NHS
North West London

Joint Forward Plan for North West London

Draft, July 2024

Contents

Foreword

We are delighted to introduce our five-year Joint Forward Plan (JFP).

The plan builds on the Health and Care Strategy we published last year, which sets out how North West London's eight local authorities and the local NHS will improve outcomes in population health and wellbeing, prevent ill health and tackle inequalities, enhance productivity and value for money and support broader economic and social development.

The JFP is technically joint between North West London Integrated Care Board and our partner NHS trusts, and sets out how the local NHS will prioritise, sequence and deliver measurable improvements and outlines what we will do to deliver our strategy and when. It complements the Joint Health and Wellbeing Strategies developed by each of our boroughs.

The past few years have been incredibly challenging for everybody working in the NHS, with the COVID pandemic, rising waiting lists and industrial action. Although NW London is one of the highest performing integrated care systems in the country, these challenges have not passed us by and feedback from our residents is quite clear that we can do more.

So the focus of the next two years has to be on transforming our health and care services so that they continue to respond to the needs of our residents and communities.

For the next two years we will prioritise reducing waiting times and improving productivity to provide access to a common set of high quality services regardless of where our residents live. We will, for example, test proactive approaches that prevent, reduce or delay the onset of need; support our residents to stay well; and identify and support people at risk of, or diagnosed with, illness by providing best practice interventions.

To deliver the plan, we will continue to work with local authorities, primary care, the voluntary sector and our communities across North West London to coproduce and develop services that meet our communities' needs and that they can have confidence in. Our aim is to be ready to roll out these programmes over time, within the context of a resilient, efficient and effective NHS.

Delivering this Joint Forward Plan will require building on the shift to working as a system we saw during the pandemic. It means working across sectors to foster an environment which supports healthy behaviours and lifestyles. With the commitment, expertise and resources of our partners across our collaboratives and borough-based partnerships, we are confident that we can deliver on our ambition.

Rob Hurd
Chief Executive Officer, NHS North West London ICB

Penny Dash
Chair of NHS North West London ICB

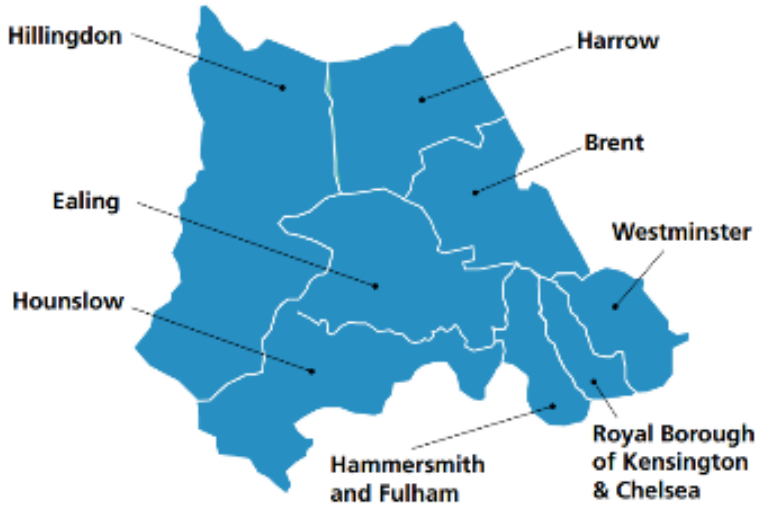
Section 1: Introduction

Who we are – our system and population

Welcome to the Joint Forward Plan for North West London. This plan sets out how the NHS will support the delivery of North West London's Health and Care Strategy, published in 2023.

North West London is one of the biggest and most complex Integrated Care Systems nationally. We have a diverse population of over two million people, who come from over 200 different ethnicities.

While in general our residents are more affluent than the national average, we also have significant clusters of multiple deprivation and concentrations of groups we struggle to hear. These include asylum seekers, travellers and members of particular ethnic groups.



Our population is:

- **Younger than elsewhere in England.** The median age across our boroughs ranges from 35 to 39 with the median age across Integrated Care Boards in England averaging 40.
- **One of the fastest growing.** Population projections are uncertain due to the ongoing impact of factors like immigration, COVID-19 and Brexit, but an increase of over 100,000 by 2040 is predicted.
- **More diverse**, with our residents speaking well over 60 different languages. Brent, Harrow, Ealing, Hounslow and Hillingdon all have a higher share of non-white population than the London average. After 'white ethnicity' the largest ethnic population is 'Asian/Asian British'.
- **More affluent than the national average, but with pockets of significant deprivation.** Kensington and Chelsea and Westminster have the highest gross disposable income in North West London and nationally, however we also have significant clusters of residents experiencing deprivation in each of our boroughs.
- **Has a higher life expectancy** than the national average, but with a **difference in life expectancy** between our most affluent and most deprived neighbourhoods of almost two decades.
- Has **higher unemployment rates and rates of people economically inactive** than the national average, and this is higher still in our most deprived populations

North West London by numbers

2.1m resident population
1,300 GPs
65,000 NHS employees
8 Boroughs
276 care homes
349 GP practices
1,500 adult social care staff
1 ambulance trust
4 acute trusts
1,500 voluntary organisations
4 community and mental health trusts

How we collaborate with our people and our communities

How we work with our voluntary partners

We are committed to help residents and our frontline staff to get the very best out of our health and care services.

Our voluntary partners are key in supporting this. Within NW London a group of like-minded charities have joined together to support & develop health and statutory services – called **3ST, Third Sector Together.**

Their mission is to combine our specialist skills and knowledge to ensure residents have equal access to services and to improve the health and wellbeing of all residents of the eight boroughs of NW London.

3ST are supporting us to develop the voluntary and community sector as a strategic partner and helping to drive closer links with our communities. Examples of work where they are supporting the NHS include: reducing health inequalities, engaging with patients and residents and supporting strategy and policy developments.

Case study: Compassionate Hillingdon

Compassionate Hillingdon, funded through the Hillingdon Health Care Partnership, is a friendship programme that supports residents who have a life limiting condition, are approaching end of life or long-term health condition.

The programme currently supports 208 people, with a volunteer group of 36. We offer in person visits and telephone calls, with a focus on friendship, as well as a monthly coffee morning, with visiting speakers.

This service makes a difference – A Compassionate Hillingdon Volunteer was asked to speak at a funeral by a family because of the difference they had made.

How we engage with our residents and communities?

Working alongside our residents and communities is critical to delivering excellent and equitable health services for our population. To ensure wide reaching involvement, our '*What Matters to You*' programme engages in a range of ways:

- Our **community outreach** programme reaches up to 60 community groups across NW London each month, going into communities and asking what matters to them as well as raising specific questions about NHS services and proposed service changes. Most of our work is targeted to specific communities to ensure we are reaching as many people as possible.
- Community representatives from some of the most deprived and marginalised communities in NW London make up our **Co-design Advisory Body (DAB)**. DAB plays a vital role in shaping the collaborative approach, ensuring that community voices and insights are central to the decision-making process. Each participant represents one community group.
- Our **Citizens' Panel is** a large group of local residents, randomly selected from people across our 8 boroughs. Some targeted recruitment took place to ensure that the panel is representative. The number of members is around 4,000 and it is used for surveys and interactive online engagement.
- We hold regular North West London **Residents' Forums** on specific topics and most borough-based partnerships hold regular forums for residents. There is an independent **Patient Participation Group Forum** which we support.
- We use a range of social media to engage with our residents and communities: Next Door, Twitter, Facebook, Instagram.
- Our Integrated Care Board and Integrated Care Partnership meet in public, with the public invited to ask questions at both meetings.
- Feedback and questions to the ICB can be submitted via our dedicated email address nhsnwl.communications.nwl@nhs.net

The health and care needs of our residents and communities

What our needs assessments across North West London tell us

- **Progress in improving health has slowed**, particularly in the past few years, and overall healthy life expectancy has probably declined.
- While North West London's population is generally younger than England as a whole, the **share of the elderly is growing** fastest. Our residents also tend to move more often.
- Local and national tragedies such as the COVID-19 pandemic and the Grenfell Tower fire have exacerbated long standing inequalities in health and care.
- Across all of our boroughs, **cancers**, **circulatory diseases**, and **respiratory diseases** are the leading cause of death. Ischaemic heart disease, followed by dementia and COVID-19, was the leading cause of death in 2022.
- Preventable mortality, such as those dying before their 75th birthday from diseases such as lung cancer, differs hugely between different areas in North West London. Some of our communities experience much higher death rates from diseases which can be effectively prevented.
- **Various demographic groups face health inequalities**, including those of different ethnicities and socioeconomic backgrounds, as well as individuals with autism or learning difficulties.
- **While progress has been made, stigma persists**, particularly in mental health among certain of our communities, and there's a call for more focus on prevention and healthy living.
- The rise in the cost of living has challenged many, while the gap between our communities in income, economic inactivity and unemployment has widened over the last five years.
- Despite efforts to improve, access to healthcare services remains inconsistent, with variations in delivery and quality across different areas.

What our residents tell us

NHS North West London, in partnership with local authorities and NHS provider trusts in our area, has an extensive outreach programme to hear from local residents and communities. This includes discussions in all eight boroughs, some on specific topics, conversations via organised public events and social media, and insights collected through our borough HealthWatches.

Every month, we publish a summary of what local people have told us in our community insight reports. These insights inform and shape our thinking on health and care services across North West London.

Consistent themes from residents include:

- Difficulty in securing timely access to primary care/GPs
- Confidence in mental health services, especially waiting times and inpatient capacity
- Hospital discharge, waiting times and cancellations
- Poor communication: a range of issues including complexity/clarity, language barriers and communication with people with learning and physical disabilities
- Barriers to accessing dental care – its cost and its availability through the NHS
- Appreciation of the potential digital healthcare offers, and concern over its potential for excluding those who most need it
- Cost of living concerns
- Potential for improving community engagement and the need to be more inclusive of communities furthest from decision-making
- Requests for more information on specific health concerns, such as cancer awareness, diabetes, mental health care services, and vaccinations

More detail on health and care need, and insights from our communities, can be found on our website**: https://www.nwlondonicb.nhs.uk/**

Our financial challenge (i)

Updated planned spend numbers
Added bottom left para in response to LA feedback

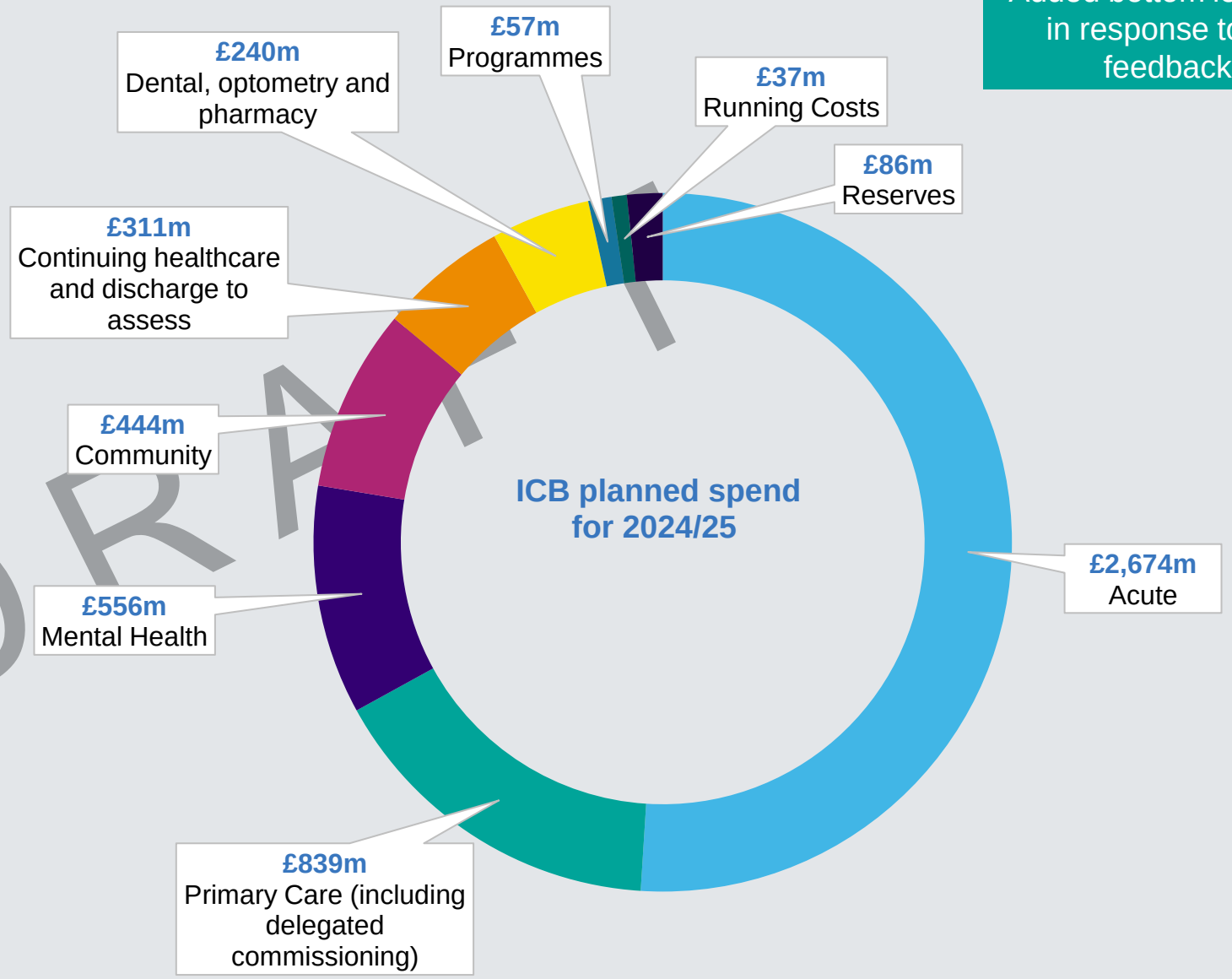
NW London Integrated Care Board receives a direct allocation of £5.3 billion. This includes spend on primary care – including dentistry, ophthalmology and pharmacy, but excludes specialised services commissioned by NHS England. This represents 4% of the national allocation to integrated care boards, and is the fifth largest nationally. The allocation is based on a formula which reflects a range of factors including demography, morbidity, deprivation, and the unavoidable cost of providing services in different areas. The formula gives North West London the sixth lowest target allocation in the country, and our actual allocation is in line with this target. This means that our allocation is 3% lower per needs weighted head of population than the national average.

£1,887
Year

Vs

£1,946
National average

Compounding the issue of the in year financial allocation, the outlook for the NHS' finances also appears challenging. The population of North West London, in common with almost all areas of England, continues to age. The Office of Budgetary Responsibility's latest fiscal risks report increased the risk of demand and cost pressures in health materialising. This suggests that pressures on health budgets – including the ICB's – are likely to be sustained.



Our financial challenge (ii)

Fairer financial allocations

While progress has been made, allocations within North West London are still largely based on decisions made by our predecessor clinical commissioning groups. Our aim is to ensure that resources and funding are allocated based on the needs of our residents. In 2023/24, North West London ICB spent more on acute care (3%), community care (9%) and continuing healthcare (9%) than need would suggest we should, and less in mental health (20%).

Over a period of three years we aim to move our expenditure allocation in line with need and will address this by:

- Ensuring all expenditure is consistently captured;
- Managing growth into those overfunded areas and increasing services commissioned in underfunded areas; and
- Commissioning services in line with the core North West London standard, eliminating duplication in services and ensuring that the correct care is provided in the most appropriate setting at the required level of productivity.

Given the low likelihood of significant growth in allocation, the bulk of this shift in allocation will need to be funded by changing models of care and improving productivity.

Our capital challenge

The NHS in North West London has some of the most challenged infrastructure in the country with a backlog of maintenance work at a cost of £1.2bn. This is more than three times the size of some other ICBs.

Ensuring that the estate remains available for use puts significant pressure on both revenue and capital budgets, whilst driving capacity issues and poor patient experience. The capital available to us to improve our estate is insufficient; we continue to push for capital support for major investments, such as the rebuilding of our four hospitals in the New Hospitals Programme.

To prioritise how and where we invest our money, we have brought together all NHS and local authority stakeholders within each borough to plan health and social care. This includes placing primary care services where the population requires it, improving utilisation of space and, wherever possible, bringing together services that improve user experience into fewer, higher quality buildings.

Our productivity challenge

The NHS is experiencing unprecedented pressures,– struggling to balance being financially sustainable whilst tackling significant waiting lists and long A&E waits as our residents age, and the acuity and complexity of their needs increase. Although North West London is typically one of the better performing systems in the country, this position is also true for us.

While money and staff have increased substantially in the last two years, productivity and efficiency have not yet recovered to pre-pandemic levels and therefore remains a critical focus for us all. It is improving productivity that will free up the funds for investing in better, more equitable services for our residents and communities.

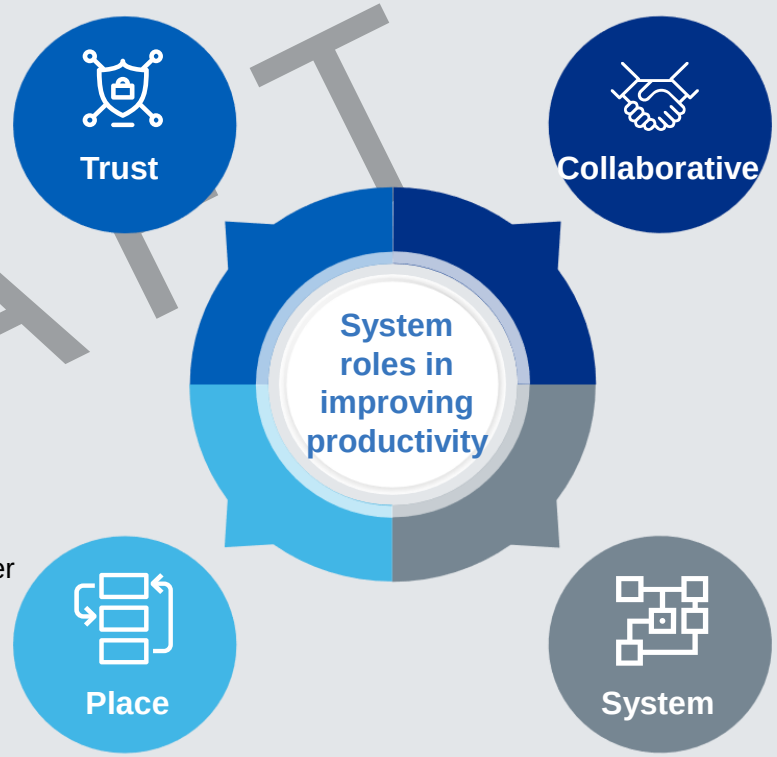
Like all parts of the country, the NHS in North West London faces a challenging position. To date, we have been able to use one off savings to ensure our expenditure matches income, but this is not sustainable in the longer term. Delivering a sustainable financial position by the 2026/27 financial year would require a 3.7% improvement in efficiency over and above normal productivity gain in each of the next three years.

Productivity is not about telling already pressed staff to work even harder. It is about changing how we work, as the examples on the next page illustrate:

- It is about how each of organisations work smarter - for example, using technology to perform routine tasks better, or to improve scheduling and minimise waste and rework;
- It is about addressing our residents' need in the least intensive setting appropriate – for example, supporting more self-care, supporting more prevention, or establishing digital options where these improve access, quality and/ or equity at lower cost
- It is about seeking to promote wellness and actively manage illness, rather than reacting to people becoming acutely unwell

Each of four levels - organisation, collaborative, place and system - has a role in bringing the system back to balance by improving productivity as laid out opposite.

Expanded definition of productivity to include the left shift, in response to LA feedback



- Recover and increase productivity to pre-pandemic levels
- Address patient waiting lists
- Improve utilisation of space
- Treat patients in lowest acuity setting appropriate

- Review payment mechanism and local prices
- Service developments to replace Mental Health Investment Standard
- New workforce roles and Additional Roles Reimbursement Scheme (ARSS) productivity

- Reduce number of physical beds open
- Better use of the Better Care Fund, develop additional capacity / winter funding, place-based innovation to increase productivity and improve flow
- Improve data capture to inform planning
- Deliver shift to lowest acuity settings where clinically appropriate

- Standardise core offer
- Embed population health data and consistent evaluation
- Align commissioning to financial recovery
- Sector led change programmes to improve access and address unmet need
- Evaluate & consolidate non-clinical services
- Enable shift to lowest acuity setting (acute to community) where clinically appropriate

Our productivity challenge: Case studies

Case study: North West London Elective Orthopaedic Centre (EOC)

In autumn 2023, the APC opened a centre of excellence for planned orthopaedic care at Central Middlesex Hospital. The EOC will deliver productivity and quality of care for patients that consistently meets best practice and delivers value for money. It supports productivity through dedicated facilities, staff and economies of scale which together embed best practice pathways, support efficient scheduling and effective outcomes.

The EOC opened 3 theatres in December 2023 and 5 theatres in April 2024, achieving so far:

- An average length of stay of 2.8 days in the first 10 weeks of operation, already almost reaching the Y2 target of 2.3 days
- Productivity benefits of £545k FYE in 2023/24
- 100% patient satisfaction

Case study: Improving flow through the autism diagnostic pathway - Community Paediatrics

The Community Paediatrics Service was struggling to cope with increased referrals and had received complaints from parents that children had to wait too long following their first appointment for assessment and diagnosis. The multidisciplinary team used quality improvement methodology to identify and test changes to the clinical pathway to reduce wait times. This resulted in:

- A reduction in time from assessment to diagnosis for children under 11 from an average of 25 weeks to 3 weeks.
- Tested new pathway for children over 11 years which has reduced journey time from referral to diagnosis from an average of 82 weeks to an average of 48 weeks.
- Improved staff morale, despite rising workload and ongoing challenges
- Encouraged a culture of improvement and learning across the department.

Case Study: National Wound care strategy

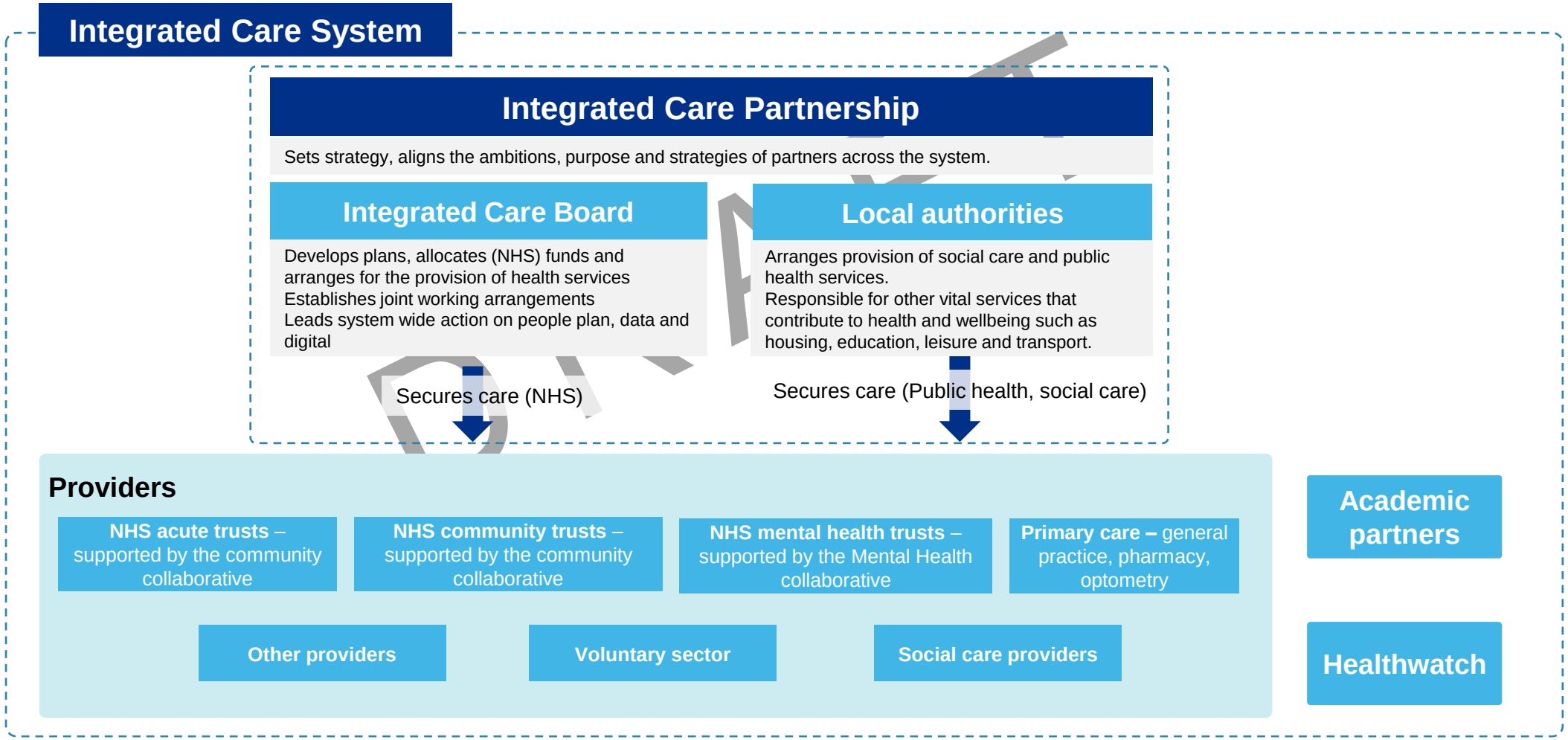
Community services in Goodall, hosted by Central North West London Community Services (CNWL) is an early implementer site for the national wound care strategy. We have focused on more consistent, and improved pathways which has resulted in wounds being healed quicker, but also not having recurring wounds which has reduced pressures on a range of services that include district nursing, complex wound care but also primary care services and acute hospitals. Patient experience has also improved.

Healing rates at 24 weeks have improved from 14% in April 2023 to 57% in December 2023 for venous leg ulcers.

There is now greater awareness across the system to identify and support wound care earlier, the new pathways support a preventative rather than reactive approach, and there is increased capability and confidence across all the teams to support patients with wounds.

The way health and care is organised has fundamentally shifted in the last years

Integrated care systems (ICSs) are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration.



Our organisational challenge

Our Integrated Care System is still new, and managing a series of changes

The Health and Care Act 2022 led to significant changes in how the NHS operates. This included establishing Integrated Care Boards with new statutory responsibilities (in place of Clinical Commissioning Groups), and the furthering of partnerships between trusts, otherwise known as provider collaboratives. As a system across North West London, including our local authority and voluntary sector colleagues, we continue to work through the implications of these changes so we can continue to deliver the changes our residents need.

We are restructuring our workforce

In addition to the new responsibilities, the Integrated Care Board is required to reduce its internal administration (running) costs by 30% by 2025/26. The Integrated Care Board is therefore restructuring its teams to match skills more closely to expectations and duties with fewer staff. Over 2024/25 we will need to spend significant time embedding this change and developing ways of working within the resource available, This includes some of our largest areas of spend such as continuing healthcare.

We are continuing to develop our values and operating model

Our ways of working – known as our operating model - have been agreed with partners across North West London. The model has our borough based partnerships at its core, supported by our ICS programmes and other ICB teams. Working collectively will help us to simplify across our 8 boroughs. The ICB's values stress empowered communities, always being inclusive, growing together, driving innovation and being mutually accountable, and will support us to increase our effectiveness and productivity. However, as we continue to develop, we will need to update the model so we continue to improve how we deliver our objectives.

Our nascent provider collaboratives are establishing resilience

North West London currently has three provider collaboratives - acute care, mental health and community care. The collaboratives provide a great opportunity to capture the benefits of scale, reduce unnecessary variation and create greater resilience within our system and their role will grow and evolve over the period of this plan.

We continue to build relationships with our Local Authorities

Improving health and care for our residents and communities requires close working with our eight local authorities – including their children's, adult social services and public health teams - to address the needs of our residents. Our borough based partnerships are the vehicle for achieving this by working differently and more effectively with local authorities to share resources and expertise across the system.

What does this mean for our Joint Forward Plan?

The Integrated Care Board has established an organisational design programme to improve how the ICB can deliver its objectives more effectively. This includes:.

- Identifying and building the right capacity, capability and culture;
- Changing the way we work to clearly define roles, responsibilities and expectations of different parts of the system – for example aligning commissioning with local authorities;
- Redesigning our organisation to ensure functions, structures and governance enable the right conditions to deliver our objectives;
- Revamping our processes to enable our staff to work as slickly as possible; and
- Building and embedding ways of evaluating the effectiveness of all of our work.

As part of this, this Joint Forward Plan prioritises and phases the implementation of objectives over a period of five years, committing to doing the right number of things well and tracking progress effectively rather than attempting everything at once.

It also means that this plan will be updated annually as the operating model develops and the change programmes across partners in North West London deliver and evolve.

What we promised in our Health and Care strategy

The health and care system in North West London aims to:

Support population health and well-being.

North West London aims to address wider determinants of health by partnering to improve access to education and employment, utilising NHS land for housing, ensuring fair wages, boosting digital skills, supporting local businesses, and promoting sustainability efforts.

Regarding healthy behaviors, we plan to collaborate with public health partners to reduce smoking rates, improve diet and exercise, identify and treat residents at risk of high blood pressure, and increase uptake of preventative services through cross-sector collaboration and lessons from the COVID-19 vaccination programme.

Address inequalities in health outcomes, access, and experience.

We aim to address health inequalities through several initiatives. This includes developing a unified approach for residents regardless of location, ensuring consistent quality of care, understanding population health data, supporting unpaid carers and addressing structural racism in healthcare.

Improving access and outcomes for vulnerable groups like the homeless and asylum seekers, enhancing early cancer diagnosis and long-term condition management, combating mental health stigma. Providing tailored support for specific communities such as black women and those with learning disabilities or autism is also a key priority.

Improve access to care.

Efforts will focus on improving access to primary care by effectively organising and managing access to urgent care, embracing digital technology for triage and appointments, and implementing integrated neighbourhood teams, with general practice at their heart, to coordinate community physical and mental health services.

Additionally, investments in expanding capacity for mental health, learning disabilities, and autism services are a focus, along with improving access to specialist expertise and diagnosis through integrated teams and digital tools.

Promote home-based care when possible.

While hospitals and care homes may be the right place for some of our residents, for many we can provide a better service with less disruption to people's lives by bringing expertise and support to people's homes.

To do this we will implement joint care planning across all health and care settings, give personalised support for long-term conditions, and proactive care planning for end-of-life care. Collaboration with social care partnerships with voluntary providers aims to prevent hospital and care home admissions, while ambulatory care services will be provided in GP practices and urgent care centres.

Prioritize the health and well-being of babies, children, and young people.

We will invest more in supporting babies, children and young people to be happy healthy adults, by addressing obesity, promoting healthy weight in early childhood, increasing breastfeeding rates, and improving immunisation uptake and oral health.

Efforts also aim to enhance access to mental health support, especially through schools and digital platforms, and to develop consistent models of care through child health and family hubs.

Enhance the productivity and quality of the health and care system, collaborating with residents and communities.

We know that the resources available to providers of health and care are limited and funding available for social care and public health has constrained. While the number of health and care staff have risen, we face difficulties in recruitment and retention.

We must therefore continue to innovate, improve and deliver as effective care as we can within the budget available to us while valuing and developing our people.

How we have reflected the Health and Care strategy in our Joint Forward Plan

In November 2023 we published our Health and Care strategy for North West London, with six key areas of focus.

The Joint Forward Plan takes the strategy, the nationally set NHS operating plan and agreed national and local targets together, and translates them into meaningful milestones and activities. This clarifies where the NHS will prioritise resources and objectives now and where we should invest in the future. We have focussed on nine specific priorities, supported by a number of enabling programmes, to deliver this Joint Forward Plan.

Our Joint Forward Plan sets out the time period for delivering these priorities and intended outcomes.

Delivery will require cross-system collaboration from our providers through provider collaboratives, ICS programme teams, clinical networks, voluntary and community sector organisations (VCSEs) and borough teams.

Our borough based partnerships and provider collaboratives will continue to have their own specific plans to improve health and wellbeing and to deliver the operating plan. However, aligning these with the Joint Forward Plan will mean that we can concentrate resources across the system in the most effective way possible.

We published our Health and Care strategy in November 2023

- Support population health and well-being.
- Address inequalities in health outcomes, access, and experience
- Improve access to care.
- Promote home-based care when possible.
- Prioritize the health and well-being of babies, children, and young people.
- Enhance the productivity and quality of the health and care system, collaborating with residents and communities.

Financial considerations | **Our annual NHS operating plan**

Which formed our nine priorities

Our enabling programmes are vital in supporting all of our priorities

WORKFORCE | **DIGITAL & DATA** | **ESTATES** | **COMMUNICATIONS & INVOLVEMENT**

With locally-specific support driven through our Boroughs

- Hammersmith & Fulham
- Hounslow
- Brent
- Harrow
- Kensington & Chelsea
- Ealing
- Hillingdon
- Westminster

NHS partners across North West London are committed to reviewing and updating this Joint Forward Plan each year. This will enable us to respond to future pressures and changing population need. In 2024/25, we will agree strategies for **Digital and Data, Estates, Urgent and Emergency Care, Maternity and Mental Health Learning Disabilities and Autism.** Our **Acute Provider Collaborative** will also publish a strategy covering **Planned Care.**

Once agreed, these strategies will be incorporated into next year's plan

Section 2: Our priorities for North West London

What are North West London's priorities over the next five years?

We have collectively identified nine priorities for the NHS across North West London to focus on over the five years period covered by this Joint Forward Plan. These priorities will benefit from a system-wide approach. Our collaboratives and enabling teams will support these priorities, while our borough based partnerships will supplement these with local priorities where there is specific local need.

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management	Develop and embed a population health management capability and focus on areas where outcomes, access and experience vary most to reduce inequalities and improve health and wellbeing
PRIORITY 2: Improve children and young people's mental health and community care	Improve health and wellbeing outcomes for children and young people, including targeted interventions for our core at risk groups
PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with general practice at their heart	Establish INTs with primary care at their heart to improve same day access to care for those who need it and provide proactive joined-up care for people with long term conditions or complex needs
PRIORITY 4: Improve mental health services in the community and for people in crisis	Maximise the productivity of community-based mental health services and increase access to mental health crisis services
PRIORITY 5: Embed access to a consistent, high quality set of community services by maximising productivity	Implement a common core offer in community services (initial focus on community nursing, community beds and neuro rehab) and then drive increased productivity across these services.
PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place	Deliver improvements across the system to ensure patients are treated in the most appropriate setting – avoiding admission, minimising hospital stays and supporting timely discharge
PRIORITY 7: Transform maternity care	Improve maternity services to reduce inequalities in outcomes and improve quality for all
PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment	Improve early diagnosis by tackling variation in screening and deliver faster and more efficient access to diagnosis and treatment.
PRIORITY 9: Transform the way planned care works	Transform planned care to reduce waiting times for diagnostics, outpatients and elective surgery and manage rise in demand for hospital services so patients can be seen in the most appropriate setting

Our enabling programmes are vital in supporting all of our priorities:

- WORKFORCE
- DIGITAL & DATA
- ESTATES
- COMMUNICATIONS & INVOLVEMENT

Our priorities build on and incorporate the objectives laid out in North West London ICB's medium-term financial strategy

System level

- We will aim to allocate system funding to the health needs within the system and use payment mechanisms that facilitate the movement of care to the appropriate setting
- Work as a system to improve urgent and emergency care easing service pressures and reducing system cost.
- We will bring together specialist services to reduce duplication and cost whilst improving clinical pathways and clinical outcomes
- We will maximise the potential and effectiveness of London Ambulance Service (LAS), reducing the number of patients being transported to acute settings by increasing 111 services, more suitable pathways, the use of mental health cars that mean that mental health patients are initially seen by a mental health nurse, identifying and treating health issues early and making the offering central to the emergency pathway
- We will aim to consolidate non-clinical functions looking to provide once for North West London wherever we can e.g. Procurement, Payroll, Business Intelligence & Occupational Health
- We will work as a system to reduce our estate footprint and cost creating an affordable, sustainable fit for purpose rationalised estate in all sectors and North West London boroughs
- Improve our digital capability supporting improved patient outcomes, digital patient access, data quality and business intelligence to drive continuous improvement with data
- Jointly invest in North West London assets e.g. hubs for simple medical procedures that are performed frequently, shared health records and increased expert opinion
- Create a more sustainable workforce that takes advantage of flexible working, new roles and links to planned activity and staff wellbeing

Provider level

Primary Care

- Close the funding gap in all areas and target investment to communities with highest need
- Continue to expand the single offer of enhanced services for general practice
- Reduce unwarranted clinical variation and advice and guidance to reduce referrals to secondary care, prescribing and testing
- Ensure we get value for money for all we do, including continuing healthcare (CHC) placements, prescribing and procurement

Acute Care

- Protect acute services by ensuring people only go to hospital when they need to and improving support for them to leave hospital safely
- Work collaboratively to increase standardised approaches, reduce the cost base and improve efficiency, using measures like Model Hospital and Reference Costs, bring our expenditure in line with population need.
- Offer support to transfer services between organisations where there are inefficiencies that cannot be improved – with appropriate public engagement

Mental Health Services

- Invest in mental health, funding the Mental Health Investment Standard and establish a consistent set of services on offer to residents across North West London
- Improve access and target investment to those communities with the highest need
- Have a consistent way of reporting to understand drivers of the cost base and improve productivity
- Reduce the cost of, and reliance on, treating patients outside North West London
- Reduce service duplication by working as a system.

Community Care

- Establish a consistent offer for residents across North West London, funded by improving efficiency
- Invest to ensure our out of hospital provision supports faster discharge of patients and alternative patient pathways are available
- Have standard activity reporting to understand drivers of the cost base and improve productivity.
- Improve efficiency, using measures like bench-marking against other providers and average costs of secondary care in the NHS.

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

Summary

The success of the Integrated Care Board will be judged by whether we have reduced inequalities in outcomes, access and experience for our residents and communities. We will do this in three ways:

- By establishing a common set of services that all our residents can access, no matter where they live in North West London
- By working with our communities to tailor and improve access to those services, so that all residents have confidence in seeking access and in the experience they will receive
- By complementing these services in common with activities which address the holistic needs of our communities and where the needs of particular groups of residents cannot be met by tailoring the services in common.

Population health management brings together health-related data to identify specific populations and/or individuals that can benefit from the tailoring of services, or from services that are bespoke to their particular needs. This builds on the 'Core20Plus5' – improving the equity of experience, access and outcomes to those of our residents living in the most deprived 20% of neighbourhoods, in particular in the 5 areas NHS England has identified for both adults and children.

To enable this, we will:

- Continue to expand the Whole System Integrated Care (WSIC) database, aligning this with other data sources to better understand need across our communities;
- Continue to foster closer working relationships with our communities to ensure that the quantitative data is supported by qualitative data and insight;
- Use this intelligence, and a comprehensive review of costs and activity, to support decisions which make the best use of resource and have the greatest impact on health and wellbeing;
- Develop and implement approaches to co-producing solutions that meet specific hyperlocal needs and in turn build trust with our communities;
- Develop and roll out a Population Health Management and Health Equity Academy to develop core skills across the ICS, including how we meaningfully engage with our residents;
- Work closely with our partners to encourage a proactive, preventative approach that maximises our impact on the social, environmental and behavioural determinants of health;
- Build our capacity to effectively evaluate the work of the ICB and its partners;
- Use population health as an exemplar for how we introduce and scale innovations – starting with cardiovascular health – across North West London.

We will embed these approaches across all care settings, including borough-based partnerships, primary care and Integrated Neighbourhood Teams. We will also give all staff the tools they need to demonstrate value and evidence impact, and systematically embed evaluation through all our work and build skills in our frontline staff to make every contact count.

Through these changes we will reduce inequalities in access, experience and outcomes, increase levels of trust with marginalised communities, improve value for money and opportunity to build on 'what works' across the system.

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

Case for change

- In in our least resourced neighbourhoods in North West London people are dying a over decade earlier than in other areas. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years.
- When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. For example, children from households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those in the highest fifth. There is a high level of overcrowded households in NW London, more than double the national average, and this is strongly correlated with non-White British ethnicity
- Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health – risk factors such as smoking and obesity are strongly causally linked to our population's most common long term conditions such as cardiovascular disease, chronic respiratory disease, cancers and diabetes. NWL's hospital admission rate is one of the highest in the country (even when taking into account the needs of our population), demonstrating that we are not investing in upstream, proactive, preventative care.
- People from our different communities also have very different experiences of the health and care services that we provide, including differential access to preventative care, meaning that we are not routinely identifying people early at risk of illness and are diagnosing conditions later. Examples include gaps in the early diagnosis of prostate cancer amongst black communities and in maternity outcomes for black and Asian mothers compared to white mothers.
- We are not tailoring services to be culturally competent to meet people's needs, meaning that they are not provided in a way that meets their cultural, ethical or religious needs. This is leading to very different and varying health outcomes in different neighbourhoods.
- In a challenging financial environment, it is essential that activity across the system is aligned with need so spend can be targeted on the most effective interventions to ensure equitable and proactive care for our population.

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

What do we want to achieve?

	Aim	Target date	Outcomes	Dependencies	Owner / governance
Improving PHM capability	Embed Population Health Management (PHM) skills through PHM & Health Equity Academy	March 2025	• Health and care services designed around the needs of our communities • Improved value for money through delivery of services that are most appropriate for the local population	• BI to enable data sharing and investment in technology • OD/CPOs to embed PHM skills in BAU	• Health Equity Programme team and board, PHM steering group • ICB effectiveness governance
	PHM roll out across functions, including primary care and INTs	2027/28	• PHM approach embedded in all services. Services designed around population need and addressing inequalities	• Primary care, community services redesign • Data and digital capabilities to enable data-driven decision making in different settings	• Health Equity Programme team and board, Primary Care Board • Borough partners
Targeted interventions to reduce healthcare inequalities	Embed tools and frameworks to address barriers to access and differential outcomes, building a culture of tackling inequity	2027/28	• Consistent system-wide approach to inequalities • Improved trust in health and care services, overcoming hesitancy and supporting delivery of the common offer • Clearer oversight of differences across North West London and where action is needed, through common core metrics • Improved connection to local communities • Reduced levels of digital exclusion • Fewer access barriers related to communication	• Ownership of equity metrics/planning by ICB teams, and commitment to action plans • Co-delivery of metrics with BI and performance teams • Digital team to improve access to services • Communications and engagement	• Health Equity Programme team and Board, Data and Digital programme boards, wider Programme boards
	Co-design interventions to reduce inequalities in access, experience and outcomes, focusing on areas of greatest inequity.	2027/28	• Reduced variation with a focus on conditions with worst outcomes/highest inequalities, complementing common offer through additional services tailored to need • Integration of actions, incentives and tools to drive equity for our population	• Prioritisation of Core20Plus5 clinical areas in programme workplans • Whole system collaboration • On-going support from primary care to increase reach, referrals, treatment targets	• Health Equity Programme team and wider Programme boards, CRGs and North West London ICB Board
Take action on wider determinants of health	Build partnerships to address the wider determinants of health	2027/28	• Reduced gap in healthy life expectancy • Increased employment with focus on Core20Plus • Reduced poor health related to housing conditions • Reduced levels of smoking and unhealthy weight	• Public health teams • Local authorities and West London Alliance • NHS Trusts as Anchor institutions • VCS organisations	• Programme team • Local Authorities

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

What do we want to achieve?

	Aim	Outcomes	Dependencies	Owner / governance
Enabling functions	Workforce	• Increased local employment, increasing black and ethnic minority staff in senior roles to reflect North West London population • PHM skills in workforce, including analytics and co-production: services to better meet community needs. • More opportunities for Making Every Contact Count	• Business intelligence (BI) and data and digital programmes • Wider workforce programme • Primary care workforce programme	• North West London People Board with oversight by the Joint Lead Chief People Officers
	Data and digital	• Strategic reporting to support ICB teams, BBPs and INTs, identifies inequalities and areas of need. • Development of an easy to use front-end for primary care, and other care settings, to case find patients	• Interoperability with FDP to make use of existing data feeds in Foundry and linking with primary care and community data held in WSIC	• North West London Data and Analytics Steering Group, reporting to Digital Transformation Board and ICB Board
	Communications	• Communication/engagement with communities are culturally competent, build trust and reduce inequalities	• Consistent approach to co-production with communities, working with Borough teams	• Communities and engagement, BBPs

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

How will we achieve our outcomes?

	Aim	Focus year	Year 1	Year 2	Year 3 +
Improving PHM capability	Embed Population Health Management (PHM) skills through PHM & Health Equity Academy	Year 1	• Delivery of PHM & Health Equity Academy – upskilling ICS staff • Map financial position to need (activity/costs plus demographic, geographic etc. data)	• Expansion of PHM Academy with focus on analytics across all staff and working with ICS partners • Start to develop a medium term financial strategy aligned to need	• Embed PHM Academy into wider ICB training offer and expand connection with system partners. Monitoring and maintaining support in line with need. • Development of ICS Intelligence Function – supporting BI maturity against known criteria/development framework
	PHM roll out across functions, including primary care and INTs	Years 2-3	• Trial PHM in Primary Care across reactive, planned/preventative care services • Start to roll-out clinical effectiveness	• Embed PHM in Primary Care • Undertake impact assessment • Fully embed clinical effectiveness	• PHM pilot in wider system and community; built on learning. • Identify functions to enable PHM implementation/evaluation • Embed PHM in all INTs to drive service design and investment decisions.
Targeted interventions to reduce healthcare inequalities	Embed tools and frameworks to address barriers to access and differential outcomes, building a culture of tackling inequity	Years 1-2	• Focus on increasing trust, addressing hesitancy, and digital inclusion • Update inequalities metrics/dashboard • Develop use of metrics and community insight to drive action • Embed equity in ICB processes	• Focus on addressing barriers related to communication • Consistent tracking of metrics; spread equity index approach • Embed co-production approach • Deep dive and redesign of HIT funding	• Deliver inequalities community impact report • Redesign Health Inequalities Transformation funding to have maximum impact, mainstreaming successful interventions into BAU • Embed closer link to communities and culture of learning, sharing and co-production
	Co-design interventions to reduce inequalities in access, experience and outcomes, focusing on areas of greatest inequity.	Years 1-5	• Focus on hypertension, mental health, maternity, and cancer diagnosis in black communities • Map inequalities in ICB priorities, using PHM approach • Implementation of High Intensity Use programme in Urgent and Emergency Care	• Focus on diabetes and gynaecological conditions • Tackle inequalities in ICB priorities, complementing common offer	• Target PHM approaches to deliver interventions to reduce inequalities of access and outcomes across other pathways • Focus on specialist services and dementia

PRIORITY 1: Reduce inequalities and improve health outcomes through population health management

How will we achieve our outcomes?

	Aim	Focus year	Year 1	Year 2	Year 3 +
Take action on wider determinants of health	Build partnerships to address the wider determinants of health	Year 1-4	• Focus on tobacco dependency • Test system approach to, and strengthen ICB delivery in prevention through ICP priority areas (oral health, vaccinations, and cancer screening) • Focus on employment and housing • Delivery of Anchor Charter and VCS infrastructure support	• Focus on healthy weight • Refresh Anchor Charter; and monitor impact • System volunteering strategy • Grow VCS relationship and support	• System-wide approach to proactive prevention • Continued focus on healthy weight • Roll out refreshed Anchor Charter and create networks to share expertise and ideas • Roll-out training on Making Every Contact Count • Embed VCS ways of working and infrastructure development
Enabling functions	Workforce		• Embed PHM skills in BAU • Deliver leadership training schemes for local graduates	• Improve capability for data-driven decision making and engagement with communities to reduce inequalities • Create opportunities for Core20plus communities to access high-quality work, including in health and care	
	Data and digital		• Link 111, 999, VCS data to WSIC • Create population health dashboards for whole sector	• Roll out Additional use cases for linked data • Further development of technical PHM infrastructure	
	Communications		• Improve ICB link to our communities: focus on engagement, culture of learning from and working with our communities, and targeted and co-produced messaging.		

PRIORITY 2: Improve children and young people's mental health and community care

Summary

Our aim is to ensure for children, and young people to have the opportunity for the best start in life – leading safer, healthier, more fulfilling lives. Our strategy confirms we will do this by:

- Implementing new 'models of care', for example: integrated neighbourhood teams of GPs, social workers, and community paediatric teams work identifying and reaching out to families at risk of missing out on preventative care through family hubs and child health hubs;
- Establishing 'system enablers', for example: using innovative models of age-appropriate engagement and changing some of the contracts to incentivise preventative care; and
- Coordinating 'programmes of work' with the aim of reducing waiting times, improving access and focussing prevention activities where we know there are high inequalities of outcomes.

Our focus in year one will be full implementation of the Thrive Framework to ensure comprehensive improvement across mental health services leading to a reduction in waiting times, improved quality in CAMHS and a reduction in the high levels of mental health attendances for children. We will extend the successful model of family hubs and child health hubs across all boroughs and focus on reducing inequalities in educational settings by ensuring children and young people with Special Educational Needs and Disabilities (SEND) or in Local Authority Care (LAC), have the same access to specialist school nurses wherever they live.

Our focus in future years will be to extend Mental Health Support Teams (MHSTs), already operating in over 40% of schools, to all publicly funded schools in North West London to support greater prevention and early intervention for our young people who may be susceptible to mental ill health. In community services we will reduce waiting times for ADHD and autism assessments, which are among the highest in London, and provide a common offer for speech and language therapy.

To support all segments of the population in a proactive way, we will use the WSIC dataset to share intelligence between health, education and social care. This will also support longer term transformational improvements and ensure that children and families who have the highest level of need have better access, outcomes and experience of care than now.

The expected impact of our actions include:

- Children and families have better access to timely advice, they are less reliant on emergency care and are seen in the most appropriate setting
- Consistent core healthcare offers for children so that everyone has equitable access to the same offer of care, focussing on mental health provision and early intervention in schools, CAMHS, specialist nursing support and speech and language therapy
- Reduction in children seen in emergency departments for mental health crisis
- Equity of outcomes for the most vulnerable children with Special Educational Needs and Disabilities (SEND) or in Local Authority Care (LAC)

PRIORITY 2: Improve children and young people's mental health and community care

Case for change

Current ICS strategic plans do not adequately identify and tackle the needs of children

- **Lack of data:** Far more evidence on health equity and outcomes is available for adults than children in our ICS data sharing systems. This hampers progress to improve and integrate care for young people.
- **Inequity in health outcomes for children**: from deprived areas and low-income families; from minority ethnic backgrounds; from population groups that suffer social discrimination.
- Delays and inequity in **emotional wellbeing and resilience** from as early as Year 2 for boys, children of Black or traveller ethnicity, and children with SEND.
- NW London has the **longest waiting list for ADHD and ASD assessment in London**. There is greater demand for services, a decrease in workforce availability and deterioration in mental health whilst waiting for a diagnosis.
- The number of children and young people with identified mental health needs have approximately doubled since 2019, and the severity and complexity of issues and needs has also increased. Young people consistently say that emotional health is their greatest concern
- **Speech and language therapy services** have some of the highest waiting lists and variation in outcomes.

PRIORITY 2: Improve children and young people's mental health and community care

What do we want to achieve? (i)

Priority area	Sub priority	Target date	Outcomes	Dependencies	Owner / Governance
CYP mental health provision and access	**Improve mental health community services provision**	2024 - 25	• Reduction in waiting times, shorter waiting list and improved quality for CAMHS. • Improvement of Community-Based Crisis services to ensure 7 day service.	• Joint working with other CAMHS pathway commissioners in ICB • LA partners • Capital support form NHSE/ICB	Led by the North West London programme teams, with support from the BCYP network and collaboratives Key governance: • Primary Care Partnership Board • MHLDA PC ODG • MHLDA Programme Board
		2026 - 27	• Reduce known gaps, including for children known to be at high risk of health inequity (Y3)		
	Inpatient and acute provision	2025 - 26	• Low numbers of Tier 4 admissions • Lowest appropriate length of stay • Thrive Framework implemented across North West London		
	Mental Wellbeing in Schools	2026 - 27	• Increased access to Mental Health Support Teams across all boroughs (at least 200 contacts per team, per year in 2024/2025) • An MHST, or equivalent, is available to 100% of NW London's publicly-funded schools.		
CYP community support	**Community services**	2024 - 25	• Close known gap in special school nursing • Improved consistency of services for children and young people with SEND • Supportive care and prevention at the earliest opportunity • Improved compliance with statutory duties relating to SEND and LAC	• Acute elective care • Child health hubs • Borough based partnerships • Provider collaboratives • organisational design and workforce teams • Parent and/or family groups • Voluntary services	• Led by the North West London programme teams, with support from the BCYP network and collaboratives • Community collaborative lead on speech and language therapy project
		2025 - 26	• Equity in access and outcomes for speech and language therapy • Reduce the waiting times for ADHD and autism assessments • Increased access to pre and post diagnostic support		
	Transformational improvements for specific conditions with known health inequity	2026 - 29	• Reduced inequity for epilepsy and asthma • Reduced inequity in oral health outcomes • Reduced inequity for people with a learning disability and/ or autistic people • Reduced inequity for diabetes and healthy weight		
	Equity of experience of care	2027 - 29	• Equitable access to core, essential community health services		

PRIORITY 2: Improve children and young people's mental health and community care

What do we want to achieve? (ii)

Priority area	Sub priority	Outcomes	Dependencies	Owner / Governance
Enabling functions	**Workforce**	• Sufficient specialist nurses recruited to support SEND • Sufficient staff available to community CYP MH services – in particular, MHSTs, eating disorder services, and neurodevelopmental services.	• Wider workforce programmes	• North West London People Board with oversight by the Joint Lead Chief People Officers
	Digital and data	• Incorporate children's social care data into WSIC • NHS and LA data linked so better able to assess need	• Partner agencies integrating contract monitoring • Closing the data gap for child health care and disaggregating activity / finance with adult services	• North West London Data and Analytics Steering Group, reporting to Digital Transformation Board and ICB Board
	Estates	• Child health hubs in place across all boroughs • Forensic examination hub for child sexual abuse in operation	• Input and engagement from Boroughs, Programmes and Trusts	• TAP, Estates Board & respective internal ICB Scheme of Delegation

PRIORITY 2: Improve children and young people's mental health and community care

How will we achieve our outcomes? (i)

Priority area		Focus year	Year 1	Year 2	Year 3+
CYP mental health provision and access	**Improve mental health community services provision**	Year 1	• Support implementation of the Thrive Framework • Improve access and quality of community CYP MH services. Develop Integrated CAMHS framework.	• Improvement of community-based crisis services • Integrated pathway for NW London to reduce the waiting times for ADHD and autism assessments • Improve access and outcomes for care-experienced children with mental health needs.	• Improve data on known gaps, including for children known to be at high risk of health inequity • Review of non-NHS community CYP mental health services.
	Inpatient and acute provision	Year 2	• Identify innovation to improve CYP crisis provision	• Implement plans for sustainable provision to meet demand and changing needs	
	Mental Wellbeing in Schools	Year 3	• Roll out Wave 11 and Wave 12 MHSTs (6 additional teams). • Enable access to non-MHST equivalent for schools that are not currently partnered with an MHST.	• Additional roll out of MHSTs (subject to funding from NHS England).	
CYP community support	**Community services**	Year 1	• Special school nursing: closing known gap in SEND and LAC • Implementation of child health and family hubs across North West London • Identify children and young people speech and language therapy priority quick wins	• Reduce school exclusion rates • Improved consistency of services • Development of a common core SALT offer	• Implementation of a common core SALT offer
	Transformational improvements for specific conditions with known health inequity	Year 3+		• Oral health • Diabetes and healthy weight	• Epilepsy • Asthma
	Equity of experience of care	Year 4-5			• Equitable access to core, essential community health services • Children's palliative care common standard

PRIORITY 2: Improve children and young people's mental health and community care

How will we achieve our outcomes? (ii)

Priority area		Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	• Recruitment of specialist nurses to support SEND (for asthma, epilepsy, and diabetes management at school)	• Recruitment of staff to community CYP MH services – particularly MHSTs and eating disorder services.	• Support any further areas of targeted recruitment required
	Digital and data and innovations	• LAC & SEND linking NHS and LA data – improve quantitative data on health assessment notification (LA) and completion (NHS) timeliness	• Trial and roll out digital innovations for neurodevelopmental pathways	• Further development of reporting tools in WSIC to support teams, helping them identify inequalities and areas of need e.g. Children's Social Care data • Further explore options for the Federated Data Platform to support CYP Transformation Programmes, in line with INT requirements
	Estates	• Forensic examination hub for child sexual abuse to open in North West London (NHSE, ICB, & police funded) • Start to roll out child health hubs across all NW London Boroughs	• Continue, with the aim to complete, the full roll out child health hubs across all NW London Boroughs	

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

Summary

Integrated Neighbourhood Teams (INTs), with general practice/primary care at their heart, are central to delivering North West London's Health and Care Strategy preventing, reducing and delaying the onset of need while improving access to care, quality of care and health outcomes, supporting population health and wellbeing, and enhancing productivity through integrated working.

INTs will bring together all health and care services – primary care, community services, community mental health services and social care (excluding care that requires specialist expertise and equipment and/or inpatient care) including the voluntary sector around general practice for a defined neighbourhood, typically around 50-70,000 population (around one square mile in central London, 2-3 square miles in outer London). The neighbourhoods are areas that are meaningful to local residents and allow efficient service delivery. They will be run by a single management and leadership team with services designed and planned around residents' health and care needs, using population health data. Teams will be organised in a coordinated way to ensure a single location of care provision wherever possible (e.g., for child health hubs and/or women's health hubs). There will be a common core operating model across North West London, with Borough Based Partnerships leading local implementation and delivery. Where the core set of services does not meet local need (e.g., a bespoke service is needed to address inequalities), the INT can offer supplementary services.

Our focus to date has been on defining the boundaries, establishing the constituent leadership and putting in place community engagement programmes within INTs. Our focus for 2024/25 will be to develop and implement improvements in urgent care – particularly for those with non-complex needs, in order to improve access and to free up resource to define and deliver a proactive common offer for frail and complex patients who most need continuity of care. We will roll out child health hubs followed by other pathways in line with a population management approach that makes best use of the available resource – including community rapid response, additional roles in primary care (paramedics, pharmacists, physios, etc.) across all sectors – all tailored towards the specific needs of our residents to ensure their needs are met in a holistic, integrated way.

Our intended outcomes for our residents in establishing integrated neighbourhood teams:

- Clarity for residents on how to get the care they need.
- Reduction in hospital led emergency care, enabled by support in homes and care homes across both pre-admission and post admission pathways
- Earlier detection of people at risk of ill health and earlier diagnosis of ill health
- Improved quality of care for people with long term conditions
- Easier access to specialist opinion, often without having to travel
- Reduction in health inequalities by providing more outreach services targeted at local populations and by improving access to care
- A safe and manageable workload for practice/ PCN staff, improving their satisfaction and retention and reducing sickness absence

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

Case for change

- The population across NW London is getting older and sicker with more people at risk of, or suffering from, one or more long term conditions.
- We currently have a very fragmented model of care delivery outside of hospitals, typically with GPs working in very small teams, not very well aligned to community or mental health or social care services, not effectively working with the voluntary sector
- This fragmented model of care makes it difficult to effectively plan services, deploy digital tools or to link in with specialist expertise based in hospitals, it does not make the most of the significant and highly skilled non GP workforce (paramedics, pharmacists, physios etc.) and it also doesn't work for residents who view it as impersonal and difficult to navigate.
- We can now see examples of larger, more integrated service models from other parts of the country, and internationally, which bring all staff together into a single team. In so doing, they are better able to provide same day access to care, earlier identification and diagnosis of ill health, better management of care when people do have a long term condition and far better support for people increasingly living with frailty or pre-frailty. Better care improves quality of lives and life expectancy.

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

What do we want to achieve? (i)

	Sub priority	Target date	Outcomes	Dependencies	Owner / Governance
Form and function	**Leadership and operating models**	April 2025	• Clarified management structure with single team per INT • Common range of services in places in all INTs, including early help services, voluntary and community sector, 0-19 and children's community teams and other primary care services (pharmacy, dentistry, optometry) • Population health needs mapped	• ICS/ICB programmes, acute, LAs, community collaborative	• Local borough team governance • INT executive Group • INT oversight group • Local Care Board
		2028/ 2029	• Appropriate care plans in place for all population segments based on population health management approach • Operating model that makes best use of the resource across primary, community, mental health, social and voluntary sectors and creates capacity for preventative and pro active care		
Improve core areas	**Same Day Access**	2024/25	• All residents of North West London can access same day primary care services with confidence • Increase of availability of appointments in General Practice (5% increase) • 2-hour Urgent Community Response (UCR) first care contacts 90%	• Place Input, Finance, BI, Acute/Community Services where shift of activity is required	• North West London ICB • Primary Care Programme Board • Boroughs
		2026/27	• Sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions)		
	Complex, elderly and frail patients	2025/26	• Proactive care providing timely impact on people with escalating health and care risks, improved patient experience and outcomes, • Elimination of inequality and differential access to current services that support the frail population and focus on the right care, at the right place and at the right time	• Close collaborative working with all place/ borough Frailty stakeholder forums or delivery groups, wider Frailty stakeholders (including Local Authorities, Acute providers, Primary Care, and community providers)	• North West London ICB • NW London JHOSC • LA overview and scrutiny committees;

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

What do we want to achieve? (ii)

	Sub priority	Target date	Outcomes	Dependencies	Owner / Governance
Improve core areas	**All long term conditions**	2028/29	• Reduction in the number of people living with unidentified LTCs. • All residents and their carers / families with long term conditions have access to prevention, advice and support to help them stay well at home, with 90% of high/medium need with a care plan and 70% adherence to care plan • Care plans make best use of local authority and community resources, alongside more traditional health services. • Increased ability of patients to self-manage and support, ensuring they access the most appropriate services in a timely and safe manner. • Improved patient experience through early and accurate diagnosis of disease • Rapid clinical access to specialist advice and guidance which will also support elective recovery and reduce long waits	• All place/ borough stakeholder forums or delivery groups, Local Authorities, Acute providers, Primary Care, and community providers	• Boroughs, ICB Board TBC
Enabling functions	**Workforce**	2028/29	• A safe and manageable workload for practice/ PCN staff, with reduced sickness/absenteeism and increased satisfaction from staff surveys • Clear workforce model included new and fulfilling roles with demonstrable productivity gain		• North West London People Board with oversight by the Joint Lead Chief People Officers
	Digital and data	2028/29	• Data available to enable top-down management of demand, capacity and patient flows across the ICB, and clinical and service decision-making across all services (with implementation across more services within each year of the JFP). • Multi-disciplinary integrated care pathways spanning health and social care settings will be enabled via shared digital care records, tasks and plans. • Enhancement of Primary Care systems to enable neighbourhood working	• Further enhancement of data and intelligence tools – acquire VCSE data and link with WSIC • NHSE One London • Potential additional funding for software and transformation	• ICB Digital Transformation Board
	Estates	2028/29	• Fit-for-purpose estate, improved utilisation, sustainable estate, cost efficiencies.	• Input and engagement from Boroughs, Programmes and Trusts	• TAP, Estates Board & respective internal ICB Scheme of Delegation

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

How are we going to achieve our outcomes? (i)

	Aim	Focus year	Year 1	Year 2	Year 3+
Form and function	**Leadership and operating models**	Year 1	• Core common approach to working with local adaption/variation depending on starting point and local assets (workforce, estate), linked to PHM and community core offers • Common approach to PHM and care planning • Standard operating procedures for the three Fuller areas, plus elective care, based on evidence based care and with greater consistency of deployment	• Tailored preventative programmes and preventative service delivery operating within the INTs based on local priorities	
Improve core areas	**Same Day Access**	Year 1	• Launch of same day access model • Design, develop outcome-based payments for both service and system level services • Implement North West London Target Operating Model for same day access (SDA), to increase capacity and manage demand, including establishing pathways for UCR links to same day access model	• Ongoing implementation and monitoring of primary care same-day demand (forward, seasonal, over the 24-hour period)	• Potential integration within wider IUC contract, along with 111 as a fully integrated service
	Child and Women's Health Hubs	Year 1	• Roll out child health hubs to remaining boroughs • Define and start implementing women's health hubs	• Roll out women's health hubs	
	Complex, elderly and frail patients	Year 2	• Determine core common offer – including links with district nursing	• Full implementation and mobilisation across all Boroughs	
	Other areas / pathways	Years 2+	• Review and improve primary care clinician access to specialist advice and guidance • Proactive care planning in line with PHM approach	• Identification of areas and pathways for common implementation • Supporting development and scale of in-reach models across Core20plus groups • Borough specific initiatives	• Implementation across Boroughs

PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs) with primary care at their heart

How are we going to achieve our outcomes? (ii)

	Aim	Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	• Maximise the impact of ARRS funded roles to enable Primary Care to deliver Integrated Neighbourhood teams, GP Access and joint MH ARRS roles • Shared approach to workforce management agreed with community services enhancing capacity and demand and improving productivity	• Scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of INTs	• New roles in place across INTs
	Digital and data	• Deploy London Care Record to all remaining healthcare settings and tackle data quality. • Enhancement of Primary Care systems to enable neighbourhood working • Requirements for shared records and cross-organisation workflows articulated and agreed	• Reprocurement of primary care systems • Plan and implement the transformation required to make use of shared records across multi-disciplinary patient pathways to support optimisation of resources and safe management of patients.	
	Estates	• Co-location of teams • Numerous big ticket projects, including developing hubs, increasing primary care-at-scale offerings and supporting national programmes (e.g. CDCs).		

PRIORITY 4: Improve mental health services in the community and for people in crisis*

Summary

We have expanded mental health services considerably across North West London in recent years, with an extra ~£78m allocated to mental health services from 2019/20 to 2023/24. The number of residents in contact with community mental health teams has increased by ~50%. Provision for those experiencing crisis has expanded, with the expansion of healthcare based places of safety, psychiatric liaison in our hospitals, Mental Health Crisis Assessment Centre, and community crisis teams. Nonetheless, we know we have more to do – addressing variation in outcomes and productivity will deliver a consistently better experience for patients and enable us to meet more need. Ensuring accessible and effective mental health support within the community – tailored where appropriate for vulnerable groups that may face barriers to accessing care through traditional routes - helps prevent crises, reduces hospital attendances and admissions, and promotes early intervention, improving overall mental well-being.

Effective crisis mental health services are crucial for providing immediate support during times of acute distress, reducing the risk of harm and preventing crises from escalating.

We will:

- Implement a consistent core set of services for community and crisis care for adults, including severe mental illness, that can be tailored where needs differ; services will be responsive to population health needs with no unwarranted variation in outcomes, we will reduce long waits in ED and provide new pathways, including with partners in the voluntary sector;
- Reduce variation and increase productivity in caseloads and staffing across community services, with no person staying longer in a mental health bed than they need to and both patients and staff reporting better experiences.
- Continue to raise awareness across North West London so that every resident knows how to access mental health support both in crisis and in the community; all people known to mental health services will have a crisis management plan that supports them to use crisis alternatives to A&E where possible;
- Integrate care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.
- Work together with our Local Authority partners to develop solutions to the housing and employment pathway challenges, providing integrated solutions to housing pathways and resulting in more people gaining and staying in meaningful employment.

Our intended outcomes include:

- Reducing unwarranted variation in outcomes.
- Patients and staff reporting better experiences.
- Optimal community capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting.
- All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E where possible
- No person staying longer in a mental health bed than they need to.
- More people gaining and staying in meaningful employment.

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 4: Improve mental health services in the community and for people in crisis*

Case for change

- Mental health disorders are the fourth largest driver of years lost to disability and death in North West London and therefore presents one of our biggest opportunities to improve the health and wellbeing of our residents.
- While we have expanded community and crises services significantly, many of our population do not yet have confidence in the services that we offer.
- Demand and complexity are increasing, demonstrated by a greater number of people presenting at A&E in mental health crisis who are not previously known to services.
- In order to be successful North West London needs to establish appropriate systems and frameworks that enable Provider Collaboratives to design, commission and deliver a wide range of pathways and services is key to driving the transformation and improvement of all mental health, learning disabilities and autism services across North West London.

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 4: Improve mental health services in the community and for people in crisis*

What do we want to achieve? (i)

Priority area	Sub-priority	Target Date	Outcomes	Dependencies	Owner/ governance
Community mental health	**Capacity Improvements and reduction in waiting times**	2024 - 25	• Improve Dementia diagnosis rate to 66/7% and post-diagnostic care	• Primary care • Borough based partnerships • NHSE London and other national NHSE teams • Acute & Community Collaboratives • Population Health management ICB programme	• Mental Health team and Mental Health Collaborative • MHLDA Provider Collaborative Operational Delivery Group and Board • Provider Boards and sub-committees • North West London ICB MHLDA Board and sub-committees • North West London ICB Finance
		2025 - 26	• Improved capacity and reduce waiting times of Adult ADHD and Autism		
		2025 - 26	• Improved access and capacity of Talking therapies to enable reliable improvement (67%) and reliable recovery (48%)		
		2025 - 26	• Consistent performance reporting for primary care providers		
		2025 - 26	• Core common offer of services for all residents • Reduce variation in caseloads and staffing across community services. • Develop an assets-based approach to promoting mental health and wellbeing		
	Inpatient care - maintain flow and reduce variation across the specialist bed base	2028 - 29	• High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.		
		2025 - 26	• Improve flow and quality for all inpatient care • Improved integration with community provision		
		2026 - 27	• Improved culture across wards		

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 4: Improve mental health services in the community and for people in crisis*

What do we want to achieve? (ii)

Priority area	Sub-priority	Target Date	Outcomes	Dependencies	Owner/ governance
Community mental health	**Capacity Improvements and reduction in waiting times**	2024 - 25	• Improve Dementia diagnosis rate to 66/7% and post-diagnostic care	• Primary care • Borough based partnerships • NHSE London and other national NHSE teams • Acute & Community Collaboratives • Population Health management ICB programme	• Mental Health team and Mental Health Collaborative • MHLDA Provider Collaborative Operational Delivery Group and Board • Provider Boards and sub-committees • North West London ICB MHLDA Board and sub-committees • North West London ICB Finance
		2025 - 26	• Improved capacity and reduce waiting times of Adult ADHD and Autism		
		2025 - 26	• Improved access and capacity of Talking therapies to enable reliable improvement (67%) and reliable recovery (48%)		
		2025 - 26	• Consistent performance reporting for primary care providers		
Crisis mental health	**Mental health in ED**	2026 - 27	• Reduction seen in the use of s136 • Reduction seen in 12 hour waits in ED	• Primary care • Borough based partnerships • NHSE London and other national NHSE teams • Acute & Community Collaboratives	
		2027-28	• Increased use of alternative care pathways and VCSE services		
	Suicide prevention and support	2026 - 27	• Reduction in suicide rates, and increased support for people bereaved by suicide		
Enabling functions	**Workforce**		• Reduction in variation between Mental Health nursing support in EDs • Improved recruitment on Mental Health nurses	• Wider workforce programmes	• North West London People Board

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 4: Improve mental health services in the community and for people in crisis*

How are we going to achieve our outcomes? (i)

	Aim	Focus year	Year 1	Year 2	Year 3+
Community mental health	**Capacity Improvements and reducing waiting lists (add in rows 3 &4)**	Y1	• Review to ensure sufficient and appropriate capacity • Dementia diagnosis and care • Agreed set of core performance metrics	• Improve capacity and reduce waiting times of Improved capacity of Adult Autism • Joint performance and VFM dashboards • Improve productivity of core community services	• Improve capacity and reduce waiting times of Talking therapies
	Impatient care - maintain flow and reduce variation across the specialist bed base	Y2	• Improve flow and quality for all inpatient care	• Review of the Limes and Rehab inpatient models • Improved integration with community provision	• Improved culture across wards
Crisis mental health	**Mental health in ED**	Y2	• 111 first for Mental Health implemented 24/7 • Drive initiatives to reduce 12 hour waits in ED	• Drive initiatives to reduce use of s136	• Increased use of alternative care pathways and VCSE services
	Suicide prevention and support	Y2		• Development of a multi-agency suicide prevention plan	• Expansion of suicide postvention offer

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 4: Improve mental health services in the community and for people in crisis*

How are we going to achieve our outcomes? (ii)

	Aim	Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	• Recruitment to the top five hard to fill vacancies (MH nurses)	• Drive to reduce variation between Mental Health nursing support in EDs	• Develop and implement Mental Health workforce models for Acute Trusts
	Digital and Data	• Data to be acquired and linked to WSIC • Implement plan for enhancement of Community and Mental Health EPRs • Articulate digital requirements for better sharing of MH crisis plans and requirements of community and crisis care (e.g. IAPT data)	• Embed evidence based practices	

Please note: all Mental Health services related to children are covered in priority 2

PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

Summary

We want to support people in North West London to stay well and live independently; supported by integrated neighbourhood teams that deliver a seamless service to our residents by bringing together community physical and mental health services, social care and the voluntary sector health around primary care. To ensure these services are high quality, comprehensive, and timely, we need to improve productivity and reduce unwarranted variation.

This means we will:

- Develop a consistent, productive set of effective and equitable community services, tailored to the needs of our residents, using the population health management approaches in priority one to support residents who would benefit from proactive care, prevention programmes and/ or bespoke services
- Support our borough teams to implement the consistent set of services – starting with community nursing, urgent care response (including support to care homes) and children's speech and language therapies – improving productivity to the highest levels in North West London to ensure we level up;
- Work with primary care to continue to develop models of care for cohorts of residents as part of the integrated neighbourhood teams, e.g., for frailty, diabetes and cardiovascular disease;
- Deliver a consistent musculo-skeletal and specialist palliative care services across North West London;
- Embed co-production as a way of developing and delivering services, with patient and carer voice at the centre of our offer.

Our initial focus is on maximising productivity and reducing waits across those areas that will most contribute to system resilience and recovery.

As a result, we aim to achieve:

- Reduction in waiting times for community services (5% in 2024/25)
- Increase in Urgent Community Response for first care contacts
- Reduction in length of stay in community beds
- Reduction in demand for emergency care with stable provision of community services
- Best use of clinical time and greater staff satisfaction
- Consistency in access and patient experience of services across North West London
- Clear and transparent understanding of how services are used, resulting in optimal use of resources across North West London

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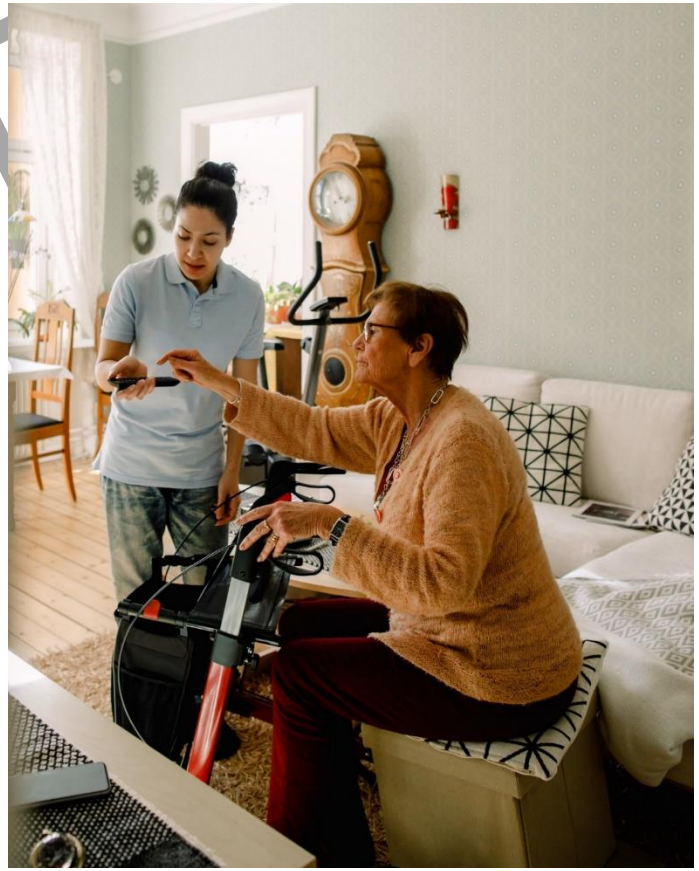
PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

Case for change

- The health and care system are currently under significant pressure and waits for some community outpatient services can be long – this has an adverse impact on patient experience and can result in unnecessary attendances/ admissions at hospitals;
- Data across services is not consistent, which means that we do not have a clear picture of baseline demand and capacity or the impact that this may have on equity of access to services. It is likely that productivity and experience vary considerably;
- Some services exhibit high levels of vacancies (e.g., community nursing).



PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

What do we want to achieve? (i)

	Sub priority	Target date	Outcomes	Dependencies	Owner / Governance
Quality	**Data quality improvement**	April 2025	• Reduction in workload on Trusts • Clear understanding of demand on services supporting planning and productivity work	• ICS/ICB programmes, acute, LAs	• Community collaborative
	Service design	2027/28	• All services designed together with, and responding directly to, service users and communities		
Common core offer	**Implement consistent, high quality set of community services**	April 2025	• Reduce community waiting list numbers by 5% • Specialist palliative care offer in place for all residents at end of life	• ICS/ICB programmes, acute, LAs	• NW London ICB • Community collaborative
		April 2025 - 2026/27	• Equitable access, better outcomes and reduction inequalities initially in community beds and nursing and subsequently to all community services	• ICS/ICB programmes, acute, LAs	• NW London ICB • Community collaborative • Boroughs
Maximise productivity	**Maximise productivity Demonstrate value for money**	2025/ 2026	• Best use of resources and maximum value for money at trust and system level	• ICS/ICB programmes, acute, LAs	• NW London ICB • Community collaborative • Boroughs

PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

What do we want to achieve? (ii)

	Sub priority	Target date	Outcomes	Dependencies	Owner / Governance
Enabling functions	**Workforce**	2028/29	• Right sized workforce from local communities equipped with skills for new models of care, supported by the delivery arm of the NW London Health & Social Skills Academy	• Wider workforce programmes	• NW London People Board
	Digital and data	2024/25	• Standardised and consistent reporting across all community services and measures	• Inter-operability with FDP to make use of existing data feeds in Foundry and linking with primary care and community data held in WSIC	• NW London Community and MH Digital Steering Group, reporting to ICB Digital Transformation Board
		2028/29	• Records shared across providers to enable efficient wraparound care • Best use of digital tools to support clinical decision making		
	Estates	2028/29	• Most efficient use of community assets • Interoperability across estate and infrastructure	• Input and engagement from Boroughs, Programmes and Trusts to ensure all needs are captured and acted on.	• TAP, Estates Board & respective internal ICB Scheme of Delegation

PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

How are we going to achieve our outcomes? (i)

	Aim	Focus year	Year 1	Year 2	Year 3+
Quality	**Data quality improvement and service design**	Y2	• Develop and start to implement data quality programme with QI focus • Establish Data Quality strategy & procedures • Review, rationalize and standardize quality indicators	• Embed data quality programme and quality of community care services using standardised metrics • Implement best practice approach to enhancing our patient, staff and community voices in design of services	
Common core offer	**Implement consistent, high quality set of community services**	Y1	• Determine core offer for community nursing linked into the Integrated Neighbourhood teams common range of services and common core offer • Mobilise core offer for community beds • Mobilise Length of Stay reporting • Implementation of core common offer for other services – MSK • Implementation of common core standard for care homes, linked to integrated neighbourhood teams • Develop and agree new model of care for specialist palliative care	• Implementation of model of care for specialist palliative care	• Lead a sector wide approach to uplift and make stroke and neuro service provision equitable across NW London
Maximise productivity	**Deliver productivity Demonstrate value for money**	Y2	• Demand & Capacity Modelling across all services starting with (1) Podiatry, (2) Community Nursing, (3) Urgent Care Response (4) Children's SALT • Review how we best use BCF and funding arrangements to deliver best outcomes • Drive productivity: focus - community beds • Drive productivity and reduce waiting list: focus – community nursing	• Demand & Capacity Modelling across remaining community services • Drive productivity: focus – neurorehab and other key focus areas • Implementation of consistent activity collection and data reporting	• Deliver economies of scale through infrastructure

PRIORITY 5: Embed a consistent, high quality set of community services by maximising productivity

How are we going to achieve our outcomes? (ii)

	Aim	Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	• Recruitment to high impact roles community roles utilising the Integrated Recruitment Hub • Promote volunteer-to-career pathway • Standardisation of workforce dashboard • Introduction/expansion of new roles • Shared approach to workforce management agreed within INTs, enhancing capacity and demand and improving productivity	• Expand and develop workforce now and for the future including development of future roles • Use and act on local data and insights to positively impact workforce planning	
	Digital and data	• Data standardisation across partners • Delivery of strategic reporting for community	• Implement community collaborative digital and data strategy • Shared records across multi-disciplinary patient pathways	• Identify and implement consistent digital offer
	Estates	• Implement current community estates priorities	• Implement future community estates priorities	

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

Summary

Patient flow is about directing residents to the most appropriate place that can meet their needs, and moving patients through care settings as expeditiously as appropriate – e.g., directing to alternatives to admission and ensuring timely discharge from hospital. It involves coordinating medical care, social care, physical resources, and systems between hospitals, the local authorities, GPs and community support services to work effectively.

Lengthy, unnecessary stays in hospital can arise for several reasons: People may be admitted when other settings of care, closer to home, are more appropriate to their needs; they may have to wait a long time in an emergency department to be seen or wait to return home if they are admitted. Ambulances may be delayed at hospital handing over people to the care of hospital staff. This can have an impact on patients' wellbeing, as it harder for patients to return home and their outcomes are poorer. It also has an impact on the system as a whole, as it impacts access and waiting times for everybody.

Efficient care pathways for patients improves patient flow, reducing waiting times, boosting satisfaction, and minimising patient risk by ensuring needs are met in the right setting of care, and by preventing unnecessary delays (e.g., ambulances responding to emergency calls or long waits in emergency departments). Efficient flow helps deliver faster access and enables better capacity management to respond to varying demand within healthcare facilities.

To improve patient flow, the system needs to work together, with collaboration vital across all care partners including community health, social care and housing. Flow is our third area of focus for introducing and scaling innovation - we will use technology and data enabled pathway solutions to optimise discharge coordination and increase the types of condition that can be managed while people remain at home. The national Federated Data Platform will enable data to flow across organisations, making flow easier to track and manage. Our Urgent and Emergency Care Strategy planned for publication in autumn 2024 will include further detail on the concrete actions we are taking to strengthen in hospital flow and discharge in emergency departments.

As a result, we aim to achieve:

- Fewer admissions to hospital where people can be as well – or better – treated in settings closer to (or at) home
- Patients spend more time at home
- Reduced delay for patients in hospital who are medically fit to be discharged, especially for those who need support in the community.
- More patients are discharged directly back to their place of residence than in previous years
- Reduced risk of harm by swifter discharge from hospital (when clinically appropriate)
- Reduced long waiting times in emergency rooms

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

Case for change

- As the population ages, demand for healthcare naturally increases. But many people who are currently admitted to hospital could receive better care in other settings, while others who need a hospital bed stay in that bed for longer than clinically necessary – we know that prolonged hospital stays can increase confusion and undermine independence.
- Additionally, inefficient patient flow as currently experienced contributes to longer waiting times, reduced patient satisfaction, and higher costs, highlighting the urgency for improvement.
- Meeting performance targets and regulatory standards requirements is a directive from NHSE and often reflected in the operating plan.

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

What do we want to achieve? (i)

Priority area	Sub-priority	Target Date	Outcomes	Dependencies	Owner/ governance
Flow and discharge improvements	**System flow**	2024 – 25	• Reduced length of stay for patients that are in hospital for a long time (21 days +) by at least 5% • More patients able to access virtual ward and therefore discharged from hospital faster, with virtual ward average occupancy to be at least 80% occupied.	• Local Authorities/ASC • Data/BI for Optica rollout and ongoing analysis • Finance, contracts and procurement • Community and Provider Collaboratives • UEC team • LAS	• North West London ICB • Acute Trusts and provider collaborative • Community collaborative • LAS
		2025 - 26	• Reduced the identification gap through transformation of discharge hubs to true Transfer of Care Hubs where different services such as social care, housing and voluntary services are linked to coordinate support for those patients who need it.		
	Front door improvements	2024 – 25	• All Medical SDECs within the acute providers live with LAS trusted assessor model and 111 direct booking • Fewer patients taken to ED who could better be seen elsewhere		
		2025 - 26	• More patients are discharged back to their place of residence than in previous years		
	Discharge improvements (including pathways 0-3)	Mar 2025	• Delays reduced for patients who are discharged from hospital and either need further support at home, care home or a community bed • More patients have access to bridging services, helping to get patients home quickly and safely after hospital. • Internal hospital delays eliminated for patients who are leaving hospital to return home with no additional care needed		
		2025 - 2026	• Reduced treatment gap for pathway 3 patients with behaviour concerns, dementia and delirium		

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

What do we want to achieve? (ii)

Priority area	Sub-priority	Target Date	Outcomes	Dependencies	Owner/ governance
Enabling functions	**Digital and data** – tech and innovation	2024- 25	• Effective usage of Care Co-ordination Solution, migrating to the national NHSE Federated Data Platform spanning pathways across organisations.	• Funding model for Federated Data Platform and local implementation • Discharge hubs	• ICB Digital Transformation Board • Research & Innovation programme
		2026-27	• Real time clarity of demand, capacity and patient flows across the ICB enabling accurate clinical and service decisions • Technological/ pathway solutions to optimise discharge coordination		
	Estates	2024 - 29	• Healthcare Hubs developed across the Boroughs	• Input and engagement from Boroughs, Programmes and Trusts	• TAP, Estates Board & respective internal ICB Scheme of Delegation
	Workforce	2024 - 29	• Reduced number of priority vacancies across acute hospitals, social care and primary care • More efficient deployment of staff to areas where they are most needed, enabled by improved staff mobility	• Wider workforce programmes	• North West London People Board

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

How are we going to achieve our outcomes? (i)

	Aim	Focus year	Year 1	Year 2	Year 3+
Flow and discharge improvements	**System flow**	Year 1	• Implement discharge to assess or equivalent model compliant with Hospital discharge and community support guidance • Embed system escalations and operational support to improve access to onwards discharge destinations • Enhance support to care homes to improve intermediate care	• Support discharge hubs to meet priorities and standards for Transfer of Care Hubs	• Launch additional virtual ward pathways
	Front door improvements	Year 1	• Deliver the national 5 priority areas for the delivery of the waiting times standard, including standardised Rapid Assessment and Treatment (RAT) • Enable direct referrals to SDEC services from all appropriate services, including ambulances, GPs and other HCP's • Enhanced planning for discharge at the point of attendance • Bring pre-dispatch and post-dispatch ambulance initiatives into a single care co-ordination approach and integrate with other pathways such as 111 and UCR.	• Paediatric Transformation Programme, supporting acute service improvement in tandem with integrated working across system services • Implement learning form work with LAS to	• Identify and reduce patients experiencing inequality of access, experience and outcome in UEC services
	Discharge improvements (including pathways 0-3)	Year 1	• Improve access to bridging services, enabling improvements in pathway 1 discharges • Reduce treatment gap for non CHC health related pathway 3 patients • Implement a clear process, pathway and funding source for those patients who need a package of care when being discharged from hospital that isn't funded by the NHS (also known as non-CHC)	• Embed initiatives to reduce the treatment gap for pathway 3 patients with behaviours of concerns, dementia and delirium • Improve access to out of hospital provision to support faster discharge of patients • Identify and reduce Pathway 0 and internal hospital process discharge delays	

PRIORITY 6: Optimise ease of movement for patients across the system throughout their care – right care, right place

How are we going to achieve our outcomes? (ii)

	Aim	Year 1	Year 2	Year 3+
Enabling functions	**Digital and data** – tech and innovation	• Improve the local Care Co-ordination Solution through the National NHSE Federated Data Platform so that it will span pathways across organisations. • Pilot a technological / pathway solution to optimise discharge coordination • Start to roll out OPTICA tool to Local authorities and create of a monitoring dashboard for demand and capacity data	• Scale up technological / pathway solution to optimise discharge coordination to 50% sites	• Data available to enable top-down management of demand, capacity and patient flows across the ICB • Launch shared digital care records which enable multi-disciplinary integrated care pathways spanning health and social care settings
	Workforce	• Improve staff mobility process for more efficient deployment of staff to areas where they are most needed • New models of care in North West London EOC, Ophthalmology Hubs, one stop clinics in gynae • Use North West London Integrated Recruitment Hub to reduce priority vacancies across acute/social care/primary care, supporting patient flow	• Identify workforce requirements using evidence-based establishment setting tools or capacity and demand where evidenced based tools do not exist • Develop training programme for data driven workforce redesign skills	• Workforce redesign: use new roles, new ways of working and competency-based approaches to transform the workforce in line with changing patient needs and service models
	Estates	• Development of Healthcare Hubs across the Boroughs		

PRIORITY 7: Transform maternity care

Summary

The national delivery plan for maternity services sets out four ambitions - listening to, and working with, women and families with compassion; growing, retaining, and supporting our workforce with the resources and teams they need to excel; developing and sustaining a culture of safety, learning, and support; and standards and structures that underpin safer, more personalised, and more equitable care.

North West London has six maternity units – three rated outstanding by the CQC, one good, and two as requires improvement. Following the 2015 maternity review, all are collocated with level II neonatal care units and there are no plans consolidate units. North West London's award winning Mum & Baby app continues to be adopted widely. While having half of our units rated as outstanding means our maternity services are among the best in the country, there is still more to do to improve services so that every family in in North West London has positive experience of NHS maternity services. In addition to ensuring that our two units requiring improvement do continue to improve, we also need to ensure that outcomes, in particular for black and Asian women and their babies, improve – at the moment, outcomes for these women and babies are worse than for the population as a whole. We need to ensure that we foster a culture of safety which will benefit everyone who touches our services.

This is achieved through delivering improved strategic capabilities for:

- Transformation – via the ICS Local Maternity & Neonatal System, a ICS Senior Responsible Officer, and an emerging acute provider maternity collaborative
- Assurance – via the ICB Chief Nurse, the ICB Performance Committee, and emerging ICB assurance arrangements

Over the next 5 years, we will aim to:

- Reduce the inequity of pregnancy care and outcome
- Improve the quality of our services, with more support from maternity services to higher risk cases
- See low numbers of still births and intrapartum brain injuries
- Improve access to pregnancy advice (including digital access, and real-time translation services)

PRIORITY 7: Transform maternity care

Case for change

This work will tackle the following challenges:

- Ensuring continuity of midwife care throughout antenatal, perinatal, and postnatal care
- User representatives (Maternity & Neonatal Voices Partnership chairs) not able to spend enough time building trust and lead coproduction of innovations with higher risk communities
- Higher risk of poor pregnancy outcomes for black and Asian pregnant women and their babies
- Pre-existing poor mental and physical health (often associated with deprivation) contributing to higher risks in pregnancy
- Asylum seekers who are pregnant at higher risk due to lack of antenatal reviews, disrupted care, stress, and risk of infectious disease

PRIORITY 7: Transform maternity care

What do we want to achieve? (i)

Priority area	Sub priority	Target date	Outcomes	Dependencies	Owner
Service improvements and transformation	**Service improvements and transformation** across a range of key maternity services	2024/25	• Provide Postbirth Contraception Service in all trusts within North West London sector • Aligning postnatal care in line with the NICE quality standards	• Maternity Triumvirates across the sector • Trusts' and ICB digital leadership teams • ICB digital inclusion steering group • ICB BI team • External partners • ICB Overseas Recruitment team • North West London NHS Academy • MNVP • Health Equity programme	• North West London ICB • Maternity Network
		2025/26	• All North West London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding • Achieve NHSE safe staffing standards • Improved outcomes for BME women within North West London		
		2026/27	• Availability of bereavement services 7 days a for women and families who sadly experience loss		
		2027/28	• Pregnant women and new mothers have equitable access to pelvic health services		

PRIORITY 7: Transform maternity care

What do we want to achieve? (ii)

Priority area	Sub priority	Target date	Outcomes	Dependencies	Owner
Enabling functions	**Workforce**	2025/26	• Increased international recruitment of midwives • implementation and Assurance of the CNST safety action 4&5	• Maternity Triumvirates across the sector • Trusts' and ICB digital leadership teams • ICB digital inclusion steering group • ICB BI team • External partners • ICB Overseas Recruitment team • North West London NHS Academy • MNVP	North West London People Board
	Data & Digital	2024/25	• Inequalities Dashboard launched • Improve MISs/EPRs data	• ICB BI team • Trust clinical and digital teams • ICB Digital Leadership team	ICB digital transformation Board Acute Provider Collaborative
		2025/26	• Digital maternity record standard and maternity services data set standard • System wide integration • Use of digital tools and enablers at point of care • Standardise digital maturity across 4 maternity units		
	Collaboration	2025/26	• Improved engagement and joint working between public health teams and the NHS to support healthy preconception and pregnances	• Public health teams • Borough based partnership teams	

PRIORITY 7: Transform maternity care

How are we going to achieve our outcomes? (i)

	Sub priority	Focus year	Year 1	Year 2	Year 3+
Develop a North West London maternity strategy	**Strategy development**	Y1	• Develop and publish North West London wider Maternity Strategy	• Work to deliver the published strategy	
Service improvements and transformation	**Service improvements and transformation** across a range of key maternity services	Y2+	• Provide post-birth contraception Service in all trusts within North West London sector • Align postnatal care in line with the NICE quality standards	• All North West London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding • Achieve NHSE safe staffing standards • Develop inreach offer for ethnic communities adversely affected by poor outcomes in maternity services	

PRIORITY 7: Transform maternity care

How are we going to achieve our outcomes? (ii)

	Sub priority	Focus year	Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	Y2	• Support the implementation of operational policies • Monitoring the implementation of the NHS Single delivery plan	• Review workforce data across the sector • Develop a maternity support workers apprenticeship programme • Designing retention strategy for staff retention • Appoint cultural safety lead midwives and roll out training	• Comprehensive analysis of various metrics related to maternity roles • Highlight retention challenges and escalate them to the regional team • Establish with the ICB Overseas team to internationally recruit midwives • Multidisciplinary training and training dashboard# • Apprenticeship programme go live • Implement Core Competency framework v2 across the sector • Develop and implement a plan to support for newly qualified staff and clinicians
	Digital and Data	Y1	• What Good looks like - digital Maturity Assessment • LMNS Dashboard review • Ensure that all Trusts submit the digital maturity report, and a gap analysis is undertaken to identify key points for improvement	• Develop a data strategy, improve and promote Bioinformatics analysis, develop E&E dashboard	• M&B app development

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

Summary

Cancer accounts for 3,134 deaths per year (2020/21) in North West London and is the leading cause of death in the over 40s in every borough. Over 62,000 people are living with or beyond cancer in North West London. Improving cancer outcomes is a key strategic aim for North West London ICS, and the national priority for cancer is to increase survival by focusing on early diagnosis, with the ambition to ensure 75% of patients are diagnosed at stage 1/2. As at 2018, the early diagnosis rate across NW London stood at 55%. This average masks variation in terms of both early diagnosis rates by borough and by tumour type by borough. We also know that people from our more deprived populations, or from ethnic minorities, wait longer before presenting with symptoms of cancer and can also experience greater delays in diagnosis.

Our approach to improving early diagnosis is to tackle variation in screening, time to diagnosis, and treatment by deploying both universal interventions and targeted interventions focused on those least likely to be diagnosed early. We will harness emergent innovations and work closely with partners involved in life science innovation to ensure more people get diagnosed earlier and codesign approaches with people from groups who are less likely to be diagnosed early.

Over the next 5 years, we aim to see the following outcomes:

- Reduced variation of stage of diagnosis at borough level by 8% (starting with Brent which will have the greatest impact)
- Fewer people diagnosed with cancer in emergency settings
- Narrowing of the cancer disparities gap faced by the black communities in North West London; through equity in access to information, testing, pre-treatment and post treatment options.
- Faster diagnosis: standardised secondary care cancer pathways, minimised handoffs, sustainable staffing
- Adoption of new technologies and accessible treatments that will lead to better access and faster, more efficient treatment

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

Case for change

- North West London has among the worst rates of cervical and bowel breast screening nationally and poor uptake in HPV vaccination rates
- Bowel screening rates are significantly impacted by deprivation, with a 17% difference in participation between high and low deprivation; Cervical screening rates also differ by age, with women under 30 least likely to receive cervical screening
- Early stage diagnosis has significant benefits in terms of 5 year survival and this is a significant focus. There is a 10% difference in early stage of diagnosis in the boroughs with the earliest and latest stage diagnosis
- We know that there is a strong correlation with deprivation with a 7.4% difference in early stage diagnosis between the least and most deprived population.
- There is rising demand for people with suspected cancer, and those requiring treatment for cancer means we have to plan now for the future.

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

What do we want to achieve? (i)

Priority area	Sub priority	Target date	Outcomes	Dependencies	Owner
Prevention	HPV vaccination	2026	• HPV uptake in school age children improved from bottom to middle compared to other England boroughs	• Public health agreement PGD that enables efficient delivery	• Public Health
Early diagnosis	Screening	Continuous improvement commencing 2024/25	• Reduced variation in screening uptake from national screening programmes (cervical and bowel) • Increased proportion of early-stage cancer “stage shift” in lung cancer diagnosis	• Regional screening teams and hubs Primary care ongoing funding for Targeted Lung Health Checks (TLHC)	• NSP- Joint working between Regional screening team/ ICS/ RMP Partners (West London Cancer Alliance) TLHC- RMP
	Symptomatic presentation	2028	• Variation of stage of diagnosis at borough level reduced by 8%, by addressing inequalities and variation • Reduction of number of people diagnosed with cancer in emergency settings	• Borough based partnerships	• RMP, working with Primary care and places team, specifically in Brent in 2024
Faster diagnosis		2024/5 onwards	• Delivery of the Cancer Faster Diagnostic Standard	• Acute Provider Collaborative and Specialist Trusts	• RMP via Acute Provider Collaborative membership
			• Delivery of the National Aspiration for 31 and 62 day treatment target		

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

What do we want to achieve? (ii)

Priority area	Sub priority	Target date	Outcomes	Dependencies	Owner
Treatment and care		Continuous improvement commencing 2024/25	• Adoption of new technologies and accessible treatments that will lead to better access and faster, more efficient treatment • Reduction in waits in genomic lung pathway	• Acute Provider Collaborative and Specialist Trusts BRC's and availability of novel approaches	• RMP/ BRC's
Enabling functions	Workforce	2028	• Better recruitment and retention of nurses & AHP's, through the North West London Integrated Recruitment Hub with support for retention delivered by the North West London Health & Social Skills Academy	• Acute Provider Collaborative, Radiotherapy operational delivery network	• RMP Partners (West London Cancer Alliance) • Radiotherapy operational delivery network
	Digital and data	2028	• Use of population health data to support interventions to improve early diagnosis, particularly in more deprived and ethnic minority communities	• Health Equity ICB programme	• WSIC team Primary care team Acute Provider Collaborative tech team
			• More efficient use of clinical decision tools		

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

How are we going to achieve our outcomes?(i)

	Year 1	Year 2	Year 3+
Early diagnosis	• Targeted Lung Health checks (TLHC) - ensure all high-risk wards are invited in 2024, and ensure opportunities to stop smoking are harnessed	• Continued rollout of TLHC into eligible population	• Continued rollout of TLHC into eligible population as age extension
	• Targeted population campaign to group less likely to receive bowel screening- Men	• Support age extension awareness in all populations, focussing on known groups who do not engage	
	• Focus community links support on Brent population to increase screening rates with real time coverage of rates	• Focus on delivery of breast screening pathway improvement and support new contract holder in delivering equitable service	
	• Agree actionable approaches through a series of Co-production events with the Black community, reduce population differences in the access to help and information for concerns around Prostate Cancer, focussing on Brent population • Adopt EBI policy which empowers men at increased risk of prostate cancer to have conversations with their GP about Prostate Cancer and creates a better shared decision making process	• Spread adopt and personalise approaches to our wider population in North West London, focussing on next two boroughs	• Spread adopt and personalise approaches to our wider population in North West London, focussing on boroughs as rolling programme
	• Focussed support to Brent Primary care increase early diagnosis	• Focussed support to Ealing and Hammersmith and Fulham primary care to increase early diagnosis	• Focussed support to other boroughs as rolling programme and consolidate approaches across network
	• Trial earlier approaches to earlier detection (e.g. multi cancer early detection tests)	• Continue trialling emergent early diagnosis approaches, ensuring spread and adoption of useful technology	
Faster diagnosis	• Deliver and maintain national performance requirements 77% FDS target and treatment target in North West London at Trusts by end of Q4 2024/5		
	• Support Trusts to deliver models of cancer diagnostic approaches based on best evidence and reduce inequalities focussing on: - gynaecology, lung and head and neck - embedding urology - working in partnership with endoscopy networks	• Embed: - gynaecology, head and neck and lung, endoscopy - supporting other tumour specialities	• Support other tumour specialities
	• Support approaches to non cancer pathways (breast and gynae) that will relieve pressure on cancer pathways through developing integrated community models	• Support approaches to non cancer pathways- breast and gynae specifically that will relieve pressure on cancer pathways through developing integrated community models • Ensure breast model is BAU	

PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment

How are we going to achieve our outcomes? (ii)

	Year 1	Year 2	Year 3+
Treatment and care	• Map access and capacity of chemo and treatment across North West London and develop workforce plan to support areas of concern	• Implement new models of systemic anti-cancer therapy (SACT) approaches on pilot basis	• Spread and adopt new models of chemotherapy provision
	• Implement Radiotherapy physics apprenticeships at Imperial, and Radiographer training supervisor post at Royal Marsden to support and retain staff in training	• Spread and adopt apprenticeship model if successful, and implement next workforce approach	
	• Implement improvement in the genomics pathway for lung cancer to increase speed to treatment between RMH and Imperial	• Spread approach trialled in x1 centre to other centres	
	• Continue to audit against best practice and NICE guidance for treatment, implement any changes required to standardise practice via tumour groups, MDTs and Trusts		
Enabling functions: Workforce	• Implement recommendations from workforce programmes, and ensure BAU approach exists		
	• Implement NHS England's Aspirant Cancer Career and Education Development (ACCEND) programme and novel ways of recruiting and retaining nurses & AHP's		
	• Implement clinical nurse specialist support programme		
	• Model demand and capacity requirements, and understand inequality impacts		
Enabling functions: Digital and data	• Share performance data and forecasts to enable system-wide		
	• Testing and use of Apps and Technology and AI to improve cancer pathways (breast and haematology) Implementation of a surveillance system for gastrointestinal cancers	• Testing and use of Apps and Technology and AI to improve cancer pathways (other cancers)	

PRIORITY 9: Transform the way planned care works

Case for change

Summary

A major priority since Covid-19 has been to reduce the backlog of patients who are waiting for specialist appointments and procedures. In order to do this, we need to increase activity to above historic levels. While there have been significant increases in the clinical workforce, activity hasn't increased in line with this. So our immediate priority is to increase productivity, in order to reduce elective long waits and backlogs and improve performance against the core diagnostic standard. Examples of process improvements to achieve this include reducing follow up outpatient appointments with no procedure, fully validating waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups.

The increase in demand also has an impact on our workforce. We have mitigated some of this with agency staffing, but we need sustainable staffing models where we can maximise productivity and offer rewarding jobs. We are exploring alternative ways of working, prioritising the North West London Elective Orthopaedic Centre implementation; Ophthalmology Hub and the new Community Diagnostic Centres.

Success will require digital transformation – this includes the effective use of the Care Co-ordination Solution, which provides joined-up visibility of patient and service needs, where the patient is in the pathway and innovative tools to support making the most of our capacity, it will include new care models, such as virtual clinics and remote monitoring, and it will mean driving improvements to information exchange with patients.

Transforming services is not just about improving productivity in acute settings – it will also mean reviewing clinical pathways to move services out of the acute sector into the community, delivered through our neighbourhood teams and backed up by efficient and timely access to specialist expertise.

The Acute Care Collaborative strategy – to be published in summer 2024 – will set out in more detail how the acute trusts will work together to transform elective care pathways.

ICB challenge

- Long waits for elective care and diagnostics leads to worse outcomes and a poor patient experience, impacting their physical and mental health and wellbeing, work and financial stability and relationships
- Staffing challenges leads to staff burnout, a hard to recruit workforce and high agency pay
- Too many patient initiated follow up appointments return to primary care, which is frustrating for patients and increases the burden for clinicians
- Primary care clinicians report that they are unable to access consistently timely advice and guidance from specialists
- There is a growing consensus that long waits worsen health inequalities – poor communications mean the patient is less likely to attend the appointments (DNAs) and a longer care pathway and late presentations mean that the condition may have progressed further at the point they are referred

Outcomes / Impact

- Elimination of waits over 52 weeks for elective care (initially 62 weeks)
- Reduction in avoidable outpatient referrals and activity
- Improved MDT working across Primary and Secondary care
- Effective use of Advice and Guidance from primary care clinicians
- Reduction in Follow Up Outpatient Attendances without procedure
- Increase in percentage of patients who receive a diagnostic test within six weeks
- More meaningful and effective communications with patients, leading to fewer DNAs and a better patient experience
- More productive use of estate
- More productive use of resources across the system
- Increase staff satisfaction, reduction in staff burnout

PRIORITY 9: Transform the way planned care works

Summary

A major priority since Covid-19 has been to reduce the backlog of patients who are waiting for specialist appointments and procedures. However, as waiting lists have been growing since even before the pandemic, we need to increase activity to above historic levels. Our immediate priority is to increase productivity, in order to reduce elective long waits and backlogs and improve performance against the core diagnostic standard. Examples of process improvements to achieve this include work to improve throughput and theatre utilisation for elective surgery and diagnostics, validating waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups.

Although we have increased our workforce in North West London, we have not maintained productivity at the same level to meet increased demand. We have mitigated some of this with agency staffing, but we need sustainable staffing models where we can maximise productivity and offer rewarding jobs. We are exploring alternative ways of working, prioritising the North West London Elective Orthopaedic Centre implementation; Ophthalmology Hub and the new Community Diagnostic Centres.

Success will require digital transformation – this includes the effective use of the Care Co-ordination Solution, which provides joined-up visibility of patient and service needs, where the patient is in the pathway and innovative tools to support making the most of our capacity, it will include new care models, such as virtual clinics and remote monitoring, and it will mean driving improvements to information exchange with patients.

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- More productive use of estate
- More productive use of resources across the system
- Increase staff satisfaction, reduction in staff burnout

PRIORITY 9: Transform the way planned care works

Case for change

- Long waits for elective care and diagnostics leads to worse outcomes and a poor patient experience, impacting their physical and mental health and wellbeing, work and financial stability and relationships. At end February 2024, there were 296,892 patients in North West London waiting for an outpatient appointment and 454 waiting more than 78 weeks.
- Staffing challenges leads to staff burnout, a hard to recruit workforce and high agency pay.
- Poor pathways mean that there is too much avoidable follow up activity, including unnecessary clinical referrals, and many follow up appointments that are patient initiated return to primary care which is frustrating for patients and increases the burden for clinicians.
- Primary care clinicians report that they are unable to access consistently timely advice and guidance from specialists.
- There is a growing consensus that long waits worsen health inequalities – poor communications mean the patient is less likely to attend the appointments (DNAs) and a longer care pathway and late presentations mean that the condition may have progressed further at the point they are referred.

PRIORITY 9: Transform the way planned care works

What do we want to achieve? (i)

The domains and outcomes below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

	Sub priority	Target Date	Outcomes	Dependencies	Owner
Quality	**Communications with patients**	2025/26	• Better patient experience through more targeted, accessible communications with patients • More self management	• Borough based partnerships • NHSE London and other national NHSE teams • Providers	• NW London ICB • Acute Provider Collaborative • Community collaborative
	Population health and advice	2026/27	• Improved health outcomes through supporting MECC, prehabilitation and continuing being well through recovery		
Elective Recovery & Access	**Drive elective productivity**	2024/25	• Elimination of waits over 52 weeks for elective care (initially 62 weeks) • Reduction in avoidable outpatient referrals and activity • Improved MDT working across Primary and Secondary care		
Outpatients Transformation	**New care models**	2027/28	• More care closer to home in primary care through better access to specialist expertise in primary care • More efficient use of primary care resources through a more effective approach to “patient initiated follow ups” • Better use of estate, more productive workforce and increased patient satisfaction through use of digital clinics		
	Productivity	2024/25	• More activity through more efficient utilisation of resources, increasing activity and booking • Reduction in Follow Up Outpatient Attendances without procedure		
	Diagnostics	2025/26	• Expansion of GP Direct Access to new modalities • Increase in percentage of patients who receive a diagnostic test within six weeks through maximising use of CDCs		

PRIORITY 9: Transform the way planned care works

What do we want to achieve? (ii)

The domains and outcomes below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

	Sub priority	Target Date	Outcomes	Dependencies	Owner
Enabling functions	**Workforce**	2026/27	• Better and more productive utilisation of staff • Increase staff satisfaction, reduction in staff burnout • Reduction in agency staff expenditure	• Wider workforce programmes • NHS England	• North West London People Board with oversight by the Joint Lead Chief People Officers
	Digital and Data	2024- 25	• Effective usage of Care Co-ordination Solution for Elective Care across the APC, migrating to the national NHSE Federated Data Platform.	• Funding model for Federated Data Platform and local implementation • Discharge hubs	• ICB digital transformation Board • APC tech team
		2026-27	• Real time clarity of demand, capacity and patient flows across the APC enabling accurate clinical and service decisions • Technological/ pathway solutions to optimise discharge coordination		
	Estates	2027/28	• Effectively utilised estate, designed to support the needs of patients and the services delivered in them	• Input and engagement from Boroughs, Programmes and Trusts	• TAP, Estates Board & respective internal ICB Scheme of Delegation

PRIORITY 9: Transform the way planned care works

How are we going to achieve our outcomes? (i)

The domains and activities below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

	Sub priority	Focus year	Year 1	Year 2	Year 3+
Provider strategy		**Y1**	• Develop, publish and commence delivery of North West London acute provider collaborative strategy	• Work to deliver the published strategy	
Quality	**Communications with patients**	**Y2**	• Activities to improve communications with patients to reduce DNA, including patient education, use of language, provision of languages other than English	• Activities to support MECC, prehabilitation, continuing being well through recovery • Better use of NHS App	
	Population health and advice	**Y2-3**	• Implement new national patient safety strategy (incl PSIRF)		• Best practice approaches to reduce inequalities in outcomes across elective care taking a population health management approach
Elective Recovery & Access	**Drive elective productivity**	**Y1**	• Demand and capacity modelling • Increase theatre utilisation – maximising time used and any one time • Increase number of throughput per list • Review length of stay (day case rather than inpatient) • Standardisation of pathways working with CRGs	• Development of a long term commissioning model that encourages North West London standard delivery of services, making best use of hub & spoke services	
Outpatients Transformation	**New care models**	**Y2-3**	• Development and better use of Advice and Guidance platform.	• Trialling and rollout of automated triage pathways in a number of specialities • Innovation of workforce models (nurse led clinics)	• Focus on care in most appropriate setting through transformation of clinical pathways, moving closer to home
	Productivity	**Y1**	• Activities to increase productivity, including appointment scheduling, clinical workflow • Focus on reduction of avoidable follow up activity, including through continued development and implementation of PIFU pathways across specialties		
	Diagnostics	**Y2**	• Embedded diagnostic centres • Review triage and criteria for direct access diagnostics	• Drive efficient use of diagnostic centres	

PRIORITY 9: Transform the way planned care works

How are we going to achieve our outcomes? (ii)

The domains and activities below reflect an initial prioritisation; the Acute Provider Collaborative will publish a more detailed overview of their activities, intended outcomes and how they intend to phase them over the coming years.

	Sub priority	Year 1	Year 2	Year 3+
Enabling functions	**Workforce**	• Delivery of diversification of routes into employment and new models in work streams that address known shortfalls using North West London Integrated Recruitment Hub	• Scope workforce elements to drive system wide new ways of working in support of new models of care	• Use new roles, new ways of working and competency-based approaches to transform the workforce in line with service models
	Digital and Data	• Implement the local Care Co-ordination Solution for Elective pathways across the whole of the APC. • Pilot a technological / pathway solution to optimise discharge coordination	• Scale up technological / pathway solution to optimise discharge coordination to 50% sites	• Data available to enable top-down management of demand, capacity and patient flows across the APC
	Estates	• Rolling programme on major projects including developing hubs and national programmes (e.g. CDCs) • Support for new hospital programmes		

Section 3: Our enabling teams

Our digital and data strategy underpins our programme of business and clinical transformation

The aim of the NW London ICS Digital and Data Strategy is to deliver the digital and data enablement needed to underpin the ICB's programme of business and clinical transformation; and to support the objectives to sustain a stable and secure ICT infrastructure, improve providers' digital maturity, implement shared records across health and care settings and use them for better integrated care, share data with citizens to help them manage their own health and care, harness data and use it intelligently to improve population health and reduce inequalities, and take advantage of digital healthcare innovation.

Workstream	Description	Outcomes / Impact	Activities in 2024/25	Activities from 2025/26
ICT Infrastructure	Level up our organisations to modern levels of cyber security and resilience, to ensure our systems, staff and service users are protected from risks; and address technical debt that has built up over time because of underinvestment.	Our strategic ambition is to provide ICT infrastructure that gives staff seamless access to digital records from wherever they are located.	• Develop ICB Cyber Security Plan by end 2024/25 (dependent on NHS England funding for cybersecurity) • Implement ICT Infrastructure Plan over the period to 2028/29, including deployment of Microsoft M365	
Acute EPR Enhancement Programme, including Digital Diagnostics	Standardise the way in which we use our EPR to minimise variation in patient pathways and support new initiatives as well as rationalising clinical system contracts.	Effective and efficient delivery of care requires recording it in a digital format, structuring and coding records to enable sharing, transfers of care and analysis.	• Ongoing programme to enhance Cerner EPR, specialist clinical systems, radiology and pathology systems to increase digital maturity and reduce variation across the APC, over the period to 2028/29 (dependent on Trust Capital and NHSE Frontline Digitisation funding).	
Community and Mental Health EPRs	Enhance EPR systems for Community and Mental Health Trust core activities	Improved digital maturity, better support care for delivered by clinicians and increased integration between services.	• Ongoing programme to enhance SystmOne, EMIS Community and RiO clinical systems, to increase digital maturity and support the strategy of the Collaboratives over the period to 2028/29 (dependent on Trust Capital and NHSE Frontline Digitisation funding).	
Primary Care EPRs	Support and enhance Primary Care EPR systems in response to clinical needs.	Better neighbourhood working and improved integration between primary care and other settings.	• Enhancement of Primary Care systems in line with Primary Care and INT definition of requirements (dependent on specification by Boroughs and INTs, may require ICB funding).	• NW London's Primary Care EPRs must be re-procured by the end of 2025/26.
Primary Care Digital Transformation	Promoting the implementation, understanding and improvement of digital tools within general practice, particularly in relation to improving patients' access to GP services.	- Improved access to care, digital inclusion and reduction of inequalities through technologies - Improved Patient experience at the centre of selection and implementation	• Detailed outcomes and timescales will depend on funding from NHSE and/or NW London ICB for 2024/25 and subsequent years, which is still to be determined.	
Data Sharing - London Care Record	Continued deployment of London Care Record	Clinicians able to see patient records from other settings in NW London and other parts of London (e.g. for the 15-20% of our patients treated by out-of-area acute providers).	• Deploy London Care Record to all remaining healthcare settings by end 2024/25. At the same time start to tackle data quality issues, including standardisation of coding.	• Enhance London Care Record to include social care (will require NHSE London funding) • During the period to 2028/29, plan and implement the transformation required to make use of shared records across multi-disciplinary patient pathways
Digital Patient Empowerment	Many people want to understand their care better, to help them stay well; many want to manage their interactions with the care system using more efficient digital apps; though some people cannot, or do not want to, use digital channels.	Through user-centred design, transform patient and service users' interactions via digital tools to improve efficiency and outcomes, including online appointment management and patient-initiated follow-up.	• Extend Acute Patient Empowerment self-service capabilities • Deploy Care Information Exchange to all remaining settings – including social care – and recruit beyond 660,000 to include most of the people in NW London. • Develop strategy for patient-facing systems across ICS	• From 2025/26 extend Patient Empowerment beyond Acute to Community and Mental Health settings. • Rationalise the different patient-facing systems to give citizens a more consistent experience.

Our digital and data strategy underpins our programme of business and clinical transformation

Work stream	Description	Outcomes / Impact	Activities in 2024/25	Activities from 2025/26
Digital Support for Integrated Care (including Federated Data Platform)	The ICS needs better tools to support demand and capacity management. Integrated pathways require health and care professionals to work together more effectively using shared records.	• Data available to enable top-down management of demand, capacity and patient flows across the ICB, and clinical and service decision-making. • The national NHSE Federated Data Platform, building on our local Care Co-ordination Solution, will span pathways across organisations. • Multi-disciplinary integrated care pathways spanning health and social care settings will be enabled via shared digital care records, tasks and plans.	• Complete migration from Care Co-ordination Solution to Federated Data Platform • Further development of Federated Data Platform to support APC and wider ICS • Digital support for ICS Transformation Programmes to implement multi-disciplinary integrated care pathways in line with INT requirements which are yet to be confirmed (Shared records and transformation across care settings likely to require ICB and NHSE funding)	• Future milestones to be confirmed in line with agreed ICB programme requirements and pending NHS governance and funding
Population Health Data and Intelligence	Our Whole Systems Integrated Care (WSIC) data base already contains records from all NW London health and social care settings, covering 99% of the population. There is ongoing work to link the quantitative data with qualitative data generated from patient engagement. Additional data feeds will further enhance the platform.	• Support for Health Equity objective to reduce inequalities • Single source of information for place-based partnerships for their population health management projects and cohort identification for intervention. • Better intelligence and needs analysis through use of qualitative data and other data feeds. • Extension of WSIC to the whole of London for population health management and clinical research purposes via Sub National Secure Data Environment.	• Migration of WSIC to a modern cloud platform to enable more cost-effective and reliable pathway analysis and commissioning decisions. • Integrating WSIC into clinical workflows to help apply data analysis to individual patients and cohorts. • Further development of reporting tools in WSIC to support teams, helping them identify inequalities and areas of need. • Implementing further feeds (e.g. Children's Social Care data and VCSE data) • Enabling data feeds from FDP to flow into WSIC. • Further development of an easy to use front-end for Primary Care and other care settings to case-find patients. • Further development of NW London Data Strategy.	
Digital Innovation in Health and Care	We want to make use of new technology innovations and research, to improve care and patient experience. We need to exploit process automation technologies to improve our back-office processes and deliver care more efficiently.	• Innovative technologies (e.g. learning systems and AI; process automation) will be applied regularly to support clinical decision making. • New, transformational models of care will be made possible by digital innovations such as ambient documentation.	• Establish the principles, approach and governance mechanism for the evaluation, implementation and exploitation of Artificial Intelligence in NW London. • Continue the programme of innovation to support Primary Care Access through Digital Transformation. • Continue the pilots of Robotic Process Automation to improve the efficiency of back-office processes	• Future milestones to be confirmed in line with agreed ICB programme requirements
Digital Workforce	Digital Workforce Plan - for digital professionals and care professionals using digital and data	• Increase retention and effectiveness of digital workforce • Free up staff time and improving the efficiency of services. • Improve accuracy and efficiency in diagnostic services and administrative processes.	• Develop a Digital Workforce Plan for ICB, covering digital professionals (to be mandated by NHSE) and reflecting the need of the clinical and business workforce to use digital systems and data effectively as part of their roles (Trust investment in resources will be required).	• Implement Digital Workforce Plan.
Digital Clinical Safety	ICS-wide clinical systems must have clinical safety built in as a fundamental requirement	• Assure the quality and safety of clinical systems and data in providing care	• Recruit a Digital Clinical Safety Officer to support ICS-wide clinical systems (funded by a levy on NHSE Frontline Digitisation funding to Trusts)	• Will require ICB funding from 2025/26 onwards

Our workforce plan supports each priority and will make North West London a great place to work

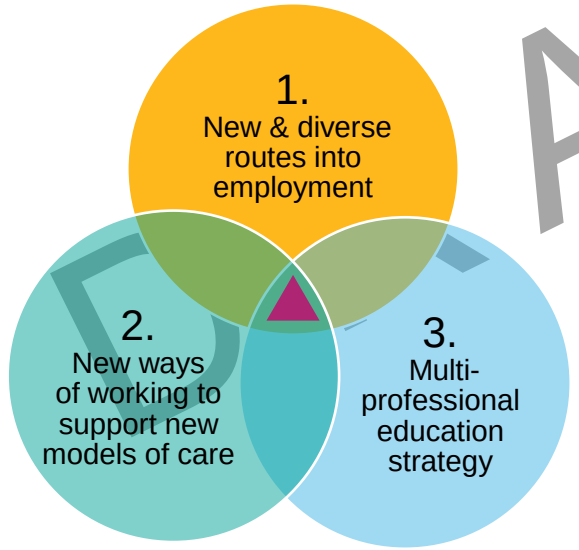
Our ICS workforce priorities are grouped together into two strategic intentions:

A great place to work by bringing together our ICS wide collective **recruitment** and **retention** initiatives to ensure availability of the workforce capacity required, minimise attrition and maximise the capability of the registered and non-registered workforce.

Transform for the future by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and productivity and to maximise the opportunities afforded by **digital and technological innovations.**

These align to the NHS Long term workforce plan. **'A great place to work'** speaks to 'Recruit: Grow the workforce' and 'Retain: Embed the right culture and improve retention'. Whilst '**Transform for the future**' is our approach to 'Reform: Working and training differently'.

We have identified at system level, **three high impact programmes**, two that fit with the two workforce strategic intents within the ICS strategy; and a third which addresses the development and delivery of a clear vision and delivery plan for education and training in NW London. Each ICB has a duty to promote education and training as an essential lever of an integrated workforce plan:



Strategic workforce planning is central to all three programmes

We will focus on NW London challenges and opportunities but with alignment with NHS Long term Workforce Plan requirements

1. Expand and diversify routes into employment

At system level, we will maximise the investment in the Health and Social Care Skills Academy to raise awareness of health and care roles, create more diverse entry routes; focus on key system wide retention initiatives; and design skills programmes. Key initiatives include:

- Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage
- Provide a pipeline of staff into our entry level roles, to enable progressive employment with career pathways
- 100% of NW London's NHS Trusts to be fully accredited as London Living Wage employers
- Recruit 50 Senior carers into roles across 8 boroughs; 70 refugees and 50 volunteers into employment across health and social care by March 2025

2. New ways of working to support new models of care

The lack of staff to fill traditional roles, high temporary staffing costs and the need to maximise productivity require us to re-design roles, teams and staffing structures to improve productivity through a more efficient use of skill mix within teams. There is a two phased approach, key initiatives include

- The **first phase** covers the current known priorities: including the NW London EOC initial launch, Ophthalmology hubs, and Community Diagnostics centres.
- Supporting the key workforce deliverables for the community nursing collaborative and supporting the delivery of the mental health strategy and transformation .
- The **second phase** will be to scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of new models of care
- Improve capability of staff in making best use of digital systems towards more data-driven decision making
- Create and implement a productivity tool

3. Multi-professional education and training strategy

The NHS long term workforce plan signals a significant expansion to fund additional education and training places. Each ICB also has a duty to promote education and training as an essential lever of an integrated workforce plan. Key initiatives include:

- Develop an education strategy that sets out a clear vision for education and training
- Launch the NW London Graduate Leadership scheme
- Set up a NW London undergraduate placements scheme to fill hard to recruit roles.
- Develop an ICS Oliver McGowan Mandatory Training Hub

Our Estates strategy seeks to make best use of all community assets in delivering our ambitions for integration

Our NW London ICS Estates Strategy

We have recently revised the North West London ICS Estates Strategy. Through this it is outlined that we seek to improve the use of key primary & community care sites; support the transformation of mental health services; improve accessibility and fitness-for-purpose of primary and community sites; support PCN and ICP delivery; delivery an achievable and affordable capital pipeline of projects; improve trust estates performance measures; support the delivery of North West London's Covid Recovery Plan' and process plans for affordable housing for healthcare staff.

We will deliver this by providing primary care at scale, delivering from hub locations in all of our boroughs; reducing our void and using space effectively and efficiently; managing a reduced footprint of fit-for-purpose estate and making best use of technology and hybrid working best practice; working collaboratively without internal and external partners.

Our delivery principles

In delivering our Estates strategy we aim to deliver according to four important principles:

1. **Our estate is designed to support services and patients**

   Buildings support/facilitate services which respond to the needs of the local population and is service led.

2. **Our buildings are effectively utilised**

   Every building meets a set of core standards (85% clinical utilisation rate, Sites open for a minimum of 10 hours every weekday, and 5 hours on a Saturday for 50 hours p/a, Virtual consultations accounting for around 27% of total consultation rate (growing to 45% by 2040), An overall contract rate (contracts per patient per year) of 7.5 used for primary care activity, No void/unused sessional space – active management of flexible sessional space, Clinical rooms prioritised for face-to-face appointments.

3. **Our buildings are integrated**

   All buildings with best design for integrated working, improved efficiency and multi-agency.

4. **Our investment is focused on estate important to us in the long-term**

   Investment (DCC, IPC, building survey conditions, patient experience, NZC) prioritised in sites which are long-term integrated solutions.

Our Estates strategy seeks to make best use of all community assets in delivering our ambitions for integration

Description	Activities in 2024/25	Activities from 2025/26
Business-as-usual (BAU) Schemes		
The ICB has already identified a minimum of 40 BAU schemes in need of address. The programme will implement a system for governance and resource allocation to prioritise, oversee and support local BAU schemes across the ICS.	Ongoing BAU activity	
Digitisation of Records		
This programme will support Technology teams with ongoing digitisation of records to free up additional space across NW London ICB estate which can be re-allocated to in-demand services and other clinical activity.	• Digitisation of records across Community and Primary Care Estate in collaboration with IT. Will also include conversion where possible of space into clinical, consulting or administrative space.	
Infrastructure Planning and Delivery		
This work involves the development of individual Borough Infrastructure Delivery Plans (IDPs) developed with key internal and external stakeholders (e.g. LAs). It further includes responding to large-scale planning applications and bidding for, securing, allocating and drawing down funding across a number of North West London schemes.	• Responding to large scale planning applications • Revising every boroughs Infrastructure Delivery Plans with Local Authorities and ICS stakeholders (incl. Trusts/Borough Leads) • Overseeing S106 and CIL funding and bidding	
London Improvement Grant		
Annual programme of work which seeks to identify GP practices in need of external NHSE capital funding to improve condition of estate as aligned to Six Facet Survey / Estate Strategy data and the Equality Act. Successful schemes receive a 33% reimbursement.	Allocating national LIG funding to GP sites across NW London and monitoring delivery/expenditure with the London Estates Delivery Unit	
Major Projects		
These schemes offer significant space e.g. from void and unused bookable space, provide opportunities for urban expansion, and offer potential financial savings that can be reinvested back into the NHS. These also focus on developing hubs, increasing primary care-at-scale offerings and supporting national programmes (e.g. CDCs).	• HQ Rationalisation Activity • Alexandra Avenue Hub Optimisation • Community Diagnostic Centres - Ealing • Chiswick Health Centre Rebuild • Grand Union Village GP expansion • The Old Vinyl Factory • Wembley Park Practice GP Scheme • Hillcrest Surgery Relocation • South Kilburn GP Scheme • Golborne Medical Centre / Kensal Road	• Heart of Hounslow Hub Optimisation Project • Alperton Health Centre • Northwood & Pinner • Nestle • North Ealing Hub • Southall Gasworks & Park Avenue • Beaufort House - Uxbridge Hub development • Newcombe House • OPDC related projects, including Willesden CFH Moves.
New Hospital Programme		
Supporting the development of the two new hospital development programmes in Hillingdon & Imperial.	-	-
Right Size, Right Place		
Assesses space across NW London estates and encourages boroughs to work together to use space more effectively and collaborative. Leases will be proactively reviewed, helping to inform decision-making and current and future use of space and business case proposals, whilst highlighting circumstances where it may be appropriate to surrender leases or close single GP practices in favour of utilising vacant space to enhance at-scale delivery.	• Lease negotiations and relocations of Hounslow, Brent, Hillingdon, Harrow and Ealing Borough Teams into new HQ premises • Renting of flooring space of Marylebone Road	• GP, NHS PS and CHP proactive lease management
Void Management		
A joined up void, sessional and unused bookable space programme of work designed and delivered in collaboration with other NHS property companies and stakeholders. Includes bringing void space back into use for clinical, consulting or administrative activity; handing back no longer fit-for-purpose sites; and transferring space to the 'Open Space' booking system where possible to generate additional revenue for the ICB.	• Handback of Wealdstone Health Centre • Strategic Review of all unused void, bookable and sessional space • Scrunitinising Annual Charging Schedule Costs with NHS PS and CHP	• Full or partial handback of The Meadows Health Centre • Ongoing void reduction at a number of sites, including: Jubilee Gardens, Feltham Centre for Health, St Charles and South Westminster

The views and experiences of our local residents are a key factor in shaping the success of our priorities

The NW London communications and involvement team are key in the successful delivery of many of the priorities, whilst balancing the delivery of their own. Their key areas of focus are outlined below:

Work stream	Description	Expected outputs
Insights into action	Programme to combine resident insights with other data and ensure central to decision-making.	• Plan developed with BI, ICHP, Population Health and other teams • Biannual insight/data reports to ICB Board, programmes and partners • Strong focus on specific metrics: reduction of patients not attending appointments; reduction of unnecessary A&E attendances; uptake of vaccination/screening
Keep it Simple	Communications campaign to simplify use of language across ICB and then wider ICS	• Publication of ICB guidance, 'Plain language' approach to ICB website and publications • Involvement of residents, e.g. via a reading group, Rollout to wider ICS including consistent use of terminology
Delivery of ICB involvement strategy	A range of activities including: Community outreach, Community insight reports, Resident and patient forums and Lay partner programme	• Range of activity planned quarterly
Corporate communications	A range of activities including: Public communications, Public health messaging, Staff communications, annual report, ICB website, ICS/ICB publications, FOI and Media relations	• Range of materials as required
Equality, Diversity and Inclusion	Deliver EDI strategy, Ensure ICB meets and Public Sector Equality Duty	• Implementation of first stage of EDI strategy, including Race Equality strategy, Clear system for ensuring EHIAs take place when changes proposed and Ensure involvement strategy reaches groups with protected characteristics

For each identified North West London priority, the Communications and Involvement team will organise support as follows:

	How communications and involvement will support our NW London priorities
PRIORITY 1: Improve health outcomes through Population Health Management	• Continued communication of population health approach including strategic advice and specific support to initiatives • Key metrics to be applied to ICB communications and involvement team.
PRIORITY 2: Improve Children and Young People's Mental Health and Community Care	• Involvement of children, young people, parents and schools • Development of communications materials
PRIORITY 3: Establish Integrated Neighbourhood Teams (INTs)	• Maximise understanding and involvement across system and communities
PRIORITY 4: Improve mental health services in the community and for people in crisis	• Publication and communication of mental health strategy • Communicating decisions on Gordon/Hope and Horizons proposals • Resident involvement on mental health strategy
PRIORITY 5: Embed the core community offer and maximise productivity	• Involve residents in developing standardised services • Potential for public consultation where changes proposed
PRIORITY 6: Optimise patient flow across the system – right care, right place	• ICS winter plan, • Co-design of solutions with residents e.g. primary care changes • Communication of changes to residents
PRIORITY 7: Transform maternity care	• Support acute provider collaborative with messaging and reaching community groups
PRIORITY 8: Increase cancer detection rates and deliver faster access to treatment	• Further work with residents and the cancer alliance to address barriers to screening uptake
PRIORITY 9: Transform elective care pathways	• To be led by Acute Collaborative communications

Section 4: Our Provider Collaboratives

Who we are – our Provider Collaboratives

Our provider collaboratives span acute, mental health and community services. These collaboratives are central to delivery of our ICS vision: recovering core services and productivity, delivering a consistent offer for all our residents and meeting operational planning requirements.

NHS
North West London
Acute Provider Collaborative

Our provider collaborative is a formal partnership of the four acute NHS trusts in north west London:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust

Between us, we run 12 hospitals and employ 33,000 staff.

Collectively we have developed a structured approach to collaborative working across the 4 Trusts:

- **"Do it once"** – priorities we can only deliver by working collaboratively together
- **"Do it the same"** – priorities we could chose to deliver as 4 Trusts as it will enhance the efficiency, benefits and/or shared learning
- **"Do it locally"** - Priorities we need to get on and deliver within each of our individual Trusts, while sharing learning

Our vision: Our core reasons for collaborating are to improve equities in access, experience and outcomes for our patients and the experiences of our staff across our acute services within North West London.

The acute provider collaborative is currently developing its own strategy (building on the ICS strategy). Publication is anticipated in summer 2024.

Our areas of focus over the next 5 years include:

Quality

- Clinical harm review, access and inequality
- Infection prevention and control
- Peer reviews of Emergency pathways
- Developing a stronger user insights focus
- Care of the deteriorating patient
- End of life care
- Maternity and neonatal – delivery plan
- Mental health in an acute setting
- Implement new national patient safety strategy including PSIRF and a shared system for incident and risk management

Finance, Productivity and Performance

- Delivery of the activity and performance targets in our operational plan
- Support services consolidation
- Discharge planning and reducing medically optimised patient LOS with ICB and collaborative partners
- Improving productivity and financial sustainability
- Outpatient Transformation

Workforce

- Reduce premium rate staffing expenditure
- Elective orthopaedic centre workforce transition
- Recruitment hub for hard to fill vacancies
- Career hub and staff transfer scheme
- Increase apprenticeship levy uptake
- Reduce violence, aggression, bullying and discrimination

Digital programmes

- Finalise the APC digital and data strategy
- Implementation and optimization of Cerner system
- Improving patient flow and capacity using care coordination solution

Who we are – our Provider Collaboratives

NWL Mental Health, Learning Disabilities & Autism Provider Collaborative

Our Collaborative comprises two NHS Trusts:

- Central & North West London NHS Foundation Trust (CNWL)
- West London NHS Trust (WLT)

We are the delivery arm for transformation of MHLDA services in North West London. Our focus over the next five years is on using a productivity lens to drive consistency of patient outcomes and better manage rising demand. We will be the principal engine of transformation and operational delivery by working with and amplifying the voices of Experts by Experience, clinicians, strategic partners and supporting coalitions to reimagine integrated care pathways across providers and within Borough Based Partnerships, working with them to agree shared priorities and offering high quality, equitable, responsive and more sustainable services.

Our areas of focus over the next 5 years include:

Reduction in unwarranted variation

Deliver shared offer, improve productivity for and demonstrate improvements to waiting times.

Crisis and acute demand management

Improve patient flow, reduce length of stay LOS and minimise use of out of area beds.

Child and Adolescent Mental Health Services

Review and improve inpatient and A&E provision, including Learning Disability provision.

Sustainability

Work with data, digital and workforce programmes to embed changes.

Programme and strategy

Deliver agreed programme priorities and operating plan targets and implement priorities in new strategy.

North West London Community Collaborative

Our Community Collaborative comprises four NHS Trusts:

- Central & North West London NHS Foundation Trust
- Central London Community Healthcare NHS Trust Hounslow & Richmond Community Healthcare NHS Trust
- West London NHS Trust

Our key aims of the Collaborative are to work together to:

- **Drive service consistency** - reducing unwarranted variation for service users
- **Manage operational performance** - transparency and collective accountability
- **Increase collective efficiencies and effectiveness** - benefitting from scale

Our areas of focus over the next 5 years include:

Community Nursing

Demonstrate community nursing productivity and a core offer

Community beds

Mobilise Length of Stay reporting, demonstrate community beds productivity and a core offer

Neuro rehab

Uplift and make stroke and neuro service provision equitable and productive across NW London

Children's Speech and Language Therapy (SLT)

Mobilise a core offer and realise quick wins

Digital and data

Identify and implement a consistent digital offer

Community Waits

Reduce children and adults waiting list numbers and develop Community Access Policy

Productivity

(1) Podiatry, (2) Community Nursing, (3) Urgent Care Response (4) Children's SLT

Workforce

Building capabilities and supporting health and wellbeing

Section 5: Our Borough Based Partnerships

Working together at place – our Borough Based Partnerships

We are clear that the key to health and care improvement lies in each of our seven borough partnerships to address the health and care needs of local people. Recently, local health and care partners refreshed local health and care strategies, of a which a core number align with NW London common priorities.

Our local place-based partnerships bring together the NHS, our eight local authorities and public health teams, Healthwatch, voluntary and community sector organisations and local residents to work together to understand and meet local health and well-being needs.

We want to make sure that our Joint Forward Plan and the priorities take proper account of local health and wellbeing strategies.

We have set out local plans, where these align with NW London priorities and can therefore be delivered at scale and additional activities that will be implemented in line with local population needs in agreement with their Health and Wellbeing Boards. As with the priorities, we have set a clear expectation that the plans be deliverable within the resource envelope available.

Bi-Borough – bringing together Westminster, Kensington and Chelsea

Our Bi-Borough's vision is "People want to live healthy and happy lives to the fullest, in ways they choose, in communities that are safe"

The Bi-Borough is a partnership between the boroughs of Kensington and Chelsea with Westminster into one partnership team. The bi-Borough's Health and Wellbeing Board published a Joint Health and Wellbeing Strategy across 2023-2033. and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy has is supported by a clearly articulated vision

- Live longer and fulfilling lives.
- Have their mental wellbeing regarded as equally as important as their physical health
- Live in communities that are healthy, safe and with good quality schools, housing and environment.
- Have access to good quality and fair services that meet their needs.

Priorities and annual plans set out in the strategy align closely with the NW London priorities.

Westminster has **205,100 residents**. Kensington has **143,900 residents**.

About **1 in 4** adults report high levels of anxiety for both Boroughs.

About **1 in 4 children live in poverty** within Westminster and about **1 in 5** live in poverty in Kensington and Chelsea.

18 years Westminster has the **highest life expectancy gap** for men, Kensington has the 4th highest life expectancy for women.

Unemployment is at ~ 5% across both Boroughs.

39% in Westminster and **31%** in Kensington and Chelsea identify themselves as from a Black, Asian and Multiple Ethnic background.

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Bi-Borough – bringing together Westminster, Kensington and Chelsea

Priorities for Bi-Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Bi-Boroughs resourced through partners

Integrated Neighbourhood Teams

Outcomes: Reduce health inequalities in local population and tackle underlying causes of ill health. Delivered through a number of focused programmes.

Adult mental health

- Dementia Assessment and Diagnosis*
- Talking Therapies access rates*
- SMI Physical Health Gloji MIND weight management pilot project*
- Early Intervention and Prevention**
- Overrepresentation of people from the Global Majority detained under the MHA**

Care homes

- Implementation of signs of deterioration training across all care homes – Q2 24/25**
- Implementation of personalised care and community connections programme across all care homes – Q4 24/25**
- Development of workforce strategy for care home staff**

Healthy weight

- Increased bi-borough primary care prevalence of adults on obesity register**
- Delivery of 3 Change4Life neighbourhood projects**
- Delivery of the Westminster Superzone project**
- Improving living conditions via maximisation of income of people on benefits and work to improve housing conditions**

Children and Young People

- Family Hubs Q4 25/26*
- Autism Waiting times Q4 24/25*
- Mental Wellbeing in Schools Q3 24/25*
- Asthma Friendly Schools*
- Speech, Language and Communication Needs Q4 25/26*
- Occupational Therapy Q4 25/26 **

Homelessness

- Integrated Care Network services**
- Health and Wellbeing/Seasonal Vaccinations**

Primary Care Development

- Primary Care Networks**
- Patient Access & Technology**
- Out of Hospital Services**

Hospital discharge

- Pathway 1*
- Pathway 3*
- Mental Health*
- Housing**
- Social Isolation**

Vaccinations and Screening

- Covid & Flu Vax**
- Cancer Screening*

North Kensington Recovery

Outcomes:
- Local community-led initiatives, engagement feedbacks, and health data.
- Those affected by the Grenfell Tower fire can feel and express that they have received the right support from the NHS.
- NHS's Regulation 28 responsibilities are fulfilled.

- Supplementary Personalised Health Assessments**
- Future services (2024-9) co-design phase – Q2 24/25**
- Future services (2024-9) transition phase – Q4 24/25**

Vibrant and healthy communities

Outcomes:
- Enhanced delivery of preventative healthcare work
- Minimum 50% uptake of Cervical screening by end Q1 24/25 via identified cohorts
- Additional 35 connector roles in bi-Borough by end Q4 23/24
- Reduced A&E attendances for HIUs by 25% by end Q4 23/24

- Building Voluntary and Community Sector capacity and influence*
- Understanding and measuring impact*
- Community based approaches to address health inequalities*
- Our workforce*

Enabling functions

Business Intelligence

Organisational Development & Workforce

Digital

Estates

Brent

About Brent

Brent has published their Joint Health and Wellbeing Strategy for 2023-27. Informed through community conversations it agreed the following priorities:

- Prosperity and stability in Brent,
- Thriving Communities,
- A Healthier Brent.
- A Cleaner, Greener Future,
- The Best Start in Life.

This will be delivered through a number of workstreams, those areas which are supported through delivery with NW London ICB are outlined to the right. Brent's ppriorities and annual plans set out in the strategy align closely with the NW London priorities.

With a **population of 339,800 (with 500,000 registered patients)** Brent is the seventh most populous London borough.

Brent covers an area of **4,325 hectares**, 22% of this is green space.

65% of the local population is from Black, Asian and other minority groups – the second most ethnically diverse borough.

Brent's median age is 35, with **22%** of local people are under the age of 18, it has a young population.

56% of Brent residents were born overseas, over 149 languages are spoken and 37% of residents do not have English as their main language.

66% of residents aged **16-64** are in employment, including **16%** who are self employed.

27% of workers earn below the London Living Wage.

Brent

Priorities for Brent's Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Brent resourced through partners

Community

Outcomes: focused activities to improve outcomes and access prioritising frailty, respiratory, heart failure, rehab, reablement and care homes, and discharge (BCF).

Activities
- Align core offer for community frailty service by September 2024*
- Reduce HF preventative admissions and activity in hospital**
- Improve outcomes and goals following 6-week rehabilitation treatment*
- Reduce A&E attendances from care homes**
- BCF and Discharge*

Mental Health, Learning Disabilities, Autism and Complex Care

Outcomes: several areas of focus including employment, housing, access and demand, complex care and children and young people.

Activities:
- Crisis outreach to key neighbourhoods (NW10 and NW2), Community connectors, Community Mental Health Wellbeing and Living Well hubs, Educating and Empowering Communities*
- Neurodiversity for 0-5 *
- Reducing waiting times for ADHD/ASD*
- IAPT - Talking Therapies - All Age*
- Reducing LoS and Rehab for complex care patients*
- Improve access and inequalities in mental health services for children and young people – waiting well initiatives*
- Implementation of THRIVE programme for young people *
- Reduce reliance on specialist CAMHS. Reduce waiting list and waiting times for specialist CAMHS referrals*

Primary Care

Outcomes: focus on primary care access, proactive and planned care, enhanced services, workforce and community pharmacy.

Activities
- Development of the Same Day Access Hub with sign posting to appropriate partner organisations*
- Improving management of Proactive and Planned Care at practice level *
- Development the workforce to manage triage and proactively planning for future needs.*
- Communications and Engagement: Empowering patients to manage their own health through the NHS App/self care and peer support**

Health Inequalities

Outcomes: focusing on community involvement, informing and supporting residents, improving access and active community partners.

Activities:
- Co-produce and co-deliver local action plans with communities**
- Support people to register with a GP**
- Health education, digital inclusion and peer support groups**
- Co-produce and deliver health and wellbeing events in the community (includes health checks and mental health support) **
- Contact target patient groups on GP lists on the clinical priorities (bowel cancer screening, SMI health checks and hypertension)*
- Award Community Grants to local organisation
- To reduce Health inequalities for children and young people a new work programme and funding streams established**
- To improve uptake and accessibility of key immunisations and vaccines for children and young people**

Integrated Neighbourhood (Spans across all the 4 priority work streams to the left)

Outcomes: We aspire to have core 'team of teams' in 5 Neighbourhood areas, co-located in integrated health + care hub sites, supported by specialists.

Activities
- Ensuring that we are developing the roles and skills (Workforce & OD) and supporting even greater collaboration and partnership working (Leadership).*
- Developing 'integrated hubs' within the neighbourhoods to deliver services together in campus of premises (Estates Optimisations).*
- Ensuring that staff can access the information they need about a patient/resident to deliver the best possible care**

Children Programme (Spans across all the 4 priority work streams to the left)

Outcomes: focused activities to improve outcomes and access focusing on special school nursing, children continence, CAMHS, paediatric Hublets, asthma, SEND , THRIVE and neurodiversity.

Activities
- Participating and aligning with NW London wide Special School Nursing programme to identify service gap and resources required*
- Reducing Waiting Times for ADHD and ASD assessments in the shorter and longer-term*
- Clinical leaders and the Place based team established 4 operational hubs**
- Asthma - Epipens and spacers Business Case approved and rollout of initial 6 participating schools*
- We worked collaboratively to prepare our narrative and documentation for a SEND inspection
- We ran a workshop interrogating which of the 4 quadrants each of the services sit in – service mapping.

Ealing

"Together in Ealing" – we will see Ealing's communities thriving, with good health and wellbeing, and with fairness and justice in the building blocks of health and wellbeing.

Ealing's Health and Wellbeing Board published a Joint Health and Wellbeing Strategy for five years across 2023-2028. and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy has is supported by underlying principles of:

- Putting communities at the heart of everything
- Systems and structures that leave no one behind
- Connecting the building blocks of health and wellbeing

Priorities and annual plans set out in the strategy align closely with the NW London priorities.

The proportion of children (under 16 years) in Ealing living in poverty is **14%**, having increased by **10% since 2015**.

Men and women on average in Ealing live to **80.3 years and 84.4 years** respectively. However, there are differences for men and women living in different areas.

Ealing has **4 residential areas** that are in the **10%** most deprived in the country, with the highest deprivation concentrated in and around Southall, Northolt and Acton.

Ealing is the third most ethnically diverse borough in England and Wales, with **less than 50%** identifying in the overall White ethnicity category.

The number of people stating they had a limiting long-term health problem or disability is approximately **12%**.

Approximately **15%** of all households receive housing benefits, with **13%** living in overcrowded conditions.

The number of people stating they had a limiting long-term health problem or disability is approximately **12%**.

Ealing

Priorities for Ealing Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Ealing resourced through partners

Population Health

- Reducing health inequalities in the most 20% deprived areas
- Increase hypertension detection
- Improve uptake of Immunisations
- Increase physical health checks for people with SMI
- Increasing utilisation of IAPT

- Academic Partnership**
- Core20Plus5*
- Establish Population Health Capability*
- Outreach to vulnerable groups**
- Development of JSNA chapters*
- Planetary and Healthy Food Choices**
- Race Equality Commission**
- Working with Voluntary Sector**

Children & Young People

- Reduce school exclusion rates
- Implementation of the iThrive model for CYP Mental Health
- Child Health Hubs across all PCNs/INT
- Transition to Family Hubs
- 'Good' CQC/Ofsted rating for SEND
- Improve child Dental hygiene

- Care Leavers*
- Children's Asthma*
- Emotional Wellbeing and Mental Health Resilience*
- Giving children a health start in life*
- Inclusion for all Children and Young People - SEND Board*
- Supporting Children to Achieve Healthy Lives*

Integrated Neighbourhood Teams

- Embedded Integrated Neighbourhood Teams across Ealing
- Annual priority programme in place that incorporate inequalities and HIU
- Robust community engagement programme implemented
- Community of teams and services working together

- Ealing Community Partners and Mental Health Integrated Network Teams Stocktake*
- Implement agreed priorities for Programme Year Two*
- Implement key learnings from 2022/23 Evaluation*

People with Complex Needs

- Establish Care Home Liaison Service
- Reduce care home callout and conveyancing to LAS
- Improve utilisation of UCP
- Review EoL services at Meadow House
- Bring Reablement and Rehabilitation pathways together

- Care Homes*
- Falls and Frailty*
- Dementia*
- Reablement and Rehabilitation pathways*
- End of Life Pathway*

Value for Money & Contracts

Communications & Engagement

Seasonal Summits & Patient Flow

- Increased utilisation and accuracy of Same Emergency Care Data Set
- Increase Adult Social Work capacity
- Improve Reablement Bed pathway
- Implement Care Home Liaison and staff training
- Expand Bridging Service

- Data systems at Ealing and London North West Acute Hospitals Trust*
- Improving Discharges (Mental and Physical Health)*
- Seasonal Summit**

Primary Care

- Implement Same Day Access Programme
- Evaluation of enhanced services
- Improvement in Flu, Pneumococcal and COVID vaccinations uptake
- Increase Children's vaccinations rates
- Resilient and Sustainable Primary Care

- Access*
- Clinical Effectiveness**
- Immunisations and Vaccinations Programme**
- Procurement

Corporate & Other

Enablers- Estates, Workforce and Digital

Hammersmith and Fulham

The Hammersmith & Fulham Health and Care Partnership is a collective of health, care and wellbeing organisations dedicated to improving health and wellbeing for local people.

We are doing this by working with and for our different communities in Hammersmith and Fulham, making the changes that matter most to them, placing the resident at the centre of care and tackling health and wellbeing inequalities that exist across the borough.

To deliver on these priorities, we have a number of work streams, outlined to the right, that are implementing changed to health and care services. In addition we have two specialist partnership boards – the Children's Health, Education and Social Care Partnership Board and the Dementia Partnership board:

- The Dementia Partnership Board drives the implementation of the H&F dementia strategy with a focus on co-produced activities, and in doing so works to address the eleven local priorities identified by our residents with dementia, their carers, the organisations and services and local businesses supporting them.
- The Children's Health, Education and Social Care Board holds the local area to account on the progress of actions and priorities across a range of programmes within Children's health, education and social care. It is co-chaired by health and social care leaders.

The largest proportion of residents are working aged adults between **25-49 years (46%)**.

Hammersmith and Fulham has **201,400 residents**.

Children and young people make up the second largest age group in H&F, with **29% aged 0-24 years**.

8% of the population are aged 69 years and above.

Potential years of life lost due to alcohol in males is significantly **worse than the national average**.

65% of residents are from a 'White' ethnic group and **79% speak English** as a first language This is larger than the London average of **56%**.

Hammersmith and Fulham has the **highest rates of preventable mortality** in North West London.

Hammersmith and Fulham

Priorities for Hammersmith and Fulham Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hammersmith and Fulham resourced through partners

Partnership boards

Dementia Strategy Implementation
Via Dementia Partnership Board

The Dementia Partnership Board will drive the co-production (working together) activities going forward and in doing so address the eleven local priorities identified by our residents with dementia, their carers, the organisations and services and local businesses supporting them.

- Implementation of the H&F Dementia Strategy**

CYP Strategy & Transformation
Via the Children's Health, Education and Social Care Board

The Partnership Board holds the local area to account on the progress of actions and priorities across a range of programmes within Children's health, education and social care.

- Performance monitoring of Children's services in the borough*
- Preparedness for SEND inspection*
- Family hub development in the borough*
- Implementation of the SEND strategy*

Integrated Neighbourhood Teams

Support our complex patients, through proactive care planning and delivery, enabling early intervention and prevention, and reduction in escalation of need therefore improving outcomes for our population; remove the barriers to integrated working and work towards a having a single team around place.

- Agree geographies & principles of Integrated Neighbourhood Teams in H&F*
- Embed Family Hubs in H&F through a fully integrated, multidisciplinary approach to supporting residents in the community*
- Further develop the MINT offer to INTs within H&F*

Children and Young People

Support our children and young people to thrive by delivering earlier support, reducing wait times and personalizing care where appropriate

- Support Mental Wellbeing in schools.*
- Ensure equity in access and outcomes for speech and language and occupational therapy**
- Deliver a flexible and dynamic offer for Initial Health Assessments*
- Prepare young people for adulthood through timely Health transitions*/**
- Reduce waits for autism assessments*
- Support children in or on the edge of Tier 4 NHS provision without a mental health diagnosis but clear mental health need**

Mental Health

The work stream strives to expand the community offer, guaranteeing residents access to timely services, including employment support, VCSE services, and secondary care. Additionally, services will be co-produced with residents, utilizing a population health approach to cater to the local community.

- Improve community mental health service provision via the improvement of flow in acute wards, the development of the MINT teams, the wrap around of voluntary sector providers and interface with primary care*
- Increase quality and availability of supported living so fewer people are placed in residential placements far from home**
- Improve physical health for people on the SMI register*

Tackling Inequalities

To agree a shared understanding of the principles of population health management, and how the HCP wants to work collectively to tackle inequalities, looking at both short term projects and interventions and longer term collective transformation across the system.

- Act on the findings of the Building Trust project**
- Implementing a project management approach in H&F*
- Administer and monitoring the Health Inequalities Transformation fund locally*
- Develop a long term local approach to tackling inequalities based on the Health and Wellbeing Strategy*

Access to Health and Care Services

Reduce health inequalities and improve health outcomes in Hammersmith & Fulham by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

- Improve same day access*
- Complete Access Surveys across all practices*
- Expand the work stream across health and care.*
- Patient videos on routes through healthcare facilities*

Enabling functions

Communications and engagement- communication purpose externally, strengthening links with VCS and further embed co-production**

Estates – maximising the use of public estates in H&F, including Parkview*

HR, OD and identity – develop shared roles, standard induction process and cross organisation training.**

Data and insights – systematic embedding of data, develop population health management capability.*

Finance and resources – implementing an open book policy across providers.**

Local Response to system issues – flexibly respond to system pressures and operational/quality issues.*

Harrow

Working with children, families, and communities, in Harrow to support better care and healthier lives

Within Harrow, the Harrow Borough Based Partnership brings together our NHS organisations, London Borough of Harrow, our GPs, and local Voluntary and Community Sector. This strong partnership that operates within the Integrated Care System for North West London and works to both support delivery of the wider system objectives. This includes a range of statutory and non-statutory partners.

Harrow Health and Wellbeing Board has adopted its Health and Wellbeing Strategy for 2022-2030 and this is supported by a three year delivery plan for which 2024/25 is the final year. As a system, system partners have committed to coming together annually to consider our approach for the following year.

Harrow is **culturally diverse** with most residents coming from an Asian or Black background.

Poverty is a key determinant of health outcomes. Parts of Harrow are in the most **deprived 20% nationally**.

31% total burden of ill health is caused **by tobacco, hypertension, inactivity, alcohol, and obesity**.

Harrow **has 28 large parks** and other green spaces, although this is more limited in poorer parts of the borough.

Most **adults would be regarded as overweight or obese** (BMI>25). 1 in 5 children starting primary school are an unhealthy weight.

High rate of hospital admissions due to falls in older adults.

Housing affordability and overcrowding are **significant problems**.

Harrow

Priorities for Harrow Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hammersmith and Fulham resourced through partners

Mental Health

Outcomes:
- Targeted preventative intervention in the community through the expansion of our community offer
- Improve access and reduce inequalities in mental health services for residents

- Improve community mental health service provision via the improvement of flow in acute, voluntary sector services. and community and wrap around of voluntary services. interface with primary care*
- Establish a robust post diagnosis dementia pathway for Harrow*
- Improving physical health for people on the SMI register**
- Review and redesign of supported living model and pathway for Mental Health accommodation**

Proactive care and reducing health inequalities

Outcomes:
- Reducing health inequalities through embedding PHM, CORE20Plus 5 focus and increasing community capacity for action and strengthening our preventative approach

Activities:
- Deliver our community leadership programme, evaluation impact and align to the development of neighbourhood teams.*
- Build on the Harrow winter wellness programme to secure a robust preventative approach for the Harrow population**
- Secure our Population Health Management capacity and capabilities as a partnership and within our neighbourhoods, with focus on delivering CORE20 plus 5 programme*

Integrated Neighbourhood teams

Outcomes:
- Deliver and embed our integrated neighbourhood teams and create the conditions for them to succeed

Activities:
- Deliver and embed integrated neighbourhood teams in Harrow in partnership with local communities to deliver proactive, complex and reactive care for the Harrow population*
- Leverage our partnership with local higher education institutions to secure the Harrow workforce**
- Digital integration between health and social care*
- Focus on delivery of our integrated care pathways at a neighbourhood level (with priorities in complex adults and frailty) *

Reactive care

Outcomes:
- Admission (and A&E attendance) prevention (with a strong focus on frailty for admissions and preventing A&E attendance for those in mental health crisis), discharge pathway, reducing readmissions

Activities:
- Implement the integrated intermediate care pathway for Harrow and more widely, support the safe and timely discharge of patients to the most appropriate setting*
- Implement our admission and attendance avoidance plans for physical and mental illness to secure a stable health and care system*

Children and Young People

Outcomes:
- Strengthening our integrated approach for children, young people and families.

Activities:
- Delivery of integrated CYP care pathway at a neighbourhood level, including the alignment of Family Hubs to INTs. *

Complex Care

Outcomes:
- Delivering truly integrated community based care, leading to improved citizen and staff experience and reduction in unplanned care episodes

Activities:
- Implement the Harrow frailty model
- Secure the integrated model of diabetes care in Harrow*
- Strengthen our support to carers and deliver the Harrow Carers strategy**
- Implement community focused HIU MDT**

Primary Care

Outcomes:
- Support the development of a resilient and sustainable primary care offer.
- Improve primary care access, delivery of enhanced services and community pharmacy.

Activities:
- Implement Same Day Access Programme
- Improve delivery of enhanced services
- Improve Flu, Pneumococcal and COVID vaccinations uptake
- Increase Children's vaccinations rates
- Embed the Pharmacy First offer

Hillingdon

Hillingdon's Joint Health and Wellbeing Strategy 2022-2025 seeks to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities. Our strategy aims to deliver a vision shared by all health and care partners in the borough.

Our shared vision is that by 2025 most people who live in Hillingdon are able to say:

- "I am helped to take control of how my own health and social care needs are met."
- "I only have to tell my story once and my details are passed on to others with an appropriate role in my care."
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay."
- "Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital."
- "I am treated with respect and dignity, according to my individual needs."
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs."
- "Systems are sustainable and money that once might have been spent on hospital care for me is now spent to support me at home in my community."

Hillingdon **includes more affluent areas** (within the top 20% nationally) as well as areas of deprivation (within the lowest 20% nationally).

Overweight and obese children between ages 4 and 5 and 10 and 11 is higher than the national average.

The 2011 census showed that there were over **25,000 carers** in Hillingdon providing unpaid support.

Life expectancy in Hillingdon is estimated at **80.8 years** for males and **83.8 years** for females.

34,000 people in Hillingdon are known to have one or more **long-term conditions**.

Dental health of children is **worse than the national average**.

An estimated **3,033 people aged 65 or over in 2020** are likely to have dementia.

Hillingdon

Priorities for Hillingdon Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hillingdon resourced through partners

Year 1

Defining place governance and accountability within the wider NW London Integrated Care system

- Agreement to, and implementation of a Common Framework for Place Leadership and Accountabilities ((by July 2024) **

Developing and progressing the required new clinical models

Fast Track development of Integrated Neighbourhood Teams using PHM approach and mobilising local communities to tackle health inequalities with 3 core functions:

1. Same Day Urgent Primary Care for people with non complex needs*
2. Proactive Care for at risk population cohorts with a emphasis on Frailty in the first instance*
3. Preventative Care for a range of population health JSNA priorities with an emphasis on Hypertension, Anxiety/Depression and Obesity in the first instance.*

Years 1-5

Delivering the main priorities in our Place based Transformation Programmes

- New model of reactive care through:
  - Development of a new 24/7 Place Based Out of Hospital Reactive Care delivery model for those with complex needs and multi morbidity. *
  - Move from 'Good to Great ' in hospital discharge*
- Improve the health and wellbeing of CYP & families in Hillingdon - Experts by experience; THRIVE; Access and school based MH support; community based crisis; CYP neurodevelopmental pathway, Care experienced children; Health and Justice*
- Improve quality of care & health and wellbeing of people with a Mental Health or emotional wellbeing issue*
- Improve the health and wellbeing of people with a Learning Disability and/or autism**

Workforce estates and digital enablers to underpin integrated teams

- Building three integrated neighbourhood teams supporting 2 PCN's each, led by neighbourhood director, to include adult mental health in the team*

Embedding integrated neighbourhood teams and linking in community assets

- Deliver the priority programmes as agreed in the business case - hypertension, obesity, falls prevention, Children's oral health, proactive care and MH with a particular focus on the health needs in the south of the borough. Recruit to PHM roles to support PHM infrastructure and support recruitment of neighbourhood directors for INT's to support PHM into BAU*

Integrated end of life

- Implement integrated end of life hub*
- Hub developed in 23/24 - continued development of integrated team in 24/25*

Ensuring best use of resources to address financial deficit

- Developing a 3-5 Year Place Based Financial Recovery Plan**
- Commission Reviews of those Services non recurrently funded by the ICB to ensure that they represent value for money and do not duplicate other services**
- Ensure Benefits realisation of the 3 HHCP Transformation Scheme**

Change management programme

Years 2-5

PHM priorities and programmes to underpin integrated neighbourhood teams and embedding PHM into BAU

- Development of HHCP estates strategy and 10 year plan; HHCP workforce passport, supporting new ways of working and building workforce skills within neighbourhood teams**

Integrated therapy reablement and rehabilitation

- Development of an integrated therapy team across THH, CNWL and ARRS First Contact Practitioners to support discharge and prevention of admission*

Hounslow

Vision: Our communities are healthy, happy, connected and enabled to realise their full potential.

Hounslow Health and Wellbeing Board published a Joint Health and Wellbeing Strategy for the three years 2023-2026 and has implemented a process of oversight to monitor and assure itself that the priorities agreed in the Strategy are being implemented with an annual update on each thematic area prepared for the Board.

The strategy is supported by underlying principles of:

- Promoting a life course approach
- Place based and localities focused
- Prevention and early intervention

Priorities and annual plans set out in the strategy align closely with the NW London priorities.

Hounslow has a **diverse population 52%** of the population from Black, Asian and Minority Ethnic groups.

Hounslow's population is ageing. Between 2020-2041, the number of **residents aged 65 and over** is projected to increase by **71%**.

Hounslow's infant mortality rate (2018-20) is the highest in London at **4.7 per 1000 live births**.

8% of the population living in Hounslow live in the 20% **most deprived** areas in England.

The suicide rate for people of all ages in is **11.1 per 100,000 population**, the second highest rate of suicide in any London borough.

The rate of emergency admissions to hospital **due to dementia** for residents aged 65 and over has continued to increase in Hounslow.

Hounslow has a **higher rate of alcohol specific hospital admissions** than the national average.

34.3% of 5 year olds have experience of visually obvious dental decay.

Hounslow

Priorities for Hounslow Borough Based Partnership for 2024/25 – 2027/28

*local implementation of NW London common priorities
**identified local priorities for Hounslow resourced through partners

Health and Care Integration

Aim to reduce health inequalities and improve health outcomes in Hounslow by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

Activities:
- New Frailty Model of Care Implementation*
- Health and Care Integration Outline Business Case Implementation*

Frailty programme

Our aim is for Hounslow residents with frailty, living with dementia, or those who are receiving end of life care to be able to live more independently at home and in the community through our redesigned 'Home First' model.

Activities:
- Falls Prevention*
- Dementia*
- Intermediate Care*
- Integrated Discharge*
- End of Life Care*

Prevention and health inequalities

The purpose of the work stream is to reduce health inequalities in the population so that fewer residents miss life opportunities due to avoidable long-term health conditions. This will be achieved through prevention and early detection of illness to reduce people developing long term conditions.

Activities:
- Core20PLUS5 and Health Inequalities Projects*
- Wellbeing Services (includes cancer screening)*
- CVD, Hypertension & Atrial Fibrillation*
- Childhood Obesity and Oral Health**

Community mental health

Aim to reduce health inequalities and improve health outcomes in Hounslow by ensuring access to health and social care is equitable across the whole borough regardless of the patients postcode.

Activities:
- Integration with Primary Care*
- Link Workers across the System*
- VCSE Programmes*
- Older Adults Interface Work*

Children with SEND, Disabilities and Complex Needs

Enable children with SEND and / or complex needs to achieve their potential by building system capacity to enable families and children to effectively support them

Activities:
- SEND*
- Children's Therapies*
- Children and Young People Mental Health*

Integrated Neighbourhood Teams

The INT essential offer will be based on:
1. Streamlining access to care & advice for those that get ill but use health services less frequently.
2. To give people more choice about accessing care & make sure it is always available when they need it in their community.
3. Providing more proactive & personalised care with support of a Multi-Disciplinary Team to those with complex needs but not necessarily limited to those with Long-Term Conditions.
4. Helping people stay well for longer with a joined approach to prevention.
5. To support better management of the demand & capacity & build resilience and sustainability.

Activities:
- MDT Working at Neighbourhood level through improved interface with housing*
- Alignment with Family Hubs and Community Hubs*
- Local Workforce and mapping into INT footprints*
- Estates*

Section 6: Supporting plans

Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (i)

Quality

We have a responsibility to coordinate the approach to oversight patient safety incidents response to all the services within the system. The current SI process is currently been transition to the Patient Safety Incident Response Framework (PSIRF) and the ICB is responsible for reviewing provider's PSIRF policies and processes and endorsing their move to the new system. The quality team receives quality and safety information which is discussed and challenged at System Oversight Meetings and areas of concern are raised at the ICB Performance and Quality Meetings. To review opportunities for learning and improvement plans and lessons learnt at the System Quality Group meetings. Promote positive safety culture, encouraging staff to gain insight and share learning from good and poor practice. Providing Patient Safety Specialist advice to the ICB. We will use the learning from complaints to improve patient experiences.

The complaints team receives and manages complaints that are received at the ICB. They mainly involve complaints regarding Primary Care and CHC. Complainants are encouraged to engage with the service for which they have raised concerns. The ICB provides clinical oversight of complaints as required.

- Support providers in the transition to PSIRF. This will also involve support in closing SIS that are currently in the system.
- Work with NHSE with regarding the delegation of specialist commissioning and clinical networks.
- Review the ICB Quality Impact Assessment process for procurement.
- Assume responsibility for maternity services which will need to be embedded within current roles and responsibilities.
- Work with the CQC following their new inspection process which includes inspection of ICSs.
- Support the development of Primary Care Quality Improvement and Assurance Framework
- Work with independent providers to provide quality assurance data
- Manage complaints that are sent to the ICB in line with best practice and ensure that learning is reviewed and shared.

Continuing Healthcare

The function of the continuing healthcare service (CHC) is to provide comprehensive and ongoing healthcare and support to individuals with complex, long-term health needs. Following being assessed as eligible for continuing healthcare. The eligibility outcome is based on the use of national frameworks and in line with the statutory responsibilities of the ICB for CHC.

The key objectives of the service include undertaking; assessment, care planning, brokering care, monitoring and review of care packages, quality assurance of care providers. As well as providing an appeals process for individuals who have been assessed as not eligible for CHC. We will also ensure that people who have multiple care health and social care conditions are supported in an environment to keep them safe and provide high quality care.

- Promote and support collaboration to ensure high quality offer across key areas that affect provision of care for patients, such as, CAMHS, children community nursing, adult community nursing and mental health to reduce inequalities and the need for individualised commissioning.
- Understand he domiciliary and care home market capacity across North West London against future demand, including the type of beds, and support into nursing homes to ensure adequate provision and what they need to manage increasingly complex people.
- Promote and support the provision of consistent bladder and bowel support for nursing homes. This is to ensure, appropriate evidence based continence assessments and appropriate containment products are in place.

Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (ii)

Safeguarding

Strategic leadership and partnership working support the efficiency of the safeguarding system in place across all boroughs. Assurance is achieved through working closely with Safeguarding Adult Boards, Children's Safeguarding Partnerships, health providers and partner agencies. The ICS Safeguarding group and ICS Violence against Women and Girls group ensures that the profile of Domestic Abuse and Sexual Violence is high on the agenda, with due regard to provisions of the Domestic Abuse Act 2021. Updates and system learning is discussed within the ICS System Quality Group. In addition, in line with legislative change (Police, Crime, Sentencing and Courts Act, 2022), and to support reduction of serious violence, implementation of the Serious Violence Duty is achieved through utilisation of health based data collection initiatives that support borough based strategies in each local area. Equity of health offer for children and young people in care is monitored through review of service provision and for children placed in and outside of NW London. The Safeguarding Strategy ensures practice is aligned with NHS England recommendations and ICS ambitions. The ICB has a statutory responsibility to review child deaths on behalf of the Child Death Partners, the ICB and Local Authorities across North West London. The ICB also has a similar duty to review adult deaths where Learning Disability and Autism are identified.

- Review the ICB's function following publication of Working Together to Safeguard Children (2023)
- Continue to progress with work initiatives related to Domestic Abuse and Violence against Women and Girls including White Ribbon accreditation and Sexual Safety in Healthcare
- Work with providers to ensure that Children Looked After health assessments are completed in a timely manner
- Work and support providers to ensure statutory safeguarding responsibilities are met

Infection Prevention and Control (IPC)

To provide oversight and scrutiny of ICS and individual provider progress against IPC related ambitions / thresholds / regulatory and contractual requirements / intelligence and improvement programmes. Oversight of local compliance with IPC training. Support to local networks re professional development opportunities and succession planning. Seek assurance that local services are commissioned against and are working to national IPC guidance and policy. Work towards the Antimicrobial Resistance agenda (AMR) with colleagues in pharmacy and diagnostics for an integrated approach for individuals and communities at greater risk of ill-health.

- With Provider organisations develop a robust IPC assurance system ensuring that IPC related risks and learning are identified and shared and improvement programmes are put in place and develop and implement strategies for preventing and reducing avoidable HCAIs
- With Local Authorities review and understand provision of IPC and continence services in care homes and ensure policies and processes are in place to identify and manage patients with infections.
- With Urology and Continence leads to undertake a mapping of Trial without Urinary catheter services across NW London to ensure that all patients have the same access to urinary catheter services
- Support the development of the IPC services across Acute, Primary Care and Community, ensuring leadership, capability, capacity, and succession planning in all roles and areas of IPC

Our Joint Forward Plan aligns with and meets our legislative requirements (i)

As an ICB we have several statutory duties that we are required to fulfil by law. The key priorities outlined through this Joint Forward Plan details how these duties will be delivered. We have outlined below a summary response in how we are fulfilling each requirement:

Legislative requirement	Description	NW London ICB response
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: improve quality of those services reduce inequalities in access and outcomes.	Our Joint Forward Plan outlines how the ICB will meet the health needs of our population in an integrated way. This is worked through each priority – in particular please see *Priority 1* and *Priority 3*.
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	We have outlined the health services we will make arrangements for in the section on *'Who we are'.* Additionally, each priority outlines the services in which it will impact.
Duty to consider wider effect of decisions	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the triple aim of: (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	NW London ICB is committed to the 'triple aim' and our Joint Forward Plan outlines our plans to reduce inequalities – see *Priority 1*, improve quality of our services – see *quality section* and ensure sustainability of our services – see our *medium term financial strategy summary*.
Implementing any JLHWS	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	Within our Joint Forward Plan we have outlined for each of our places (our Boroughs) their plans, as reflected in their JLHWSs, please see *'Borough section'*.
Financial duties	The plan must explain how the ICB intends to discharge its financial duties.	Our financial duties are outlined in detail through our medium term financial strategy, we have summarised this in the *'Our financial challenge'* section and ensured our priorities align to the plan and it's expenditure limits.
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illnessoutcomes including safety and patient experience.	Ensuring quality of services is a key priority for the ICB and is woven through each of the priorities in our Joint Forward Plan. Please see the *'Quality, safeguarding and IPC section'* for further detail.

Our Joint Forward Plan aligns with and meets our legislative requirements (ii)

Legislative requirement	Description	NW London ICB response
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to: (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	Involvement of both residents and patients are key in every decision we make. We have outlined how we include them in our decision making in the Joint Forward Plan – please see the section '*How we have engaged and continue to work with our residents*'.
Duty to involve the public	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	
Duty to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in: (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	NW London ICB has a range of ways in which it gathers advice – predominately this is through its various governance forums which cross a broad range of professional expertise. Our CRGs are integral in providing clinical advice.
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	NW London ICB has a dedicated programme whose purpose is to research and develop innovative solutions to support our health services. These are key activities with our priorities.
Duty in respect of research	Each ICB must facilitate or otherwise promote: (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	
Duty to promote education and training	Each ICB must have regard to the need to promote education and training[L] so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.	Promotion of education and training is integral part of our workforce strategy, we have summarised.
Duty as to climate change	Each ICB must have regard to the need to: (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets) and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	NW London ICB is committed to NHS England's net zero targets. In 2022 we published the NW London ICS Green Plan http://www.nwlondonics.nhs.uk/download_file/view/329, which outlines how we aim to deliver our commitments on sustainability and climate change.
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	Addressing the needs of victims of abuse is covered within the safeguarding section of the JFP. NW London ICB safeguarding policy covers the provisions of the Domestic Abuse Act 2021, accompanying Serious Violence Duty Statutory Guidance, and relevant safeguarding provisions.
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	Our commitment to the particular needs of children and young people is key and outlined in *Priority 2.*

Section 7: Glossary of key terms and acronyms

Glossary of key terms and acronyms (i)

Acronym	Description
Acronym	
BCYP	**Babies, children and young people**
BI	**Business Intelligence**
CHC	**Continuing Healthcare:** a package of care for adults aged 18+ who have complex, long-term needs.
CQC	**Care Quality Commission:** the independent regulator of health and adult social that make sure services provide people with safe, effective, high-quality care.
DAB	**Co-design Advisory Body:** a group of representatives of community groups, voluntary groups and watchdogs who share their views to support the development of local healthcare and NHS services
EPR	**Electronic patient record:** all staff involved in a patient's care have access to their health record, giving them a complete overview of patients' care needs.
FDP	**Federated Data Platform:** Software that will bring together data from across different NHS organisations – currently stored in separate systems – so that staff can access the information they need in one safe and secure place.
GP	**General Practice:** A clinic made up of medical professionals, including doctors, who treat all common medical conditions or refer patients to services that can help
ICP	**Integrated Care Partnership:** A joint committee run by NHS organisations and local authorities to improve local health, care and wellbeing.
INT	**Integrated neighbourhood team:** Teams made up of health and care workers, volunteers and wider partners who will work together to deliver services that respond to local residents' needs.
LAC	**Looked after children:** any child / young person who needs support with emotional wellbeing
MECC	**Making every contact count:** A national initiative encouraging public-facing workers to make contact with patients and the public as an opportunity to support or enable them to consider healthy behaviour changes
ODG	**Operational Delivery Group**
OPTICA	**Optimised patient tracking and intelligent choices application:** Software that provides clear visibility of all tasks needed before a patient is safely able to leave hospital
PGD	**Patient group directions:** a legal framework that allows some registered health professionals to supply or administer specified medicines to certain patients

Acronym	Description
PHM	**Population health management:** The analysis and representation of data in an understandable way
RAT	**Rapid assessment and treatment:** The process of quickly assessing and determining what immediate response is needed for patients initially attending an emergency department.
SDEC	**Same day emergency care: c**ertain emergency patients can be rapidly assessed, diagnosed and treated without being admitted to a hospital ward.
SEND	**Special educational needs and disabilities:** a child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support.
UEC	**Urgent emergency care:** services that provide care for patients who need urgent care. This ranges from life-threatening emergencies to illnesses or injuries that requires immediate attention
VCSE	**Voluntary and community sector organisations**
WSIC	**Whole System Integrated Care:** a database providing a summary of patient's health and social care data to help build a better understanding of need across our communities

Organisations, teams and groups
Anchor institution: large organisations that are unlikely to relocate and have a significant stake in their local area, such as trusts and local authorities
Borough/place based partnership: partnership between local authorities, primary care, community care, mental health, acute trusts and the voluntary sector to tackle local challenges and improve health and wellbeing
Local authority: the organisation responsible for public services and facilities in a borough, often referred to as councils
Mental Health Support Teams: increase access to early intervention for common mental health problems such as anxiety and low mood in schools
Multidisciplinary team: teams that bring together a range of expertise with a common goal to improve health outcomes
Provider collaborative: partnership that brings together two or more NHS trusts
Task and finish group: a group that focuses on an existing issue to identify what concerns there are, if any, with a certain project and resolve these
Trust: an NHS organisation that provides services to patients, : e.g. hospital treatment, mental health care, ambulance service

Glossary of key terms and acronyms (ii)

Schemes, programmes and platforms

Additional Roles Reimbursement Scheme: initiative to grow capacity through new roles in general practice and by doing so, helping to solve the workforce shortage

Cancer faster diagnostic standard: national target is that you should not wait more than 28 days from referral to finding out whether you have cancer or not

Foundry: a solution that helps doctors, nurses and other NHS professionals by organising information that trusts hold on different databases in one place.

Health equity programme: working to tailor services to the level of need in our communities, rather than providing a one-size-fits-all approach.

High intensity use programme: making contact with the most frequent attenders of the local A&E to find out how the local health and social care system could better meet their needs

NHS single delivery plan: a plan for maternity and neonatal services intended to provide support to services in achieving safer, more personalised care

Paediatric transformation programme: a collaboration of organisations working to improve health outcomes for babies, children and young people in London

Population Health Management and Health Equity Academy: population health management resources and case studies for health and care professionals (see PHM above for information on population health management)

Frameworks and approaches

Anchor Charter: sets out the ways which our partners aim to have a positive impact on their local communities through their role as employers, land and asset owners and in the way they impact the environment

Core20PLUS5:

Core 20: the most deprived 20% of the population
PLUS: Population with protected characteristics as defined by the Equality Act 2010
5: five areas of focus which require accelerated improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

Operational process of discharge to assess (pathway 1, 2 or 3): ensures that patients are able to leave hospital safely by directing them to the right next step in their care:

Pathway 1: discharged to their home or to a usual place of residence with new or additional health and/or social care needs
Pathway 2: discharged to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover
Pathway 3: discharged to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care.

NHS initiatives

Transfer of care hubs: Different services such as social care, housing and voluntary services are linked to coordinate support for patients who need it

Virtual wards: also known as hospital at home, patients can be cared for at home safely and in familiar surroundings, helping speed up recovery while freeing up hospital beds for patients that need them most

Additional terminology

Acute care: patients treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery

Capital: the money used to build, run, or grow an organisation

Care pathway: a plan for patient care that is comprehensive and may include care from multiple services

Co-production (or co-design): a way of working that involves people who use health and care services, carers and communities in equal partnership

Elective care: non-urgent services, usually delivered in a hospital setting

Estates: NHS buildings and the grounds they are on, or around them.

Health equity: everyone has a fair and just opportunity to attain their highest level of health

Health outcomes: broadly agreed, measurable changes in health or quality of life that result from delivery of care

Hospital discharge: when patients formally leave a hospital after review that it is safe for them to do so

Inpatient: a person who stays one or more nights in a hospital in order to receive medical care

Outpatient: a person who visits a hospital for diagnosis or treatment without staying overnight

Patient flow: The movement of patients across the healthcare system, including how they interact with and between services and the systems needed to get them from the first point of contact to being discharged.

Primary care: the first point of contact in the healthcare system, including general practice, community pharmacy, dental and eye health services

Protected characteristics: it is against the law to discriminate because of: age, disability, gender reassignment, pregnancy, race, religious beliefs, sex and sexual orientation