9000 people in NW London have used this service between August 2019 and May 2017.

- Over 1200 care home staff have received clinical skills training to help them identify when one of their residents' health is deteriorating. We have developed and published a pocket guide which supports this training.

- Over 50 care home registered managers have undertaken leadership development training to help them get the best out of themselves and their staff, to deliver high quality care to their residents.

- A 24 hour telephone clinical advice service offering specialist end of life care is now available to the majority of care homes.

What do we plan to do next?

We are determined that primary and community care works for everyone – for patients, carers, staff, professionals in general practice and the wider system. We will provide services that empower people to take control over their own health, address the inequalities in access and outcomes and provide accessible and responsive care for everyone, to achieve this, we will:

- Strengthen the new PCNs so that general practice teams build relationships with all staff across their network.

- Ensure each network has the tools they need to deliver care, with the right digital services for patients and staff, modern facilities and services developed through robust data and evidence-based outcomes.

- Ensure staff in each network have access to professional training and skills development, to get to a point where all practices are rated 'good' or 'outstanding' by the Care Quality Commission, with individualised career-pathways that make NW London the best place to work in the capital.

- Develop sustainable systems of care that enable us to provide care within our financial envelope of resources, while making appropriate use of energy and recyclable materials.

- Embed systems for capturing the patient and public voice across our diverse communities, engaging patients, carers and the public in the development and delivery of PCNs.

In particular, primary care will provide three key delivery models:

Accessible care:

- Use consistent standards to improve and ensure equality in service access for patients.
- Increase GP practice capacity to help more patients, by improving the use of self-care and digital technology.
- Deliver a two-hour community-team response time for people in a crisis.
- Ensure it is easy to get the right community care support, whether you are a patient, a carer or a health or social care professional.
- Develop single operating standards for core community services (district and community nursing, intermediate care and rapid care) so every resident can expect the same access to and offer of care.
- Match the skills and abilities of staff with clinical interventions required by patients. This will be done through training, development of competencies and relationship building, to improve range and speed of access.

Proactive planned care:

- Use population health information to identify cohorts of patients that can be supported through proactive planned care.
- Use dashboards and benchmarking data to improve quality, reduce variation and deliver evidence-based interventions.
- Develop holistic personalised care and support planning for patients and carers.
- Use community, mental health and voluntary sector staff working in the PCN to provide a full package of social support for people.
- Develop prevention and supported self-management work for key groups of patients (conditions).

- Embed NW London outpatient referral guidelines to improve patient access to specialist care.

- We will help more people understand when they are reaching the end of their life and support them to plan their care, enabling their wishes to be recorded and respected by all health and care professional. Personalised care planning for everyone identified as being in their last year of life will deliver better quality care and more people will be able to die in a place they have chosen.

Co-ordinated care:

- Support collaboration between multidisciplinary teams (MDTs) within PCNs, to ensure access to multi-professional skills addressing physical, mental and social needs.

- Pro-active coaching to support Patient Activation Measure assessments and self-management.

- Develop rapid access home care (including to residents of care homes).

- Agree consistent clinical and non-clinical care pathways to reduce variation of approach and clinical outcome.

- Develop integrated frailty models between networks and secondary care.

- Encourage MDTs to review patient data in real-time to support pro-active interventions, avoiding deterioration and the need for patients to be admitted to hospital, and to ensure an effective discharge following an admission.

- Provide improved care to care home residents including stronger links between primary care and care homes, consistent support for a team of healthcare professional, including named GP support, good oral health, nutrition and hydration and rehabilitation and better sharing of information.

Planned activities

- *All digital activities cited in the chapter: Digitally enabling primary care.*

- **Identify funding for investment in infrastructure** and implement shared clinical systems to support Primary Care Networks, taking advantage of the capabilities of SystmOne and EMIS.

- **Develop PCN specifications** which include input from community and mental health services partners.

- **Review and approve local estates development** to ensure sustainability.

- **Develop standard operating principles across core community services**.

- **Provide PCNs with a package of 'best practice'**, data and other resources to be able to deliver impactful support to care homes.

- **Deliver a workforce strategy** to embed clinical competencies necessary to support population health needs.

- **Establish a community services dashboard** to monitor demand and the capacity of and outcomes of community services.

- **Recruitment of additional staff at PCN level –** recruit a clinical pharmacist and social prescribing link worker to each PCN, with expansion of the clinical pharmacist roles and a common NW London induction programme for social prescribers. We will also recruit our share of the 60 physicians associates, while prioritising the retention of those already in post.

- **Develop a network of primary care and community training hubs** the current configuration of PCNs means that every network has a training practice that will link to a well-established community and primary care training hub. Our intention is to strengthen these links, and consolidate the training and education offer at borough level and above.

How will we know that we're making a difference?

- Each PCN workforce has a plan that outlines how the integrated primary and community workforce will work and train together, with a particular focus on retention of GPs and GPNs. They will also have a public and patient voice plan that includes the public's role in co-production, plans for social prescribing and care navigation.

- All PCNs use integrated care dashboards to review patients' needs and plan care in their network.

- All PCNs use the NW London referral guidance for the agreed outpatient specialities.

- By March 2020, 60% of people with serious mental illness will have had their five key physical health checks, with further coverage from 2020 onwards.

- 75% of people at expected end of life have a care plan on Connect My Care (CMC) that is used by the multidisciplinary team caring for them.

- 75% of people with a new diagnosis of cancer will have had their diagnosis by stage 1 or 2.

- 95% of children in each PCN will have had their MMR vaccination.

- Reduced variation in the three diabetes treatment targets of HbA1c, BP and Cholesterol that outlines a 3% improvement per year.

- Fewer people will be going to hospital for conditions that could be treated in the community.

- More people will have their long term conditions better managed closer to home so their needs do not escalate

What difference will this make to people in NW London?

- Shared premises and facilities, and improved work and care environments, will offer healthy places for patients and staff.

- High-quality primary care services support good mental health for patients and professionals.

- Better access to information about health and care services, (and better understanding their health and care status through access to records and online advice about conditions) will enable people to take more responsibility for their own health and care and improve outcomes.

- People will be able to access more care, in and closer to their home, more easily.

- Better access to outpatient care (specialist care) and reduced waiting times.

- People will be able to make one phone call to get the care they need rather than multiple calls to different teams, as services will be better coordinated around the needs of the individual.

- Everyone can expect and receive the same level of community care that meets their needs, no matter where they live in NW London.

- Those who have made care plans about how and where they want to be treated will their wishes respected.

5.2 Reducing pressure on emergency hospital services

The NHS Long Term Plan says:

'We have an emergency care system under real pressure, in the midst of profound change… by expanding and reforming urgent and emergency care services the practical goal is to ensure patients get the care they need fast, relieve pressure on A&E departments, and better offset winter demand spikes.

'Children and young people account for 25% of emergency department attendances and are the most likely age group to attend A&E unnecessarily. Many of these attendances could be managed effectively in primary care or community settings areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services.'

What do we know people are concerned about?

- Busy services.
- Long waits to be seen.
- Knowing which service to access.
- Greater use of health passports.
- Receiving clear consistent information.
- Awareness of NHS 111 and GP access services.

What progress has been made as a system so far?

- Implemented a range of alternate care pathways for ambulance crews so that they can treat patients on the spot rather than taking them to hospital. For example, in 2018/19, 1,355 patients accessed community based rapid response or district nursing services at home rather than being conveyed to hospital in an ambulance.

- Standardised the standard of urgent treatment services provided across all of NW London, so that patients receive the same high level of care, regardless of where they attend an urgent treatment service.

- Developed hospital front door frailty services at a number of hospital sites which has reduced the number of frail patients being admitted unnecessarily

and reduced the clinical risk associated with extended stay in hospital. This clinical model was first implemented at Hillingdon Hospital. In 2018/19, Over 2,500 patients were seen by frailty experts in the emergency department (ED), with more than 60% able to go home on the same day from ED, with enhanced care and support at home.

- Implemented same day emergency care in all seven A&E sites across NW London (services that can provide a patient treatment or intervention without the need for an overnight stay).

- Started to reduce the number of patients spending over 21 days in hospital.

What do we plan to do next?

Our health and care partnership is looking to transform urgent and emergency care services in our system, through a joined up approached between health and social care. We will work to ensure people receive the right care, in the right place, at the right time. We will look at innovative ways to reduce demand on acute hospital emergency services by helping people to more proactively manage their condition and access appropriate urgent care services closer to home, minimise unwarranted variation and maximise the value of every pound spent on urgent emergency care provision.

We will develop ambulance “Hear and Treat” and “See and Treat” services, and improve access to admission avoidance schemes.

The 24/7 integrated urgent care service will be the gateway to urgent care system and offer timely advice and support to both patients and clinicians. Where possible, enabling people to remain independent and cared for in or close to their home. We will strengthen services at the front door of the hospital including the expansion of same day emergency care and acute frailty services. We will also work to make our processes for leaving patients hospital slicker by enhancing our links to social care and community services and use discharge to assess and home first principles.

Planned activities

Data and variation: Work to ensure activity and demand data across NW London.is comparable. This will allow us to benchmark, compare and continuously improve services.

Understanding why are people attending: deep dives with each A&E delivery board to understand specific local drivers of demand.

Same day emergency care: Scaling up existing same day emergency care (SDEC) models with the aim of seeing 30% of non-elective admissions via SDEC.

Acute frailty: Expand acute frailty model to all seven A&E sites in NW London with the objectives of reducing 75+ rate of admission by 3%.

High intensity user: Manage high intensity service users in a more proactive and planned way through a pan NW London hub (as per Right Care best practice).

Extended length of stay: Continue to reduce avoidable harm for patients who have unnecessarily prolonged stays in hospital and free up further 100 beds by April 2020.

LAS demand management: Further scale a range of schemes to increase the use of alternate care pathways for ambulance crews: district nursing, rapid response referral, falls and GP in and out of hours pathways. Further initiatives with NHS111, LAS clinical hub and re-triaging service.

UTC: Review the provision of urgent treatment centres (UTC) and GP access centres to ensure they are offering maximum value to the system and taking pressure from A&Es.

Care plans and working with primary care to manage variation: We will first ensure high intensity users of urgent and emergency care services all have personalised multi-disciplinary care plans, to help them manage their complex health and social care needs.

Flu: Increase vaccination rates for staff and population and minimise flu related urgent emergency care (UEC) activity.

What difference will this make to people in NW London?

By providing the most effective access to emergency care and the best quality care, and by reducing pressure on emergency services, our local people can:

- be better able to prevent crises and unnecessary visits to hospital, avoidable admissions or lengthy stays in hospital.
- have access to the right treatment in a timely way to stabilise their condition and manage their needs.
- Achieve the best clinical outcomes from the treatment provided and a positive experience of care.

How will we know that we're making a difference?

- More 111 calls triaged by a clinician and referred to appropriate primary care and community services.

- More people who dial 999 are seen and treated without a conveyance to hospital or are treated by clinicians over the phone.

- Sustain or reduce ambulance conveyances to hospital and non-elective admissions (particularly those related to care homes, falls and a range of long term conditions such as diabetes).

- Front door frailty services at all A&E sites so these patients can receive the best possible care, receive a comprehensive geriatric assessment and avoid admission or lengthy stays in hospital.

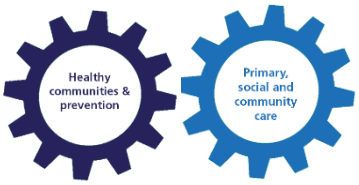
- Increase the proportion of patients with ambulatory sensitive conditions treated on the same day of their attendance to hospital and avoiding unnecessary overnight stays.

- If patients attend the hospital, more patients are treated in the most appropriate setting for their condition.

- Fewer people stay more than 14 or 21 days in both acute and community hospitals.

- More patients seen at home by rapid response and district nursing teams.

5.3 Giving people more control over their own health and more personalised care



The NHS Long Term Plan says:

'Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.

'We will support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes.

'We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade.

'We will accelerate the roll out of Personal Health Budgets to give people greater choice and control over how care is planned and delivered. Up to 200,000 people will benefit from a PHB by 2023/24.

This chapter should be read in conjunction with the chapters on Prevention, Transformed out of hospital care, Better care for major health conditions – Diabetes and Digital.

What do we know people are concerned about?

- Information that is easy to read.
- Access to self-help and peer support.
- Taking responsibility for own health.
- Innovation and the use of technology – seen as useful – but needs explaining
- Choice and control over condition and care.
- Shared decision making and making it work for everyone.
- Social prescribing is seen as a good idea, but how will it work?

What progress has been made as a system so far?

- Over 40,000 people with a long term condition have completed the patient activation measure or PAM assessment) since 2016. Patient activation is defined as *'an individual's knowledge, skills and confidence for managing their*

health and healthcare.' The PAM score is produced through a patient's response to 13 statements.

- Over 2,000 patients have accessed a digital diabetes type 2 structured education course.

- Over 7,000 patients received self-management support for diabetes since April 2018 and over 8000 patients benefited from the Diabetes Prevention Programme since April 2018.

- Over 600 patients have access the NHS approved myCOPD digital self-care tool. 98% of those surveyed said they would recommend it to others.

- The 'Digital Citizen' programme (started in 2018) to educate the population on digital health services.

- Staff trained to be digital ambassadors.

- Every secondary school has access to the Digital Healthy Schools Platform, to support children and young people to find the right self-care and service information.

- Q1 2019/20 – NW London has the highest number of patients in London managing their own Personal Health Budgets.

What do we plan to do next?

Our aim is for over 37,000 NW London patients to receive personalised care and support plans by 2023/24.

- Tailor self-care and service to individual patient needs - through the use of the Patient Activation Measurement. By 2023/24 we aim to have over 30,000 people with long term conditions annually assessed and have had their care planned with them according their knowledge, skills and confidence in managing their conditions.

- Digital self-care - By end of 2019/20, 3000 people with type 2 diabetes will have accessed a diabetes digital structured education (behaviour change) programme. With greater ambitions to build on this year on year.

- By 2020/21 20% of moderate and severe patients with a COPD being supported to self-manage their condition, through the myCOPD digital tool.

- Implement phase one of the heart failure and asthma digital projects to be completed, to inform future roll out.

- By 2022/23 digital self-management tools will be available for the six mayor long term conditions.

- The Digital Citizen and Workforce Education Programme will support the workforce to develop the digital skills they need in order to support and up skill patients, the volunteer digital ambassadors will train citizens on a variety of digital health tools for free. The digital healthy schools programme is a key enabler for prevention. Over the next two years every secondary school will be able to access a platform to help young people understand health and wellbeing much more and know how to protect themselves from online predators, harmful practices and safeguard their mental health.

- Digital Healthy Hubs will help those that don't even have basic digital access (an email address) and will support them and answer questions about data etc. Our intention is not to leave anyone behind.

- A minimum of one link worker in place across all PCNs supporting people to access social prescribing support within their communities. Link workers to be supported by local training programme and peer support. Between 20/21 to 23/24 number of link workers increased in line with GP contract funding resulting in over 32,000 people receiving social prescribing. Social prescribing supported by an increased voluntary, community and social enterprise and community support capacity.

- Personal Health Budgets (PHB) – our working group is expanding the use of PHBs across different groups of people. This work will require major change and engagement across all care providers. Digital tools will be critical to allow us to work consistently across all borough. We are currently developing early adopters for digitalised personalised care and support plans and management of personal health budgets. By 23/24 over 5100 people will be empowered with personal health budgets.

Patient Activation measure (PAM)

"The Barbara had cancer twice and had recently suffered a broken hip, due to brittle bones. She also suffers from cellulitis that causes one of her legs to be swollen and twice the size of the other, this is a very painful condition.

As part of Barbara's rehabilitation she was provided with a My Care My Way case manager, who discussed rehabilitations options with her to get her out and about and build confidence.

A PAM score of 55.7 was recorded for Barbara at this stage and she was referred to a walking support service.

"it was slow progress, at first I could only go to the end of the road and back – not very far. But with support each session allowed me to walk a little further and gain confidence with my walking stick, I would not have been confident to do this alone."

Barbara's confidence for her own self-care improved significantly and she feels her risk of falling has significantly reduced - her PAM score on increased to 67.8.

Planned activities

- Embed **PAM assessments** across NW London with people's care planned according their knowledge, skills and confidence in managing their long term condition(s).
- **Digital self-care** will be available for all people with major long-term conditions.
- Enable all local agencies able to refer people to a **social prescribing** 'link worker' to connect them into community-based support, building on what matters to the person as identified through shared decision making/personalised care and support planning, and making the most of community and informal support.
- **Personal Health Budgets** will be default offer for all Continuing Healthcare and NHS funded wheelchair service user.

What difference will this make to people in NW London?

- Supporting people with long term conditions according to their levels of knowledge, skills and confidence will ensure we focus on the support that matters for the patient and target resources appropriately. This targeted

approach will provide the platform for patients to achieve their potential in managing their long term conditions.

- Introducing a range of high quality digital tools to support will empower people to manage their long-term condition(s), and help improve, management of the condition, quality of life and outcomes. School age children will be able to find and use NHS approved apps that can help support their and their families health and wellbeing.

- Social prescribing link workers will connect people to wider community support which that can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.

- Personal Health Budgets represent a new relationship between people, professionals and the health and care system. Owning a personal health budget provides a positive shift in power and decision making that enables people to have a voice in the management of their care.

How will we know that we're making a difference?

- More people with low knowledge, skills and confidence feel supported to manage more aspects of their long term condition.
- More people with long term conditions accessing digital self-care support tools.
- More people accessing pulmonary rehabilitation (physical exercise programme and information & advice on managing condition).
- Decrease in number of emergency admissions for health needs related to flare-ups in a long term condition
- Increased referrals to social prescribing.
- Patient satisfaction – people feel they have choice and control over their care and able to self-manage the health and care outcomes.
- Increased number of personalised care and support plans and personal health budgets.
- Increased voluntary, community and social enterprise and community support capacity across eight boroughs (number of different support groups).

5.4 Prevention

The NHS Long Term Plan says:

'By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services... [together with] expectant mothers, and their partners, long-term users of specialist mental health, and in learning disability services.

'The NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity) …

'We are now committing to fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option. We will … test an NHS programme supporting very low calorie diets for obese people with type 2 diabetes. The NHS will continue to take action on healthy NHS premises… We will ensure nutrition has a greater place in professional education training.

'Hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish Alcohol Care Teams.

'While wider action on air pollution is for government to lead, the NHS will work to reduce air pollution from all sources.

With reference to our work on diabetes, this chapter should be read in conjunction with the chapter: Better care for long term conditions (diabetes).

What do we know people are concerned about?

- Having access to early intervention and education.
- Equal access to services, education and support
- Information that is easy to read.
- Cultural awareness.
- Innovation and the use of technology.
- Mental health support for rough sleepers.
- How the NHS can support them with healthy eating – want to but find it hard to.

What progress has been made as a system so far?

- The Healthy Communities and Prevention Board has been established to lead on specific prevention priorities (in addition to prevention being embedded within other programmes). This is led by a Director of Public Health with

membership across third sector, CCGs and lay partners. Prevention priorities for 19/20 include childhood obesity and alcohol misuse.

- To tackle childhood obesity, workshops are taking place with partners including lay partners, health care and local authority to develop a collaborative NW London plan, sharing best practice and pooling resources to support our population with this increasing issue.

- An alcohol strategy has been developed with key stakeholders including local authority, health care, lay partners and the third sector focussed on five key deliverables.

- A review of pregnant women at the Chelsea site found a 10-fold difference in prevalence of smoking at time of delivery between those living in the most vs least deprived areas. We worked together to identify points of intervention to increase the number of smoke free pregnancies. Opportunities at booking, scan appointments and post-partum were identified so smoking cessation trained midwives or Maternity Support Workers could available during booking clinics. Between Jan to Aug 2019, we have seen a 47% increase in referrals, compared to the same period the previous year. The quit conversion rate has remained steady, despite increased referrals. In Brent, Ealing and Harrow public health teams are working with midwives at Northwick Park and Central Middlesex Hospitals to strengthen the smoking cessation offer for pregnant women and streamline pathways to services.

- Plans are in place for a rough sleepers programme - four NHS trusts in London are piloting new ways of working, as part of a new two-year programme funded by the Mayor of London and MHCLG. In each area, a dedicated team of mental health practitioners will work with people sleeping rough along with homelessness outreach teams, accompanied by initiatives to improve learning and collaboration between the mental health and homelessness sectors. Central and North West London NHS Foundation Trust and West London NHS Trust have co-developed a local service in their areas in partnership with the local homelessness outreach teams and borough rough sleeping commissioners.

What do we plan to do next?

Alcohol misuse - we have developed a multi intervention strategy including:

  - a communication campaign to inform the public regarding the negative impact of alcohol and signpost to available services.

- identifying high risk drinking through digital systems.
- reducing alcohol consumption through training frontline staff to screen and deliver alcohol interventions.
- extending access to alcohol interventions through a digital tool.
- using population measures to limit excessive alcohol consumption across boroughs.

Childhood obesity - Three priority areas have been highlighted to focus on:

- pregnant women and new parents
- BME parents of young children and schools
- Weight management services.

Rough sleepers - The delivery of the new services will commence in autumn 2019, with funding from the Mayor and MHCLG for a two-year pilot.

Smoking - By 23/24 all people admitted to hospital that smoke will be offered NHS-funded tobacco treatment services. Model developed in West London, Brent, Harrow and Ealing to support NW London approach for expectant mothers and their partners, with a new smoke free pregnancy pathway.

Planned activities

- Address rising challenge of **alcoho**l by delivering behavioural interventions to high risk drinking individuals as well as promoting a population cultural shift to no drinking and / or low risk drinking to prevent the harmful health effects of alcohol. Those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish alcohol care teams.
- Rollout **smoking prevention** model developed in Brent, Harrow and Ealing across NW London approach for expectant mothers and their partners.
- **Childhood obesity** will have a focus on top risk behaviours, including physical activity and poor diet and a targeted focus on oral health promotion campaigns. This will include working with local BME leaders to develop plans to prevent and tackle childhood obesity, training for professionals to improve interactions with people who have excess weight, so they can communicate confidently and sensitively with individuals and working with schools to ensure healthy food policies are adopted.

- Homelessness outreach teams will work with the new teams to identify people **sleeping rough** who may have mental health needs and are in need of support or treatment. The dedicated teams of mental health practitioners will then carry out a range of activities, which may include conducting mental health assessments and or/mental health act assessments, undertaking the role of care co-ordinator and connecting people with other services. Additionally, there will be cross-sector training and learning and in each area with local innovation projects which will seek to further improve collaboration and the support which rough sleepers receive.

What difference will this make to people in NW London?

- Informing the general public about the wide ranging and long-term impact of alcohol, we can promote individual behaviour change in combination with a cultural shift away problematic drinking.

- Supporting parents to quit smoking will improve the health for both parents and children.

- By supporting people to develop and maintain healthy lifestyles from childhood to adulthood, and by providing a targeted treatment approach to tackling **childhood obesity**, people in the community can:
  - have information and support they need to lead as healthy lives as possible, whilst minimising the risk of obesity
  - access treatment and support to help them return to healthy weight.

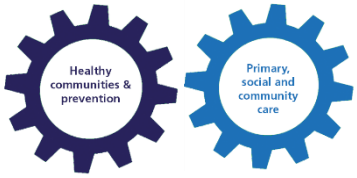
- People sleeping rough in NW London who have mental health issues will receive flexible, personalised and relationship-focus support. The learning and collaboration aspects of the programme will increase understanding of the needs of this population across both the mental health and homelessness sectors and develop how these two spheres work together to improve outcomes.

How will we know that we're making a difference?

- Reduction in percentage of people who are high risk drinking.
- Reduction in alcohol related A&E attendances, hospital admissions and primary care interventions.
- Increased referrals to alcohol services.
- Increased referrals to lifestyle services in general and in particular smoking cessation uptake rates.
- Reducing the prevalence in obesity for children in reception and year six.

- Increased choice of interventions that improve their health and care outcomes – and reducing the spend on crisis and acute support through early intervention.
- Referrals into preventative lifestyle services are a greater part of routine medical care.
- People sleeping rough who have mental health need will receive flexible, personalised and relationship-focus support.

5.5 Digitally-enabling primary care and outpatient care



NHS Long Term Plan says:

'People will be empowered, and their experience of health and care will be transformed, by the ability to access, manage and contribute to digital tools, information and services… The NHS App will create a standard online way for people to access the NHS… Support for people with long-term conditions will be improved by interoperability of data, mobile monitoring devices and the use of connected home technologies over the next few years… Patients' Personal Health Records will hold a care plan [with] information added by the patient themselves, or their authorised carer.

'We will support the workforce to develop the digital skills they need… and mobile access to digital services to allow health and care workers to work more flexibly.

'Patients, clinicians and the carers working with them will have technology designed to help them... Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a 'virtual' outpatient appointment… Technology will enable the NHS to redesign clinical pathways.

'The use of de-personalised data… will enable more sophisticated population health management approaches and support world-leading research.'

What do we know people are concerned about?

- Better access to GP appointments and advice.
- Good phone access, reliable booking services.
- Shorter waiting times and a choice of ways to get treatment and advice.
- More co-ordinated services and joined up records so patients do not have to repeat their story multiple times.
- Quicker access to outpatient appointments.
- Digital information is good for most people, but not all.
- Many are not sure of the benefits of digital services.
- Privacy and confidentiality issues.
- Loss of face-to-face relationships with their clinicians.

What progress has been made as a system so far?

Digital self-care

- The Health Help Now app is available to all in NW London, 100,000+ people are already using the app to get advice on which service to use, book appointments and look-up health advice. The app is now being integrated with the NHS App and supports the apps listed in the prevention and self-care chapters.

Improved access to direct care

- Bookings to GP extended access services or evening and weekend appointments can now be made through NHS 111.

- Online consultations – piloted successfully in two boroughs. Patients can send detailed information to their GP practice about their condition via the surgery website, patients receive advice or an appointment within two days.

Clinician to clinician interoperability

- All GP to hospital referrals are now made using e-Referrals.

Improving efficiency and productivity

- Clinical systems are now able to share records across GP practices and PCNs, supported by the new NW London's new information governance framework. This supports clinical staff to see patient's records across a range of services.

- A digital consultation blueprint, to support the new PCNs in reviewing online queries and requests for appointments to common standards – saving time for patients and reducing the admin burden for practices.

- Using our data dashboards, (Whole Systems Integrated Care) GP practices are able to look at and compare patient outcomes and interventions for urgent care and long-term conditions, which means they are able to offer advice and treatment early on and better monitor patients progress.

What do we plan to do next?

We are determined that primary care in NW London works for everyone – for patients, carers, professionals in general practice and the wider system, our statutory and voluntary sector partners, NHS community, acute and mental health trusts, community pharmacies, primary care networks and our GP Federations.

To achieve this, we will:

Digital self-care

- Continue to invest in the Health Help Now app, and integrate it with the NHS App, to help people engage with local health and care services

Improved access to direct care

- Provide all patients access to online consultations, which will help provide better access to GPs and primary care services without the need to call the surgery or book an appointment.

- Improve systems and processes for patients, reduce waiting times and improve access to secondary care by using technology to support referrals with more clinical information to support faster decision making by specialists e.g. use of images in dermatology referrals.

Clinician to clinician interoperability

- Use data and to support patient care and further develop evidence supported by robust data and evidence-based outcomes and care-pathways.

- Roll out of teledermatology, with the use of an app for GPs to securely send images of skin lesions to a specialist for swift triage and ongoing care.

Improving efficiency and productivity

- Ensure each PCN has the tools they need to deliver care, with a ‘Digital First’ service offer.

- Continue to develop a new cyber secure network (CASSIUS) to improve cyber security and improve access to digital systems for staff who work across more than one site.

Online consultations

To use the service, patients simply go online and visit their GP practice website and fill in the online consultation form. The form is easy to fill in and patients can describe their symptoms and provide their GP with all their details in the comfort of their home. The form goes through all the questions a doctor would ask at an appointment.

The secure online service also means there is no need to hang on the phone to try and book an appointment, and a doctor will review and get back in touch with the patient within one working day.

"Once the online consultation form was sent, a receipt email was returned with a scheduled time to have my query responded to, which was met. The GP called and clearly evidenced knowledge of my case and the next steps required. I was made to feel at ease and not rushed." – patient feedback on online consultations

Planned activities

Digital self-care

- Develop an app strategy to help people manage their own health, care and wellbeing. This will link to the 'NHS App' and NW London's 'Health Help Now' app, as a 'front door' for public digital support.

Improved access to direct care

- Build on NW London's online consultation programme – by the end of 2020, 75% of GP practices will provide online consultation services, with all patients having access to online or video consultations by April 2021.

Clinician to clinician interoperability

- Add to the population health management database and dashboards to the functionality needed to manage PCNs; incorporate children's data and develop algorithm logic for children's care, including the risk stratification tool; alongside facilitating greater use of anonymised primary care data from WSIC for research purposes (Ongoing agreement for revenue funding in 19/20 and 20/21 will need to be agreed).

- Further explore how technology can improve the flow of clinical information and speed up referrals to specialists for a clinical decision.

Improving efficiency and productivity

- Design an exemplar digital GP practice and urgent treatment centre, to model all sites on in the future.

- All primary care sites to have super-fast broadband by April 2020.

- Identify funding for investment in infrastructure and implementation of shared clinical systems to support PCNs taking advantage of the capabilities of SystmOne and EMIS.

- Link primary care records across health and social care (Health and Care Information Exchange) – making GP patient data securely available in other care settings, sharing data with GPs from providers in other STP footprints through the One London LHCRE programme.

- Develop and launch a network to join up all primary care sites, to improve access and cyber security.

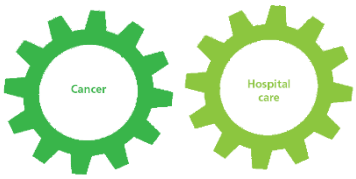
What difference will this make to people in NW London?

- Faster access to clinical decisions in both primary and secondary care, improving patient experience and outcomes.
- Shorter waiting times for access to the services and information.
- Improved access to care records and online advice for patients about their conditions, will enable people to take more responsibility for their own health and care and improving outcomes.
- Delivering safe and high quality care, and listening to patient and carer experience – we can improve population health, reduce unwarranted variation, improve staff experience, and improve value to achieve healthier lives across NW London.

How will we know that we're making a difference?

- Patients have better access to their GP online through online consultations.
- All PCNs use the WSIC dashboards regularly to plan care in their network.
- Reduced waiting times and faster triage of GP to specialist services.
- Patient records will be joined up, improving continuity of care for all patients.
- Health and care services will be offering services fit for the digital age we live in.

5.6 Improving cancer outcomes



NHS Long Term Plan:

'Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival… We will raise greater awareness of symptoms of cancer, lower the threshold for referral by GPs, accelerate access to diagnosis and treatment and maximise the number of cancers that we identify through screening.

'By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. After treatment, patients will move to a follow-up pathway that suits their needs, and ensures they can get rapid access to clinical support where they are worried that their cancer may have recurred.

'Cancer is now the biggest cause of premature death among children and young people aged 5-14 years. We will therefore develop and implement networked care to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.'

What do we know people are concerned about?

- Better communication and information about treatment.
- Having a named contact.
- Good levels of communication.
- Consistency across services.
- To be included and involved in care planning, treatment and decisions making.
- More emphasis on prevention and education.

What progress has been made as a system so far?

- Introduction of integrated primary and secondary care cancer partnership boards, working closely with our Cancer Alliance, Transforming Cancer Services Team, Macmillan and Cancer Research UK.

- Working together during 2018/19 we have regularly achieved the 62 day standard. As of May 2019 performance for our Cancer Alliance was the highest nationally, and NW London STP performance was fourth highest nationally.

- Our one year survival rates are significantly higher than England as a whole. Significantly higher survival rates are also seen in specific tumour groups: Breast, Colorectal, Kidney, Lung, Myeloma, Non Hodgkin's Lymphoma and Prostate cancer.

- Full roll out of FIT for low risk symptomatic patients (NICE DG30) - this new test enables earlier diagnosis of bowel cancer and ensures more appropriate referrals to secondary care.

- Continued work to improve compliance with GP e-referrals to cancer services.

- 50% of all GP surgeries participating in the cervical screening pilot, showed an increase in screening uptake.

- A pilot to increase screening uptake in bowel cancer has been undertaken and results are awaited. A similar pilot conducted in SW London showed a 25% increase in screening uptake as a result of being telephoned.

- Rolled out best practice pathways – 'Straight To Test' for colorectal cancer and successful piloting of the HSJ award winning RAPID prostate pathway.

- Rolled out of Macmillan funded psych-oncology support for London North West University Healthcare NHS Trust.

- All trusts are in the process of completing optimisation audits for CT, endoscopy and most recently MRI.

What do we plan to do next?

- Working collaboratively with our Cancer Alliance and system partners we aim to drive and support improvements across all cancer standards, supporting the strategic priorities of the national cancer strategy.

- We will:
    - develop and redesign services and pathways to improve cancer diagnosis at stage 1 and 2
    - meet national waiting times standards for diagnosis and start of treatment
    - improve survival rates
    - maintain performance in the face of increasing referrals and cancer prevalence; current data shows 5.7% of urgent referrals are diagnosed with cancer.

- Particular focus will be given to:
    - improving access and use of primary care diagnostics
    - further improvements in screening uptake facilitating earlier diagnosis
    - focussing on system improvements to reduce emergency diagnoses of cancer
    - the “Living Well and Beyond Cancer” agenda and stratified follow up pathways.

Planned activities

Screening:

- Build on the success of 18/19 and further improve screening uptake of bowel, breast and cervical screening to detect cancers earlier.
- Work closely with screening providers and commissioners to improve our Faster Diagnosis Services (FDS).
- Work with primary and community care providers to increase bowel screening uptake by phoning non-responders to screening invitations
- Increasing access to cervical screening by providing additional, suitable clinic times
- Work with endoscopy units to increase capacity to accommodate current and future demand.
- Extend HPV vaccination programme to boys aged 12-13 from September 2019.

Earlier and faster diagnosis:

- Complete current targeted lung health check pilot in Hillingdon/Hammersmith & Fulham CCGs to contribute to national learning.
- Work towards establishing one rapid diagnostic centre for a defined population/geographical area.
- Work with local trusts to record faster diagnosis standard data reporting to support 28 day patient diagnosis improvements.
- Roll out of RAPID prostate pathway, timed oesophago-gastric (OG) and lung pathways to improve patient experience and support Faster Diagnosis Standard pathways.
- Work with emerging Primary Care Networks to improve early diagnosis.
- Deliver GP cancer educational events 2019/20.
- Pilot the GP decision and at risk patient management tool “C the Signs” to improve referral quality and patient management to reduce emergency diagnoses of cancer.

Treatment:

- Development and establishment of local radiotherapy networks.
- Delivery of children and young people’s cancer services networks.

- Support greater access for children to clinical trials
- Working with Genomic Laboratory Hub (GLH) and NHS Genomic Medicine to ensure local access for eligible patients is available for appropriate cancer genomic testing.
- Ensure that genomic testing is delivered by designated providers.

Personalised care:

- Working with RM Partners and Macmillan partners continue to roll out and improve quality of personalised care interventions such as needs assessments, care planning and health and wellbeing support.
- Continue to roll out stratified patient pathways for post cancer treatment support, for breast (by 2010); prostate and colorectal cancer by 2021.

Workforce:

- Deliver local actions to improve recruitment and retention of Clinical Nurse Specialist and support workers to ensure all cancer patient have access to the right expertise and support - 2019-2024.
- Highlight and promote careers in cancer nursing through career and educational development.

What difference will this make to people in NW London?

- Improved uptake of screening programmes, prompt diagnosis and treatment, and support to people living with and after cancer.
- Prompt access to diagnostic services and where necessary, to high quality treatments.
- Information sensitively and fully explained.
- Cancers will be found earlier which results in earlier curative treatment leading to better patient experience, and survival rates.
- Use of care navigators to co-ordinate the care of patients and link to community support.

How will we know that we're making a difference?

- Improvement in early diagnosis of cancers by 2028; the proportion of cancers diagnosed at stages 1 and 2 will rise from around half (now) to three-quarters of cancer patients.
- An improvement in the percentage of patients who commence treatment <62 days from GP urgent referral.
- Patients having positive experience – patient experience surveys; National Cancer Patient Experience Survey.
- Improvement in survival rates.
- Improvement in uptake of FIT testing.
- Reduction in 'don not attend' DNA rates for first outpatient appointment and diagnostic tests.

- Reduction in number of late inter-trust transfers.
- Reduction in number of patients starting treatment >104 days.
- Achievement of new 28DFD standard in 2019-20 alongside 62 day standard. performance, which includes percentage of patients waiting <2 weeks from GP referral to first consultant appointment (including breast symptomatic).
- Increased screening coverage and uptake performance.

5.7 Improving mental health services

The NHS Long Term Plan says:

'We will continue to expand access to IAPT services, with a focus on those with long-term conditions. We will then set clear standards for patients requiring access to community mental health treatment... New and integrated models of primary and community mental health care will support adults and older adults with severe mental illnesses.'

'The NHS will provide a single point of access and timely, universal mental health crisis care for everyone…We will also increase alternative forms of provision for those in crisis. Specific waiting times targets for emergency mental health services will take effect from 2020… Ambulance staff will be trained and equipped to respond effectively to people in a crisis.'

'We will contribute to ending acute out of area placements by 2021, allowing patients to remain in their local area – maintaining relationships with family, carers and friends.'

'Through increasing access to Individual Placement and Support, the NHS will support [more] people with severe mental illnesses where this is a personal goal to find and retain employment by 2023/24.'

'By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS-funded mental health services, including through schools and colleges.

'The Government has pledged £1.25 billion by 2020 to support improvements in children and young people's mental health and wellbeing, along with £150 million for eating disorder services.

'Funding to deliver the NHS Long Term Plan includes further additional investment, and this will grow faster than both NHS funding and mental health investment overall.

Perinatal mental health

Perinatal mental illness will affect one in ten women. Maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy. However, it remains the leading cause of direct deaths occurring

within a year after the end of pregnancy (MBRRACE-UK, 2019).There is high and rising overrepresentation of people with mental health problems amongst unemployed and economically inactive people.

What progress have we made as a system so far?

- Achieved full coverage of perinatal mental health services which means that women with mental health needs during pregnancy and the post-natal period can receive psychological support when needed.

Improving mental health services for children and young people

Mental health issues have high prevalence amongst NW London's children and young people (CYP). Over 32,000 CYP aged between 5 and 19 years have a mental health disorder; 4,811 of these CYP have three or more mental disorders. Over 16,000 females and 6,000 males aged between 5 and19 years show signs of an emotional disorder.

Fifty per cent of all cases of diagnosable mental illness begin by age 14 and 75% by the age of 24. Helping CYP at an earlier stage can avoid them falling into lifelong struggles with poor mental health.

What progress have we made as a system so far?

- Worked with children and young people to develop and implement a comprehensive plan to transform CYP mental health services, working across health, care, education and the justice system.
- Ensured access to services that is in line with national standards.
- Strengthened the relationship between education and mental health services through the rollout of CYP trailblazers in West London and Hounslow in 2018/19.

What do we plan to do next?

- A key element is the expansion of access to community mental health services: with an additional 1,514 children and young people across NW London to access services by 2024 (in part delivered by schools based mental health support teams).
- Rollout mental health support teams in schools across Ealing, Central London, Hammersmith & Fulham and the expansion of teams in Hounslow.
- Development and implementation of a comprehensive model of care to support seamless care through the transition for children and young people's mental health services to adult mental health services.
- Ensure 24/7 access to crisis care via the NHS 111 single point of access.

How will we know we are making a difference?

- By 2020/21, 35% of CYP with mental health needs will be able to access services.
- Continue to ensure that of 95% CYP with an eating disorder receive treatment within one week for urgent cases, and four weeks for routine cases.
- Inpatient stays will take place where clinically appropriate and have the minimum possible length of stay as close to home as possible.
- All commissioned providers of CYP mental services will flow data to the Mental Health Services Minimum Data Set (MHSMDS).

Planned activities

CYP mental health

- Further strengthening of the relationship between education and mental health services through the rollout of CYP Trailblazers – Ealing, Central London, Hammersmith & Fulham and the expansion of Hounslow in 2019/20.
- Develop a comprehensive 0-25 support offer.
- Development work on CYP eating disorder services, to ensure that children are provided with a consistent offer across the locality.
- Harnessing digital transformation to further improve access to children and young people's mental health services.

Improving mental health services for adults with common and severe mental health needs

What do we know people are concerned about?

- Londoners experiencing chronic and relapsing mental health needs do not consistently experience timely access to Community Mental Health Teams (CMHTs), or the quality of care and support that would ensure they have the best opportunity to avoid a mental health crisis.
- People in NW London in mental health crisis do not consistently experience timely access to mental health crisis responses. It is also known that care whilst in crisis does not meet the basics of dignity, respect and high quality compassionate care. Services are often not delivered in the right environment to help people recover.
- People in mental health crisis are often denied access to HBPoS sites and Emergency Departments (EDs), left in the back of police cars and ambulances, or transferred unnecessarily between EDs and HBPoS sites due to a lack of appropriate and co-ordinated care.
- In 2017, there were 568 suicides in London; 110 of these (19.3%) were in NW London.

What progress has been made as a system so far?

- Through the IAPT-long-term conditions programme, we have increased referrals to IAPT services and data shows a reduction in people with long-term conditions using other NHS services after intervention with 'Talking Therapies'/IAPT-LTC.
- Taken learning from significant outreach work as part of the response to Grenfell to implement initiatives that support access within our communities, such as outreach to mosques.
- Secured funding for the expansion of Individual Placement and Support (IPS) services at Central and North West London NHS Foundation Trust and the development of services at West London NHS Trust. In 2018/19 the current IPS service supported 565 service users with around a third being supported into work.
  Recently started developing transformation plans to introduce new community services through stable and more developed PCNs.
  Through the crisis care concordat, NW London has improved mental health crisis care for its local population.
- Developed a proposal to provide bereavement support to families in NW London affected by suicide, as well as worked with our two main mental health providers to develop plans to achieve the zero suicide inpatient ambition.

What do we plan to do next?

Community mental health services

Future provision of community care will be based on a core model of delivery of care with specific provision for patients with a personality disorder, eating disorder and have complex rehabilitation needs.

This will include strengthening local relationships between primary care, secondary care, local authorities and voluntary care services. We will also be testing two different models of community mental health services across a total of 36 PCNs.

Crisis care

- 2019/20 and 2020/21 proposals developed to expand Community Resolution Home Treatment Teams (CRHTTs) and alternative crisis services.
- Funding will ensure fidelity to the CRHTT model, clearer allocation of resource to Tier 1 and Tier 2 functions (MH provider trusts and CAMHS), improvements to waiting times for assessment and quality of service.
- A focus on increased levels of staff to support older people and additional crisis response in areas of high need e.g. long wait periods in A&E.
- Work with Thrive London to establish the regional deployment of bereavement support services.

Planned activities

Community mental health services

Testing two community models:

1) Provided by CNWL, a new model of care to redesign and reorganise existing borough-based community resource to form new 'Community Mental Health Hubs' (CMHH), each of which would be aligned to the local PCNs in Harrow, Hillingdon and Central London. Working in this way allows each CMHH to have a consistent core structure and function but also allows flexibility to tailor staffing and provision of services to meet the needs of the local PCN population.

2) Provided by WLT, the proposed primary and community integrated mental health (PCIMH) model, will enable the achievement of greater integration between primary care, secondary and community services. This will be tested across Hammersmith & Fulham, Ealing CCG and Hounslow.

Both models will support streamlined integrated care, joint management of demand on services so that care is delivered that provides satisfaction for both patients and staff, and ensure appropriate standardisation of good quality care to mitigate current variation (between CCGs, PCNs and individual practices) whilst allowing tailoring of services to meet specific local needs.

Crisis care

At least one crisis/acute alternative will be provided (either a new service or increasing capacity in existing services). Funding will offer support to further develop the following crisis interventions, including roles for peer support workers:

- Crisis haven – inner boroughs serving Kensington, Chelsea and Westminster
- Crisis haven – outer boroughs serving Harrow, Brent
- Crisis café – Ealing
- Assessment lounge pilot – the Gordon Hospital, Northwick Park Hospital
- Enhanced work in Amadeus Recovery House – Ealing
- Safe Haven – Hounslow

What difference will this make to people in NW London?

- People will have better access to and experience of crisis care.
- More people will use and understand the benefits of talking therapies, especially those managing long term conditions.
- Adults and older adults with severe mental illnesses will have greater choice and control over their care and be supported to live well in their communities via new and integrated models of primary and community care. NW London will also test four-week waiting times for adult and older adult community mental health teams.

How will we know that we're making a difference?

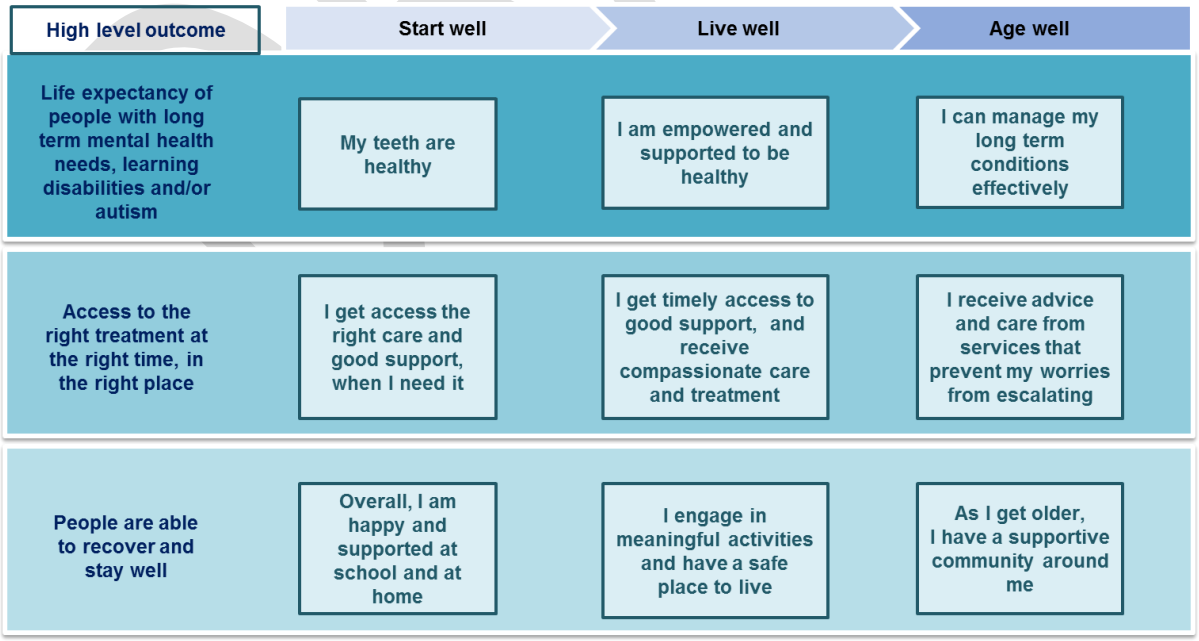
Community mental health services:

- 60% of those on the SMI register will receive the complete list of physical checks and follow up
- At least 56% of people aged 14-65 experiencing their first episode of psychosis will start treatment within two weeks with 50% of services to be graded at level 3
- Increased access to Individual Placement and Support (IPS) services
- Adults and older adults with SMI (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) receiving care from integrated primary and community mental health services.

Crisis care

- 100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams operating in line with best practice.
- More alternatives for people in mental health crisis to be cared for in, preventing attendances to emergency departments and admissions to hospital.

The North West London Health and Care Partnership has developed outcome measures to understand how our mental health system is performing as part of an integrated care system, identify areas for service improvement and to reduce health inequalities and address unwarranted variation.



5.8 Shorter waits for planned care

NHS Long Term Plan says:

'Waiting times remain low by historic standards, and GP referrals are flat, but in recent years treatment capacity has not grown fast enough to keep up with patient need, and the number of patients waiting longer than 18 weeks has been steadily increasing.

'Under the Long Term Plan, the local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list.

'The NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity.

'This will be supported by continued roll out of Capacity Alerts as a tool for CCGs to use to support GPs and patients to make informed decisions about where to have their treatment. Patients will continue to have choice at point of referral and anyone who has been waiting for six months will be reviewed and given the option of faster treatment at an alternative provider, with money following the patient to fund their care.'

What do we know people are concerned about?

- Planned hospital appointments and planned surgery being cancelled and rearranged.
- The process for being referred to hospital care is confusing.
- Inconsistent care between NHS trusts.
- Hospital waiting times.
- Slow waiting times for diagnosis.
- Is the care being offered over the phone or online as good as face-to-face in a hospital?
- Chronic and long-term conditions – being unable to access a specialists during a flare up.
- Poor communication between hospitals and GPs.

What progress has been made as a system so far?

- Clinicians have been working together to develop care plans that are consistent across our acute hospitals.
- Clinically agreed common referral forms across six specialities that ensure that when a patient is referred to a specialist as much appropriate information is transferred with them.
- Senior clinicians now review referrals upon receipt to identify whether a patient could be better managed by their GP with advice and support, or through community services, rather than attending a hospital appointment.
- Initial development of a tele-dermatology service which allows GPs to securely take photographs and attach them to dermatology referrals. Dermatologists can then review the photograph, in some cases saving an unnecessary hospital appointment and delivering rapid specialist advice.

What do we plan to do next?

- Further develop our care plans and associated common referral forms.
- Attach images to all dermatology referrals for faster diagnosis.
- Further develop paths for how patients with long-term conditions can access support when their condition flares up.
- Increase GP access to advice and guidance for all clinical areas, meaning that GPs will be able to access expert advice from specialist without making a referral.
- Scaling up of virtual appointments, particularly for follow up care, to reduce unnecessary hospital attendance.
- Collectively initiatives will reduce referrals by 20% within 3 years.
- We are keen to use Capacity Alerts as an information tool for GPs and their patients, and are working through the operational issues encountered during the first pilot phase.
- We are actively costing the future management of waiting-lists, alongside a review of how lists are managed and appropriate ways to manage demand. The requirements for 26 week choice will cause significant transactional cost pressures at Trusts, and the consequences and management of this are also being reviewed.
- Work is in hand to minimise the risk of patients waiting for more than 52 weeks for treatment.

Planned activities

- Develop clinical care plans and common referral forms for use by all specialist and GPs across NW London for the following specialties:
    - Respiratory

- Neurology
- Urology
- Haematology (non-cancer)
- Endocrinology
- ENT
- General Surgery

- Embed patient initiated follow up (where patients request a follow up as they need it or have a flare up, rather than being called into routine follow up appointments) for chronic long term conditions including Irritable Bowel Disorder (IBD) and Crohn's Disease.

- Improve GP access to education and support through advice and guidance for all clinical specialities.

- Increase the use of digital care and consultation methods, including telephone and video calls.

What difference will this make to people in NW London?

- Having care in place that is consistent across NW London will ensure that all residents are able to access the right clinical advice when they need it, avoiding the need to go to hospital when their GP can provide care closer to home. By changing which patients and which cases we refer to hospital we can also ensure that hospitals have more capacity to deliver a more responsive service.

- Ensuring that GPs carry out necessary tests prior to making a referral will reduce the necessity for some referrals to be made and ensure hospital appointments are not wasted as all the right results will be available to the specialist when attending an appointment requests.

- Introducing digital methods of care, including telephone and video calls will mean that patients spend less time attending appointments in the hospital. This will reduce the need for travel and substantially reduce the impact upon a patients' daily life.

- Attaching photographs to dermatology referrals will mean that dermatologists can provide rapid support to patients, identifying those patients who need further investigation but also ensuring that those patients who do not require a hospital appointment are supported by their GP.

- Providing more advice and guidance for GPs from consultant experts has the potential to avoid unnecessary hospital referrals and means that patients are

not required to attend a busy outpatient clinic.

- Ultimately this should mean that our outpatient services are more focussed upon delivering the right care to the right people at the right time, valuing our patients' time and supporting them in getting the right care, in the right place at the right time.

How will we know that we're making a difference?

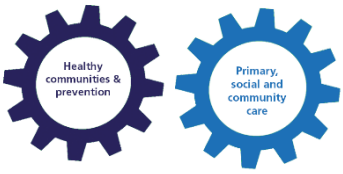
- We will see a reduction in the number of referrals sent to our hospitals and help to reduce demand on their services.

- Patients will only need to attend a face-to-face specialist appointment when there is a real clinical need.

- By ensuring all necessary tests i.e. blood tests or scans are available at specialist appointments, it will make the appointment outcome better for the patient and allow the specialist to provide the right support first time.

- Follow-up care for those with chronic and long term conditions will be provided in new ways, that don't require a face-to face appointment including: over the phone, advice passed on from specialist to GP and email.

5.9 Population health



NHS Long Term Plan says:

Develop collaborative and inclusive multi-professional system leadership, partnerships and change capability, with a shared vision and objectives…improving patient experience, outcomes and addressing health inequalities.

This chapter should be read in conjunction with the chapter: London Vision and chapter 3: Our population.

NHS and social care services recognise that our contributions to preventing ill-health, promoting wellness and wellbeing, and treating illness and disease must be reinforced by local, London-wide and national strategies to tackle employment air-quality, road systems, housing provision, safer streets, healthy eating, poverty and social or economic inequalities – and many other factors that contribute to a 'Wellbeing Index' that is meaningful for individuals, families and communities (see our 'London Vision')

What health and social care partners are doing is to work with public health specialists and local communities themselves – 'the real experts' – to identify the factors that we can have a direct impact on, and the areas that we, and other system stakeholders, can influence together.

What do we know people are concerned about?

- Knowing how to access relevant and trusted advice on looking after themselves and their families, and how to navigate the health and care system for further support.
- Consistent messages from schools, care professionals, voluntary sector about health.
- Communication and co-ordination between health and care professionals, so that they are receiving personalised advice, based on an understanding of their own or their family's history.

What progress has been made as a system so far?

- A range of case-finding tools have been developed to identify adults who are high A&E attenders, or with a high rate of non-elective admissions, and those

with an out-of-date care plan, or recently diagnosed with a long-term condition.

- Significant advances have been made in joining up acute, community and primary care sources of information to build ‘Whole Systems Integrated Care’ dashboards.

Whole Systems Integrated Care (WSIC) dashboards

The Whole Systems Integrated Care Dashboards (WSIC) are a suite of tools available to clinicians and care professionals who are providing direct care to patients.

The WSIC dashboards provide a linked integrated summary of patient's health and social care which can be used to case find and case manage patients who require more targeted and proactive care. Foe example for patients with a long term condition, they can show if a patient has had trips to A&E, or changes in test results as a result of their condition is not being managed as well as it could be. The dashboards have a series of flags that highlight patients that clinicians should proactively see to help manage their condition better.

Using WSIC in GP practices – case study

The WSIC dashboard was used to identify patients with poorly controlled Asthma based at a GP practice. Patients were identified through frequency of A&E attendances which are flagged in red on the WSIC dashboard

For one practice the WSIC dashboard identified 12 most ‘at risk patients’. The GP reviewed these patients’ compliance with inhaler therapies and regularity of annual asthma reviews to see how these patients could be helped.

Discussions with nurses & GPs at the practice led to the recommendation of initiating group consultations. This was seen as a better choice for patients as opposed to the conventional asthma review clinic and an opportunity for patients and children alike to meet with families going through similar issues. These sessions now provide regular support for this group of patients, reducing the need for attendances to A&E for help.

What do we plan to do next?

- We will develop a similar risk-stratification algorithm for children (to include healthy children, children diagnosed with long-term conditions, and children with complex health needs) and incorporate that alongside the current adult model, to include links to their family’s records.

- We will work with social care to include further appropriate details from social care records into the dashboard.

Planned activities

The key first steps are to:

- Understand in detail the nature of the local population and identify key groups for whom improvements in care specifically need to be made – including vulnerable groups due to age, background, previous or current health status, and language or other social skills.

- Enable targeted interventions - by segmenting the population into groups of people with similar needs - for both these population cohorts and the individual citizen within.

- Stratify by risk the individuals and groups for whom health and care interventions can make the most difference to their health and wellbeing, whether by immediate intervention at time of crisis, pro-active support to prevent future deterioration, or co-ordinated care between several agencies.

- Provide appropriate support by the right professional at the right time to achieve the right outcome for both the individual and the population group as a whole.

- Develop Quality Improvement models to help teams to sustainably and iteratively use these tools to demonstrate improvement in care delivery.

What difference will this make to people in NW London?

- Overall improvements to health and wellbeing for individuals, their families and the people they care for.
- Development of accessible and trusted provision of advice, information and urgent care.
- Reduced waste, inefficiency or duplication of care.
- If we do risk-stratification well, we will reduce the incidence of people having unplanned care.
- Improved co-ordination of care, and more pro-active, rather than reactive, care.

How will we know that we're making a difference?

- Multi-disciplinary teams working with a case management approach across both health and social care, for the most complex clients.

- Networked teams of general practice staff working to assess population needs and design integrated care services, for their ‘rising risk’ and moderately complex clients.
- Local general practice, as the first point of contact, providing collaborative planning and delivery of holistic accessible trusted care, 8am – 8pm 7 days a week, via shared hubs where necessary.
- Digital technology working to support individuals and care professionals.
- Using informatics and key performance indicators to demonstrate sustainable improvement in care outcomes, experience and cost reduction.

6.0 Care and quality outcomes

6.1 A strong start in life for children and young people

The NHS Long Term Plan says:

'By 2028, children and young people in England will have better physical health, mental health and wellbeing.

'Children and young people, and their parents and carers, will experience a seamless service delivered by an integrated health and care system.

'There will be a skilled workforce that listens to them, responds, and meets their needs.

'Improved care for children with long-term conditions, such as asthma, epilepsy, diabetes, and complex needs; through the development of epilepsy, diabetes and asthma networks.'

What do we know people are concerned about?

- More health checks in school.
- More health and wellbeing advise and support.
- Cultural awareness.
- Partnership working with community groups.
- More education around vaccinations.
- Parent education.
- Use more technology to engage young people.

What progress has been made as a system so far?

- Established a local children's and young people (CYP) board with named clinical and management leaders from across the NHS, local government, Children's Services and Directors of Public Health other partnership to design and deliver transformation for the system.
- Asthma primary care audit and use of WSIC dashboards to improve care and outcomes.
- Designed a CYP transformation programme comprising three child health work streams based on the following segments of the CYP population:

    - 1. The Early Years - First 1,000 days and Oral Health
    - 2. Children with Long term conditions
    - 3. Children with complex needs

Each work stream is focusing on achieving a number of ambitious outcomes.

1. The First 1,000 days project is a joint CYP and maternity programme focusing on prevention and education opportunities in early years of life. This is, a critical phase of life during which the foundations of a child's development are laid down. An early priority for this work-stream will be to explore how childhood screening and immunisation rates can be improved.

   The team will also focus on improving oral health in early childhood to reduce the number of children admitted to hospital for extraction. The team have set an ambitious target of reducing admissions by 10% which will generate significant savings that can be used to further educate children and young people in living health lives.

2. Children with Long Term Condition work-stream will focus on improving the care delivered to children with asthma. This will be delivered in part by ensuring that all children with asthma have a comprehensive care plan. It is intended that this will reduce attendances and admission to hospital by 5% and improve the provision of same day emergency care. The team will also focus on system-wide working to improve other long term conditions such as diabetes and epilepsy.

3. Children with complex needs can spend a great deal of time in hospital. These stays can often become extended as arranging a safe discharge requires multiple organisations to work with each other to support the family.

   The aim of this group is to focus on patient / family experience by ensuring children with complex needs have a comprehensive life plans. These plans will be agreed with the families and form the basis of a co-ordinated approach to care delivery. The plans will allow greater co-ordination between health and social care organisations and will be designed around the patient and family's needs. The plans will empower patients and families to take more control ensuring better care management thereby reducing unnecessary healthcare use.

What do we plan to do next?

Healthy child (first 1000 days)

- Improving uptake of immunisations across PCNs.
- Reduce emergency attendances at urgent treatment centres and A&E for jaundice, feeding problems and gastroenteritis through improved education and prevention.
- Improve provision of perinatal mental health support.

Healthy child (focus on oral health)

- Improve inequalities across communities and reduce the number of under by fives affected by tooth decay by 10%. To do this we will ensure every child:
    - sees a dentist before their first birthday
    - aged 2-3 is enrolled in a supervised brushing programme
    - of reception age receives oral health advice at school.

Long term conditions (focus on asthma)

- Over the next three years, we will reduce unwarranted variation in care of children and young people with asthma by improving our approach to correctly identifying and diagnosing asthma, ensuring every child:
    - has a co-designed Asthma Action Plan (and receives the education that is in the plan).
    - has an annual check and teaching session around inhaler technique
    - has a clinical review, by a trained professional, after any exacerbation of asthma.

Children with complex needs

Two main areas of focus:

- identifying all children and young people who have complex health needs
- offering all of these children and young people access to a Personal Care Record - #mylifeplan - (e.g. a digital Care Information Exchange record) that they and their parents / carers can use to improve their care and their wider life.

Planned activities

Healthy child 'The First 1,000 days' (a joint Maternity/CYP project)

- Improve immunisation rates across PCNs.
- Embed health visitor across PCNs to support transition from antenatal to perinatal period and infant feeding, to help reduce the number of CYP attendances to UCC and A&E.

Healthy child (oral health)

- Co-design stories, health messages, and educational support.
- Introduce a collaborative approach to drive these improvements across PCNs.
- Establish a programme that trains up a wide and diverse group of people across our communities in 'community organising' methods.
- Establish a measurement system that allows near real-time monitoring of the two main outcomes (a) the incidence of dental caries and (b) the

number of admissions to hospital for dental extraction for children under 5 at PCN level.
- Develop a seamless universal oral health prevention system in nurseries, children's centres and schools, with links to community and acute dentistry.

Long term conditions (Asthma)

- Invite children, young people and families to help with the design of the health system, including the development of pilots.
- Establish multi-disciplinary teams without walls so that children can freely access the right level of care for their needs (across primary, secondary and tertiary services).
- Unified approaches and materials will be developed for the education of staff and patients for dissemination across PCNs
- Collection of baseline data for inhaler technique, asthma action plans, asthma review numbers, plus outcomes such as emergency department and urgent care presentations and school attendance will be collected.
- Integrate the existing Paediatric Asthma Network to provide leadership for this work.

Children with complex needs

- Professionals will work with CYP and their families to understand their needs, improve their skills in order to manage their condition and achieve better outcomes.
- Health care, education and social care staff will be up-skilled to support the health needs of CYP.
- Three-way consultations with MDT (specialists), GP and family to ensure better transition at key stages in the CYP journey from pre-school to school to adulthood will be introduced.
- 'Teams without walls' will be established– specialists, including general paediatricians, children's community nurses, and paediatric therapists supporting complex care in the setting best suited to the CYP.
- A less bureaucratic 'Shared Education, Health and Care plan' will be developed through sharing of information across the system so CYP needs to tell their story only once.
- A CYP dashboard will be developed for the purpose of identify children with complex needs, enabling greater data linkage between health systems and local authority.

What difference will this make to people in NW London?

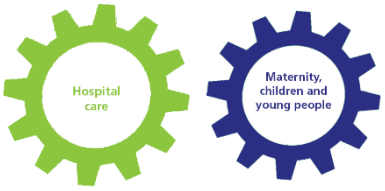
- Fewer children will:
    - be admitted to hospital for tooth extractions
    - have decayed, missing and filled teeth
    - need to take time off school
    - experience the emotional impact following dental problems.

- An improved quality of life for children and young people with asthma and their families.
- A reduction in A&E attendances and hospital admissions for CYP with asthma and babies need support with feeding difficulties and jaundice.
- A reduction in avoidable deaths from asthma.
- More parents and children and young people with complex health needs, confident to manage their condition.
- More CYP with complex needs seen in the GP practice/primary care network supported by the broader multidisciplinary team.
- More parents able to be at work.

How will we know that we're making a difference in NW London?

- Improved dental health for children under five and a 10% reduction in dental caries (decay and cavities) and reduce hospital admissions for dental extraction.
- A reduction in the unwarranted variation in care of children and young people with asthma in NW London.
- Fewer A&E and urgent treatment centre attendances for children and young people.

6.2 Maternity



NHS Long Term Plan says

'We will roll out the Saving Babies' Lives Care Bundle across every maternity unit in England in 2019. To care for women with heightened risk of pre-term birth, including younger mothers and those from deprived backgrounds, we will encourage development of specialist pre-term birth clinics across England. By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.

'The NHS will continue to improve how it learns lessons when things go wrong and minimise the chances of them happening again.

'We will continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.

'Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth. Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy. Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support … will contribute to helping to care for the 5-10% of fathers who experience mental health difficulties during the perinatal period.

'We will improve access to postnatal physiotherapy to support women who need it to recover from birth.

'We will redesign and expand neonatal critical care services to improve the safety and effectiveness of services and experience of families... We will develop our expert neonatal nursing workforce… We will enhance the experience of families during the worrying period of neonatal critical care.'

What do we know people are concerned about?

- Mothers want to be given clear consistent information about their maternity journey.
- Care needs to be safe and personal.
- Good communication.

- Continuity of care.
- To be listened to and involved in decisions.
- Feel supported.
- Easy to use booking systems.
- Cultural awareness about care and choice.
- Information that is easy to read.
- Education for new mothers.
- How to keep well in pregnancy.

What progress has been made as a system so far?

- In March 2019, over 20% (up from 1% in 16/17) of all women booked into maternity care were allocated a named midwife in a team of 6-8 midwives to provide antenatal, intrapartum (birth) and postnatal care. Plans are underway to increase the usage of the continuity of carer pathway to 35% by March 2020.

- All maternity service users can now create personal care plans with their care providers. The plans are available in digital, online or paper format.

- Information about all NW London maternity services and information about what to expect throughout pregnancy and beyond has been standardised across all maternity services. Information is available both in paper booklets and a digital app.

- All NW London maternity units are UK UNICEF Baby Friendly accredited.

- Each maternity unit has an active service user group called Maternity Voice Partnership, working with the service provider and commissioners to shape service design.

- A maternity support worker apprenticeship programme has been developed with our education partners, to support the workforce by standardising the job role and creating a career pathway into midwifery.

- We are on track to fully implement all aspects of the Saving Babies' Lives version 2 care bundle.

- Professionals from health care, local authorities and voluntary support groups are working collaboratively to reduce the number of women smoking at time of birth.

What do we plan to do next?

- Strengthen partnerships between health visiting, maternity and GPs to improve care and services offered to parents and children at the start of life.
- The Local Maternity System and Neonatal Operational Delivery Network to work collaboratively to produce local plans to implement the neonatal critical care review.
- Model and launch new continuity of carer teams targeted at populations known to have higher levels of morbidity and mortality.
- Embed the use of personal care plans with staff and users, to improve patient choice and continuity of care.
- Develop perinatal mental health services including maternity outreach clinics.
- Support the development of our local maternal medicine network.
- Implement initiatives to increase the number of smoke free pregnancies.
- Develop initiatives to improve provision of and access to women's health physiotherapy services both in the antenatal and postnatal period.

New ways of working to provide continuity of care

"This new way of working brings joy to our midwives as you can really take the time to get to know each woman you are taking care of. Life becomes a lot easier because when it's time for the woman to give birth you won't have to spend time looking at their notes as you will know the woman well already. You get the opportunity to build lasting relationships, work in really close-knit teams and for the women, care is seamless." - Consultant Midwife for Chelsea and Westminster Hospital NHS Foundation Trust

Planned activities

- Produce a detailed postnatal gap analysis to benchmark for improvements to be made to the provision of postnatal care against national guidance.
- Phase 2 of smoke free pregnancy project.
- Develop trust level transformation plans to model plans to implement 51% continuity of carer by 2021.
- Implement strategies to increase the number of midwifery led births.
- Pilot maternity social prescribing for targeted populations.

- Pilot peer to peer community perinatal support hubs.
- Develop digital strategy with ambition to provide women with digital access to their personal health records.
- Launch version 4 of Mum & Baby app. Within the next 5 years, this app will be connected to the personal health records at maternity departments, enabling parents to have an electronic version of the RedBook and access to hospital information.
- Maternity participation in system wide personalisation and obesity work groups.

What difference will this make to people in NW London?

- Clear consistent information about maternity services will be available across the NW London area, giving women choice and enabling them to access care at the right time and in the right place with the right information that they need.

- Fewer women will require medical interventions, meaning that more babies and mothers have a healthier start to parenthood.

- Continuity of carer is known to have positive outcomes on mortality and morbidity, and providing most women with this resource will make care safer.

- Women from deprived areas and those from BAME communities are more likely to suffer adverse outcomes. Improving continuity of carer for this group will reduce mortality and morbidity rates.

- Supporting women to initiate and maintain breast feeding will contribute to a healthier population. Breast feeding reduces the risks later of diabetes, obesity and ill health in infancy.

- Supporting staff to work in new ways and increase skills will aid recruitment and retention, providing our population with more midwives.

- Improved provision of postnatal care will ensure that families get off to the best start in life.

How will we know that we're making a difference?

- By March 2021, 51% of women will be booked onto a continuity of carer pathway.
- Increase in the uptake and use of personal care plans.
- Strong collaborative relationships with our local populations.
- Increased service user satisfaction.

- By 2024 a 50% reduction in stillbirth, preterm birth, neonatal intrapartum brain injury, neonatal and maternal mortality.
- Increasing numbers of women giving birth in maternity led settings.
- Robust measuring of outcomes associated with midwifery led and continuity of carer.

6.3 Learning disabilities and autism

The NHS Long Term Plan says:

'Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.

'The whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing.

'Over the next three years, autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services.

'To move more care to the community, we will support local systems to take greater control over how budgets are managed… Where possible, people with a learning disability, autism or both will be enabled to have a personal health budget. Increased investment in intensive, crisis and forensic community support will also enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services.

'We will focus on improving the quality of inpatient care across the NHS and independent sector.'

What do we know people are concerned about?

- Access to urgent specialist care.
- More proactive and person-centred community support.
- Flexible and responsive local services.
- Improved autism awareness, care and support for autistic people within mainstream care settings, especially in mental health care.
- Improved diagnostic and post-diagnostic integrated autism pathways.
- Improved support for families.
- Early identification and treatment of health conditions to prevent premature mortality.
- Having equal access to, experience of and outcomes from health care and treatment.
- Provision of annual health checks for people with learning disabilities which lead to health action plans.

- Common understanding of pathways of care for people with learning disabilities and/or autism: for example, crisis pathways for children and young people (CYP).
- Meaningful and active involvement in planning and developing new services.
- Having more choice and control, with opportunities to lead a healthy and fulfilling life in an inclusive community.
- Creative and timely transition planning with personalised support.

What progress has been made as a system so far?

Implementation of the Transforming Care Programme has seen a considerable reduction in the number of people cared for in an inpatient (overnight bedded) setting over the past four years: 67 adults with a learning disability and/or autism were receiving inpatient care at the end of March 2019, compared to 95 adults at the end of March 2016, when the programme started. As a system we are on track to meet our March 2020 adult inpatient target of 58.

Collaborative patient surgeries have improved our understanding of the needs, challenges, and gaps in services, and helped improve discharges and share learning. We have produced guidance around establishing risk of admission registers, and dynamic support registers are now routinely being used to support people with learning disabilities who are in, or approaching crisis, to remain in the community.

We have commissioned training courses including: autism awareness training for staff working in mental health services; learning disability and autism awareness training for frontline staff working in acute services; family and carer-led training on challenging behaviour for families; and Positive Behaviour Support.

The NW London Transforming Care Partnership (TCP) has also produced a housing plan, and supported local authority partners to apply for capital funding to develop specialist respite, crisis accommodation and supported living.

What do we plan to do next?

- Implementing the NHS Long Term Plan locally in NW London will mean a continued focus on reducing the number of CYP and adults who are cared for in an inpatient setting, in line with national targets.
- Our programme of work will also expand, shifting to reflect the broader commitments in the NHS Long Term Plan to support people with learning disabilities, autism or both to live longer, happier, healthier lives. This will mean local work around:
    - Improving the wellbeing of, and reducing inequalities faced by people with a learning disability and/or autism.

- Ensuring that people get the right treatment, in the right place, at the right time. Increasingly, this will mean expanding and improving our ability to care for people in the community, closer to home.
- Helping people to recover and stay well.
- Ensuring that the right activities are in place to enable this programme of work – for example, supporting the development of local provider collaborations, ensuring that a digital patient flag is in place, improving commissioning standards in line with best practice, and involving people with lived experience in the planning and checking of our local services.

Planned activities

Improving wellbeing and reducing inequalities:

- Continued roll-out of 'STOMP' and 'STAMP' programmes (Stopping over medication of people with a learning disability autism or both, and Supporting treatment and appropriate medication in paediatrics Programmes). From April 2020, as part of the new Structured Medications Review and Optimisation Service Specification, PCNs in NW London will have a dedicated focus on supporting people with learning disabilities and autism through the STOMP programme.

- Work with developing PCNs in NW London to increase the number of annual health checks we do for people aged over 14 years with learning disabilities, to ensure early identification and treatment of health conditions.

- Work with primary care and experts by experience to explore opportunities to deliver further training on autism and learning disabilities. This will be done through the Primary Care Network training hubs to help ensure that reasonable adjustments are made and the needs of autistic people and those with learning disabilities can be better met within primary care.

- Continue to monitor progress with Learning Disability Mortality Reviews (LeDeR) and ensure findings are used to address health inequalities.

- Explore options for specialist autism posts within mental health providers, to ensure reasonable adjustments are made for people accessing mainstream mental health services.

Right treatment, right time, right place:

- In line with NHS Long Term Plan investment over the coming years, we will improve the capacity of intensive, crisis and forensic community support services for CYP and adults. In 2019/20 work will focus on mapping and assessing current community provision, utilising the forthcoming national tool.

- Modelling work in Q2/3 2019 to review the demands and costs associated with the provision of inpatient care. This will help explore the opportunities

for more local, cost effective care for our population, when specialist inpatient care is required.

- Understand the circumstances of CYP admissions to inpatient units and identify opportunities for early intervention, improvement and alternatives to hospital admissions particularly for autistic children.

- Increase the uptake of Community Care (Education) and Treatment Reviews (C[E]TRs) and improve performance of repeat C[E]TRs in line with national targets, and evolving national policy.

- Mapping work is underway to understand current provision of diagnostic services and support for CYP and families across our eight boroughs, to help improve diagnostic wait times for suspected autism.

- In collaboration with local authority partners, progress bids for further capital funding to develop housing and alternatives to inpatient placements such as respite and crisis accommodation.

- Continued work to ensure the systematic use of dynamic support registers by commissioners and local community teams as a tool for proactive crisis and contingency planning, including autistic adults where this is not already fully embedded.

Supporting people to recover and stay well:

- Accelerate the rollout of personal health budgets for people with learning disabilities.

Enabling activities:

- Map current local forums for people with autism, their families and carers, to identify opportunities for co-production.

- Focus local engagement work on community provision for people with a learning disability and/or autism, and with CYP with learning disabilities and/or autism.

- Refresh our local governance arrangements to support implementation.

- Supporting the development of local NHS-led provider collaboratives that will manage specialist learning disability and autism services; this will start with the expansion of the current new models of care site in NW London from April 2020 to include CYP learning disability and autism inpatient care.

- Work with NHS England to develop a Quality Framework, focusing on improving the quality of inpatient care across the NHS and independent sector.

- Development and trial of a learning disabilities Whole Systems Integrated Care dashboard in Brent and Hillingdon with a view to rolling out across NW London.

What difference will this make to people in NW London?

- By 2023/24, in NW London, no more than 48 adults with a learning disability and/or autism, (consistent with national targets of 30 per million of our population), will be cared for in an inpatient unit. For children and young people aged under 18 with a learning disability, autism or both**,** we are aiming for no more than 7 to be cared for in an inpatient facility (consistent with national targets of between 12 and 15 per million of our population). This will represent a significant achievement against our 2015 figures.

- At least 75% of people aged over 14 years with a learning disability will have an annual health check and a health action plan.

- Reduced length of stay in specialist inpatient care, when this type of care is needed.

- Reduction in the use of restrictive practices.

- Improved quality of life for people who can be supported to identify alternatives to overmedication.

- Specialist care, closer to home.

- Reduced diagnostic waiting times for CYP with suspected autism.

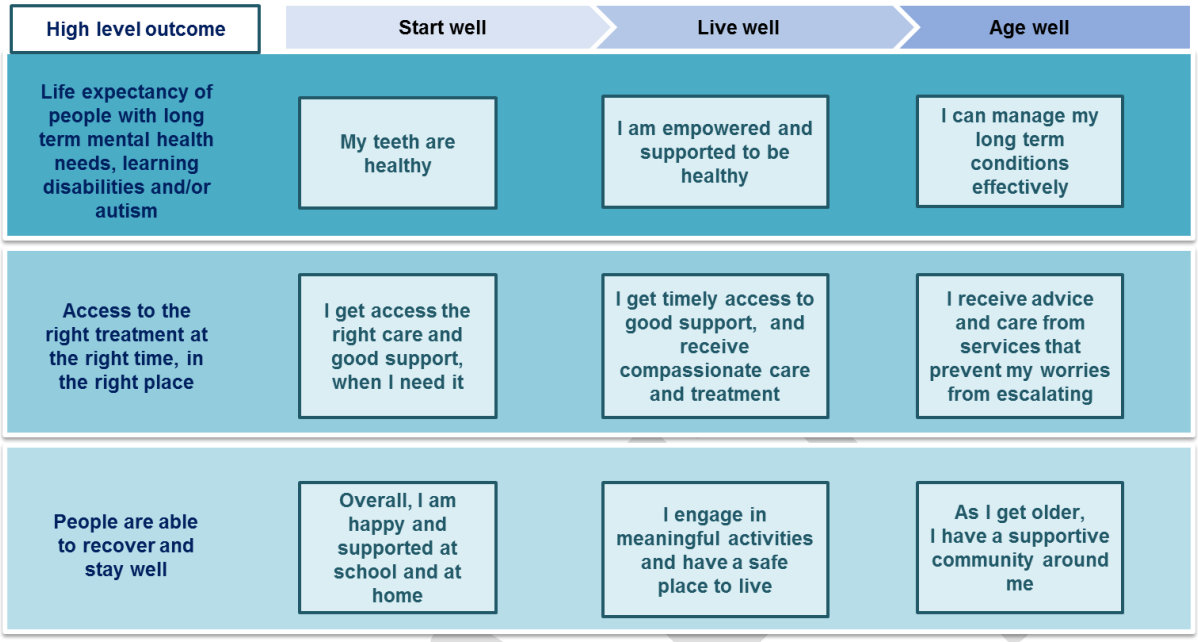
- Better support for the most vulnerable CYP with autism and/or a learning disability, and their families.

- Improved access to local mainstream health services.

- Reduced morbidity and mortality – people living longer, healthier and happier lives.

- Improved choice and control about how care and support is planned and delivered.

How will we know that we're making a difference?



Better care for major health conditions

- **Cardiovascular disease and stroke care**
- **Diabetes**
- **Respiratory disease**

6.4 Cardiovascular disease and stroke care

NHS Long Term Plan says:

'We will improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions. Where individuals are identified with high risk conditions, appropriate preventative treatments will be offered in a timely way.

'*Expanding access to genetic testing for Familial Hypercholesterolemia (FH), which causes early heart attacks and affects at least 150,000 people in England, will enable us to diagnose and treat those at genetic risk of sudden cardiac death. Currently only 7% of those with FH have been identified, but we will aim to improve that to at least 25% in the next five years through the NHS genomics programme.*

'Increasing the numbers of people at risk of heart attack and stroke who are treated for the cardiovascular high risk conditions; Atrial Fibrillation, high blood pressure and high cholesterol. This will be supported by the roll-out in 2020 of the CVDPREVENT audit.

'People with heart failure and heart valve disease will be better supported by multi-disciplinary teams as part of primary care networks… A national network of community first responders and defibrillators will help save up to 4,000 lives each year by 2028… Cardiac rehabilitation … can save lives, improve quality of life and reduce hospital readmissions.

'Integrated Stroke Delivery Networks (ISDNs)… will ensure that all stroke units will, over the next five years, meet the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke… and will support STPs and ICSs to reconfigure stroke services into specialist centres, improve the use of thrombolysis and further roll out mechanical thrombectomy.

What do we know people are concerned about?

- Access to up-to-date easy to understand information.
- Fast access to a clinical diagnosis.
- Good follow-up care and advice.
- Self-help advice.

What progress has been made as a system so far?

- The NW London cardiovascular disease (CVD) programme is being developed in partnership with the London Clinical Networks, the London CVD Prevention Partnership and specialised commissioning.

- The aims of the programme are to improve care in four main project areas: CVD prevention, heart attack, stroke and heart failure.

- Atrial Fibrillation (AF) and hypertension dashboards have been created to help better understand the needs of the local population.

- Heart failure lounges at West Middlesex and Ealing hospitals have been established with the aim to reduce hospital admissions and prevent people from deteriorating.

What do we plan to do next?

We will know our population and target prevention opportunities

The CVD prevention work stream will take learning from across the country and use evidence-based interventions to reduce the detection gap for AF, high blood pressure and high cholesterol. This includes understanding the population, and focusing on prevention and early management, so that patients receive optimal care in the community.

We will detect and diagnose sooner and better

CVD prevention seeks to improve early detection rates and management of high blood pressure, high cholesterol and irregular heart rhythm or rate (known as atrial fibrillation, or AF) in primary care.

We will work together with voluntary sector partners, and community pharmacists. GP practices will also provide opportunities for the public to check on their health, through tests for high blood pressure and use of technology for early detection. We will also identify the number of people in NW London who are at risk of heart attack and stroke. This will be supported by the roll-out in 2020 of the CVDPREVENT audit. NHS England will help support genetic testing for high cholesterol as part of the NHS genomics programme.

NW London has already made substantial progress to reduce the amount of time that it takes to diagnose AF but there is still more work to do. However, we need to identify and treat an additional 2,336 high-risk AF patients in order to meet our treatment targets.

We will effectively manage people's needs in the community

We seek to offer community based rehabilitation for people with heart conditions. We will ensure hospital and community care teams work together to ensure people's needs are managed as close to home as possible.

We will manage people with complex needs more holistically

Early treatment of heart attack can improve prognosis, reduce mortality and reduce the time people need to stay in hospital, which is better for patients. We will redesign the process for providing assessment and treatment, learning from South London who have completed this work.

- We have gathered lots of learning from other NHS regions on their existing care plans for heart attacks and stroke. We will use this data and input from expert clinicians to reduce variation in care. Support will also be provided by the London Cardiac and Stroke Clinical Network including pilot schemes in 2020/21 and 2021/22 to increase access to echocardiography and improve the investigation of those with breathlessness and the early detection of heart failure and valve disease. From 2022/23 funding for wider roll out will be included in fair shares allocations to systems.

Planned activities

- Use technology for early detection of AF and to increase our uptake of cardiac rehabilitation referrals.
- NHS England support for pilot schemes in 2020/21 and 2021/22 to increase access to echocardiography (ECGs) and improve the investigation of those with breathlessness and the early detection of heart failure and valve disease.
- Identifying and treating people at risk of high blood pressure, AF and high cholesterol. (This will be done by using the whole systems dashboard to identify people moving from no risk to some risk to rising risk, so patients can be contacted and provided the right advice and treatment)
- Redesign acute pathway for rapid diagnosis and early treatment of heart attacks.

- Improve efficiency of stroke care by co-ordinating hospital stroke services with community-based stroke rehabilitation.

What difference will this make to people in NW London?

- In general, reaching the detection and treatment targets for both AF and CVD will increase survival and improve population health.
- The right support will prevent ill health and help people manage their own care where appropriate.
- Finding the best ways to treat our residents who have any of the three high risk conditions (high blood pressure, high cholesterol and atrial fibrillation), will improve health and wellbeing.

How will we know that we're making a difference?

- Reduction in strokes and heart attacks in NW London.
- Better patient experience and patient reported outcomes for patients with CVD conditions in NW London.
- Early detection, timely and optimal treatment for our patients.
- Diagnose more people with AF and increase treatment rates.
- Diagnose more people with hypertension and increase treatment rates.
- Increase the diagnosis of Familial Hypercholesterolaemia.

6.5 Diabetes

The NHS Long Term Plan says:

'The NHS will be taking action to prevent type 2 diabetes and reduce the variation in the quality of diabetes care. For those people living with a diagnosis of type 1 or type 2 diabetes the NHS will enhance its support offer. We will support people who are newly diagnosed to manage their own health by further expanding provision of ***structured education and digital self-management support tools****, including expanding access to HeLP Diabetes, an online self-management tool for those with type 2 diabetes.*

'We are now committing to fund a doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option. We will … test an NHS programme supporting very low calorie diets for obese people with type 2 diabetes. The NHS will continue to take action on healthy NHS premises… We will ensure nutrition has a greater place in professional education training.

'The NHS will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash ***glucose monitors*** *from April 2019, ending the variation patients in some parts of the country are facing. In addition, by 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.*

'Through continuing investment in supporting delivery across primary care we will enable more people to achieve the recommended ***diabetes treatment targets*** *and drive down variation between CCGs and practices to minimise their risk of future complications. Further, for those who periodically need secondary care support we will ensure that all hospitals in future provide access to multidisciplinary footcare teams and diabetes inpatient specialist nursing teams to improve recovery and to reduce lengths of stay and future readmission rates.'*

What do we know people are concerned about?

- Better solutions, including digital, for diabetes self-care.
- More health and wellbeing advice, and more information on available services.
- More effective management of hospital admissions through better-informed referral.
- Better training for doctors on mental health and diabetes.
- Reduced risk of experiencing diabetes-related complications.
- Joined up care for patients with diabetes-related complications.
- Safe, integrated diabetes care at all levels, providing a positive patient experience.

- Mental health and emotional support especially designed for diabetes patients.

What progress has been made so far?

- Overall reduction in people diagnosed with diabetes for the first time since 2005, due to the Diabetes Prevention Programme.

- Over 7,000 patients received self-management support for diabetes since April 2018.

- Over 8000 patients benefited from the Diabetes Prevention Programme since April 2018.

- Over 1500 healthcare professionals were trained in diabetes management programmes such as the Diabetes Ten-Point Training, Cambridge Diabetes Education Programme, PitSTOP and Pre-PitSTOP programmes.

- The growth in hospital admissions for diabetes-related complications has been almost halved to 4.9% in 2018/19 from 8.3% in 2017-18.

- Continued reduction in hospital activity due to diabetes related complications (for example, heart disease, foot complications, amputations, kidney-related and eye-related complications)

What do we plan to do next?

We will know our population and target prevention opportunities

The ambition set out in the NW London Diabetes Integrated Specification aims to improve outcomes for people with diabetes by standardising diabetes care across primary, community and secondary care. This includes the following key performance indicators that will be monitored using our business intelligence tools like the Whole Systems Integrated Care (WSIC) dashboard.

We will detect and diagnose sooner and better

- We will **i**mprove the detection of non-diabetic hyperglycaemia (NDH) and reduce the gap in prevalence between people at risk of diabetes (e.g. with NDH) and diabetes prevalence.

- Increase the number of people referred to the National Diabetes Prevention Programme, with a target of 65% to have started or completed the

programme by year 2024/25 of all people eligible to have started or completed.

We will effectively manage people's needs in the community

- We will increase the number of people with diabetes (including newly diagnosed) attending structured education (as measured over a five year period). Target is for 45% of people with diabetes to have attended structured education by year 2024/25 compared to just under 10% currently.

- We will increase the number of people with diabetes meeting all 9 key care processes (as defined by NICE including sugar control, eye checks, foot checks etc.) at their annual check with GPs. Target is for 69% to have achieved all 9 key care processes by the year 2024/25 compared to the current 60% currently.

- We will increase the number of people with good control of diabetes (as measured using blood sugar, blood pressure, cholesterol) to 42% of people with diabetes achieving control by 2024/25, compared to 32% currently. This will have a significant impact on reducing the subsequent development of complications and unwanted hospital admissions.

We will manage people with complex needs more holistically

- We will reduce unwanted foot amputation rates in people with diabetes by 50% following successful harmonisation of footcare pathways, early detection and early intervention across primary, community and secondary care.

- We will reduce the number of hospital admissions due to diabetes related complications (including hyperglycaemia or hypoglycaemia) by 40% by 2024/25, compared to the current baseline.

Diabetes apps

"I was diagnosed with diabetes in 2001, it has been a gruelling journey but now I am smiling. When my GP spoke to me about these new digital apps, I was desperate to try anything. I logged on, got some equipment sent to me, changed my diet and my physical activity. I started going on lots of walks which I have grown to love. I recommend this to anyone who is living with diabetes, having difficulty losing weight and getting their HbA1c down because mine has reduced dramatically. I am delighted to have made a turnaround and want to keep it that way. I want to thank my doctor for putting me on this trial; my results have given me so much joy." - Patient in Hammersmith and Fulham living with Type 2 diabetes

Planned activities

- Full launch of the KnowDiabetes online and telephone service to benefit over 300,000 people either with diabetes or at risk of diabetes through digital or remote access and face-to-face education and support.
- Roll out the diabetes remission programme to reverse diabetes and corresponding risk of complications in over 10,000 patients.
- Redesign the multidisciplinary foot care pathway redesign and launch the footcare dashboard to support patient level and population level monitoring - and ultimately reduce amputations through better data-sharing and more staff.
- Implement NW London diabetes integrated service specification in a shadow form to enable providers across primary care, community care and secondary care to deliver care that is high quality and outcomes-based.
- Use Whole System Integrated Care dashboards to monitor and benchmark diabetes dashboards. This will help monitor patients and provide early intervention.
- Train healthcare professionals with the award winning 'Diabetes Ten-Point' training and Cambridge Diabetes Education programme.
- Update and publish diabetes clinical guidelines for use by health and care professionals in managing patients.

How will we know that we're making a difference?

- More people with diabetes having access to face to face and digital/remote structured education to improve self-care and management of their diabetes. More than 25,000 people will do this through the KnowDiabetes service to improve their quality of life.
- Increased numbers of staff trained through 'Ten Point' training which will reduce clinical errors in hospital and primary care settings.
- Improvement in diabetes control in several thousand more people. This will be measured through the three treatment targets (blood sugar, blood pressure and cholesterol). This will have a significant positive impact on their health and wellbeing.
- Continued reduction in hospital activity due to diabetes related complications (e.g. heart disease, foot complications (amputations), kidney related and eyes related).

- Diabetes care is more standardised and integrated through the use of the integrated service specification for diabetes across providers in NW London.

- Improved diabetes foot pathway and patients getting improved diabetes foot care to prevent amputations.

- More patients receiving prevention support via the National Diabetes Prevention Programme, with a reduction in new diabetes diagnoses as a result of this.

- More patients getting support to reverse their Type 2 diabetes, and using the NW London diabetes remission programme to see a sustained impact on their health and wellbeing.

What difference will this make to people in NW London?

- People with diabetes will have access to excellent on-going support at home and seamless high quality diabetes care across different care settings (e.g. GP, hospital and community).
- There will be a reduction in unwarranted variation in health outcomes.
- People will be better engaged and informed to make decisions about their own health.
- Fewer people with diabetes will need hospital care, as their condition will be well managed.
- Patients can have more confidence that a wide range of healthcare staff understand how to manage diabetes.

6.6 Respiratory

The NHS Long Term Plan says:

'The NHS will do more to detect and diagnose respiratory problems earlier. New models of providing rehabilitation to those with mild COPD, including digital tools, will be offered … We will increase the number of patients with COPD who are referred to pulmonary rehabilitation … We will do more to support those with respiratory disease to receive and use the right medication… Patients identified with community acquired pneumonia in emergency departments will be supported to be cared for safely out of hospital by receiving nurse-led support.'

What do we know people are concerned about?

- Access to up-to-date easy to understand information.
- Fast access to a clinical diagnosis.
- Good follow-up care and advice.
- Self-help.

What progress has been made as a system so far?

NW London already has some excellent primary, community and hospital support for people with respiratory conditions. For example, there are well developed community teams in the inner boroughs where patient care is joined up across local GP and community teams and hospital services. In other parts of NW London there are good rehabilitation facilities for patients. However the delivery of care and the experience of care for people with respiratory conditions is not the same across our region and there are opportunities to improve it.

What do we plan to do next?

We will know our population and target prevention opportunities

- We will use our population level data to understand where those most at risk of developing respiratory conditions live so we can tailor preventative care to their needs.

- We will use flu and pneumonia prevalence data to ensure those most at risk are offered vaccinations as soon as possible.

We will detect and diagnose sooner and better

- We will improve the diagnosis of COPD in particular, ensuring local communities have access to clinicians with recognised training and

experience in diagnosing respiratory conditions. By getting a more accurate diagnosis, we will ensure quicker access to the right care at the right time and enable more people to take control of their health while better able to influence it.

We will effectively manage people's needs in the community

- We will improve our community care offer for people with respiratory conditions to stop them needing emergency hospital care. We will make our community pathways more consistent for everyone.

- Our pharmacists will take a more significant role in supporting people with respiratory conditions, particularly reviewing people's medicines and helping them make best use of their inhalers.

- We will support more people to access pulmonary rehabilitation programmes through different methods, depending on what they feel most comfortable with – this could be face-to-face support or through an app.

We will manage people with complex needs more holistically

- Many people have multiple long term conditions and we will join up care better for them. For example, we will seek to offer joint pulmonary and cardiac rehabilitation for people who have respiratory and heart conditions.

- When people with respiratory conditions are in a crisis, we will keep them in hospital for as little time as possible, aiming to give them the treatment they need in an ambulatory setting on the same day so they can go home.

- For people at the end of their life, we will ensure they have a say in their care plan and their wishes are respected. We will make sure they and their families get the right support in the community.

Planned activities

- Create and use an asthma, COPD, pneumonia and flu dashboard to gain a better understanding of the needs of the population and support local clinicians to target their support to the right people.

- Improve the training of clinicians in the community who diagnose respiratory conditions.

- Support pharmacists in conducting medications reviews and helping people to optimise use of their inhalers.

What difference will this make to people in NW London?

- More people able to enjoy daily life to the full without feeling breathless.
- More people feeling comfortable and confident with their medications, and taking fewer medications to better effect and experiencing fewer side effects.
- More people getting care closer to home.

How will we know that we're making a difference?

- Fewer people with respiratory and exacerbations of respiratory conditions admitted to hospital in an emergency.
- Fewer people developing flu or pneumonia and being admitted to hospital with these conditions.

6.7 Research and innovation to drive future outcomes improvement

Outcomes driven by our research and innovation work have contributed to the development of the previous chapters of this document. Examples include: digital access to primary care, use of apps in our prevention and improving outcomes work and use of the Whole Systems Integrated Care dashboards to drive behaviour change and improve early intervention in patient care.

Research and innovation are key elements for the NHS to improve and deliver care for the next generation.

NW London has a significant commitment to transformation through research and innovation and is home to one of the most advanced innovation systems in the country with: world leading research organisations, the largest single site academic campus at White City and NHS hospital trusts with academic clinicians and embedded research facilities. All these contribute to both national and international changes in policy, healthcare practice, and improved care for patients.

Research

Imperial College London (ICL) and the associated Academic Health Science Centre (AHSC) are the "engine room" for health research in the sector. As one of only six Department of Health & Social Care-designated AHSCs in England, the Imperial College AHSC brings excellence in research and discovery to NW London.

We also work with the Institute of Cancer and NHS providers to provide health benefits for patients.

The AHSC is focussed on developing and evaluating new approaches to reduce the burden of disease; prevention, detection & diagnosis and better, precision treatments for cancer, infection, cardiovascular, respiratory, metabolic and brain disease.

The sector has all of the infrastructure necessary to take promising research out of the laboratory into the clinic, from proof-of-concept patient studies through to multicentre evaluative clinical trials.

AHSC's priority programme in health informatics includes linkage with whole systems integrated care (WSIC), in association with Imperial College Health Partners. In addition, expertise in artificial intelligence research are being applied to healthcare challenges around clinical decision making, diagnostics and population health analytics across the AHSC partners.

Similarly as NW London moves towards an integrated care system, the AHSC's focus on prevention and early detection of disease will become increasingly relevant. Supporting this ambition, the new Imperial vision for its School of Public Health includes a renewed and greater focus on interventional studies, child and community health.

The AHSC will also support new clinical alignment initiatives in the sector. Working with Imperial College Healthcare NHS Trust and Chelsea and Westminster NHS Foundation Trust, it is already a partner in the new West London Children's initiative and will ensure that the clinical academic model is embedded in this new service offering from the outset. Similarly there is also opportunity to align promising research technologies developed at Imperial and across the AHSC with the sector's solutions for radiology, pathology and genomics.

Proof of implementation

The NW London Applied Research Collaboration (ARC) will support implementation of research into practice, making tangible improvements for patients, the public and to health and care services. The ARC partnership in NW London brings together universities, NHS organisations, social care services, leading academics, innovators, and local authorities. The investment from the National Institute for Health Research will drive ground-breaking new projects that will address the increasing demands on the NHS and give patients greater independence and choice about how they manage their healthcare.

Our aim is to improve health in NW London through maximising the effectiveness of health improvement in areas such as prevention, early detection of disease, management of acute and long-term conditions, reducing unwarranted variation in care, and thereby achieving more equitable health outcomes. There will be a strong focus on implementation of evidence-based practices and policies, working collaboratively with our member organisations, patients and the public, and with community organisations.

Across NW London we will deliver high-quality, evidence-based health and social care services, and a greater proportion of services in community settings. We will make use of the exceptional clinical, public health, NHS management and academic capabilities in the sector to develop a system that allows innovations to be developed, adopted and evaluated rapidly. NHS efficiency will be improved and resources used more optimally by cutting duplication through the integration of services. Achieving these aims is critical to ensuring the UK has a sustainable NHS and internationally leading health outcomes.

Through our networks we are well-positioned to contribute advancements in these areas by bringing world-leading academics in public health, primary care, mental health, biomedical science and digital technology together with a strong partnership of health and care providers, patients and the public. We will continue to make significant impacts in care quality, patient outcomes and patient experience; addressing areas of significant population need. There will be a sustained focus on prevention and health improvement, as well as on mental health and social care, in our work. We will embed health economic analysis of interventions across all themes. To do so, we will conduct feasibility assessment of economic data

collection; estimate return on investment from interventions; and use simulation modelling to assess long-term cost effectiveness of programmes.

Adoption and spread

NW London recognised the need for dedicated support to utilise best practice, new technology and service models to transform healthcare some years back. Imperial College Health Partners (ICHP) was created and is today working on behalf of all NW London healthcare organisations to understand and define their most pressing issues, identify existing or emerging solutions backed by evidence, and support the sector to implement these solutions.

ICHP is also a dedicated Academic Health Science Network (AHSN), helping the sector implement seven national innovation programmes, supporting the uptake of high priority solutions identified by the Accelerated Access Collaborative (AAC) as well as the Innovation Technology Payment schemes.

Enabling patients to benefit from better quality care, proactive care management and breakthrough discoveries is key to care in NW London. A new Digital Innovation Hub (DIH), is now hosted in NW London; this hub links the Discover patient register and health data from the Whole Systems Integrated Care (WSIC) Dashboards.

The digital hub

Through the safe and secure curation of patient information and with the appropriate and agreed access methods, the hub will aim to provide leading researchers, innovators and industry access to de-identified linked patient information in near to real time to enable them to make discoveries that have not been possible before now, creating cutting edge developments in disease treatment and prevention.

The hub is also promoting a consent to contact register which aims to link gained consent to participate in future research to a medical record in WSIC which will support feasibility for clinical trials and research and recruitment supporting the LTP’s ambition to improve patient participation in research.

Genomics

In NW London there are two Genomic Medicine Centres (GMC). The main centre is hosted by Imperial, with Northwick Park and Hillingdon Hospitals serviced through the Kennedy-Galton Centre at Northwick Park.

These services form the NW London Genomic Laboratory Hub (GLH) which is hosted by Great Ormond Street Hospital. The consolidation of these services through the GLH allows for the same standards and protocols for genomic testing to be offered for the population of NW London.

7.0 Enablers

7.1 Workforce

The NHS Long Term Plan says:

'*As a service, we will now take sustained and concerted action to: ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well; ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare; strengthen and support good, compassionate and diverse leadership at all levels –managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.'*

What do we know people are concerned about?

- Recruitment is a problem, and outsourcing to agency staff reduces continuity of care.
- Staff can appear overworked and rushed.
- Poor levels of staffing.
- Reluctant to call services for help, as people know they are busy.
- Pharmacists need more training and knowledge.
- More mental health training and awareness across primary care.
- Training for carers.
- Better understanding and use of voluntary organisations.

What progress has been made as a system so far?

The NW London Workforce Board has been working collaboratively to develop and implement our workforce strategy, which looks at our workforce challenges, vacancies and agency worker use and includes plans to address these.

Workforce planning and identifying future need has so far:

- Improved staff retention by an average of 2%
- Reduced agency spend by £55m and shifted the balance from agency to bank staff in the last two years.
- Developed a training academy at Central London Community Trust to support skills development and retention.

Recruitment and retention

- Recruitment to new roles including: nursing associates, physicians associates, and clinical pharmacists in primary care.
- Successful roll out of the NHS England's International GP programme.
- Trust–driven and Capital Nurse initiatives to improve nursing recruitment.
- Introduced a "grow your own" plan to promote health careers in NW London connecting health and social care college students to NHS careers.
- Established innovative local schemes to support retention in primary care; GPs working in areas of high deprivation, GP development programmes, preceptorship and a legacy, mentorship and supervision scheme for nurses.
- The radiography career framework now provides career pathways for radiographers.

Workforce transformation and new ways of working

- Supported Primary Care Networks (PCNs) with change management.
- Training in care homes to support reduction in hospital admissions and improved quality of end of life.
- Information and training for carers.
- Provided health coaching training to inform and empower patients to self-care and provide carers with skills in caring and emotional resilience.
- Implemented 'Make Every Contact Count' to encourage changes in behaviour that have a positive effect on everyone's health and wellbeing. Over 2500 people trained and 16 trainers to ensure sustainability.
- Published with trade unions and West London NHS Trust a fair and safe shift allocation charter, which we monitor through electronic rostering.

Talent, leadership and organisational development

- Established the NW London Change Academy programme to support health and social care staff to develop and apply practical skills and knowledge to deliver place-based, integrated care.
- Implemented leadership and change management programmes to support multidisciplinary working across health and care.
- Delivered transformation programmes to increase capacity and capability to lead and accelerate change, commission for outcomes and value, and deliver sustainable solutions.

Volunteering

- Developed use of volunteers to improve and enhance the patient experience, complementing the work of employed staff across our trusts and representing the diversity of the communities we serve.

What do we plan to do next?

We are committed to changing the shape of health and care services by shifting the centre of care away from hospital into local communities, supporting people to take control of their own health and wellbeing. This will also contribute to returning to financial balance through transforming care pathways away from high cost hospital settings into the community and developing extended roles to offer care and treatment from different health professionals, more widely than from hospital consultants and GPs alone. We will have effective workforce plans that transform approaches to use of current roles, establish and embed new roles and upskill the workforce to work in this new way. Training and education for non-hospital staff will be delivered through training hubs enabling a system wide approach to staff training and development. This will provide parity with hospitals and enable new roles, or dual roles, and enable extension of existing modes of delivery to be developed, including work-based learning opportunities.

Our workforce plan

NW London workforce plans support the move to integrated care while working within planned budgets. The workforce is planned to increase by 2% over the next five years with the following components:

- The workforces for community, mental health trusts and primary care are planned to increase as we focus on moving health care out of hospital, alongside enhanced mental health provision.

- The workforce of acute and specialist trusts will reduce as we focus on treating people in the community where it is safe to do so; and, reducing the length of time people stay in hospital.

- GP numbers are planned to rise, so that we meet the current national average GP: Patient ratio.

- Nursing numbers are planned to increase slightly.

- General practice nursing numbers are expected to stabilise over the next five years.

- Plans to recruit and retain nurses will be supported by increases in multidisciplinary qualified staff delivering direct patient care in non-acute settings. There is planned recruitment of over 500 additional roles in primary and community care including: therapists, clinical pharmacists, physician's associates, and nursing associates. London Ambulance Service qualified ambulance staff is also planned to increase.

- The ambition is to ensure reductions in management and support staff so that focus can be given to front-line care.

Planned activities

Make the NHS the best place to work

- Develop a wellbeing of workforce strategy for staff.
- Consolidate occupational health provision to improve access and quality of service provided to staff.
- Create flexible, portable and attractive career opportunities for GP trainees on qualifying, including portfolio careers and fellowships through the SPIN programme.

Improve leadership culture

- Develop a system-wide leadership and organisational delivery (OD) programme for system leaders and lead clinicians to support the organisational challenges in developing an Integrated Care System (ICS).
- 'Compassionate and inclusive' leadership for Primary Care Network Clinical Directors Leadership and OD Programme.
- Develop ‘Talent Board’ programmes to improve diversity of senior leaders impacting on race and disability equality standards.
- Embed values and behaviours frameworks, focusing on recruitment, appraisals, leadership, management and behaviours development and measuring impact equality, diversity and inclusion.
- Continue to roll-out care home training and information for carers

Deliver a holistic approach to workforce transformation and workforce growth

- ‘Grow Your Own’ programme to develop NW London as a place to work for the local population, working with colleges to increase access and applications to health and care careers and apprenticeships.

- Implement and embed new roles and apprenticeship programmes including: maternity support worker, physicians associate, leadership and management.

- Develop International mental health nurse recruitment strategy and plan and extend international GP recruitment programme.

- Extend agency worker plan to reduce dependence on and cost of agency workers.

- Utilise staff passports to enable flexible movement of staff and quicker transfer between roles focussing on medical workforce and locums, in the first instance.

- Collaborate with higher education providers to improve delivery of undergraduate and postgraduate qualifications including the ‘Advanced Clinical Practice’ qualification.

Change the workforce operating model

- Pool resources and funding, where possible to deliver workforce development across provider organisations, aligned to system needs.
- Upscale nursing recruitment and retention initiative and implement nursing associate roles to increase capability to support the nursing workforce, using apprenticeships and direct entry.
- Increase nursing placement capacity in areas with greatest nursing shortages.
- Ensure equitable distribution of medical training posts linked to quality of training and service activity.
- Further roll-out of successful local retention initiatives to grow the primary care workforce.
- Develop and implement workforce plan for community pathways to improve nursing and wider staffing group utilisation within out of hospital settings and care aligned to Integrated Care Systems.

Volunteering

- Review and explore STP/ICS integrated volunteering approaches to optimise the use of volunteers to improve and enhance the patient experience, providing volunteers the opportunity to view health care as a career, alongside work experience programmes.

What difference will this make to people in NW London?

By increasing training, employment and retention of healthcare professionals and by developing new roles and professional capabilities, local people can:

- Access professionals with the right mix of skills and expertise to deliver safe and high quality care in the right way, at the right time and in the right place.
- Know that staff are well supported and have the time and resources they need to care for and support them.
- Have services locally that are commissioned and provided by organisations with the values and positive culture to put the patient first in everything they do.

How will we know that we're making a difference?

- The workforce has increased resilience, health and wellbeing – as demonstrated through staff /stakeholder surveys.
- Staff development needs are met, with monitoring of agreed action plans, improvements in partner engagement, and achievement of ICS workforce milestones.
- Values and behaviours are embedded throughout organisations.
- Feedback on health and wellbeing initiatives are positive.

- Performance systems are embedded and achieve high level of engagement.
- Clinical and staff engagement increases.
- A system wide approach to workforce development is in place.
- Recruitment and retention rates increase, as well as local recruitment rates.
- Retention of GPs increases with positive feedback on retention initiatives.

The investment in introducing the nursing associate role and introducing high quality place-based placements for all undergraduate nurses improves recruitment and retention in nursing and support to nursing roles.

We will measure improvement including:

- Reduction in vacancy rate, turnover and bank and agency spend.
- Increased stability and retention.
- Improved experience and retention of all newly qualified staff.
- Increased number of apprentices and utilisation of apprenticeship levy.
- Increased number of new roles introduced.
- Improved staff engagement and stability.
- Increases in how encouraged and supported staff feel.
- Increased engagement.
- Increased number and diversity of participants attending leadership programmes.
- Improved appraisal quality measures in staff survey.
- Increased number of staff accessing learning.
- Increase number of internal promotions.
- Reductions in gender pay gap.
- Increases in BME and female representation at senior levels.
- Reduction in sickness and absence.

7.2 Digital – Delivering digitally enabled care across the NHS

In NW London we have a strong focus on digital solutions to support and improve services and patient care. This chapter should be read in conjunction with all other chapters in this plan to see the full digital transformation picture for NW London. This chapter focusses on digital priorities not yet discussed in previous chapters.

The NHS Long Term Plan

'The NHS is made up of hundreds of separate but linked organisations, and the burden of managing complex interactions and data flows between trusts, systems and individuals too often falls on patients and digital services.

'In ten years' time, we expect the existing model of care to look markedly different…. with improved NHS IT systems and in developing new technology. We will make sure staff have the technology they need to do their jobs, and our systems can talk to each other and share vital information to support the delivery of care.'

The NHS Long Term Plan (LTP) sets out how the NHS will move to a new 21st century service model, and this is set out through the implementation of five major practical changes:

- Boosting 'out-of-hospital' care and dissolving the historic divide between primary and community health services.
- Redesigning emergency hospital services.
- Giving people more control over their own health and more personalised care when they need it.
- Digitally-enabling primary and outpatient care into the mainstream.
- Increasing the focus on population health and local delivery through new Integrated Care Systems (ICSs).

The LTP reiterates the need for investment in digital programmes, while emphasising that the current arrangements do not work well for either patients and citizens or health and care professionals, since neither has access to all the information they need at the point of care. NW London is using the recent NHS England London work on a Strategic Development Investment Framework, in order to develop a comprehensive digital strategy and prioritised investment plan. This will set out how we will address the specific digital sections of the LTP and how digital technology will enable and underpin our wider transformation plans over the next five years. NWL is also working with the other STPs across London to align strategies and deliverables as well as working on a number of joint programmes to achieve consistency for patients and deliver wider benefits and economies of scale.

Strategic Development Investment Framework

		BASIC	DEVELOPING	ADVANCED
0	**System leadership and collaboration** for digital transformation	Providers focus on individual digital visions. Local system governance lacks collective vision, purpose and/or authority to pursue shared goals. There is no dedicated digital delivery team at system level.	Local system leadership and governance mobilised to deliver a shared digital vision, across health and social care. Evidence of shared decisions carrying across system. Dedicated digital delivery team defined and mobilising.	Collaborative multi-disciplinary digital leadership across health, social care and third sectors. Dedicated digital team established with a track record of taking strategic decisions to deliver sustainable digital solutions that enable ICS outcomes.
1	**Robust foundations and digital maturity** in each provider organisation (infrastructure, solutions and skills)	Patient and clinical data captured electronically by default.* Roadmap to achieving robust infrastructure in place – incl. meeting cyberstandards, and delivering sustainable and resilient infrastructure, devices and performant connectivity across the organisation. Development of digital skills and capability planned.	IT solutions support streamlined clinical and operational processes across the organisation – incl. scheduling, rostering, referrals, prescribing and meds admin, diagnostic orders and results. Cross system use cases include radiology reporting, referrals and transfers of care. Multi-disciplinary digital team established and sharing skills at STP level.	Digital solutions enable realisation of organisational objectives and new operating models which improve patient experience and address inefficiencies,, e.g. virtual outpatients, real time bed monitoring, demand and capacity modelling, enterprise resource scheduling.
2	**A single view of a person's health and care information**, at point of care, available ubiquitously enables multi-disciplinary, multi-agency collaboration around the patient	Digital solutions enable patient level information viewing across primary and secondary care within an STP/ ICS – meds, orders & results, general health information. Staff access is based on unique identity and their role in patient care.	Ability to order and monitor requests for clinical services across the STP/ ICS – referrals & triage, transfers of care, labs, radiology, medication. Information sharing expanded across IUC and social care to support holistic patient experience and co-ordination of care.	Digital solutions enable co-ordination of care across the health and social care system – meds management/ monitoring, shared care plan creation and updating, multi-disciplinary team co-ordination. Clinical information exchangeable across the country for specialist use cases.
3	Use of **real-time information for proactive care** as part of PHM	PHM Analytics team & tools developing at system level. System PHM objectives defined (aligned to LTP priorities). Information model developing - diagnoses, meds, admissions, lab and rad orders/ results, meds. Basic population segmentation. Local data service alerts live.	PHM Analytics team embedding effective operational and technology methods/ tools. Expanded common information model to include social care. Digital solutions support basic personalisation – pop. segmentation, care gap identification, shared protocols, alerts.	Established and respected multi-disciplinary PHM Analytics team. Widespread GP adoption of digital solutions enables pro-active evidence-based interventions. Evidence of digital solutions enabling progress against system priorities and having an early impact on Pop. Health outcomes.
4	**Information and control** for **patient empowerment**	Patients are consulted about digital solutions. Apps can validate citizen ID and log meaningful preferences. Digital solutions enable primary care patients to view parts of their clinical record incl. some results in near real time, book and change appointments, order and manage prescriptions.	Patient needs and views are central to the development of digital solutions. Apps enable patient visibility of their record across care organisations. Users can see and contribute to care plans. Education, self-mgmt and triage functions are available and adoption increasing.	Patients are engaged at all stages of design and testing of digital solutions. Alpha/ beta testing supports rapid functional improvement. Apps allow users to contribute data to record. Digital interaction/ communication/ consultation with care teams is emerging. Apps consume data from the data service in near real time. Basic pro-active care functions.
5	**Leveraging population information for health improvement**: QI, PHM planning and research	Linked data is viewed retrospectively to identify patterns in specific pathways (e.g. UEC) to inform demand and capacity planning, and for local Quality Improvement projects. Data is anon/pseudonymised as needed. Consent and data protection are embedded.	Linked data is automatically anon/ pseudonymised/ and used to understand, predict and plan system capacity & flow, identify patterns in resource use, and redesign pathways. Data is made available for medical research based on a clear accreditation process.	Linked data is used to generate and test novel algorithms for early intervention; and evaluate the effects of pathway and protocol changes. Insights gained are disseminated back into care processes to drive improved outcomes via improved direct care delivery, resource usage and personalisation.

What do we know people are concerned about?

- Digital information is useful and accessible for most people, but not for all.
- Lack of 21st Century-standard digital systems in the NHS.
- Potential loss of face to face relationships with their clinicians.
- The inability of many professionals across different services to see a patient's medical records, meaning that people have to repeat their medical history many times. 'Fragmented knowledge is not good for care!'
- Not everyone is sure of the benefits of digital services and do not see them as a priority until unwell or needed urgently. Having to access digital services at those times can then be seen as an unnecessary barrier or burden.
- Privacy, security and confidentiality issues.
- GDPR compliance and the ability to opt-out.

What progress has been made as a system so far?

- Two of our hospitals are part of the 'NHS Global Digital Exemplar' programme. Imperial College Healthcare NHS Trust has successfully implemented a new comprehensive electronic patient record system, with Chelsea & Westminster NHS Foundation Trust in the process of implementing the same system. These Trusts have started to realise the long-term benefits of integrated digital patient records in terms of quality, safety and efficiency of hospital care.

- However, London North West University Healthcare NHS Trust (LNWUHT) and The Hillingdon Hospitals NHS Foundation Trust (THH) have suffered from a historical lack of investment in technology. Both hospitals operate on a

mixture of digital clinical systems and paper (e.g. medication prescribing and administration are still paper-based). Together these hospitals serve half of our boroughs in NW London, and 50% of our patients. These trusts have appointed a new Chief Information Officer who will drive forward the procurement of a digital care record; however, this is dependent on funding from NHS England and the Trusts, which has yet to be confirmed. The projected cost over 10 years is £43m against expected benefits of £125m. Until this project is funded, it will not be easily possible to realise shared care records or support service transformation through integrated care in the four boroughs of Hillingdon, Brent, Harrow and Ealing.

- Our local community and mental health trusts all have digital clinical systems that are reasonably mature, though in some boroughs they use different systems from primary care, so records cannot currently be shared with GPs.

- In primary care, GP practices are largely paperless through the use of digital systems (SystmOne in five CCGs, EMIS Web in three CCGs). Within each CCG, sharing between practices supports evening and weekend services across practices (extended access hub services), for which direct appointment bookings can be made by NHS 111. The GP systems have additional capability to support sharing across practices as part of Primary Care Networks, although further funding is required for full implementation. Implementation of electronic patient triage and online consultations is under way to meet the "Digital First" target of the NHS Long Term Plan.

- NW London has successfully developed a comprehensive patient database – Whole Systems Integrated Care (WSIC) to collect annonymised information about people's healthcare and social care. This informs the dashboards and analytical tools to enable doctors to identify patients who may be at risk and require additional help, and to support managers to allocate the right resources.

  This information is already critical to the management of the emerging Integrated Care Partnerships and will be essential for Primary Care Networks. WSIC is also a platform to share de-identified data for research purposes, subject to appropriate Information Governance, as part of national 'Digital Innovation Hub' intentions and is an exemplar for population health management within the 'One London' Local Health and Care Exemplar (LHCRE) programme.

- NW London is in the process of implementing a Health & Care Information Exchange (HCIE), led by Imperial as a Global Digital Exemplar and part of the 'One London' LHCRE programme. This will share information when needed

between health and care professionals, and with patients, their families and carers (subject to strict confidentiality rules). This capability is essential for making GP patient data securely available in other settings, sharing data with other partnership areas (15% of our acute activity is performed by trusts outside NW London), and enabling the transformation of out of hospital care and virtual outpatients. Initial efforts are concentrating on provisioning the viewing of shared records between health care environments using CERNER HIE and subsequently on supporting clinical workflows using the One London Discovery architecture.

- Our 'digital citizen' engagement programme has over 100 patient digital ambassadors, who support patients with digital care services like 'Health Help Now' app (downloaded by over 100,000 people) and the patient portal (the 'Care Information Exchange') in use by over 30,000 patient users. These are expected to be extended further through the 'One London' programme – although again dependent on further funding to ensure continuity.

- Development of 'Cassius' - a new cyber-secure shared network that will support all of our 390 GP practices, using Microsoft Cloud technology to provide one network for all practices rather than having individual network servers in each practice. This will help protect data and NHS IT systems from cyber attack and make it easier for staff to work across many different sites.

- NW London has established an advanced information governance framework to support the sharing of patient records where required for people's care, while protecting confidentiality.

What do we plan to do next?

Subject to the availability of funding, we plan to:

- Continue the roll out of Cerner electronic patient records at the two trusts where this has been initiated.
- Procure and implement a new electronic patient record system in LNWUHT and THH.
- Integrate community and mental health systems with the Health and Care Information Exchange, to support integrated care and patient engagement.
- Extend primary care systems to support PCNs and integrate with the Health and Care Information Exchange.
- Continue to invest in Whole Systems Integrated Care (WSIC), to enable doctors to have a holistic view of patients' health and care, and to support development of PCNs.
- Build a 'Digital Innovation Hub' in NWL capitalising on the success of WSIC and enabling research use of anonymised data.

- Continue to invest in the Health and Care Information Exchange, extending it to other care organisations, linking it to other London footprints as part of 'One London', promoting it to further patients, and exploiting it to deliver better and more efficient care. This will include sharing social care information, subject to strict confidentiality rules and respecting patients' wishes about whether to share.
- Continue to engage with NW London citizens about the use of digital technologies and further the use of digital technologies.
- Continue to develop the NW London Information Governance framework.

Planned activities

Current plans are uncertain given the local System Financial Recovery Plan and consequent constraints on funding, and awaiting announcements from NHSX regarding its capital programmes (Health System Led Investment – HSLI, Electronic Prescribing and Medicines Administration – EPMA, Global Digital Exemplar - GDE, and Estates and Technology Transformation Fund – ETTF).

Internal system programmes in providers, such as Cerner within Imperial and Chelsea & Westminster, will continue. However, our wider digital programme awaits confirmation of future funding before its extension can be secured.

What difference will this make to people in NW London?

- People will have easier access to information about services, and understand their health and care better, through access to their records and online advice about their conditions, enabling them to take more responsibility for their health and care and improving outcomes.
- Care professionals will be able to look after people better because they will have more information about their health and care in other settings.
- People will know that the information held about them is accurate and secure, and has been shared with those professionals who need it, so that they do not have to repeat their story, and so that care can be co-ordinated efficiently.
- People's treatment and care services will be targeted to meet their own needs, and the needs of the wider community they live in.
- The care system as a whole will run more efficiently and deliver higher quality, which should bring better outcomes across the population.

How will we know that we're making a difference?

- The hospitals of LNWUHT and THH will have digital systems to support patient care, removing the reliance on paper (e.g. for prescribing and medicines administration).
- More people have access to and use of online health and care records, measured by the numbers of users of the Health & Care Information Exchange and other patient portals such as GP Patient Online.
- Measures of the numbers of times health and care records are shared by professionals across partner organisations.
- People have better tools to help manage their heath and care, measured by increased uptake of online patient services and apps.

7.3 Estates

NHS Long Term Plan says:

'The NHS will improve the way it uses its land, buildings and equipment. This will mean we improve quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the government's target to build new homes for NHS staff. We will work with all providers to reduce the amount of non-clinical space by a further 2%. By 2020, we aim to reduce the NHS' carbon footprint by a third from 2007 levels.

'We will also improve the way we manage our estate to help to reduce emissions and to improve air quality.'

What do we know people are concerned about?

- Accessibility
- Premises that fit the need for modern health and care services
- Clean and energy-efficient premises, that do not waste resources or harm the environment

What progress has been made as a system so far?

NHS England has graded our current estates strategy as 'strong', one of only a limited number in the country to achieve this top rating. The strategy captures our response to the clinical strategy, population need, demand and population growth.

We have also:

- Developed a detailed delivery plan, bringing together all priority projects into a single plan.
- Developed a capital investment plan across acute, community and primary care estate.
- Established an effective and collaborative Strategic Estates Committee with representatives from commissioners, providers and key partners.
- Aligned with 'One Public Estate' – Partnership between Cabinet Office, Ministry of Housing, Communities and Local Government, CCGs, and NHS Property Services (PS), working to support collaborative property-led projects in local areas.
- Developed Kingswood Hospital - £4.190m invested to develop additional beds for people with learning difficulties/autistic spectrum disorders.

What do we plan to do next?

- Deliver local services hubs to support the shift of services from a hospital setting to a community-based location.

- Align estates and technology strategies to maximise the potential impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation.

- We will optimise property costs by maximising use of existing space and using technology to reduce physical infrastructure required for service delivery.

- Continuing to identify opportunities for consolidation and co-location of primary care services to maximise the potential availability of NHS England's Estates Technology Transformation Fund to improve services.

- We have identified key areas for investment (utilising local SSDPs and estate strategies) to ensure future primary care premises are fit for purpose to support delivery of high quality primary care.

- Work with Trusts to ensure unoccupied floor space does not exceed 2.5 per cent; floor space used for non-clinical purposes should not exceed 35 per cent.

Successful capital schemes

- **St Mary's Hospital** - £1.865m awarded for the development of an Endovascular Hybrid Theatre. This will facilitate integration of fixed imaging equipment into an operating theatre to enable safer surgery and intervention.

- **Park Royal Mental Health Wards** - £2.35m awarded to reconfigure wards to deliver single sex accommodation on two adult in-patient wards.

Planned activities

- Development of an estates delivery plan.

- Evaluate and map current health estate, including tenure, current void and under-utilisation across the health system. Develop strategies to reduce the void and improve efficiency of estate usage.

- Utilisation and optimisation studies will continue to be used to review the performance of existing estate and buildings. This will inform the design and

development of new efficient and technologically advanced buildings and facilities.

- One public estate – to work closely with public sector partners to optimise joint opportunities for estate rationalisation, utilise creative investment that delivers transformational change, generate efficiencies (capital receipts and reduced running costs) and support economic growth (homes and jobs).

- Work effectively with local authority planning teams to develop Local Plans, IDP and Neighbourhood plans that convey the health requirements and estate renewal to secure funding (s106 or Community Infrastructure Levy) from housing developers.

- Develop outline and full business cases that support strategic investment for acute, community and primary care transformation, including reviewing revenue implications and cost pressures.

What difference will this make to people in NW London?

- Hubs will offer more services in one place, closer to home.
- Improved and better value services.
- Reduced the cost of our estate so that money can be put back into patient services.
- Improved the quality of existing buildings.

How will we know that we're making a difference?

- More patients can access services at the right time, at the right location and to be seen by the right person.
- Patients benefit from modernised and appropriate primary care accommodation.
- Capacity for primary care is better aligned to the recent and forecast increases in our population.
- Optimised use of the health estate.
- Void space costs are reduced.

7.4 Finance

Currently the services we provide cost more than the resources allocated to us and we need to address this. In NW London as at April 2019 we collectively have an underlying NHS deficit of £324million across our clinical commissioning groups and NHS service providers, with financial challenges also present for our local authorities. The £324m represents 6.5% of the total NHS resources in NW London.

Building a Financially Sustainable System

The North West London system therefore faces difficult choices as we work to ensure we are able to continue to deliver world-class care and realise the ambition of London being the healthiest global city within the financial and staffing resources available to us. We have to review each one of the Long Term Plan commitments and assess how we are able to deliver it and over what time scale and importantly we have to leverage the synergy of working as a system. Using the experience and knowledge of our clinicians working together across organisations to standardise and consolidate our services so that all our residents are provided equal opportunity to access high quality care when they need it.

To provide more financially sustainable services we are working together to deliver 3 key aims:

- ensuring we **maximise the amount of money available to spend on direct care delivery** through reducing our back office, administration and supplies costs,
- **maximising value and delivering our services as cost effectively as possible** through standardising our approaches, enabling our staff to operate at the top of their license
- developing more proactive and preventative care thereby **managing demand for high-cost hospital services**

Within these broad areas we will specifically focus on the following areas as we work to reduce the gap in our system finances. We believe that these give us the greatest opportunity to reduce expenditure, improve value and increase the quality of care our residents receive. Our approach to these drives our transformation focus and is embedded within our integrated programme areas (as previously described).

Maximising expenditure available for direct care

- Reducing our back office costs and developing more shared services
- Moving to the top quartile for procurement
- Managing the cost of our medicines
- Assessing and reducing our programme costs
- Reducing the cost of our estates and maximising the digital opportunity to drive automation and less intensive care models

- Working as a single CCG to reduce duplication and fragmented commissioning

Maximising cost effectiveness of services

- Developing consistent and standardised pathways within the community and through our acute providers
- Enabling our staff to work at the top of their license, introducing new roles and standardising roles
- Reducing the number of people staying in hospital for a very long time
- Focussing on how we use our drug budgets
- Using our clinical expertise and tools such as the GOLD diagnostic to identify services that can be provided across providers

Managing demand

- Support to GPs and consistent referral arrangements
- Working with our new primary care networks and integrated care partnership to drive this consistent and proactive approach
- Developing alternatives to A&E so patients and professionals feel confident being cared for outside of hospital
- Developing a more proactive approach to managing long term conditions
- Better detection of cancer

How will we involve local people and organisations?

We will be talking to local authorities, local residents and other stakeholders as our plans for the next few years take shape. Some elements of our plan may require specific public engagement plans and we will work with patients, the public and all our stakeholders to get their input and build consensus around the best ways forward.

8.0 Glossary

Academic Health Science Network (AHSN) Created by NHS England to work with local health and care systems to select, encourage, develop and deliver innovative solutions that improve patient care and aid economic growth across our region.

Better Care Fund (BCF) A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

Care Programme Approach (CPA) The Care Programme Approach is a national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.

Care Quality Commission (CQC) Regulates health and care services in England and ensures these services provide people with safe, effective, compassionate, high-quality care.

Clinical Commissioning Group (CCG) Clinically led statutory NHS body responsible for the planning and commissioning of health care services for their local area. They plan, commission and monitor services. Commissioning of health services can take place at the local level by CCGs, or at a nation-wide level by NHS England. Local authorities also commission social care.

Continuing Health Care (CHC) NHS funding that meets the health and social care needs of people with the most complex health needs.

Co-production Is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Fundamentally, co-production recognises that people who use services (and their families) have knowledge and experience that can be used to improve services. The Social Care Institute for Excellence describes co-production as “people who use services and carers working in equal partnerships with professionals toward shared goals.”

Diabetes remission – Patients with type 2 diabetes can reduce their blood sugar levels weight and cholesterol through healthy life style choices. Doing this can mean the patient no longer has diabetes symptoms, called remission.

Diabetes Ten-Point Training A simple ten point guide for clinicians to use to help patients with diabetes.

Digital Accelerator An NHS England programme to support embedding of new technology to enhance and improve NHS services.

Digital First Providing digital alternatives to accessing GP appointments, this includes the use of online forms, apps and other digital technology.

Discover The 'Discover health research register' was launched in 2018. Discover is a register of adults 18 and over living in NW London who are interested in health research and want to find out more about health research opportunities. The register is for both healthy people and also those with a medical condition.

Elective care Treatment that is scheduled in advance as it does not involve a medical emergency.

Enabler A person or system that makes something possible. In the NHS enablers are the systems and processes that help achieve change and improvement. These include IT, estates, workforce and communication and engagement teams.

End of life care Support for people who are in the last months or year of their life.

Engagement Is a term commonly associated with many forms of patient, service user or public involvement. It describes processes, both formal and informal, through which commissioners may invite local communities to become involved in discussion about the shape of their local services.

Equality Health Impact Assessment (EHIA) A process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

e-Referrals – Electronic referrals made from a GP to a clinical specialist

Extended access services – GP evening and weekend appointments that are available in each borough for all patients registered with a GP to access.

Governance The ways that organisations ensure they run themselves efficiently and effectively, and the ways organisations are open and accountable to the people they serve for the work they do.

Health Help Now An app available in all NW London boroughs that provides health advice and access to GP appointments and care records. It is linked to the NHS app.

Health and Wellbeing Board A statutory formal committee of the local authority that promotes greater integration and partnership between bodies from the NHS, public health and local government. It produces a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Health Education England Health Education England is an executive non-departmental public body of the Department of Health, which provides national

leadership and coordinates education and training within the health and public health workforce within England.

Health inequalities Differences in health status between different population groups, or in the personal, social, economic, and environmental factors that influence health status.

Health Overview and Scrutiny Committee

(HOSC) Reviews and scrutinises matters relating to the planning, provision and operation of local health services. A Joint Health Scrutiny Committee oversees all eight boroughs in NW London

Healthwatch Local statutory organisation, commissioned by the local council to listen to the needs, experiences and concerns of people who use health and social care services to make sure that service commissioners and providers put people at the heart of care

"Hear and Treat" and "See and Treat" provision of telephone advice and treatment of people in their homes saving needless trips to hospital.

IAPT - A service providing evidence-based treatments for people with anxiety and depression- also called talking therapies.

Integrated Care System (ICS) A partnership of NHS organisations, local councils, the voluntary sector and others in a geographical area, who take collective responsibility for managing resources, standards, and improving the health of the population they serve.

Integrated Care Partnership (ICP)

Integrated care partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

Joint Strategic Needs Assessment (JSNA) This looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

Learning from Deaths Review (LeDeR) National programme to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

Local Medical Committee (LMC) local representative committees of NHS GPs who represent their interests in their localities to the NHS health authorities.

My Care Choices a plan for people to record and share their choices for care, including for their end of life care. Once completed consent can be given for the person's GP to record their choices on the My Care Choices Register, which is accessible for the professionals involved in the person's care.

My COPD An app that helps people with COPD (chronic obstructive pulmonary disease) to better manage their condition.

National Institute for Health and Care Excellence (NICE) Evidence-based guidance for clinicians, commissioners and providers of health and care. Neighbourhood integrated care across a range of services around populations of between 30,000 and 50,000. These services typically include general practices, community teams, some mental health services and adult social care.

NHS England (NHSE) Sets the priorities and direction of the NHS in England, and encourages and informs the national debate to improve health and care. It commissions some NHS services directly, and delegates authority to CCGs to commission other services.

NHS Long Term Plan The plan for the transformation of NHS services in England over the next 10 years, to improve quality of care and the health outcomes of the population.

Online/e-consultations A form on the GP website that can be used by patients to get advice from their GP without the need to book an appointment.

One London (LHYCRE) A programme running across London looking at how both medical and social care records can be joined up and made available to professionals across health and social care, to benefit patient care and outcomes.

Out of hospital care A form of care that is available outside of major hospitals, often referred to as primary and community care. 'Primary care' is the advice and treatment you receive from your local GP.

PAM – patient activation measure An assessment a GP does with a patient with a long-term condition to see how much of a patient's own healthcare they can manage them self.

Palliative care Aims to improve the quality of life of anyone facing a life-threatening condition. It includes physical, emotional and spiritual care.

Personal Health Budget (PHB) An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioner. It is a different way of spending health funding to meet the needs of an individual, and gives the individual greater choice and control over their care.

Population health management Collection and analysis of data on patients and the public, to help improve planning and management of health and care services in the local system.

Primary care Principally GP practices, but also includes community pharmacists, dentists and opticians.

Primary Care Networks (PCN) GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas.

Providers Acute, ambulance, community and mental health services that treat patients and service users in the NHS; social care providers including local authorities, care homes and home care organisations; and community and voluntary organisations.

Psychiatric Liaison Service Specialist mental health assessment and treatment for patients attending general hospitals.

Quality and Outcomes Framework (QOF) Indicators of the overall achievement of a GP practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. Put simply, the higher the score, the higher the financial reward for the practice.

Reconfiguration Changing the arrangement, structure or model of organisations or services.

Referral to Treatment (RTT) The framework for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently.

Rightcare NHS programme to improve spend and outcomes in care, by diagnosing the issues and using evidence to identify opportunities for improvement, developing solutions and delivering improvements for patients, populations and systems.

Risk stratification Identifying patients who are at high risk of an adverse event so that they can be offered preventive care today aimed at averting costly, unpleasant health problems tomorrow.

Secondary care Either planned (elective) care such as a cataract operation, or urgent and emergency care.

Self care or self management All the actions taken by people to recognise, treat and manage their own health, either independently or in partnership with the healthcare system.

Sustainability and Transformation Partnership or Health and care partnership (STP) Created in 2016, to bring local health and care leaders together to plan around the long-term needs of local communities. England is divided into 44 STPs

System Delivers what cannot be achieved in neighbourhoods and places, to improve and transform care, to provide oversight and accountability at ICS level.

Agenda Item 7

NORTH WEST JOINT HEATH AND OVERVIEW SCRUTINY COMMITTEE

Work Programme 2019/20

The work programme below is intended to be iterative and can be amended to reflect emerging issues.

Date and Time	Host	Activity
24 May 2019	Brent	**Members Workshop:** Annual Review and work programme
21 June 2019 1-2pm Premeeting 2-4pm Main meeting	Hounslow	• *Case for a single CCG and borough arrangements** • *Development of integrated care**
30 October 2019 1-2pm Premeeting 2-4pm Main meeting	Hammersmith & Fulham	• *North West London Financial recovery* • *Long-Term Plan submission**
10 December 2019 10:30-11.30 Pre Meeting 11:30-13:30 Main meeting	Kensington and Chelsea	• *Citizens' Panels* • *Estate Strategy for NHS London*
February 2020 *TBC Date and Time*	Richmond	• *Patient Transport and the CQC report* • *TBC*