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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 15th September, 2016**
Time:	**4.00 pm**
Venue:	**Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP**

Members:

Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Melissa Caslake	Tri-borough Children's Services
Barbara Brownlee	Housing and Regeneration
Dr Philip Mackney	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Sarah Mitchell	Westminster Community Network
Dr David Finch	NHS England

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 3.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Toby Howes, Senior Committee and Governance Officer.

Tel: 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1.	**MEMBERSHIP** To report any changes to the Membership of the meeting.	
2.	**DECLARATIONS OF INTEREST** To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.	
3.	**MINUTES AND ACTIONS ARISING** I) To agree the Minutes of the meeting held on 14th July 2016. II) To note progress in actions arising.	**(Pages 1 - 18)**
4.	**UPDATES ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER JOINT HEALTH AND WELLBEING AND STRATEGY** To consider updates on the North West London Sustainability Transformation Plan and the Westminster Joint Health and Wellbeing and Strategy.	**(Pages 19 - 82)**
5.	**FAMILY HUBS** To consider a report on developing Family Hubs.	**(Pages 83 - 88)**
6.	**CHILDREN AND FAMILIES ACT IMPLEMENTATION AND PREPARATION FOR LOCAL AREA INSPECTION** To consider a report on progress on the Children and Families Act Implementation and Preparation for Local Area Inspection.	**(Pages 89 - 100)**
7.	**PRIMARY CARE MODELLING** The Board to receive a verbal update on the Primary Care Modelling project.	

8. PUBLIC HEALTH VISION STATEMENT **(Pages 101 - 106)**

To consider a report on the Public Health Vision Statement.

9. DRAFT ROUGH SLEEPING STRATEGY 2017-20 **(Pages 107 - 110)**

To consider a report on the Draft Rough Sleeping Strategy 2017-20.

10. HOUSING SUPPORT AND CARE JOINT STRATEGIC NEEDS ASSESSMENT **(Pages 111 - 118)**

To consider a report on the Housing Support and Care Joint Strategic Needs Assessment.

11. WORK PROGRAMME **(Pages 119 - 120)**

To consider the Work Programme for 2016/17.

12. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
8 September 2016

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CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Thursday 14th July, 2016**, Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP.

Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group:
Dr Neville Purssell
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barrie Taylor
Deputy Director of Public Health: Eva Hrobonova
Tri-Borough Director of Adult Services: Chris Neill (acting as Deputy)
Tri-Borough Children's Services: Melissa Caslake
Director of Housing and Regeneration: Barbara Brownlee
Clinical Representative from West London Clinical Commissioning Group:
Dr Naomi Katz (acting as Deputy)
Chair of Westminster Community Network: Sarah Mitchell

1 MEMBERSHIP

1.1 Apologies for absence were received from Janice Horsman (Representative of Healthwatch Westminster) and Dr David Finch (NHS England).

1.2 Apologies for absence were also received from Councillor Danny Chalkley (Cabinet Member for Children and Young People), Liz Bruce (Tri-Borough Director of Adult Social Care) and Dr Philip Mackney (Clinical Representative from NHS West London Clinical Commissioning Group). Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People), Chris Neill (Director, Whole Systems) and Dr Naomi Katz (Clinical Representative from NHS West London Clinical Commissioning Group) attended as their respective Deputies.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

1. That the Minutes of the meeting held on 26 May 2016 be approved for signature by the Chairman; and

2. That progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

4 UPDATES ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER JOINT HEALTH AND WELLBEING STRATEGY

4.1 Chris Neill (Director, Whole Systems) provided an update on the North West London Sustainability and Transformation Plan (STP) and advised that the draft STP had been submitted to NHS England. He referred to the nine priorities in the base case submission and advised that these had been allocated to the relevant delivery area, of which there were five. The STP had been designed to fit in with the Westminster Joint Health and Wellbeing Strategy. The Board noted that it was anticipated that the final STP would be implemented by the end of October 2016.

4.2 The Chairman clarified that the STP addressed plans across the eight participating North West London boroughs. Local authorities were also meeting regularly to discuss the STP and the Chairman represented the Council at these meetings, along with the Chief Executive. In respect of the four workstreams, Westminster was taking a lead on the finance element.

4.3 Meenara Islam (Principal Policy Officer) then updated Members on progress on the Westminster Joint Health and Wellbeing Strategy. The draft strategy had gone to consultation on 6 July which was due to close on 16 October. The consultation would involve events with the business community, providers, a public open house event and private healthcare providers. An analysis of the response would take place from October, with the strategy reviewed in November and the Board would give its final approval at the 17 November meeting. The strategy would then be put to the Council's Cabinet for approval in early December with a view to adopting and publishing the strategy that month and implementation would commence in January 2017.

4.4 Meenara Islam stated that posters to be used during the consultation would be to be sent to a variety of stakeholders, such as GPs, and she would email the posters to Members for their information. Other organisations that would receive consultation materials included Healthwatch Patient Participation Groups, Westminster Reporter, the Carers Network, Open Age Newsletter, CityWest Homes Tenants Newsletters, notices on Council-managed websites such as People First and Young Westminster and through internal Council communications. Meenara Islam then referred to the various consultation events and meetings and stated that she would circulate to Members the dates that these would be take place.

4.5 During discussions, a Member suggested that consultation on the strategy also include churches, mosques, synagogues and other places of worship. Another Member suggested that touchscreen surveys be used in order to increase consultation responses. He added that residents would want to know what resources were being used to deliver the strategy and felt that there should be more details on costs. Sarah Mitchell (Westminster Community Network) enquired what consultation events were taking place with voluntary organisations, stating that the voluntary sector represented a significant workforce in terms of the priority areas identified in the draft strategy.

4.6 In reply, Meenara Islam concurred that consultation could also be undertaken with places of worship. Consultation with the voluntary sector was taking place, including at voluntary sector forum meetings, and voluntary sector organisations could also be invited to the business community events.

4.7 The Chairman stated that the strategy helped informed the STP and would also inform, govern and shape the STP's commissioning intentions and this would be highlighted in the strategy. She felt that it was also important that residents understood what work local authorities, CCGs and Public Health did beyond the strategy. The Chairman welcomed any future suggestions from Members and thanked Council officers and CCG staff for the work done to date.

4.8 **RESOLVED:**

1. That the final draft of the Westminster Joint Health and Wellbeing Strategy which has been released for public consultation be noted; and

2. That the proposed consultation process be noted.

5 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

5.1 Eva Hrobonova (Deputy Director of Public Health) introduced the item and stated that the intention of the annual report was to highlight important issues in public health in the last few years. In particular, the report emphasised the importance of physical activity to improve both physical and mental health and how health inequalities could be addressed through more physical exercise. The report also built upon the work of the Physical Activity Joint Strategic Needs Assessment (JSNA).

5.2 Colin Brodie (Public Health Knowledge Manager) then presented the report and advised that its main theme was in emphasising the importance of physical activity, including the benefits of undertaking this and the implications of being physically inactive. He stated that there was no need for there to be any financial costs involved for residents to be physically active. Members noted that although Westminster adults were fairly active when compared nationally with other areas, around 25% of adults were still classified as inactive, which could potentially contribute to a number of conditions developing.

5.3 Colin Brodie referred to the areas that benefitted through physical activity as set out in the report, including improved life expectancy, being able to live independently for longer, increased academic performance and achievement and also in reducing pollution through cycling and walking helping to reduce transport use. The report also included suggestions on how key messages could be used to promote existing and future interventions to improve public health.

5.4 Members highlighted other initiatives being used to promote physical activity, such as the draft Walking Strategy. A Member emphasised his preference that the report be Westminster specific as opposed to tri-borough. He felt that the report should provide more information on costs and that there should be a greater focus on what activities Westminster was undertaking and what responsibilities it had. Another Member suggested that it would be useful to compare data between the tri-boroughs and to provide an explanation, for example, as to why Westminster compared well amongst the tri-boroughs in terms of physical activity, but was also spending more than the other two boroughs on health care services costs attributable to physical inactivity. Barbara Brownlee (Director of Housing and Regeneration) commented that she was impressed with the presentation style of the report and that she would be in discussion with the Regeneration Teams to consider what other activities health and wellbeing hubs could offer.

5.5 In reply to some of the issues raised, Colin Brodie confirmed that the annual report was a tri-borough one, however where individual borough data was available, this had been provided. He added that Public Health would be working with the Communications Team on how to circulate the information locally and align it with existing communication campaigns, such as Active Communities.

5.6 In acknowledging the comments above, Councillor Barrie Taylor indicated that he did not favour a tri-borough presentation and felt there should be individual borough annual public health reports.

5.7 The Chairman stated that Public Health was a tri-borough service and it had been agreed that the annual report be tri-borough, however she added that a Westminster vision statement was also being drafted. She also emphasised the need to ensure that the messages communicated would be taken on board by local residents, including taking into account that English language was not the first language for all residents.

6 HEALTH VISITING RE-PROCUREMENT

6.1 The Chairman introduced the item and emphasised the importance of the Health Visiting Service, however it had been acknowledged that more could be done to support people and the joint re-commissioning and re-procurement of the service sought to achieve this outcome. She stated that consideration needed to be given as to how the Health Visiting Service tied in with other services, particularly children's services such as Child and Adolescent Mental Health Services (CAMHS) and other ways of reaching out to young people. The Chairman advised that there would be information on the children's

workstream in the Health and Wellbeing Hubs Programme report for the 15 September meeting.

6.2 Eva Hrobonova (Deputy Director of Public Health) then presented the report and advised that the views of users and proxy users were being sought, including where health visitors were operating with other parties, as this had also obtained useful feedback. Consideration of what health visitors did during their visits would be undertaken and to working even closer with other services and partner organisations. Members noted that a further report would be presented to the Board on a review of the service and a number of different delivery models were being considered. There would also be closer cooperation with the Clinical Commissioning Groups (CCGs) in helping to deliver the Health Visiting Service and there would be regular updates to the Board on the service.

6.3 During Members' discussions, the importance of the Health Visiting Service providing help the whole family as well as children was emphasised. A Member spoke of the importance of a joined-up approach in providing effective safeguarding of 0-5 year olds and this included taking such an approach during the commissioning stage. He commented that some GP practices used to have health visitors available, although now most practices would be considered fortunate if they had a health visitor available for one day a week to provide support for families, however co-locating of health visitors would be of some help. Another Member stated that it needed to be recognised that whilst some families got real benefits from having a health visitor support them, other families did not have such a great need, and this needed to be taken into consideration when assessing who to target for the service, with the appropriate evidence needing to be provided. She also felt that there needed to be more progress in providing single reviews for children rather than separate ones depending on the service being provided.

6.4 Members commented on the desirability of relevant organisations sharing the same information during the re-procurement process. Whilst health workers often worked alone, it would also be beneficial if they could meet with other professionals, such as paediatricians, at least once a month.

6.5 In reply to issues raised, Eva Hrobonova advised that the whole household and setting would also be considered as well as the child in delivering the Health Visiting Service. The need to take a joined-up approach and picking up the connecting role health visitors played was acknowledged, whilst also considering allocation of resources in providing what was an important early years' service for some, but not all, families. Eva Hrobonova also acknowledged that a single review of cases was also desirable and that there should be more efforts to move towards this.

6.6 The Chairman concurred that the Health Visiting Service did not need to provide the same service for all and that there needed to be further consideration of how the service linked with other services and in shaping the service and delivering it where it would be most effective.

7 TACKLING CHILDHOOD OBESITY TOGETHER

7.1 Eva Hrobonova gave a presentation on the Tackling Childhood Obesity Together programme and began by informing Members that nationally one in five of 4 to 5 year olds and one in three of 10 to 11 year olds were classified as obese. She advised that the earlier the issue was tackled, the more effective the outcome. Members were informed of the costs of obesity to services and the implications for individuals and to society in general. Eva Hrobonova advised that childhood obesity rates in London were higher than many other international cities that had been measured. There was no simple solution to the issue and it was important to change both the behaviour of children and their families and to change the environment and the programme sought to address both these factors. Eva Hrobonova advised that the programme was tri-borough, however each borough would feed back individually on how the programme was performing.

7.2 Eva Hrobonova stated that there were three strands to the programme, these being Healthy Weight Services, the Environment and a Pilot Project to communicate national health messages to residents to allow them to make healthier choices. The relevant services were now in place and there would be a particular focus in delivering in schools. Eva Hrobonova emphasised the importance of the programme to make progress, working will all the relevant partner organisations and services and ensuring residents were referred to the relevant service.

7.3 A Member, in acknowledging that it was a tri-borough programme, stressed the need to demonstrate a Westminster focus and although the report set out the funding that had been allocated, he felt there should be more details on specifically how this funding would be spent. He suggested that there should be a focus on place-based actions and it would also be worth focusing on community networks. Another Member suggested that the programme be aligned with other strategies such as the draft Walking Strategy. It was queried whether an analysis had been undertaken to see whether there was sufficient play space to support the programme. In acknowledging the extent of the programme, a Member remarked that there was a need to publicise the programme more. Another Member stated that the earlier the intervention, the more likely it would be effective.

7.4 In reply to some of the issues raised, Eva Hrobonova acknowledged that the programme should align with other strategies, such as the draft Walking Strategy, and she remarked that she would like to see the report appear on the JSNA website. She also confirmed that a JSNA on play space was in progress.

7.5 The Chairman advised that progress on the programme would be reported back to the Board in a year's time and she welcomed any further suggestions from Members. She emphasised the importance of changing behaviours and the environment, which was a particularly important and challenging element of the programme. Whilst recognising that some initiatives would be easier than others to implement, she stated that it was important to take an ambitious approach. The Chairman suggested that a wish list of initiatives be

put together and consideration be given as to how each initiative could be supported. She concurred that there was a need to publicise the programme more and have more services involved in the programme across the Council, as well as engaging with the wider community to be more effective in preventing childhood obesity. The Board endorsed the annual report.

7.6 **RESOLVED:**

1. That the progress of the Tackling Childhood Obesity Together programme as outlined in the paper and the attached report in Appendix B be noted.

2. That the whole-Council approach be noted; and

3. That the annual report in Appendix B be agreed.

8 HEALTH AND WELLBEING HUBS

8.1 Eva Hrobonova provided an update on the Health and Wellbeing Hubs programme and advised that there had been further progress on mapping the range of services for older people. A further report would be presented to the Board explaining how the mapping exercise helped identify using assets and resources to provide additional services. There was to be a re-focus on the Children's workstream and attention would be given to ensure that the Early Help Service's objectives aligned with it. Eva Hrobonova informed Members that Melissa Caslake would provide an update on the Children's workstream at a future meeting. Members noted that an asset mapping exercise of voluntary organisations in respect of the Newman Street project was underway which also sought to build on existing relationships with voluntary organisations.

8.2 **RESOLVED:**

That the progress the Council and partners have made on the Health and Wellbeing Hubs Programme to date and the further proposals and next steps of the Programme be noted.

9 PRIMARY CARE MODELLING UPDATE

9.1 Eva Hrobonova introduced the item which provided an update on population projections and modelling. Rianne Van Der Linde (Public Health Analyst) then gave a presentation on progress on the Primary Care Modelling project and advised that the first phase of the project had now been largely completed. She stated that data was available at Westminster, Central London and West London CCG and at the eight North West London borough level. In respect of Westminster, it was anticipated that the number of older people would increase, whilst cancer levels were expected to rise over 50%. As phase 1 of the project had produced a local population segmentation model that can show estimates for the local authority, CCG resident and CCG registered population, the user could determine which of these populations was most appropriate for the information they seeked to obtain. Rianne Van Der Linde added that this tool was already being used to identify health issues and

needs, however the tool would continue to be updated and refined as new population projections and local data became available.

9.2 Rufus Fearnley (NHS North West London Collaboration of Clinical Commissioning Groups) then provided details of phase 2 of the project, which involved mapping local CCG data with the 15 population groups. More accurate information would be available for the next meeting, including figures and costs. However, preliminary results from the NHS Central London CCG estates audit, which had so far audited 27 of 35 properties, had identified that 22 premises had been built before 1961 and 25 premises have high utilisation. This meant there was not much room in terms of capacity. The next steps included matching the CCG's GP lists to the 15 population groups. Rufus Fearnley advised that there was some discrepancy in the data between the NHS Central London CCG data and the London Health Commission data. Damian Highwood (Evaluation and Performance Manager) added that this discrepancy could be attributable to definition differences between the two organisations and he suggested that the number of older people may have been over counted.

9.3 Members enquired whether the London Health Commission could be provided with the local data obtained in the project and whether the discrepancy in data could affect funding. The Chairman, in recognising the importance of the work the project was undertaking, sought further details of how the project could assist the Board and how would the relevant partner organisations work together, such as in respect of estates. She also asked if there were any plans already in place on how to deal with areas where there would be increased demand, such as the anticipated increase in cancer rates.

9.4 In reply, Damien Highwood stated that the project's data could be shared with the London Health Commission and an analysis could be undertaken comparing the differences between each other's data. He advised that Adult Social Care were already involved in working with partner organisations and the models had identified, for example, a discrepancy between the number of residents in Westminster and those who were GP registered, particularly in respect of children. Damien Highwood advised that meetings with the Office for National Statistics were taking place to discuss these differences in population and it was possible that the number of older people had been over counted. In respect of expenditure within the model, tests needed to be given for example on whether costs of GP visits in respect of cancer felt realistic to GPs and work also needed to be undertaken in respect of projected growth costs.

9.5 Members welcomed the progress made to date and emphasised the need in ensuring that the data was used to help plan for future services and address issues such as GP capacities and use of estates. A Member also commented that matching GP lists with the 15 population groups would be particularly useful for future planning.

9.6 **RESOLVED:**

1. That the close collaboration between partners in developing the model be noted; and

2. That the next steps proposed be agreed.

10 PRIMARY CARE CO-COMMISSIONING UPDATE

10.1 Helena Stokes (NHS Central London Clinical Commissioning Group) provided an update on progress on primary care co-commissioning and advised that the CCGs had been invited to put forward bids for funding from the Estate and Technology Transformation Fund. In respect of the Primary Care Medical Service review, some concerns had been raised, however NHS Central London CCG had circulated its proposed model of care to members for feedback.

10.2 **RESOLVED:**

That the contents of the report on Primary Care Co-Commissioning update be noted.

11 MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 16 JUNE 2016

11.1 The Board noted the Minutes of the last Joint Strategic Needs Assessment Group meeting held on 16 June 2016.

12 WORK PROGRAMME

12.1 The Board noted the work programme for 2016/17.

13 ANY OTHER BUSINESS

13.1 There was no other business.

The Meeting ended at 5.56 pm.

CHAIRMAN: _____ **DATE** _____

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 14th July 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Meenara Islam then referred to the various consultation events and meetings and stated that she would to circulate to Members the dates that the consultation events and meetings are taking place.	Meenara Islam	Members to provide comments by 30 June.
Tackling Childhood Obesity Together		
Progress on the programme to be reported back to the Board in a year's time.	Eva Hrobonova	
Health and Wellbeing Hubs		
Details of the children's workstream to be reported to the Board at the next meeting.	Melissa Caslake	To be considered at the 15 September meeting.

Meeting on Thursday 26th May 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Members to provide any further input on the strategy before it goes to consultation at the beginning of July.	All Board Members	Members to provide comments by 30 June.

Meeting on Thursday 17th March 2016

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Strategy Refresh Update		
Members requested to attend Health and Wellbeing Board workshop on 5 April.	All Board Members	Workshop to take place on 5 April.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	

NHS Central and NHS West London Clinical Commissioning Group Intentions		
Clinical Commissioning Groups to consider how future reports are to be presented with a view to producing reports more similar in format and more user friendly.	Clinical Commissioning Groups	On-going.

Meeting on Thursday 21st January 2016

Action	Lead Member(s) And Officer(s)	Comments
Commissioning Intentions: (A) NHS Central London Clinical Commissioning Group; (B) NHS West London Clinical Commissioning Group		
Update on the Clinical Commissioning Groups' intentions to be reported at the next Board meeting.	Clinical Commissioning Groups	To be considered at the 17 March 2016 meeting.
Westminster Health and Wellbeing Strategy Refresh		
Draft proposals for the strategy refresh to be considered at the next Board meeting	Adult Social Care, Clinical Commissioning Groups and Policy, Performance and Communication	To be considered at the 17 March 2016 meeting.

Meeting on Thursday 19th November 2015

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Hubs Programme Update		
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 21 January 2016 meeting.
Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change		
Board to receive report on Future In Mind programme to include details of how it will impact upon Westminster and how the Board can feed into the programme to provide more effective delivery of mental health services.	Children's Services	To be considered at earliest opportunity.
Board to receive report on young people's services, including how they all link together in the context of	Children's Services	To be considered at

changes to services.		earliest opportunity.

Meeting on Thursday 1st October 2015

Action	Lead Member(s) And Officer(s)	Comments
Central London Clinical Commissioning Group – Business Plan 2016/17		
West London Clinical Commissioning Group to circulate their Business Plan 2016/17 to the Board.	West London Clinical Commissioning Group	
Westminster Health and Wellbeing Hubs Programme Update		
Board to nominate volunteers to be involved in the Programme and to be on the Working Group.	Meenara Islam	
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 19 November 2015 meeting.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	To be considered at the 21 January 2016 meeting.

Meeting on Thursday 9th July 2015

Action	Lead Member(s) And Officer(s)	Comments
Five Year Forward View and the Role of NHS England in the Local Health and Care System		
That a document be prepared comparing NHS England's documents with the Clinical Commissioning Groups to demonstrate how they tie in together.	Clinical Commissioning Groups/NHS England	To be considered at a forthcoming meeting.
Board to receive regular updates on the work of NHS England and to see how the Board can support this work.	NHS England	To be considered at future meetings.
Westminster Housing Strategy		
Housing Strategy to be brought to a future meeting for the Board to feed back its recommendations.	Spatial and Environmental Planning	To be considered at a forthcoming meeting.

Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	To be considered at a meeting in 2016.

Meeting on Thursday 21st May 2015

Action	Lead Member(s) And Officer(s)	Comments
North West London Mental Health and Wellbeing Strategic Plan		
That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process.	NHS North West London	To be considered at a forthcoming meeting.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	To be confirmed.
Children and Young People's Mental Health		
A vision statement be produced and brought to a future Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach.	Children's Services	To be considered at a forthcoming meeting.
The role of pharmacies in Communities and Prevention		
Public Health Team and Healthwatch Westminster to liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society.	Public Health Healthwatch Westminster	Completed
Whole Systems Integrated Care		
That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time.	NHS North West London	First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Report being considered 9th July 2015
The Board to be informed more frequently on any new JSNA requests put forward for consideration.	Public Health	On-going.
Better Care Fund		

An update including details of performance and spending be provided in six months' time.		Update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Primary Care Co-Commissioning		
Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning.	Health and Wellbeing Board	In progress
Work Programme		
Report to be circulated on progress on the Primary Care Project for comments.	Holly Manktelow Health and Wellbeing Board	Circulated.
The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings.	Health and Wellbeing Board	To be confirmed.
NHS England to prepare a paper describing how they see their role on the Board and to respond to Members' questions at the next Board meeting.	NHS England	To be considered at the 9th July 2015 Health and Wellbeing Board meeting.

Meeting on Thursday 19th March 2015

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.	Adult Social Care	Completed

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.

Child Poverty		
Work to be commissioned to establish whether and how all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Children's Services	In progress.
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	Completed.
Primary Care Commissioning		
A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

Action	Lead Member(s) And Officer(s)	Comments
Primary Care Commissioning		
The possible scope and effectiveness of establishing a Task & Finish Group on the commissioning of Primary Care to be discussed with Westminster's CCGs and NHS England, with the outcome be reported to the Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		

That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.	Director of Public Health.	Completed.
Primary Care Commissioning		
The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November	NHS England	Completed.
Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.	NHS England	Completed.
Measles, Mumps and Rubella (MMR) Vaccination In Westminster		
That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of the number of patients who have had measles, be brought to a future meeting of the Westminster Health & Wellbeing Board in January 2015.	NHS England Public Health.	To considered at the forthcoming meeting in May 2015. This has been pushed back to later in 2015

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	Completed

Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	Being considered at the 9th July 2015 Health and Wellbeing Board
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	Completed.
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	Completed
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.

City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	**General Release**
Title:	Updates on the North West London Sustainability Transformation Plan and Westminster Joint Health and Wellbeing and Strategy
Report of:	Councillor Rachael Robathan, Chair, Health and Wellbeing Board Dr Neville Purssell, Vice-chair, Health and Wellbeing Board Jules Martin, Managing Director, Central London CCG
Wards Involved:	All
Policy Context:	
Financial Summary:	NA
Report Author and Contact Details:	Daniela Valdes, Head of Planning and Governance, Central London CCG Phoebe Morris-Jones, Policy Officer, Westminster City Council (pmjones@westminster.gov.uk)

1. Executive Summary

1.1 In July 2016 the Board received an update on the draft Joint Health and Wellbeing Strategy public consultation.

1.2 The Board also received an update on the development of the Sustainability and Transformation Plan (STP) for North West London. As agreed by the Board in January 2016, the local health and wellbeing strategy has been developed as the local plan to deliver the North West London STP.

1.3 This paper provides a summary of the current status and next steps of the STP and its impact for Westminster. The document also provides a summary as to how the amended final Strategy will be considered and adopted by the Board and

how the engagement activities for both STP and strategy are currently being interlinked.

2. Key Matters for the Board

2.1 The Board is requested to:

- Consider the summary of the public consultation programme to date, and suggest any key groups or organisations who they would seek to be engaged during the final part of the consultation;
- Consider the proposed timeline for agreeing the Strategy with both CCG Governing Bodies, and the presentation of the final Strategy to the Board for adoption, and provide comment; and,
- Note the progress in the development of the North West London Sustainability and Transformation Plan, and the proposed programme for public and stakeholder consultation, and the programme for the adoption and agreement of the final document.

3. Background

3.1 The NHS Planning Guidance released in December 2015[1] requires sub-regional groupings of commissioning groups (CCGs) to work together with local authorities and providers of health and care to develop a five year plan for how they will deliver the requirements of the NHS Five Year Forward View[2], and in doing this address the three health and care "gaps":

- The health and wellbeing gap – preventing people from getting ill and supporting people to stay healthy; and
- The care and quality gap – consistent high-quality services, wherever and whenever needed; and
- The funding and efficiency gap – making sure services are structured and delivered as effectively as possible.

3.2 Officers and senior leadership from Westminster City Council, West London CCG and Central London CCG have continued to work together with colleagues from across North West London to support the development of the regional North West London STP.

3.3 The development of the Westminster Joint Health and Wellbeing Strategy has provided local evidence of strategic priorities which has fed into the development of the North West London STP. The Health and Wellbeing Board has confirmed

[1] Delivering the Five Year Forward View: NHS Planning Guidance 2016/17 – 2020/21
[2] The NHS Five Year Forward View

at previous meetings that the Westminster Joint Health and Wellbeing Strategy should be regarded as supporting the local delivery of the STP in Westminster.

4. Refreshing the Joint Health and Wellbeing Strategy

4.1 The draft Joint Health and Wellbeing Strategy was published on 6 July 2016 and an online consultation opened at the same time[3]. The consultation will be open until October 16 2016 (14 weeks).

4.2 The Council, Central and West London CCG, Healthwatch and One Westminster have promoted the Strategy and public consultation through various networks and newsletters. In addition to being promoted online and through social media, information about the Strategy and the consultation has been included in the following publications:

- CCG Newsletters
- One Westminster E-Bulletin
- Healthwatch Newsletter
- BME Health Forum Newsletter
- Breathe Easy Westminster Newsletter
- Westminster Schools Communication Newsletter

Leaflets and information on the Strategy and promoting the public consultation have been distributed to GP surgeries, pharmacies, libraries and leisure centres. Information about the Strategy has also been forwarded to the Westminster Inter-Faith Network.

4.3 The Council and CCGs have organised consultation events during September and October:

- **Health and care Providers roundtable – Thursday 8 September, 11:30am – 12:30pm, 15 Marylebone Road**
  A roundtable with local health and care providers to discuss the emerging strategic vision for health and care in Westminster.

- **Health and Wellbeing in Westminster – Everyone's Business – Wednesday 14 September, 11:15am – 1:00pm, Somerset House**
  A business event to discuss improving health and wellbeing in Westminster. Businesses will be able to find out about the key local challenges that affect their customers and employees, how the local healthcare system is proposing to tackle these and what role their business can play.

[3] www.westminster.gov.uk/your-health

- **Public Drop-In Health Fair– 5 October, 3pm-6pm, Church Street Library** A drop-in event with local health and wellbeing organisations and the VCS offering activities and information to residents and members of the public organised around the key priorities of the Strategy.

4.4 Officers have also, and will continue to, attend meetings of stakeholder organisations (please see Appendix A for the list of meetings that officers are attending).

4.5 Following the public consultation closure, redrafted version of the strategy will be presented to the Health and Wellbeing Board on 17 November, and will be considered by both West and Central London CCGs Governing Bodies.

5. Update on the North West London Sustainability and Transformation Plan (STP)

5.1. North West London submitted a draft plan in June. This paper streamlined the initial strands of work identified in the base case submission (which the Board received in May 2016) into five delivery areas (DA):

- DA 1 Radically upgrading prevention and wellbeing
- DA 2 Eliminating unwarranted variation and improving long term condition management
- DA 3 Achieving better outcomes and experiences for older people
- DA 4 Improving outcomes for children &adults with mental health needs
- DA 5 Ensuring we have safe, high quality and sustainable acute services.

Westminster as part of the North West London consortium is leading on the development of the finance and estates elements of the final STP submission. A copy of the North West London draft plan submitted is appended to this document as Appendix B.

5.2. There is a clear alignment across the STP and Health and Wellbeing Strategy priorities.

5.3. Feedback received from NHS England was positive and focused on further development of the mobilisation for delivery as well as governance aspects, with a view of a final submission in late October (date to be confirmed).

5.4. Current priorities for the STP process include:

a. **Further engagement to complete the plan**. In Westminster, this means using the current engagement activities already planned for the Health and Wellbeing strategy as outlined in section 4 above. The STP consultation is being promoted through the Council's Joint Health and Wellbeing Strategy consultation page with links to information and the online form. In addition to this the Council will be sharing the feedback received as part of the completed online consultation questionnaire with North West London colleagues. The STP consultation will also be promoted at the JHWS open house event in October.

b. **Establishing governance arrangements**. Individual organisations will need to sign off the STP according to their local governance processes as per the agreed STP governance process. CLCCG and WLCCG in particular are looking to approve during the month of September, building on discussions at Governing Body Seminars.

   Governance and delivery arrangements are being developed and are expected to include a Joint Health and Care Transformation Group which will have representation from across local government and health, including commissioners, providers and patient representatives.

c. **Mobilising projects outlined in the STP and accelerating delivery, including measurement delivery in 2016/17.** An STP programme management team is being established across NW London which is coordinating links with CCGs, Local Authorities and Providers as well as establishing delivery/steering groups for each of the Delivery Areas.

d. **Developing a detailed plan for 2017/18 and onwards.** NHS England has recently established an accelerated process of two-year integrated planning '*designed to build on both the financial recovery to be achieved in 2016/17 and the collaborative transformational strategies being developed in the STPs'*. The STP will be a key input in the planning round.

6. Legal Implications

6.1 The duty in respect of Joint Health and Wellbeing Strategies is set out in s116A of the amended Local Government and Public Involvement in Health Act 2007.

6.2 There is also statutory guidance, the "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies" issued in March 2013. The Guidance states at paragraph 3.5 that Joint Health and Wellbeing Strategies are continuous processes and that it is a decision for the Health and Wellbeing Board to decide when to either update or refresh their JHWS or

undertake a fresh process. There is not a requirement that the JHWS be undertaken each year so long as the Board is confident that their evidence based priorities are up to date and informing local commissioning plans.

6.3 Legal Services has had an opportunity to comment on the proposed consultation documentation and consultation process. It is confirmed as being a lawful process that discharges the Council's public and stakeholder's engagement responsibility to consult.

7. Financial Implications

N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Meenara Islam

Email: mislam@westminster.gov.uk

Telephone: 020 7641 8532

Daniela Valdés

Email: Daniela.valdes@nhs.net

APPENDICES:

Appendix A – Draft Health and Wellbeing Strategy Meetings Attended/Attending
Appendix B – Draft North West London Sustainability Plan – June 2016

Appendix A – Draft Health and Wellbeing Strategy Meetings Attended/Attending

Events Summary	Date
Central CLCCG Locality Meeting	07/07/2016
South CLCCG Locality Meeting	11/07/2016
Central London AGM	13/07/2016
North CLCCG Locality Meeting	19/07/2016
WLCCG Patient Reference Group	04/08/2016
Paddington Festival (Queen's Park Communtity Festival)	06/08/2016
Community Champions Summer Health Fair	23/08/2016
South Westminster Action Network	07/09/2016
Westminster Youth Council	12/09/2016
Older People's Forum	19/09/2016
South West London Health and Wellbeing Network	21/09/2016
BME Health Forum	28/09/2016
Westminster Community Network	29/09/2016
Organised Events	
Business Engagement Event	08/09/2016
Informal Public Marketplace Event	05/10/2016
Providers Roundtable	14/09/2016
Private Providers Roundtable	13/10/2016

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NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

V1.0

30 June 2016

DRAFT

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions.

We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.3bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group and NW London STP System Leader

Carolyn Downs
Chief Executive of Brent Council

Clare Parker
Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

Contents Page

i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs have a life expectancy 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.3bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

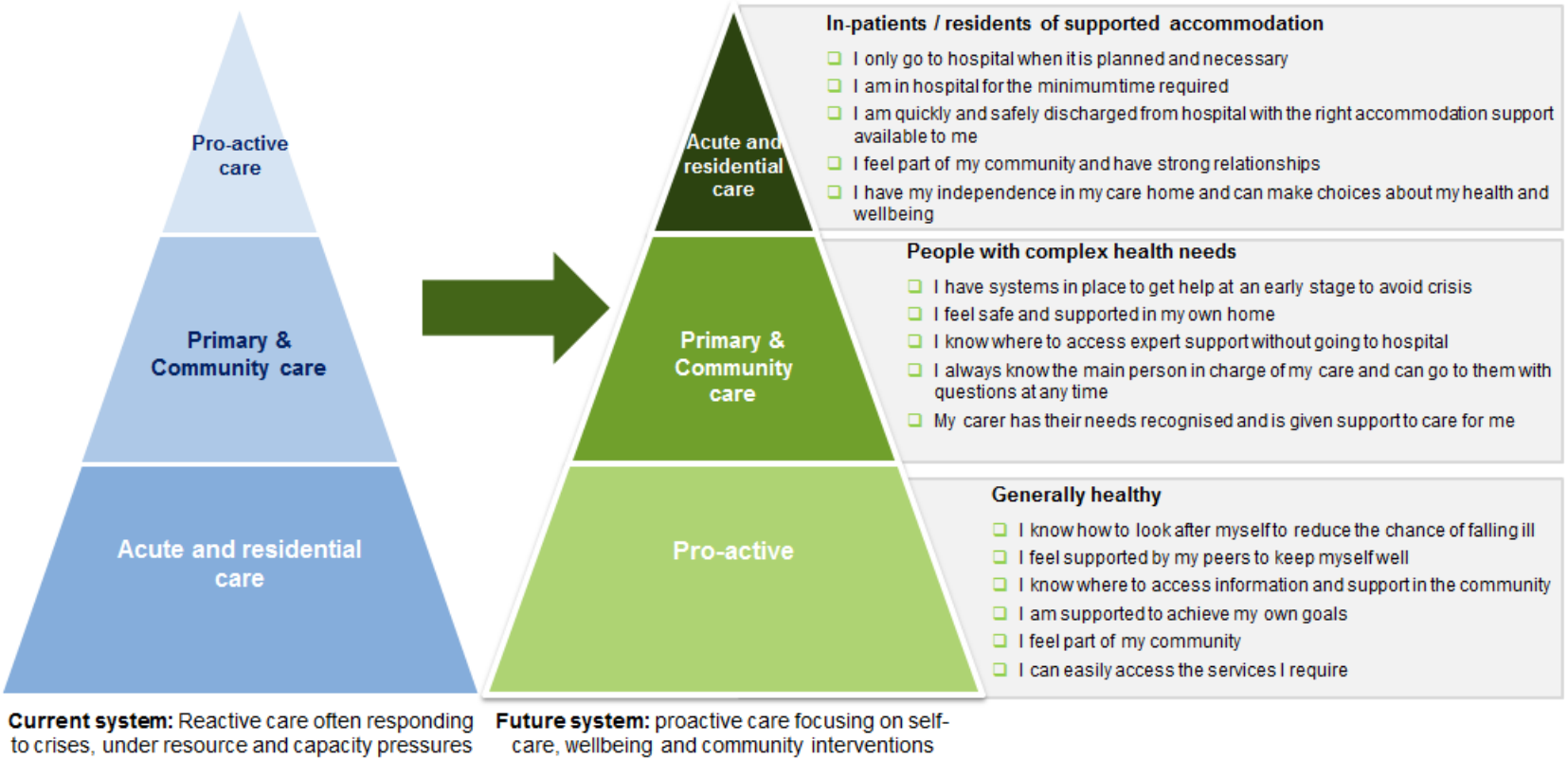
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,00	458,000	26,000	37,900	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	1%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
	4	Reduce social isolation					
Improving care & quality	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	262,000 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care. We will deliver this through primary care operating at scale through networks, federations of practices or super-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves it can benefit from specialisation and the benefits of senior clinical advice available at most parts of the day. We know from our London wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that can deliver consistently high quality, consistently well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our acute hospitals are under more strain than ever before. Some of this is due to increasing demand, and our STP sets out how we will manage demand more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. The site currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, meaning that the current clinical model cannot be financially sustainable. The vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing and for Charing Cross, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also host a GP practice and an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs.

The local government position on proposed acute changes is set out in Appendix A.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing or Hammersmith & Fulham will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

i. Executive Summary:
Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7
Delivery Area (1-5) - Investment	(118.3)	-	-	-	-	-	(118.3)	-	(118.3)
Delivery Area (1-5) - Savings	302.9	120.4	23.0	-	-	-	446.3	62.5	508.8
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0
Other	-	-	-	188.3	-	-	188.3	63.0	251.3
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**
Residual Gap (with application of business rules)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**

The solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

Additional savings have been assessed across the five STP delivery areas, and require £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings. These schemes support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.

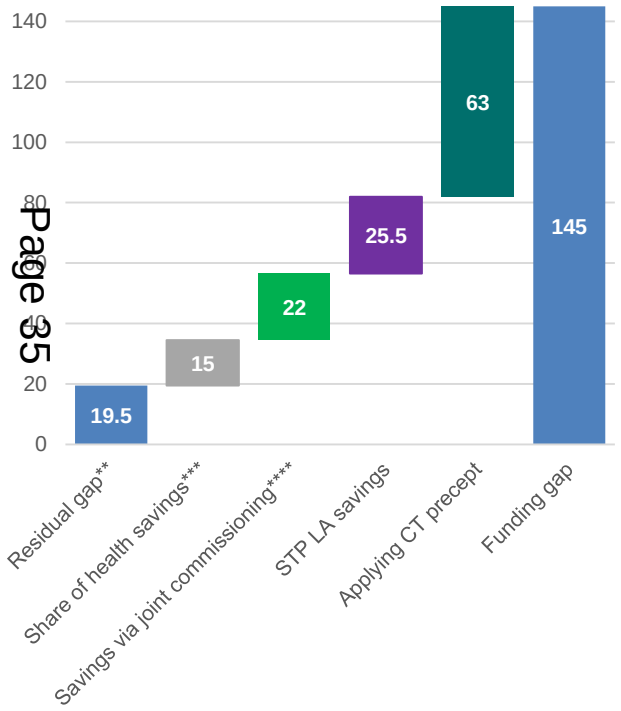
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	**-**	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	**-**	**-**	**-**	**6.1**
Caring for people with complex needs	DA3	**-**	**-**	**-**	**5.1**
Accommodation based care	DA3	**7.7**	**-**	**7.0**	**2.0**
Discharge	DA3	**3.4**	**-**	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	**-**
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	**-**	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary:
16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Increased accessibility to primary care through extended hours v. All practices will be in a federation, super practice or on a trajectory to MCP vi. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Aiming to move NW London average of 23mins/1000 people to 30mins/1000 people at pace v. Supporting sustainability, reducing unwarranted variation and preparing for Accountable Care Partnerships vi. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint bank and agency programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

i. Executive Summary:
How we will make it happen?

To deliver change at scale and pace requires the system to work differently, as both providers and commissioners. We are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. Develop a joint NW London implementation plan for each of the five high impact delivery areas

We will establish jointly led NW London programmes for each delivery area, working across the system to agree the most effective model of delivery and accountable to a new model of partnership governance. We will build on previous successful system wide implementations within Health and Local Government to develop our improvement methodology, ensuring an appropriate balance between common standards, programme management, local priorities and implementation challenges. The standard methodology includes a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. We have also developed a common project 'life cycle' with defined gateways. Models of care are developed jointly to create ownership and recognise local differences and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, seven day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

We are reviewing the total improvement resources across all providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around the delivery areas to increase effectiveness and reduce duplication

We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.

We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.

We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

We are moving towards primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system.

By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements.

By 20/21 we will worked jointly across Health and Local Government to implement Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.3bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

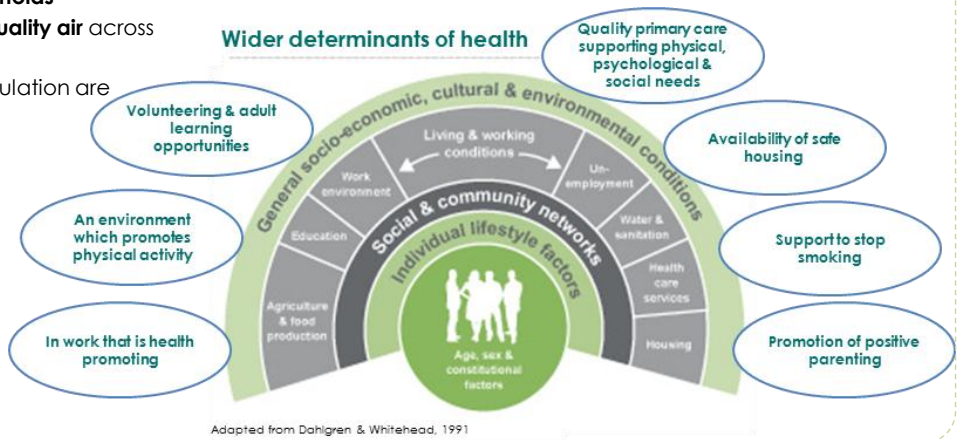
1. Case for Change:
Understanding our population

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- State primary school **children with high levels of obesity**

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Population Segmentation for NW London 2015–30[3]

Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
• 1,216,000 adults in NW London are mostly healthy • 58% of the total population • 24% of care spend in NW London In 2030: • 4% more adults • 31% more +65s	• 338,000 adults in NW London have 1 or more LTC • 16% of the population • 22% of the care spend in NW London In 2030 • 36% more adults • 37% more spend in NW London	• 17,000 adults in NW London have cancer • 0.8% of the population • 4% of care spend in NW London In 2030: • 53% more adults • 50% more spend in NW London	• 37,500 adults in NW London have serious and long term mental health needs • 2% of population • 7.5% of care spend In 2030: • 1% more adults • 21% more spend in NW London	• 7,000 adults in NW London have learning disabilities • 0.3% of the population • 8% of care spend in NW London In 2030: • 29% more adults • 35% more spend in NW London	• 21,000 adults in NW London have severe physical disabilities • 1% of the population • 18% of care spend in NW London In 2030: • 29% more adults • 26% more spend in NW London	• 5,000 adults in NW London have advanced dementia • 0.2% of the population • 2% of care spend in NW London In 2030: • 40% more adults • 44% more spend in NW London	• 438,200 children in NW London • 21% of the population • 14% of care spend in NW London In 2030 • 6% more children • 3% more spend in NW London	• Westminster has the highest recorded population of rough sleepers of any local authority in the country • There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

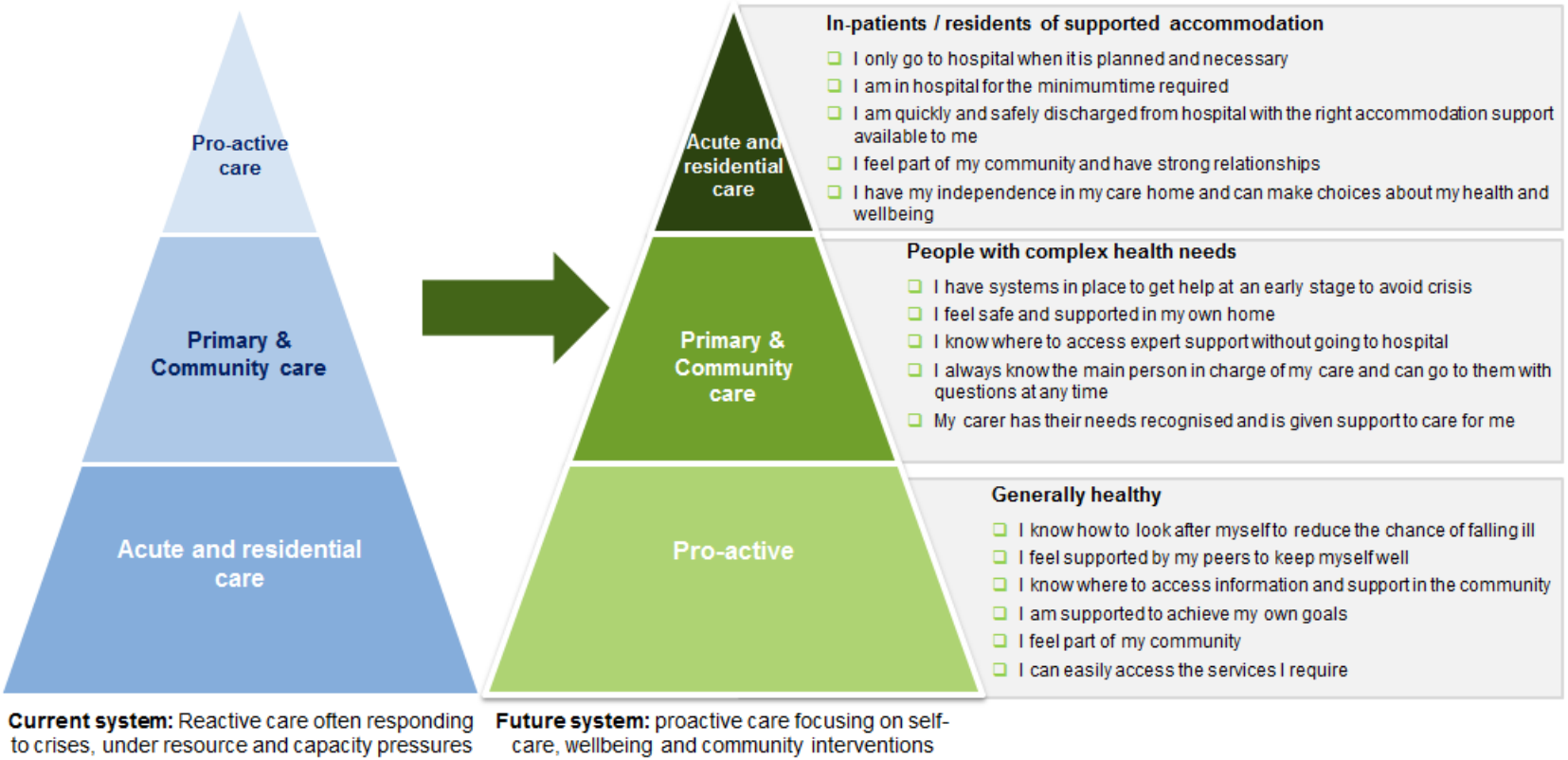
Please note that segment numbers are for adults only with the exception of the children segment

1. Case for Change:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

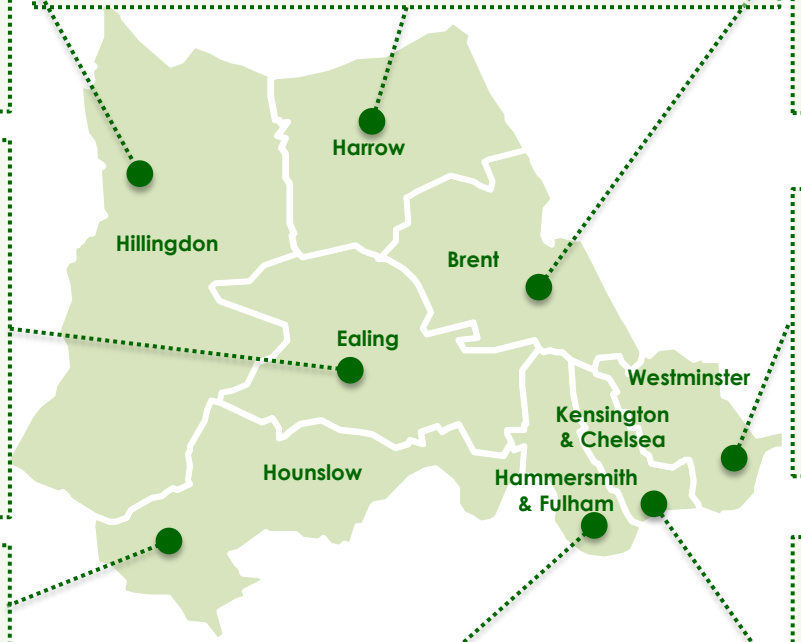
1. Case for Change:
Understanding people's needs

While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6



- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 19.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)

- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

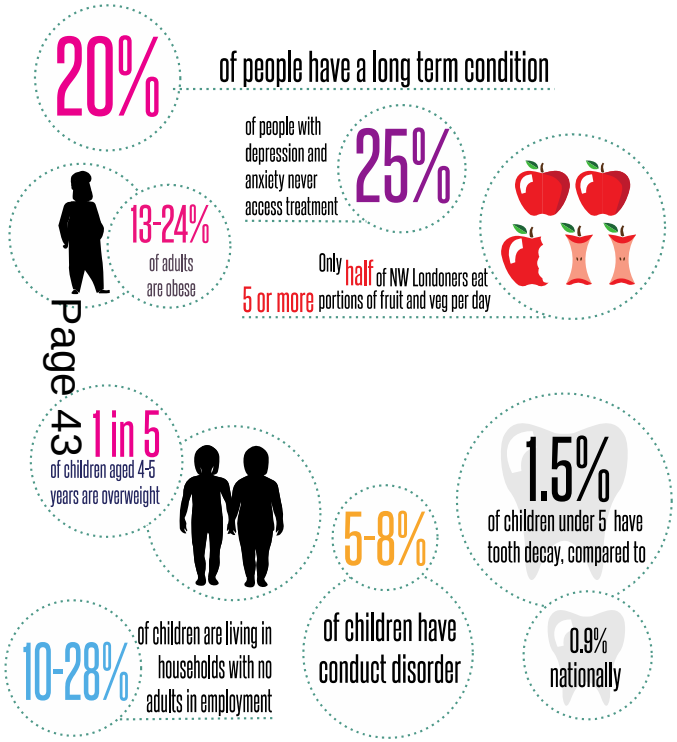
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…



1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

Our Priorities

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves
2. Improve children's mental and physical health and well-being
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

My life is important, I am part of my community and I have opportunity, choice and control

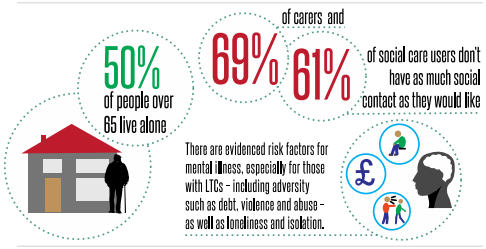
As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

My wellbeing and happiness is valued and I am supported to stay well and thrive

I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
Over 20% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

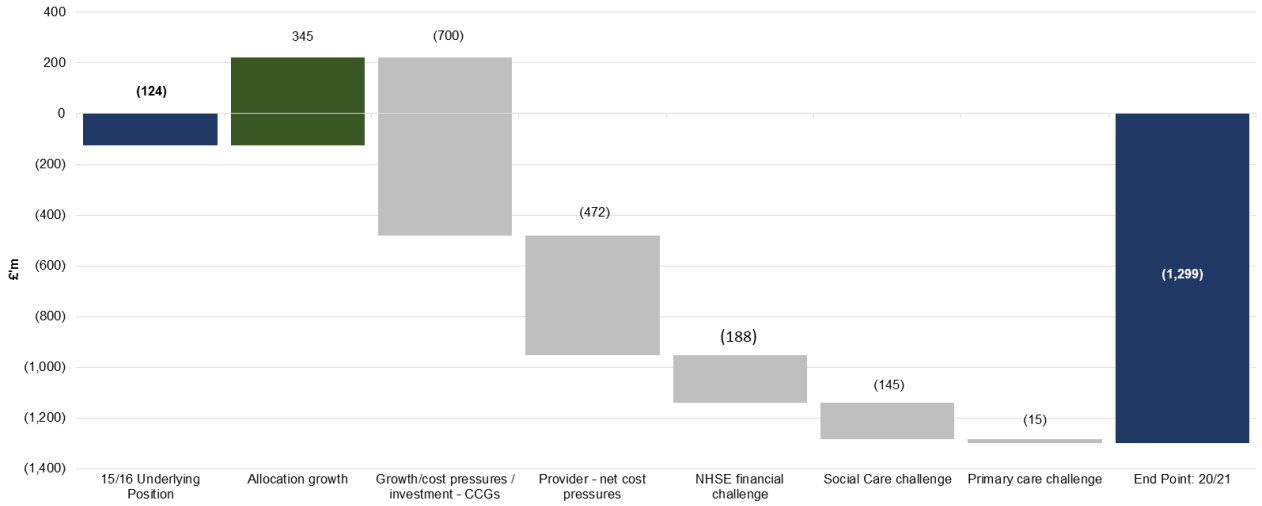


Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

£'m - Residual Gap	15/16	16/17	17/18	18/19	19/20	20/21
Providers	(190)	(304)	(374)	(462)	(544)	(659)
CCGs	60	(4)	(77)	(140)	(198)	(293)
Specialised commissioning	-	-	(44)	(90)	(138)	(188)
Primary care	-	2	(1)	(12)	(19)	(15)
Total NHS	**(130)**	**(306)**	**(496)**	**(704)**	**(899)**	**(1,154)**
Social Care	-	-	(36)	(73)	(109)	(145)
Total NWL Health and social care	**(130)**	**(306)**	**(532)**	**(776)**	**(1,007)**	**(1,299)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		DA 1 Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		DA 2 Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
	4	Reduce social isolation					
Improving care & quality	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		DA 3 Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		DA 4 Improving outcomes for children &adults with mental health needs	262,000 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		DA 5 Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1: Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

2020/2021

Target Population:
All adults: 1,641,500
Mostly Healthy Adults at risk of developing a LTC: 121,680
All children: 438,200

Contribution to Closing the Financial Gap
£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is important for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. Our residents who have a learning disability are also sometimes not receiving the fully support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Targeting people at risk of developing long term conditions and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This group includes approximately 120,000 people who are currently well but are at risk of developed an LTC over the next five years[11]. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Working across the system at both NW London and London level to address the wider determinants of health, such as employment, education and housing.
- Enabling children to get the best start in life, by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].
- Focusing on social isolation as a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs. Around 200,000 people in NW London are socially isolated and it can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Enabling and supporting healthier living	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. Establish a NW London Primary Care Cancer Board which will look at improving public messaging/advertising around preventing cancers. Launch a NW London communications and signposting campaign to more effectively guide people to support, including voluntary and community, to improve care and reduce demand on services. As part of this we will: • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Training GPs and other staff in Health Coaching and 'making every contact count' to promote healthy lifestyle choices in patients • Delivering an enhanced 111 service driven by a new Directory of Services which will signpost service users to the appropriate service • Rolling out systematic case-finding to identify and support people at risk of diabetes, dementia or heart disease, using our Whole system IT platform • Promoting a community development approach to improve health by identifying local needs and sign-posting through services, such as, information stalls, children's support sessions, health awareness sessions, debt management and maternity drop-ins • Supporting Healthy Living Pharmacies to train Champions and Leaders to deliver interventions, such as smoking cessation • Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda	0.2	2.5
B	Wider determinants of health interventions	The healthy living programme plans will also cover how Boroughs will tackle wider determinants of health. In 16/17, local government already plans to deliver some interventions, such as: • Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability • Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems • Bidding for funds from the joint Work and Health Unit to support social prescribing of employment and interventions for those at risk of losing their employment	As part of the healthy living programme, local government, working jointly with health partners, will take the lead on delivering key interventions by 20/21 such as: • Introducing measures reduce alcohol consumption and associated health risks, e.g. licence controls, minimum pricing and promotions bans • Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities • Partner with organisations such as London Fire Brigade to jointly tackle the wider determinants of health such as social isolation and poor quality housing	3.3	6.5
C	Addressing social isolation	The healthy living programme plans will also cover how Boroughs will address social isolation. In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services	As part of the healthy living programme, we will implement key interventions such as: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation.	0.5	6.6

D	Helping children to get the best start in life	• NW London will invest part of its PMS premium income in increasing immunisation rates for key areas of need, such as the 5-in-1 Vaccine by 1 Year
		• Implement the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services
		• Collaborate with the vanguard programme and the children's team at NHSE in the development of new care models for children and young people (C&YP)
		• Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough
			• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work
			• Establish a Connecting Care for Children GP hub in the majority of localities where children live, building on 3 Borough work to:
			  • reduce high outpatient and A&E attendance numbers among C&YP
			  • promote healthy eating and obesity screening pathways (e.g. HENRY)
			  • Co-locating dental professionals and deliver dental hygiene training
			• Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity
				TBC	TBC

2. Delivery Area 2:
Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is important for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Unwarranted variation covers all services, from the early detection of cancer, the management of long term conditions, and the length of stay in hospital to the survival rates from cancer and major surgery. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1) [7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from HLP's Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. We will align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18.	Through the Royal Marsden and Partners Cancer Vanguard, develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, thereby reducing variation in acute care and ensuring patients have effective high quality cancer care wherever they are treated in NW London	TBC	TBC
B	**Better outcomes and support for people with common mental health needs** (with an initial focus on people with long term physical health conditions)	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC
C	**Reduce variation by focusing on 'Right Care' priority areas**	Identified and commenced work in 2016/17 in following areas: • Mobilisation of National Diabetes Prevention Programme (commencing August 2016) • Further development of diabetes mentor/champion role within communities • Extend diabetes dashboards to other LTC, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD, enabling easy navigation through device-drug-dose considerations and supporting professionals and patients in reaching appropriate decisions and achieving adherence to therapy • The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care.	• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools • Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes • Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations • Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors • Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs • Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.	2	12.4
D	**Improve self-management and 'patient activation'**	• Identify opportunities for patient activation in current LTC pathways based on best practice – application for 43,920 Patient Activation Measures (PAM) licences in 2016/17 for people who feel overwhelmed and anxious about managing their health conditions	• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be immediately referred into expert patient training • Technology in place to promote self-management and peer support for people with LTCs • Increase availability of, and access to, personal health budgets, taking an integrated personal commissioning approach • PAM tool available to every patient with an LTC to help them take more control over their own care – planned increase in PAM licences to 428,700 • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from coordinated care and continuity with a named clinician to support them with LTCs	3.4	6.1

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

2020/2021

Target Population:

311,500

Contribution to Closing the Financial Gap

£82.6m

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is <u>important</u> for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnership(s) • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnership(s), with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	Implement new models of local services integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes in each of the eight boroughs and across NW London • Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working • Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers	18	26.3
D	Upgrade rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want. • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

2020/2021

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is important for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. But we know that poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact.

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially handicapped by their condition and **10% will die by their own hand**.
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before you are 18.
- The number of people with serious and long term mental health needs in NW London is double the national average
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing.

Our aim in NW London is to improve outcomes for children and adults with mental health needs, we will do this by:

- Implementing a new model of care for people with serious and long term mental health needs, which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing wider determinants of health and how they relate to and support recovery for people with mental health needs
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need
- Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home. This includes Future in Mind and Transforming Care Partnerships work.

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy	• More support available in primary care – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community (investment of c£12-13m)
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
			• Full roll out of the new model across NW London, including:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			• **The benefit to the patient will be tailored evidence based support available closer to home**
			Living a Full and Healthy Life in the community → Coordinated Community, Primary and Social Care → Specialist Community based support → Urgent/crisis care to support stabilisation → Acute inpatient admissions
				11	16

B	Addressing wider determinants of health, e.g. employment, housing	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care • **The benefit to the patient will be a happier, fuller way of living**	TBC	5
C	Crisis support services, including delivering the 'Crisis Care Concordat'	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS) LAS, Metropolitan police and other services – meeting access targets • Round the clock mental health teams in our A&Es and support on wards, 'core 24' • Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)	• Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis • **The benefit to the patient will be care available when it is most needed**	TBC	TBC
D	Implementing 'Future in Mind' to improve children's mental health and wellbeing	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

2020/2021

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is <u>important</u> for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Consolidate acute services onto five sites (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham– see Appendix A, condition 5).
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Specialised Commissioning**	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	**Deliver the 7 day services standards**	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

	To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C **Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites	Reduce demand for acute services through investment in the pro active out of hospital care model. Work jointly with the council at Ealing to develop the hospital in Ealing and jointly shape the delivery of health and social care delivery of services from that site, including: • a network of ambulatory care pathways; • a centre of excellence for elderly services including access to appropriate beds; • a GP practice; and • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists.	33.6	89.6

D **NW London Productivity Programme**	Implement and embed the NW London productivity programme across all provider trusts, focusing on the following four areas:
	• **Patient Flow**: address pressure points in the system that impacts on patient flow, patient experience and performance against key targets (e.g. 4 hour wait and bed occupancy).
	• **Orthopaedics**: mobilise and commence work around establishing a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT).
	• **Procurement**: assuming no mandation of the new NHS procurement operating model, establish the necessary enablers for collaboration to take forward sector-wide transformation in procurement and implement the Carter Review recommendations across the STP footprint[8]. These include establishing line of sight of sector-wide savings opportunities through agreed baseline reporting and on-going measurement of the benefits from collaborations, sector-wide visibility of contracts and establishing governance links to enable wider benefit of existing purchasing collaboratives (e.g. Shelford Group).
	• **Bank & Agency**: reduce agency spend across NW London; initiation of a range of workforce activities such as standardised pay and sector-wide recruitment. The sector is expected to reduce agency spend by £46m and deliver net savings of £32m.
		Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together through ACPs to constantly innovate and drive efficiency. Rolling programme of pathway redesign and patient flow initiatives to ensure trusts are consistently in the top quartile of efficiency. 17/18 plans against the initial delivery areas are set out below:
		• **Patient flow:** Implement system level initiatives in areas such as: improving access to GPs, better management of increasing volumes of ambulance attendances, integrated discharge processes from hospital and best practice A&E processing of patients.
		• **Orthopaedics:** Implement orthopaedics best practice based on Getting it Right First Time. Hip and knee replacements initial area of focus with estimated savings in the region of £2.6m to £4.0m across NW London, then roll out in full.
		• **Procurement:** 2016/17 will establish baselines enabling additional quantified benefits from 2017/18 onwards. Early impact areas include utilities, waste management, agency (linked with Bank & Agency workstream) and applying the GIRFT principles to commoditised purchasing for specific clinical areas.
		• **Bank & Agency:** build on work from 2016/17 , linking with South West London to share best practice. Key areas of focus are
		  • Strengthening recruitment to reduce vacancies
		  • Optimising scheduling to reduce demand
		  • Shifting usage from agency to bank to reduce costs
		  • Reducing unit costs for agency by increasing use of framework agencies and reducing rates through volume based contracts
			4.1*	143.4

*This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas	By 2020/21, Enablers will change the landscape for health and social care:		
	Estates will…	**Digital will…**	**Workforce will…**
1. Radically upgrading prevention and wellbeing	• Deliver **Local Services Hubs** to move more services into a community setting • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improving and changing our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• Deploy our **shared care record** across all care settings to improve care, reduce clinical risk, and support transition away from hospital • **Automate clinical workflows and records** and support transfers of care through **interoperability**, delivering digital empowerment by removing the reliance on paper and improving quality • **Extend patient records to patients and carers** to help them to become more digitally empowered and involved in their own care, and supporting the shift to new channels • Provide patients with **tools for self-management and self-care**, further supporting digital empowerment and the shift to new channels • Use **dynamic data analytics** to inform care decisions and target interventions, and support integrated health and social care with whole systems intelligence	• **Targeted recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers: Estates

Context

- The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.
- Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings.
- NW London has the opportunity to work across health and local government, promoting the 'One Public Estate' to leverage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.
- Some progress has been made towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £623m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs, due by end 2016
  - The hub strategy and plans include community Mental Health services, such as IAPT
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham – see Appendix A, condition 5).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local population
  - Trusts are currently developing their site proposals, which will feed into an overall N W London ask for capital from the Treasury, contained in the strategic outline case to be submitted this summer.

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:
- Local services hubs will provide the physical location to support prevention and out-of-hospital care.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:
Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7/7 access to all residents

Delivery Area 3 - Outcomes for older people:
- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of inpatient care

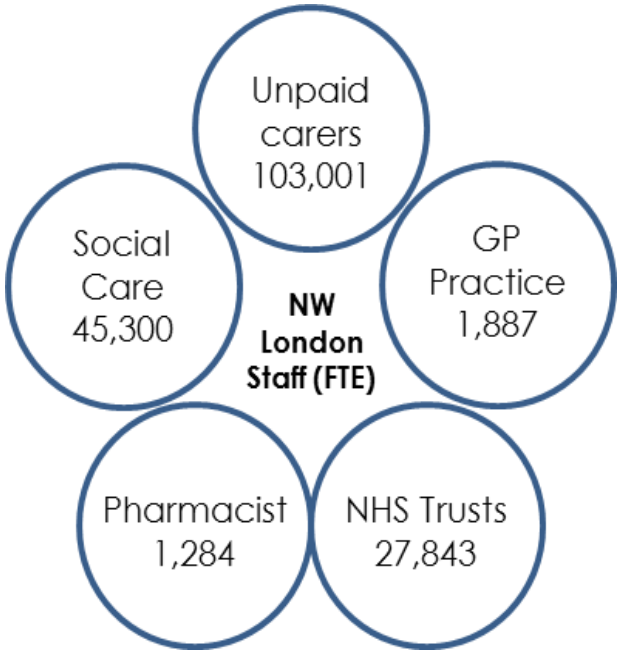
Delivery Area 4 - Supporting those with mental health needs:
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

Delivery Area 5 – Providing high quality, sustainable acute services:
- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work and will be key to achieving our collective vision through delivering sustainable new models of care to deliver improved quality of care that meets our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. Carers are a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly expand work across social care[1].
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- Appropriate workforce planning and actively addressing workforce issues is instrumental in addressing the five delivery areas in the STP
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care. Nine physician associates currently work in NW London, with 32 commencing training in September. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 36 more paediatric nurses (37 more commence in September '16) and 3 consultants paediatricians (6 appointed to start in September '16, with plans to recruit 3 more).
- Building on this track record, **key enablers** will include the collaborative and partnership working between CCGs, Trusts, HEENWL and the CEPNs (Community Education Providers Network) to support workforce planning and development, and the HLP to utilise the established workforce planning infrastructure and expertise, build on strong foundations of on-going strategic workforce investment, and embed the findings outlined in HLP's London Workforce Strategic Framework.



What will be different in 2020[6]?

Our workforce strategy will address the following challenges to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Current Transformation Plans and Benefits

Addressing workforce shortages

- Through workforce planning and extensive stakeholder engagement NW London is understanding and addressing key workforce issues. For example, NW London is leading a centralised Pan-London placement management and workforce development programme for **paramedics** with an investment of over £1.5m

Improving recruitment and retention

- NW London has plans to step up recruitment. For example, by October 2016, there is planned recruitment of over 100 additional **nursing staff** and 7 additional **children's consultant medical staff** leading to more senior provision of children's care. Further initiatives include:
  - **Scale recruitment drives**; leveraging the benefits of working in NW London.
  - Development of varied and **structured career pathways** and opportunities to **taper retirement**.
  - **Skills exchange** programmes between nurses across different care settings.
- **Promoting careers in primary care** by providing student training placements across professions to introduce this setting as a viable and attractive career option.
- Supporting the **implementation of 7 Day Services** by designing a framework to support career development and retention in radiology. Addressing workforce shortages will also support the development of the Cancer Vanguard.
- A **structured rotation programme** will support 200 nurses to work across primary and secondary care (including key areas such as mental health and care of the elderly).
- NW London's trusts will work collaboratively to **reduce reliance on agency** nurses (current spend: £172m pa on bank/agency[7])

Workforce Transformation across health and social care workforce to support integrated care

- Embedding **new roles** to support the system including: Physician's Associates, Care Navigators, Clinical Pharmacists, Peer Educators (support worker that can share experiences of mental health), and Nurse Associates.
- **Hybrid roles and developing career pathways** across health and social care will be important in the long term.
- Significant investment into Dementia, Community and Neonatal Nursing, Apprentices and the bands 1-4 workforce.
- **Optimising GPs' time** by understanding how we can develop the primary care workforce (including **practice manager development**) to redeploy GP workload where possible and increase the capability to deliver the business requirements of GP networks(Day Of Care Audit).
- **Supporting self-care** through use of patient activation measurements and Health Coaching training to help staff to have motivational conversations with patients, to empower them to set and achieve health goals, take greater responsibility for their health, and grow in confidence to self-manage conditions

Leadership and Organisational Development to support future services

- **Collective, system leadership**, will be key to the success of ACPs. Leadership development will be broader than senior leadership level; empowering MDT frontline practitioners to lead and engage other professionals and take joint accountability across services will be integral to success.
- Leadership and change management programmes will foster innovation, build relationships and trust across multi-disciplinary, cross organisational teams to deliver integrated new ways of working. The **Change Academy** will use an applied learning approach and will be underpinned by improvement methodology (38 leaders supported in phase 1)
- **Commissioning for outcomes** based programmes
- Leadership development forums will include the **GP Emerging Leaders** (providing NW London-wide workshops, mentoring, and sharing of local intelligence and education) and Transformation Network
- More effective ways of working achieved through the **Streamlining London Programme** across Trusts
- Adopting a collaborative approach to embed **health and wellbeing initiatives and ambassadorship** through the Healthy Workplace Charter

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- **Health Coaching** training will help staff to have motivational conversations with patients to take greater responsibility for their health, and grow in confidence to self-manage conditions.
- To ensure carers, the largest proportion of our workforce, are supported, we will expand the programme in 2017/18, to build carers' skills around setting achievable health and wellbeing related goals for patients.
- The NW London **Healthy Workplace Charter** will embed staff health and wellbeing initiatives and ambassadorship
- Primary care and specialist community nurse workforce development

Delivery Area 2 - Reducing variation:

The framework to retain staff and support career development in radiology will help address shortages and support **implementation of 7 Day Services** and **Cancer Vanguard**. Growth in primary care and bespoke project work on LTCs prevalent in NW London such as diabetes and heart disease.

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g.: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- **Optimising GPs' time** by developing the primary care workforce (e.g. **practice manager development**) will increase capability to deliver the business requirements of GP networks
- Leadership development forums will join up practitioners, providing NW London-wide workshops, opportunities to network and share local intelligence
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs will graduate in June 2016 with an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses and thereby the cost of service
- The **Change Academy**, underpinned by improvement methodology and alignment to achieving productivity gains will support cross-boundary working and support financial sustainability of services.

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London Informatics, and has made good progress with Information Governance across care settings. All of the eight CCGs have a single IT system across their practices and six of the eight CCGs are implementing common systems across primary and community care, and have a good track record in delivery of shared records, for example, through the NW London Diagnostic Cloud.
- The NW London Care Information Exchange is under way, funded by Imperial College Healthcare charity. This technology programme gives individuals a single view of information about their care across providers and platforms, allows sharing of information, and provides tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne.
- There is good support from NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London exchange, record locator, and IG register.

Key Challenges

- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access and retain information about the patient[1]. A potential mitigation is to share care records and converge with other Local Digital Roadmaps (LDR) via universal NHS systems.
- Due to different services running multiple systems, there is a dependence on open interfaces to deliver shared records, which primary and community IT suppliers have failed to deliver. This will require continued pressure on suppliers to resolve.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is required from NHSE to define and fund interfaces nationally.
- Clinical transformation projects have in the past been very costly and taken a long time to deliver, which need to be allowed for in the LDR plans
- There is a lack of digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.

Strategic Local Digital Roadmap Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, **removing the reliance on paper** and improving quality
2. **Build a shared care record** across all care settings to deliver the **integration of health and care records** required to support new models of care, including the transition away from hospital
3. **Extend patient records to patients and carers,** to help them to become more **digitally empowered** and involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their care, further supporting **digital empowerment** and the shift to new channels of care
5. **Use dynamic data analytics** to inform care decisions, and support integrated health and social care across the system through **whole systems intelligence**

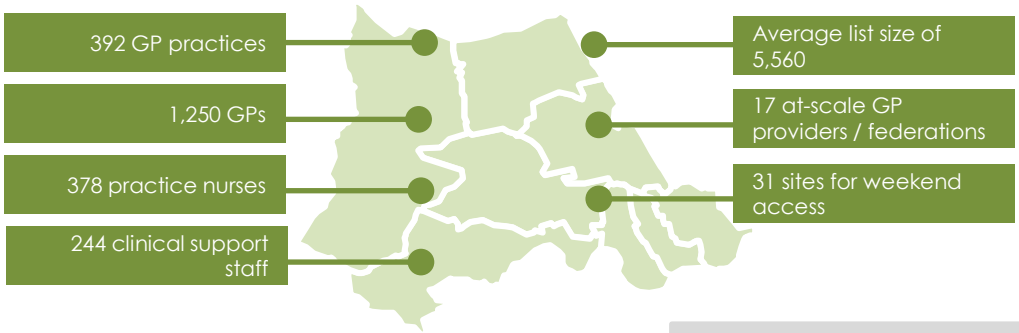
Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**, where much work has already been done
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education

3. Enablers: Digital

STP Delivery Area	Digital STP Theme	Key Impacts on Sustainability & Transformation Planning
1. Radically upgrading prevention and wellbeing	• Deliver digital empowerment • Integrate health & care records	**Enhancing self care:** • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange** to support them to become expert patients • Innovation programme to find the right **digital tools** to help people **manage their health and wellbeing**; **create online communities** of patients and carers; and to get children and young people involved in health and wellness **Embedding prevention and wellbeing into the 'whole systems' model:** • Support integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care-plans)
2. Eliminating unwarranted variation and improving LTC management	• Integrate health & care records • Whole systems intelligence • Deliver digital empowerment	**Improving LTC management** • Deliver Patient Activation Measures (PAM) tool for every patient with an LTC to promote self management and develop health literacy and expert patients • **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability and development of a share care record to deliver the **integration of health and care records and plans** • Patient engagement and self-help training for LTCs to help people manage their conditions and interventions **Reducing variation** • Integrated care dashboards and analytics to track consistency of outcomes and patient experience • Support new models of multi-disciplinary care, delivered consistently across localities, through shared care records
3. Achieving better outcomes and experiences for older people	• Deliver digital empowerment • Integrate health & care records • Whole systems intelligence	**Provision of fully integrated service delivery of care for older people** • Enable citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange**, **remote consultations** (e.g. videoconferencing) and **telehealth** • Support discharge planning and management, new models of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care • **Integrate Co-ordinate My Care** (CMC) with acute, community and primary care systems and promote its use in CCGs, where usage is currently low, through education and training and support care planning and management • **Shared information and infrastructure** to support new primary care and wellbeing hubs with mobile clinical solutions • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care dashboards have been deployed to 312 GP practices to support co-ordinated and proactive patient care, with a plan to expand to all 400 practices by 2020/21
4. Improving outcomes for people with mental health needs	• Integrate health & care records • Whole systems intelligence	**Enabling people to live full and healthy lives** • Innovation programme to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities **New model of care** • Support new care delivery models and shared care plans through **shared care records and care plans** **24/7 provision of care** • Support new models for out-of-hours care through **shared care records**, such as **24x7 crisis support services**
5. Ensuring we have safe and sustainable acute services	• Deliver digital empowerment • Integrate health & care records	**Investing in Hospitals** • Support new models for out-of-hours care through **shared care records and the NW London diagnostic cloud**, such as 24x7 on-call specialist and pan-NW London radiology reporting and interventional radiology networks in acute • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Integrated out-of-hours **discharge planning and management** through shared care records • **Dynamic analytics** to track consistency and outcomes of out-of-hours care

4. Primary care in NW London



Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. GPs are not only the first point of contact for the majority of residents, but also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

There are, nevertheless, significant challenges. These include:

- dramatic projected increases in the number of older people presenting with multiple and complex conditions, fuelling demand for GP appointments and a greater co-ordinating function within primary care – the number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26;
- 27.1% of the GP and nurse workforce is aged over 55 and 7.4% aged over 65, which represents a significant retirement bubble;
- front-line delivery pressures that are contributing to recruitment and retention challenges, whilst lowering the morale of GPs and their primary care colleagues; and
- inadequate access to primary care, contributing to a patient-reported experience of GP services significantly below the national average.

These and other challenges require fundamental changes to the design and delivery of primary care, within the context of NW London's broader system transformation across health and social care. The NW London CCGs' plan for this is described in this document.

Some other statistics: achievements and challenges

- The NW London CCGs score above the London average for 6 out of 7 facets for co-ordinated care, based largely on the achievements made through the Whole Systems Integrated Care national pioneer programme
- The NW London CCGs score above the London average for 6 out of 13 facets for accessible primary care consultations (including telephone, email, and video consultations)
- 23% of the NW London practices so far inspected by the CQC ratings are performing below the national average
- 60% of people with a long-term condition feel supported to manage their condition – below the national average of 67%.

Some of our achievements so far

- NW London is the largest national pilot site for the Prime Minister's Challenge Fund, covering 365 practices and 1.9m people. This investment has improved patient access to general practice and supported the development of at-scale organisations in primary care. The CCGs are now working with NHS England to build on this achievement through the new Prime Minister's Access Fund investment announced in the GP Forward View.
- 280,000 patients can access web-based consultations .
- 60,000 patients can access video consultations.
- 97% of practices offer online appointment booking.
- Joint co-commissioning is embedded in NW London . Over recent months each joint committee has agreed its PMS review commissioning intentions, as a first instalment to equalising the patient offer in each CCG, and recommended estates bids to the Estates and Technology Transformation Fund
- Integrated care data dashboards have been piloted in eight practices, with a rollout plan prepared for 350 practices within 12 months. The dashboards link the past two years of patient-level data from acute, primary, community, and mental health, enabling patient journeys through the health system to be tracked and their care to be improved where appropriate.
- Contracts covering 19 services have been let at federation-level across five of the eight CCGs enabling a consistent service offering to the whole population.

Additional work already under way

- CCG self-care leads and lay partners across NW London have co-produced a self-care framework. This includes patient activation measurement that is to be piloted in approximately 200 GP practices by March 2017.
- 180 Healthy Living Pharmacies have been commissioned for 2016/17. They will train Health Champions and Healthy Living Pharmacy Leaders to support local communities with wellbeing interventions such as smoking cessation.
- Hillingdon and Ealing CCGs are providing a Minor Ailments Scheme, allowing patients to self-medicate when appropriate, reducing the impact on primary care. We plan to roll this scheme out across NW London by 2018/19.
- 32 Physician Associates places have been commissioned at Buckinghamshire New University and Brunel University, starting later in 2016.
- The Clinical Pharmacists in General Practice pilot is underway at 23 GP practices in NW London .
- The CCGs plan to make seven collective technology bids to the Estates and Technology Transformation Fund. These will cover areas including digitally-enabled patients, videoconferencing, integrated telecoms and patient management systems, and care home pilots.
- On-going work on local implementation of the 10 Point Plan for workforce includes: a recruitment evening session at Northwick Park Hospital for Foundation Year Doctors, the national thunderclap campaigns organised by HEE, and Joint work with the Foundation School and Medical School to attract new GP Trainers into local training programmes.

4. The future of primary care in NW London

NW London has a clear set of primary care outcomes that the CCGs will support providers to deliver over the next five years. These are shown below, along with how they map onto the five delivery areas to illustrate the crucial role that primary care has in delivering the NW London STP.

- Radically upgrading prevention and wellbeing
- Ensuring we have safe, high quality sustainable acute services
- Eliminating unwarranted variation and improving LTC management
- Achieving better outcomes and experiences for older people
- Improving outcomes for children and adults with mental health needs

Proactive care	
Co-design	- primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
Developing assets and resources for improving health and wellbeing	- primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community
Personal conversations focused on an individual's health goals	- where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	- primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
Patients not currently accessing primary care services	- primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Accessible care	
Patient choice	- patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs
Contacting the practice	- patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations)
Routine opening hours	- patients can access pre-bookable routine appointments with a primary health care professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	- patients can access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
Same-day access	- patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network
Urgent and emergency care	- patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately
Continuity of care	- all patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate

Co-ordinated care	
Case finding and review	- practices identify patients, through whole systems data analytics, who would benefit from coordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis
Named professional	- patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	- each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in their care
Patients supported to manage their health and wellbeing	- primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing, including through health coaching, future digital tools and other forms of education
Multi-disciplinary working	- patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. Care will be coordinated via shared electronic care records.

4. Delivering the ambitions of the primary care strategy

Following the NW London-wide development of ambitions and outcomes for primary care, the CCGs are now working with primary care providers to agree how this will be delivered in each borough in a way that meets the needs of their local populations. The draft process is shown below. This will be the basis of the design and delivery of annual commissioning intentions each year until 2020/21, with delivery of the SCF achieved by the end of 2018/19.

This will ensure that the increases to the NW London primary care medical allocations (shown in the table below) are invested in a way that delivers maximum benefits to patients, alongside the national programmes – such as the Prime Minister's Access Fund, from which NW London might be able to access approximately £12m in 2016/17 – announced in the GP Forward View.

NW London CCGs	2016/17	+£19.3m	2017/18	+£11.8m	2018/19	+£11.5m	2019/20	+£15.6m	2020/21
	£279.97m		£299.26m		£311.03m		£322.50m		£338.07m

SCF implementation

2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21

June/July

A five-month collaborative process led by CCGs and supported by the local services team to define each CCG's model of care. The primary care component will include the outcomes and ambitions set out above.

August

The CCG primary care teams will, with the Local services team, then:

- undertake a gap analysis;
- translate the gaps into high-level prioritised annual commissioning intentions to 2020/21, based on confirmed allocations; and
- form a detailed plan for the design and implementation of 2017/18 priorities.

The Local services team will work with CCGs to design a standard process and format for this.

September

Governing bodies sign off:

- local model of care
- gap analysis
- prioritised annual commissioning intentions to 2020/21, based on SCF implementation by April 2019
- a detailed plan for the design and implementation of 2017/18 priorities, including business case and governance

The Local services team develops a pan-NW London plan to April 2017 to support consistency and alignment / 'develop and spread', based on detailed CCG plans and accounting for dependencies with enablers.

CCGs and the Local Services team will report on progress against this plan to the Local Services programme executive.

Shared CCG materials

HLP SCF costing and impact analysis

National programmes based on the GP Forward View and local programmes funded by the Sustainability and Transformation Fund

A **recurring annual cycle of primary care commissioning**: engagement, confirmed commissioning intentions, business case development, detailed planning, and implementation, based on the model of care and prioritisation approved by the governing body in September 2016.

Commissioning intentions that directly support the SCF will be prioritised before April 2019.

SCF commissioning intentions

SCF+ commissioning intentions

A **recurring annual cycle** of the Local services team building a NW London-wide plan against which all parties will report progress and be held accountable for delivery.

Support on enablers from Strategy and Transformation and other pan-CCG teams – including **federation development**

5. Finance:

Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that at an STP level there is a surplus of £50.5m and there is a small, £31m gap to delivering the business rules (i.e. including 1% surpluses).

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care	
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**	**note 1**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7	**note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	(4.0)	-	(4.0)	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	15.6	8.0	23.6	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	(5.4)	-	(5.4)	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	18.5	-	18.5	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	(52.3)	-	(52.3)	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	134.9	33.1	168.0	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	(11.0)	-	(11.0)	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	22.8	6.4	29.2	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	(45.6)	-	(45.6)	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	254.5	15.0	269.5	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)	**note 4**
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0	**note 4**
Other	-	-	-	188.3	-	-	188.3	63.0	251.3	
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**	
Residual Gap (see note)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**	
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**	
				note 5				**note 3**		

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since April '16 STP due to changes in the underlying position of organisations and social care, inclusion of 1% gap requirement on Trusts, NHSE spec comm gap for the Royal Brompton, removal of 16/17 CIP and the inclusion of Primary Care.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable)

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

Note: The financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

The key financial challenge that remains at 2020/21 is the deficit at the Ealing site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging. This deficit could be eliminated if acute services changes were accelerated, generating a further improvement in the sector position of £62m.

The key risk to achieving sector balance is the delivery of the savings, both business as usual and the delivery areas. There will be a robust process of business case development to validate the figures that have been identified so far and the next section of the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered.

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

5. Finance:
Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a 1% surplus for the NHS.

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

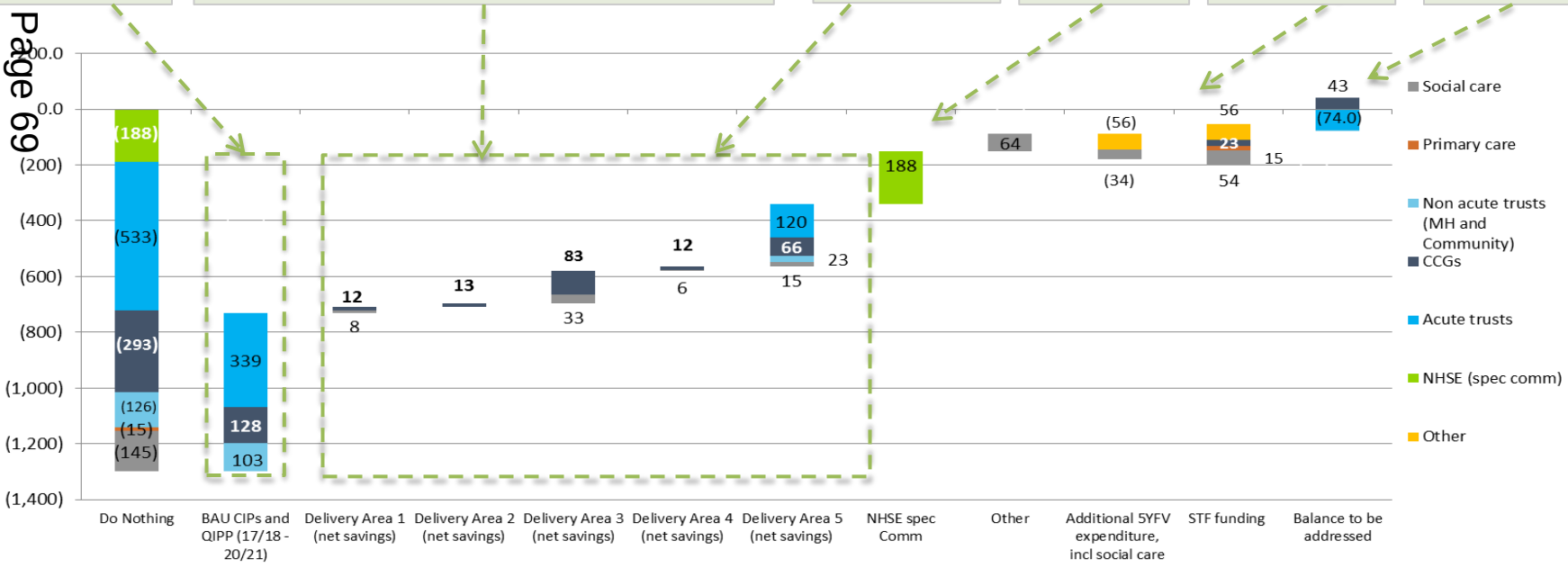
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

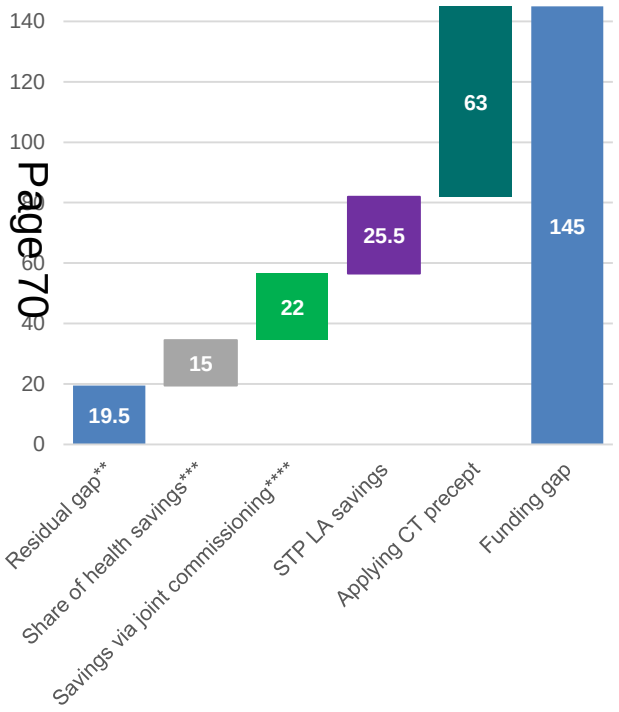
Balance to be addressed Remaining gap of £31m to be addressed – post 20/21.



5. Finance:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan
are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	-	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	-	-	-	**6.1**
Caring for people with complex needs	DA3	-	-	-	**5.1**
Accommodation based care	DA3	**7.7**	-	**7.0**	**2.0**
Discharge	DA3	**3.4**	-	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	-
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	-	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

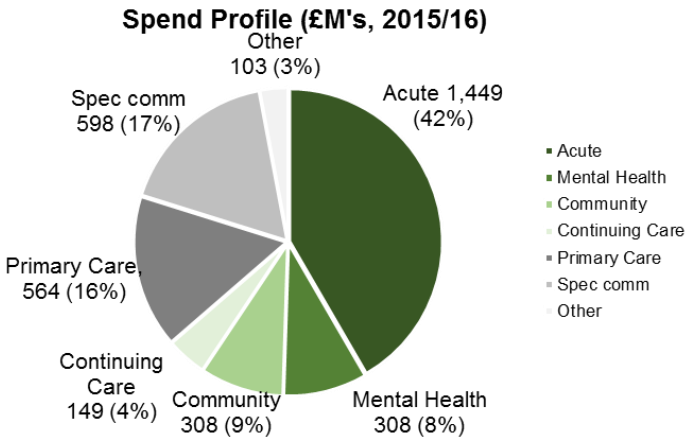
NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

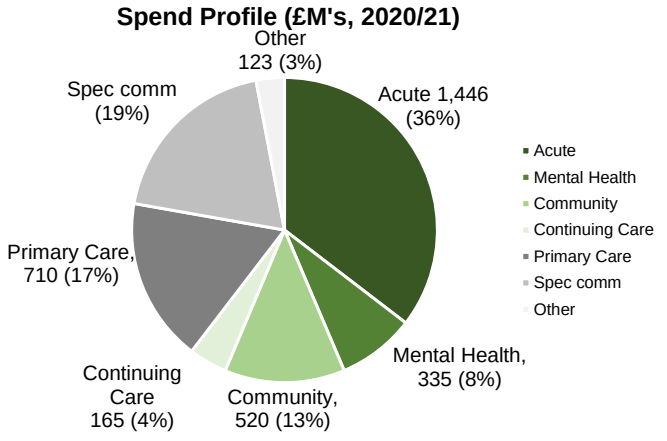
5. Finance:
STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. This is set out below, and shows our expectation of where we expect to invest the funding recurrently from 2020/21.

	16/17	17/18	18/19	19/20	20/21	
	£m	£m	£m	£m	£m	
Sustainability funding	-	112.4	82.3	61.6	0.0	
Investment in prevention and social care	-	21.0	25.0	30.0	34.0	£53.5m
Social care funding gap	-	-	-	-	19.5	
Seven day services	3.0	4.0	7.0	12.0	20.0	
Mental health transformation and invetment in services - integrated care models	0.0	10.0	10.0	13.0	20.7	
Federation and primary care development	5.0	10.0	10.0	5.0	0.0	£55.7m
Support new payment models design and implementation	3.0	10.0	10.0	5.0	0.0	
Digital roadmap	-	3.0	10.0	10.0	15.0	
Improvement resources	2.0	2.0	2.0	0.0	0.0	
Additional investment in primary care services	0.0	1.0	12.0	19.0	14.8	
Uncommitted funding	0.0	0.0	0.0	0.0	23.0	
TOTAL	**13.0**	**172.4**	**156.3**	**136.6**	**147.0**	

The charts below show how the delivery of the STP will change the commissioner expenditure profile over the next 5 years as we move from a reactive system to a proactive care model. Acute spend by CCGs reduces from 42% to 36% of total spend, while primary and community care spend increases from 25% to 30%. Mental health spend stays the same as a percentage of the total but the expenditure increases and the way in which the money is spent shifts towards community based rather than acute based interventions, enabling increased demand to be managed. Some increased mental health spend is also included within the main primary care and community expenditure totals.





5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £783m (funded by £573m from internal resources, £37m from disposals and £173m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period and the subsequent five years. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

Table 1: Do Something Capital

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	**747.9**
Disposals and contingency	-	(330.0)	-	-	**(330.0)**
Total Net Capital Requirements	**75.2**	**(82.6)**	**219.2**	**206.1**	**417.9**
Post 20/21					
Gross Capital Expenditure	252.5	1,116.0	4.5	97.1	**1,470.1**
Disposals and contingency	29.0	(681.2)	23.0	-	**(629.2)**
Total Net Capital Requirements	**281.5**	**434.8**	**27.5**	**97.1**	**840.9**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: Projected costs, land sale receipts and affordability, particularly in the second five year period, are indicative and subject to detailed business case processes

Other Additional Capital – there are additional capital cases of £303m made up of: (1) £141m for LNWH for additional investment in NPH and CMH including, ICT and EPR and other IT; (2) £53m for backlog maintenance for THH relating to the tower; (3) £79m for CNWL for strategic developments; and (4) ETTF IT Digital roadmap of £31m.

To address the sustainability challenge at Ealing hospital would require the acceleration of the capital developments and approvals process (within the 'Outer NWL'. If that were achieved the capital profile would change, with the estimated position shown below :

Table 2: Accelerated timeline

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Total Net Capital Requirements	**249.9**	**(82.6)**	**219.2**	**206.1**	**592.6**
Post 20/21					
Total Net Capital Requirements	**106.8**	**434.8**	**27.5**	**97.1**	**666.1**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: The table shows the re-phasing without any assumed inflation saving (estimated to be c. £30m)

The funding for above capital ask will be a mixture of loans and PDC, which will modelled within individual business cases.

6. How we will deliver our plan:
Our NW London Delivery Architecture

To deliver this change at scale and pace will require the system, us, to work differently, as both providers and commissioners. At its heart, this requires shared commitment to an agreed vision, a credible set of plans and the right resources aligned to those plans. We know this both from the literature but more critically through our own experiences and track record of delivery change. Therefore we are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. **Agree a joint NW London implementation plan for each of the 5 high impact delivery areas**
2. **Shift funding and resources to the implementation of the five delivery areas, recognising funding pressures across the system and ensure we use all our assets**
3. **Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities**
4. **Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital**

1. Develop a joint NW London implementation plan for each of the 5 high impact delivery areas

We will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We have built upon previous successful system wide implementations to develop our standard NW London improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges. This has been codified in the common project lifecycle, described below, with common steps and defined gateways:

Critical success factors of the standard methodology include a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. Models of care are developed jointly to create ownership and recognise local differences, and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, 7 day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures and complementary skills across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

- We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
- We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
- We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

To further support the alignment of resources we are mapping and reviewing the total improvement resources across all providers and commissioners, including the AHSN, to realign them around the delivery areas to increase effectiveness and reduce duplication. The diagram on the next page also indicates where the various delivery areas are being supported:

NW London Collaboration of CCGs Strategy & Transformation Team *Commissioner* ~ 80-100 staff	**West London Alliance Local Government** Work in progress to allocate key L G staff	**Academic Health Sciences Network (Imperial College Health Partners)** AHSN ~ 8 staff	**Provider Transformation/ Productivity (CIP)/ Integration Teams** *Providers* ~ 90 staff
DA1 a) Enabling and supporting healthier living			Business as usual CIP
	DA1 b) Wider determinants of health interventions		DA2 c) Delivering 'Right Care' priorities
	DA1 c) Helping children get the best start in life		DA4 c) Crisis support and Crisis Concordat
DA1 d) Addressing social isolation			DA5 a) Specialised Commissioning
DA2 a) Improving cancer screening			DA2 a) Improving cancer screening
DA2 b) Better outcomes and support for people with common MH			DA5 b) Delivering the '7 day standards'
DA2 d) Improving self management and patient activation			DA5 c) Configuring acute services
DA3 a) Improving market management and whole systems approach			DA5 d) NW London provider productivity programme
DA3 b) Implementing Accountable Care Partnerships (ACPs) by 2018/19			
DA3 c) Implement new models of local services			
DA3 d) Upgrade rapid response/IC services			
DA3 e) Creating a single discharge process			
			DA3 f) Improving last phase of life
DA4 a) New model of care for people with serious and long term mental health needs			
DA4 b) Addressing wider determinants of health			
DA4 d) Implement Future in Mind			
DA5 b) Delivering the '7 day standards'			
DA5 c) Configuring acute services			

Over time, we are seeking further alignment and integration between these teams, to avoid duplication and align the relevant people and skills to the most appropriate programmes of work

6. How we will deliver our plan:
Our NW London Delivery Architecture

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

- We are moving towards federated primary care primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system
- By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements
- By 20/21 we will have implemented Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

Latest progress with the provider productivity programme

Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review. These opportunities are detailed in the STP. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery the priority projects of:

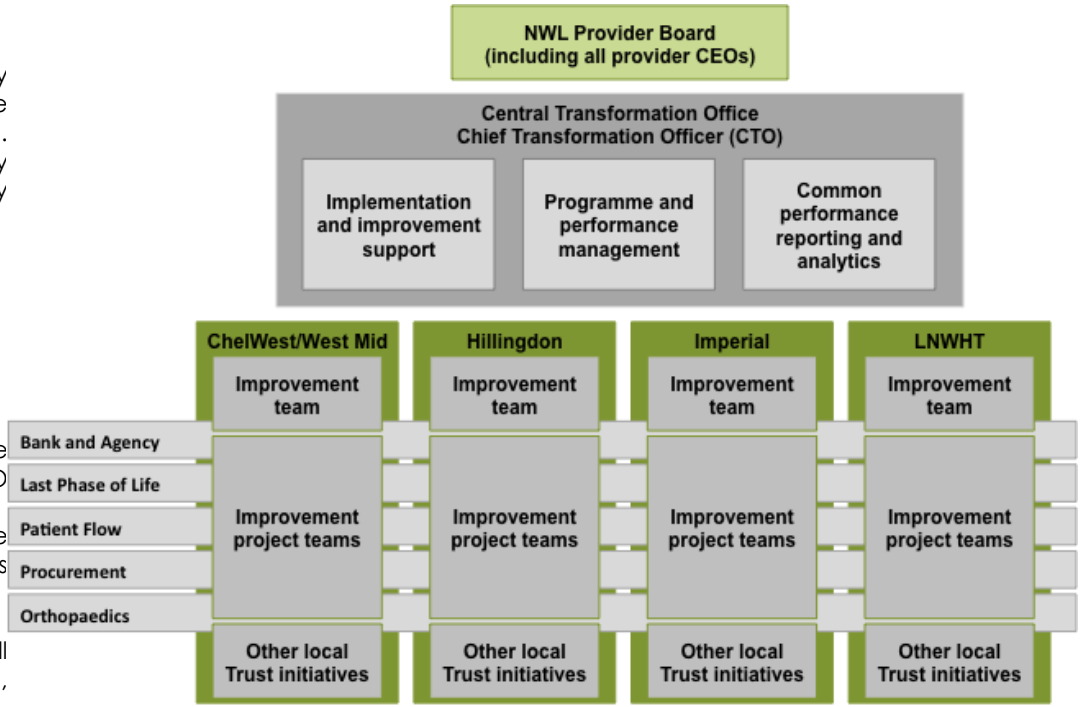
- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.

To achieve this providers are working together to:

- Recruit a sector transformation director to lead the programme, with analytics funded by CCGs and PMO provided by ICHP.
- Programme directors are now in place for all but one programmes, programme directors and project managers funded by acute trusts.

As a result savings are expected in year from procurement, all trusts expecting to deliver their bank and agency targets, planning for a pan NW London bank by the end of the year.



6. How we will deliver our plan:
Risks and actions to take in the short term

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	Development of a dashboard and trajectory, and regular monitoring of progress through joint governance Adoption of learning from vanguard and other areas	Access to learning from vanguards and other STPs
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	On-going quality surveillance to reduce risk	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	Support development of federations Early investment in primary care through joint commissioning Identification and support to vulnerable practices Digital solutions to reduce primary care workloads	Clarity about future of and funding for GMS and PMS core contracts
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	Development of joint market management strategy On-going support to homes to address quality issues	
Can't get people to own their responsibilities for their own health	Self care and empowerment	Development of a 'People's Charter' Work with local government to engage residents in the conversation	National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints	Finance and estates	Submit a business case for capital in summer 2016 Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment.	Support for retention of land receipts for reinvestment, and potential devolution asks.
We are unable to access the capital required to increase capacity at the receiving hospitals quickly enough to address the sustainability issues at Ealing hospital	Finance and estates	Submit a business case for capital in summer 2016 that sets out the clinical and financial rationale to accelerate the timeline	Support for an accelerated timeline for the capital business cases
We are unable to recruit or retain workforce to support the old model while training and transforming to the new model of care	People and workforce	Development of workforce strategy, close working with HEENWL	

6. How we will deliver our plan:
Risks and actions to take in the short term

Risks	Category	Proposed mitigations	Support from NHSE
There is resistance to change from existing staff	People and workforce	OD support and training for front line staff Wide staff engagement in development of new models to secure buy in	
Providers are unable to deliver the level of CIPs required to balance their financial positions	Finance and sustainability	Establishment of new sector wide improvement approach to support the delivery of savings	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	Establishing a new political relationship and reflecting this in enhanced joint governance, taking a 'whole systems view' to investment and market management	
BI systems aren't in place to enable shifts of activity through integrated care	Information and technology	Work within new national standards on data sharing to support the delivery of integrated services and systems.	NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality
Lack of interoperability in our primary and community IT systems, EMIS and SystmOne, which prevents shared care records which support integrated care	Information and technology	Keep pressure up on supplier to deliver open interfaces.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	Work closely with partners to understand the 'Brexit' implications and provide staff with support to ensure they feel valued and secure.	Early clarity of impact Political messaging to staff

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
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7. References

Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
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7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	25-26	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
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Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	29-31	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
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7. References

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Enablers: Digital	37-38	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

NHS Brent Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

NHS Harrow Clinical Commissioning Group

NHS Hillingdon Clinical Commissioning Group

NHS Hounslow Clinical Commissioning Group

NHS West London Clinical Commissioning Group

Brent

Harrow Council

Hillingdon

London Borough of Hounslow

The Royal Borough of Kensington and Chelsea

City of Westminster

West London Mental Health NHS Trust

Central and North West London NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

London North West Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Hounslow and Richmond Community Healthcare NHS Trust

The Royal Marsden NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust

London Ambulance Service NHS Trust

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

NHS Health Education North West London

NHS England

NHS National Institute for Health Research Clinical Research Network North West London

Imperial College Health Partners

wla West London Alliance

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City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	General Release
Title:	Family Hubs
Report of:	Cabinet Member for Adults and Public Health; Cabinet Member for Children and Young People
Wards Involved:	All
Policy Context:	*Healthier City, Healthier Lives: Joint Health & Wellbeing Strategy 2012-1206* priority one: every child has the best start in life
Financial Summary:	N/A
Report Author and Contact Details:	Melissa Caslake, Director of Family Services mcaslake@westminster.gov.uk Mike Robinson, Director of Public Health mrobinson4@westminster.gov.uk

1. Executive Summary

1.1. This report outlines the proposed direction of travel for developing a series of new Family Hubs that will improve access to preventative services (both universal and targeted). The services provided from these hubs will support families to understand and make effective changes that ultimately improve their health and wellbeing.

1.2. We outline below the proposed objectives for the new Family Hubs, the outcomes they will look to achieve, the services they will offer to families, and the next steps needed to move towards implementation.

2. Recommendations

2.1. The Board is invited to:

- Endorse the proposed direction of travel and commit to a joint programme of work to develop a detailed specification for the services that will be delivered as part of the new Family Hubs
- Consider how GPs can be closely involved in the development of the new Family Hubs and, in particular, how the new service offer could provide a single pathway for them to identify and support at risk families

3. Key Matters for the Board

3.1. The proposed Family Hubs will be a 'virtual' network of providers working with children 0 – 19 years, who share a single approach to working with families across a given area. All providers will be working to a shared purpose and outcomes framework. It is proposed that this network of provision will bring together the Early Help (including Troubled Families) offer from Children's Services, the Health Visiting and Family Nurse Partnership offers from Public Health, the joint Child and Adolescent Mental Health Service (CAMHS) offer from Central London CCG (CLCCG) and West London CCG (WLCCG) and Public Health, and the offer from GPs.

3.2. We will use our existing children's centre hub buildings to strengthen this integration and partnership working across commissioned and directly delivered services by Children's Services, Public Health, Housing and the CLCCG and WLCCG. This will provide the opportunity to bring families into a physical building, a focal point in the community where they can access help and information. The centre will also provide a space co-ordinate a range of services which will be delivered at venues across the locality.

3.3. The aim will be, through the network, to identify families with complex needs as early as possible, no matter what service they first come into contact with. This will make sure that any contact with a practitioner in the network will lead to the right intervention at the right time, with greater accountability across all agencies for identifying need earlier; leading to families understanding and making effective changes that ultimately improve their health and wellbeing.

Proposed outcomes

3.4. The key outcomes that the Family Hubs will look to achieve will be to:

- Reduce referrals to higher level interventions, including CAMHs, social care, GP consultations, youth justice, and Housing Options, by reaching families earlier and working with families to make lasting change.

- Prevent family breakdown that results in children and young people being received into care or entering the criminal justice system.

- Promote strong and resilient parents, with support to gain employment.

- Improve outcomes for children and young people across health and well-being indicators. These will include obesity, breastfeeding rates, oral health, immunisations, emotional well-being of adolescents.

Outline offer from the new hubs

3.5. To achieve these outcomes, it is proposed that the following core offer – integrating Children's Services, Public Health and CCG activity – is provided from each of the hubs:

- Integrated early years support for parents, consisting of: antenatal care, health visiting and child health clinics and early learning opportunities. Aimed at identifying families with complex needs much earlier.
- One-stop access for universal services, such as birth registrations, re-enforcing the 'hub' as the go to place for help.
- Parenting interventions with a new focus on relational support. This will be co-ordinated from within the hub and delivered across the area. Westminster is one of 12 local authorities piloting a new 'family offer' to support the couple relationship.
- Outreach to the harder to engage families.
- Access to first line mental health support – IAPT and CAMHs.
- Employment support offering meetings with the employment coach.
- Housing advice – test the co-location of Housing Options in one of the hubs from September.
- Information about childcare – all providers will promote the free early education places at two years.
- Adult education – ESOL and preparation for employment.
- Develop of community asset-based approaches – for instance, the development of peer support programmes for breastfeeding and parenting support

Implementation

3.6. To achieve the integration that is needed we will develop a shared outcomes and operating model across all early help providers - health visiting, school health services, children's centres, commissioned services, children's social care, housing and employment staff and wider partners for example schools, police,

CAMHs and the voluntary sector. This will be underpinned by better data sharing, one assessment process across all agencies, one family plan with structured progress monitoring and accountability(rather than a multitude of plans held in different agencies) closer integration between family work and employment support and opportunities.

3.7. In the short term, and alongside this wider systems change, we will implement a number of quicker changes to deliver immediate improvements to how preventative services are accessed:

- We will improve communication between practitioners working with 0-19 year olds, including early help social workers, school health services and health visitors. This should include the introduction of a new 'universal assessment tool' that all front-line workers use to capture actionable information and identify specific concerns or 'red flags' to enable fast tracking to a specialist intervention service where required.

- We will make the three new 0-19 Family Hubs one of the key locations in the community from which the School Health Teams as an agile and efficient workforce will be able to work from when they are not based in schools. The Family Hubs will provide touch-down office space and private consultation space which will ensure that the School Health service is an integral part of the partnership of providers working with children, young people and families and will contribute to improve early identification of needs and access to preventative support.

- We will provide a training package to all frontline workers operating in and around the new Family Hubs to embed expectations that all practitioners take responsibility and feel accountable for acting in the best interest of children, young people and families no matter who they are employed by. This training would be based on the ethos behind the Focus on Practice training undertaken by social workers and rolled out with the launch of the new Hubs.

Timetable

Date	**Activity**
2016/17	New early help hubs open with immediate improvements (outlined above) implemented
Summer / autumn 2016	Shared outcomes and operating model developed across all early help providers - health visiting, school health services, children's centres, commissioned services, children's social care, housing and employment staff and wider partners
Autumn/winter	First elements of new service offer become operational with rolling

2016/17	implementation of the full operating model
Autumn/winter 2016/17	New school health services commissioned
Autumn/winter 2016/17	New Health Visiting service commissioned
Spring 2019	Fully integrated 0-19 service offer operational

4. Legal Implications

4.1 None at this time.

5. Financial Implications

5.1 None at this time.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Jayne Vertkin, Head of Early Help Services

Email: jvertkin@westminster.gov.uk

Telephone: 020 7641 5745

APPENDICES:
None

BACKGROUND PAPERS:
None

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City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	General Release
Title:	Children and Families Act Implementation and Preparation for Local Area Inspection
Report of:	Ian Heggs, Director for Education
Wards Involved:	All
Policy Context:	Following the implementation of the Children and Families Act in September 2014, the Special Educational Needs Service has been working in partnership with Children's and Adults' Social Care, Health partners, Parent Carer Forums and education settings to deliver the transformation needed to implement this legislation by April 2018.
Financial Summary:	No financial implications
Report Author and Contact Details:	Steve Comber, Strategy Partnership and Organisational Development. 07739 317 307 steve.comber@rbkc.gov.uk

1. EXECUTIVE SUMMARY

1.1 Following the implementation of the Children and Families Act in September 2014, the Special Educational Needs Service has been working in partnership with Children's and Adults' Social Care, Health partners, Parent Carer Forums and education settings to deliver the transformation needed to implement this legislation by April 2018.

1.2 We are also preparing for an upcoming local area inspection by Ofsted and the Care Quality Commission, which will test the effectiveness of our delivery of the new legislation.

2 KEY MATTERS FOR THE BOARD

2.1 The Health and Wellbeing Board are requested to:

- Consider the actions that can be taken to reduce the time required to provide health advice to inform the 20-week assessment process for Education, Health and Care Plans
- Consider how pathways can be developed for the early identification of children aged 0-5 with SEND
- Consider how the local offer of health provision for young people aged 16-25 can be developed
- Consider the involvement of CCG leads in the joint planning for the Local Area Inspection of provision for 0-25 year olds with SEND.

3 IMPLEMENTING CHILDREN AND FAMILIES ACT CHANGE PROGRAMME

3.1 The requirements of the Children and Families Act, which came into effect from 1 September 2014, represent some of the most significant changes to the way that services are delivered for young people with special educational needs (SEN) in the past 30 years.

3.2 The changes aim to improve cooperation between **all education, health and social care services** and introduce a person-centred approach to supporting children with special educational needs and disabilities and their families

Education Health and Care Plans

3.3 'Statements' of SEN have been replaced with a new outcome focused 'Education, Health and Care plan', which may be maintained by the Local Authority for an extended age range (from birth to 25).

3.4 The decision as to whether to issue an Education Health and Care Plan is made as part of a joint assessment process which considers the education, health and social care needs of the child or young person. If a plan is required, the full 20-week assessment process is undertaken to establish the outcomes that the child or young person will be working towards, the support that is required and the resources that will deliver this.

3.5 During the first full year of operation (January 2015 – December 2015), Westminster has processed 25 new Education Health and Care Plans. Of these, the national SEN2 data shows that only one or two (c.4%) were completed within 20 weeks, compared with 59.2% nationally.

3.6 Local authorities have to undertake 'transfer reviews' for all children and young people who currently have statements that were issued under the previous legislation. These reviews are undertaken to establish whether an EHC Plan should be issued under the new legislation and, if required, to agree the support and resources that are included in the new plan. It is expected that all children who have a statement of SEN will have an EHC Plan, unless the young person is no longer in education.

3.7 All transfer reviews have to be completed by April 2018 and, as of December 2015, Westminster had completed 1.1% of their total, compared with a national average of 18.2%. We are currently putting additional interim resource in place to ensure that future transfer reviews are completed in a timely fashion and to a high standard. This will be funded by Westminster City Council.

3.8 A key issue to be addressed jointly by the local authority and health partners is reducing the time taken by paediatricians to provide health advice for the 20-week EHC assessment process.

The Local Offer

3.9 It is a statutory requirement for all Local Authorities to publish a 'Local Offer' that outlines the services that are available to children with Education, Health and Social Care needs.

3.10 The delivery of our offer for children aged 5-16 is generally going well and is of high quality. However, we have identified a need to improve our early identification pathways and the offer for children aged 0-5 (including the receipt and use of health notifications) and to increase our overall offer of provision for young people aged 16-25.

Co-production

3.11 Co-production is a key aspect of the new legislation and it is the responsibility of the local authority to ensure that the views of parents and young people are included in any strategic planning and decision making.

3.12 We are committed to this approach and the development of the SEN Service has been predicated on this model. We have worked closely with the local Parent Representative Group, Westminster Parent Partnership Group, in order to provide opportunities for parents to actively inform the development of services for children with special educational needs and disabilities. including the development of a Parent Reference Group, which was set up in April 2014.

3.13 Our practice when assessing young people and drafting their Education Health and Care Plans has been designed to incorporate an individualised co-production approach. This includes the scheduling of 'drafting meetings' whereby parents, carers and young people come together with key workers to discuss the outcomes that they would like to achieve and the best means by which these can be achieved within the local offer.

Joint Commissioning

3.14 A Commissioning Strategy is being developed as part of a joint commissioning project with Children with Disabilities Services, Health and Adult Social Care, which includes plans for areas such as Speech and Language Therapy and Occupational Therapy. For more details on this, please see Appendix 1.

Transition to Adulthood

3.15 The extension of some Education Health and Care Plans to the age of 25 means that there is a need for local authorities to quantify the number of young people in a local area who are approaching transition at 16 and at 19 years of age and will qualify for an Education Health and Care Plan and, on the basis of this demand, will need to develop the education, health and social care local offer to support the transition to adulthood, including planning for young people's employment and independence in or near their local community. See Appendix 2 for more details regarding this.

4 PREPARING FOR THE LOCAL AREA INSPECTION OF PROVISON FOR 0-25 YEAR OLDS WITH SEND

4.1 Following the implementation of the Children and Families Act, the Department for Education has requested that Ofsted and the CQC inspect local areas on their effectiveness in fulfilling their new duties. The inspections are resourced by additional funding provided specifically for the purpose and are part of the DfE's broader national accountability framework.

4.2 The inspection is **not** an inspection of individual providers or settings but rather makes a judgment on how well education, health and social care services work together as a 'local area', to improve outcomes for children and young people aged 0 – 25 years with a special educational need and/or disability. As such it incorporates a wide range of stakeholders including early years settings, schools & colleges, community and specialist health services, the Disabled Children's Team and third sector organisations.

4.3 Furthermore, it is not just an inspection of the provision for young people with EHC Plans, but will encompass the offer for young people with broader needs for SEN support – including the impact of Early Intervention Provision in the local area.

4.4 The current arrangements are that an inspection team of three inspectors (1x Ofsted, 1x CQC and 1x Local Authority Peer) will be on site for five days. There will be a five-day notice period for an inspection, with the following arrangements for an announcement:

- The lead HMI will normally contact the local authority's director of children's services (DCS) by telephone to announce the inspection. This notification call will normally take place between 9am and 10am. The lead HMI will make arrangements to speak with the director's nominated officer for the inspection as soon as possible in order to make the necessary arrangements for the inspection. The nominated officer should be the single point of contact for the lead HMI. Together, they will manage the coordination of the inspection.
- Once the lead HMI has contacted the local authority, the CQC inspector will contact the chief executive(s) of the clinical commissioning groups (CCG) to inform them of the inspection and to make necessary arrangements for the local health services' contribution to the inspection.

4.5 The inspection will not result in a graded judgement. Instead, the local area will receive a narrative report of what is working well and what needs to improve. This report will name specific organisations, such as the LA, the CCGs and other local stakeholders if necessary.

4.6 The focus of the inspection is threefold:

1. How effectively does the local area identify children and young people who are disabled and/or have special educational needs?
2. How effectively does the local area assess, plan for and meet the needs of these children?
3. What is the evidence that services are having a positive impact on improving outcomes for these children and young people and helping them making a successful transition to adult life?

4.7 These judgements are to be made about the performance of the local area since the implementation of the reforms in September 2014.

4.8 We are currently in a five-year cycle of inspections, and the expectations on the progress that local areas will have made will increase between 2016 and 2021. The table below sets out how the DfE propose to measure success at a national level:

	Positive experience of the SEND system for children, young people and their families	Positive outcomes for children, young people and their families	Effective preparation for adulthood
What does success look like?	- Parents, children and young people get right support at right time; feel that they are listened to and in control - Planned and well-managed transition at key points - A joined-up, transparent and accountable system	- Improved progression and attainment at all ages - Clear and appropriate expectations and aspirations leading to fulfilled lives - More resilient families	- Increased employment - Choice and control over living arrangements / Independent living - Participation in the community - Health outcomes based on need and aspiration
Examples of data and intelligence	- SEN appeals and outcomes - Education, Health and Care Plans (EHCPs) completed on time - Local authority and parent survey data - Children and young people's Personal Outcomes Evaluation Tool (POET) pilot - Feedback from Independent Supporters	- Attainment data - Outcomes for looked after children - Destinations after Key Stage 4 & Key Stage 5 - School absence and exclusion rates	- Employment status for adults with learning difficulties and disabilities (LDD) - Accommodation status for adults with LDD
When do we expect to see an impact?	**Short/medium term:** From Sept 2014 to Sept 2017	**Medium/long term:** 3 to 5 years' time	**Fully emerge:** 5 to 10 years' time

4.9 Inspectors will start the inspection expecting that the local area has a good understanding of how effective it is, including of any aspects of its responsibilities that require further development.

4.10 Inspectors will test out the evidence that the local area uses in its **self-evaluation of how effectively it meets its responsibilities**. Inspectors will report where evidence collected during the inspection supports the area's own evaluation, and where this is not the case. They will also report on where the local area does not have a good enough understanding of its effectiveness in identifying needs, and in meeting these needs and improving outcomes.

Local preparation

4.11 Work is underway to prepare for the SEND Local Area inspection including:

- The establishment of a SEND Quality Assurance Board to oversee the local implementation of the Children and Families Act, and planning for inspection. The Board includes representation from service mangers and commissioners

across children's and adults Health and social care, Head teachers and parent representatives.

- An analysis of the risk of an early inspection of the local area based on current performance against key indicators set out by Ofsted/CQC: results of previous inspections, educational and other outcomes for children and young people with SEN, rates of attendance and exclusion, success in meeting statutory timescales for assessment and level of appeal to tribunals.
- Assurance of key datasets about children and young people with SEN or a disability and defining clear procedures and responsibilities during the inspection process.

4.12 The priority over the coming months is to build our understanding of the strengths and areas for improvement in services for children with special educational needs and/or disabilities:

- Producing a summary self-evaluation of effectiveness and ensuing action plan for each borough. We will consult on this with key stakeholders including parents' groups, schools and health partners.
- Working with parents and carers to review how well current arrangements support their meaningful involvement in decisions about local services as set out in the Children and Families Act.

4.13 A dedicated project manager is in place (working within the wider Children and Families Act Implementation Programme) to manage the preparation for the inspection.

4.14 Preparation is proceeding on the assumption that all three boroughs will be inspected at the same time (to be confirmed) and that we will need to plan on this basis, whilst ensuring that we maintain a focus on the particular strengths and weaknesses in each borough.

5 RECOMMENDATION(S)

5.1 It is recommended that members of the Health and Wellbeing Board consider the contents of this paper, particularly with regards to how their organisation can contribute to (or is effected by) the implementation of the Children and Families Act and the Local Area Inspection.

6 EQUALITY IMPLICATIONS

6.1 As this report is for information only, there are no equality implications to be considered at this stage.

7 LEGAL IMPLICATIONS

7.1 As this report is for information only, there are no legal implications to be considered at this stage.

8 FINANCIAL AND RESOURCES IMPLICATIONS

8.1 As this report is for information only, there are no financial and resources implications to be considered at this stage.

If you have any queries about this Report or wish to inspect any of the Background Papers, please contact:

Steve Comber, Strategy, Partnership and Organisation Development Officer

Email: steve.comber@rbkc.gov.uk

Telephone: 07739 317 307

Appendix 1

1 JOINT COMMISSIONING STRATEGY

1.1 A Commissioning Strategy is being developed as part of a joint commissioning project with Children with Disabilities Services, Health and Adult Social Care. The work to develop the SEN strand of this strategy has been supported by the Management Consultancy, Ernst and Young.

1.2 The work to develop the SEN Commissioning Strategy was driven by data analysis, qualitative discussion and feedback from the service and the outputs of previous and/or existing projects and reviews.

1.3 Delivery of this work was split into three strands:

- Initial high level assessment of key service areas
- Analysis of current and projected future demand for services
- Development of a commissioning strategy to identify opportunities in response to the identified demands

1.4 The analysis undertaken by Ernst and Young for the SEN Service highlighted the following key priority areas for focus across, Westminster, Hammersmith and Fulham and Kensington and Chelsea around demographics, the type of needs and cost of provision:

- The proportion of the SEN cohort at secondary age will increase over five years. The number of 11-15 year olds will grow by 18% by 2020
- Autistic Spectrum Disorder is the primary need for 29% of all current statements / EHCP and demand for this support will remain high
- Speech, Language & Communications Needs in Three Boroughs is double the national proportion of statements / EHCPs
- Independent and non-maintained school provision outside of the local area costs 3.5 times more than state funded local provision

1.5 On the basis of these key priority areas, opportunities are being developed on the basis of the following priority areas:

- Increased demand
- A wider age range
- Autism spectrum disorder needs
- Speech Language and Commination needs
- High cost places

1.6 We are currently finalising the plans for taking these opportunities forward jointly with colleagues in Health and Adult Social Care. The identified priority areas to be addressed are as follows:

- Therapies (Speech and Language Therapy, and Occupational Therapy)

- Early Identification Pathways
- Personal Budgets
- SEN Outreach
- Externally commissioned short breaks
- Residential placements

Appendix 2

1 TRANSITION TO ADULTHOOD

1.1 The extension of some Education Health and Care Plans to the age of 25 means that there is a need for local authorities to quantify the number of young people in a local area who are approaching transition at 16 and at 19 years of age and will qualify for an Education Health and Care Plan and, on the basis of this demand, will need to develop the education, health and social care local offer to support the transition to adulthood, including planning for young people's employment and independence in or near their local community.

Planning for adulthood

1.2 In order to ensure that the Special Educational Needs Service, the Children with Disabilities Service and Adult Social Care are working together in order to develop robust transition plans for all young people age 14 and above, a Young Person's Tracking Meeting has been established. The meeting will review cases across Westminster as well as Hammersmith and Fulham and Kensington and Chelsea. The key activities the group are as follows:

- To identify all young people who are aged 13-25 years old and may be eligible for adult's services
- To identify what services young people may be requiring and to identify gaps in service provision and ensure that these are considered in strategic planning
- To ensure that the health needs of young people in transition are planned for and ensure they have a Health Action Plan, or Continuing Healthcare assessments, as appropriate.
- To ensure that young people get advice and or support from an appropriate resource
- To establish eligibility for specialist adult services in line with the Care Act 2015

Developing local employment opportunities for young people with special educational needs and disabilities

1.3 An internal working group has been established across Children's Services, Adult Social Care and Public Health to agree Terms of Reference and key milestones for a Supported Employment Provider (SEP) Network.

1.4 Membership of the SEP Network will include parent/carers, Schools, Colleges, Supported Employment Providers, Job Centre Plus, Housing, Economic Development, Volunteer Centre and Education Business Partnership and first meeting to take place at end of July 2016.

1.5 Four key priorities for the SEP Network will be;

- Developing a ‘Supported Employment Pathway’ on the Local Offer (who to go to get support in looking for a job, benefits advice whilst working and job coaching support). This work will be developed with young people and their families.
- Finalising the Supported Employment Strategy across Education, Health and Adult Social Care
- Developing data systems and recording processes for all education and training providers which enable us to give a meaningful and accurate picture of numbers of young people with SEND into employment and of our improvement year on year
- Jointly develop performance indicators for all providers involved in the supported employment pathway so we can continue to improve our Local Offer for young people with SEND and their families

1.6 Progress to date;

- We have a new provider - Alexandra College (based in Camden, providing a regional offer) which provides an education pathway for young people with more complex needs to support the development of skills for independence and enabling access to opportunities for supported employment whenever possible.
- Queensmill, a special school in Hammersmith for children with autism, will be extending its recent 19-25 years education pilot offer from September 2016. This will be delivered at Options Day Centre and will jointly develop their work experience and internship model to benefit both young people with complex autism and the adults utilising the Day Centre.

City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	**General Release**
Title:	Public Health Vision Statement
Report of:	Director of Public Health
Wards Involved:	All
Policy Context:	The Director of Public Health has worked with the Cabinet Member for Adults and Public Health to produce a Public Health Vision for Westminster City Council.
Financial Summary:	Not applicable.
Report Author and Contact Details:	**Ann Ramage, Bi-borough Head of Environmental Health** Ann.Ramage@rbkc.gov.uk

1. Executive Summary

1.1 The Health and Wellbeing Board is asked to note Westminster City Council's Public Health Vision. Work has been carried out with the Cabinet Member for Adults and Public Health to develop a Public Health Vision that is aligned to the Council's health strategies.

2. Key Matters for the Board

The Board is requested to:

- Consider and provide feedback on the draft Public Health vision document included as Appendix 1;

- Note the alignment of the Public Health Vision with the emerging Joint Health and Wellbeing Strategy and the North West London Sustainability and Transformation plan.

3. Background

3.1 The Director of Public Health together with the Cabinet Member for Adults and Public Health have drawn on the work in various strategic health and care documents to produce a Public Health Vision.

3.2 The Vision has been produced using existing documents and strategies which include;

- City for All - Year 2
- Joint Health and Wellbeing Strategy for Westminster
- North West London Sustainability and Transformation Plan
- Westminster Health Profile 2015
- Improving our Public's Health (Public Health Strategy)

The main task was to ensure that the Public Health Vision was consistent with the Joint Health and Wellbeing Strategy and other related strategies. The health priorities regarded as cross cutting priorities for both the Council and health and care partners have been collated into a Public Health Vision which is contained at Appendix 1.

3.3 The Health and Wellbeing Board is asked to note that the priorities outlined in the Vision are consistent with the Joint Health and Wellbeing Strategy and the North West London Sustainability and Transformation Plan and other relevant Council strategies. In particular there is consistency in highlighting the importance of health priorities in respect of children and young people, improving the management of long term conditions such as dementia, improving mental health, and creating a sustainable and effective health care system that tackles health inequalities.

4. Going Forward

4.1 In order to raise the profile of the Council's public health priorities the website is in the process of being updated and will contain the Public Health Vision

4.2 Further work is now in progress to produce a refresh of 'Improving our Public's Health' (the Public Health Strategy). This strategy has more detailed information

which expands on the priorities in the Vision and will be helpful to the public. This will also be added to the Council's website in due course.

5. Legal Implications

5.1 Not applicable.

6. Financial Implications

4.1 Not applicable.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Ann Ramage, Bi-borough Head of Environmental Health
Email: Ann.Ramage@rbkc.gov.uk

Telephone: 02073415612

APPENDICES:

Appendix 1 Public Health Vision 2016 - 2020

BACKGROUND PAPERS:

City for All - Year 2
Joint Health and Wellbeing Strategy for Westminster
Westminster Health Profile 2015
Improving our Public's Health 2015-2025

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PUBLIC HEALTH VISION 2016 - 2020

WESTMINSTER CITY COUNCIL

THE VISION

We have a vision that all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.

AMBITIONS TO DELIVER THE VISION

We will work with our colleagues within the council, the NHS and others to improve and protect health and wellbeing and to reduce the health inequalities within Westminster. Our focus will be;

1 To reduce childhood obesity and increase the number of children that leave school with a healthy weight.

2 To promote the importance of the wider determinants of health and wellbeing especially work or another clear sense of purpose within a community, and overcoming mental and physical health barriers to employment.

3 To design and deliver services that have the biggest impact on prevention, early intervention and early help where it is needed. A focus on dementia, reducing the stigma and fear associated with dementia and creating dementia friendly communities which support and include people with the condition and their carers.

4 To work with others to ensure that housing supports a healthy and independent lifestyle, supports the most vulnerable into safe housing and reduces homelessness, as a safe and secure home is a fundamental determinant of good health.

5 To improve mental wellbeing by promoting self care and sign posting to preventative and joined up services.

6 To provide public health services to the highest possible standards in terms of outcomes and reducing health inequalities.

We will work with others to deliver these ambitions through the Joint Health and Well being Strategy.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	**General Release**
Title:	Draft Rough Sleeping Strategy 2017-20
Report of:	Julia Corkey, Director of Policy, Performance and Communications Ed Watson, Executive Director of Growth, Planning and Housing
Wards Involved:	All
Policy Context:	Rough Sleeping Strategy
Financial Summary:	As set out in section 6.1.
Report Author and Contact Details:	Sarah Monaghan – Principal Policy Officer Richard Cressey – Principal Policy Officer Jennifer Travassos – Senior Manager of Rough Sleeping

1. Executive Summary

1.1 This report provides background information for the presentation which the Health and Wellbeing Board will receive about the health related objectives in the draft Rough Sleeping Strategy 2017-2020.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board will receive a presentation on the health related objectives in the draft Rough Sleeping Strategy 2017-2020, which is planned to go out for public consultation later in the month.

2.2 The Health and Wellbeing Board will be asked to provide early comments on the health-related objectives in the strategy. Comments from the Board collectively and from individual members during the consultation stage would be greatly welcomed.

3. Background

3.1 Westminster has more rough sleepers than anywhere else in the country, with 2,857 identified on its streets in 2015/16. The current 2013-16 strategy is due to expire; a new strategy is being drafted to cover the next three years. This builds on the achievements and best practice that are already in place. At its centre is recognition that rough sleeping is dangerous and damaging to health for those concerned, and that it has wider impacts on community wellbeing. The programme therefore focuses on both diverting and preventing people from rough sleeping, but also supporting those already living on the streets to improve their lives.

4. Considerations

4.1 Rough sleepers have higher rates of physical and mental health problems than the general population. Some aspects of poor health are attributable to, and exacerbated by, sleeping rough. Some can also play a role in becoming homeless in the first place, such as substance misuse and mental health problems.

4.2 National research identifies common health needs of homeless people – treatment and care for substance misuse, mental ill-health and dual diagnoses that cover both mental illness and substance misuse. This is supported by the self-assessments of former rough sleepers in our accommodation services and evidence from our Joint Strategic Needs Assessment of Rough Sleepers Health and Healthcare carried out in 2013[1].

4.3 Over the course of the last strategy period 2013-2016, there have been great strides made in addressing health issues related to rough sleepers, with considerably effective joint working with CCGs. For example, the Integrated Care Network has been successful in providing physical and mental health bed spaces in our hostels for people who need extra support, in order to support patients discharged from hospital and reduce admission to hospital. The use of Homeless Health Peer Advocates to support service users to navigate the health system has also been successful. These innovations are having an impact - 99% of people in the rough sleeping pathway and over 90% of our core rough sleepers on the streets are now registered with a GP. Over the course of the period covered by the new strategy, it is proposed that this work will continue, but also with a particular focus on addressing mental health issues and tackling the sharp increases in the use of 'novel psychoactive substances' (NPS) - often known as

[1] http://www.jsna.info/document/rough-sleepers

'legal highs' - including 'spice'. The Health and Wellbeing Board will receive a presentation on the specific health-related proposals.

4.4 The draft strategy also aligns with the priorities on rough sleeping in the draft Health and Wellbeing Strategy, to build on the expertise within Westminster to deliver better health and wellbeing outcomes for those individuals.

5. Legal Implications

5.1 There are no direct legal implications arising from this report or presentation.

5.2 The recently enacted Psychoactive Substances Act 2016 bans the production, supply and importation of the 'novel psychoactive substances' (NPS) referred to in 4.3.

6. Financial Implications

6.1 The council spent £6.4m in 2015/16 on rough sleeping commissioned services.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Sarah Monaghan – Principal Policy Officer

Email: smonaghan@westminster.gov.uk

Telephone: 0207 641 2286

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City of Westminster

Westminster Health & Wellbeing Board

Date:	15 September 2016
Classification:	**General Release**
Title:	Housing Support and Care JSNA
Report of:	Mike Robinson, Director of Public Health
Wards Involved:	All
Policy Context:	To support the Health and Wellbeing Board statutory duty to deliver a Joint Strategic Needs Assessment
Financial Summary:	There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.
Report Author and Contact Details:	Anna Waterman Awaterman2@westminster.gov.uk or 020 7641 4651

1. Executive Summary

1.1 This report presents the key findings and recommendations from the Joint Strategic Needs Assessment (JSNA) on housing support and care. The JSNA focuses on integrated solutions to shared problems.

1.2 There is considerable activity already in place in Westminster which seeks to address the challenges of providing housing support and care. The recommendations in this JSNA build on this activity and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders to ensure that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

2. Key Matters for the Board

2.1 It is recommended that the Health and Wellbeing Board consider and approve the Housing support and care JSNA and its recommendations for publication.

2.2 It is recommended that the Health and Wellbeing Board members ensure that the recommendations arising are incorporated into delivery strategies for the Sustainability and Transformation Plan, the Joint Health and Wellbeing Strategy and existing programmes such as Whole Systems Integrated Care and Like Minded.

2.3 It is recommended that the Health and Wellbeing Board champion progress on the 'foundation stones' outlined in section 8, particularly:

- joint commissioning and pooled budgets (8.1),
- IT data sharing protocols and information governance (8.2), and
- Smooth customer journeys between services.

2.4 It is recommended that the Health and Wellbeing Board add the Housing support and care JSNA as a standing item for review every 6 months.

3. Background

3.1 The Health and Social Care Act 2012 placed the duty to prepare a JSNA on Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) through the Health and Wellbeing Boards (HWB). Local governance arrangements require final approval from the Health and Wellbeing Board prior to publication.

3.2 This deep dive JSNA considers integrated approaches which support the provision of housing support and care for residents of Westminster, focussing on challenges which can only be addressed through collaborative working. It explores the ways in which collaboration can improve customer journeys and value for money, and prevent or delay deterioration in health and wellbeing, and mitigate the impact of such deterioration.

3.3 The JSNA offers recommendations that support and enable the delivery and implementation of local and national strategy and policy, including:

- The North West London Sustainability and Transformation Plan (STP) recognises poor housing and isolation as key risk factors for health and wellbeing, and the first delivery area is 'Radically upgrading prevention and wellbeing'.
- The draft Joint Health and Wellbeing Strategy makes a commitment to ensuring that "the built environment enables people to make choices that support their health and wellbeing. This includes aiming to ensure that housing is appropriate for different needs and life stages." The Strategy also

references the need for good quality and appropriate housing/accommodation in each of the three priorities.

- The Whole Systems Integrated Care and Like Minded CCG programmes focus on integrated partnership working and joined up services
- The Care Act 2014 and the NHS 5 Year Forward View have shifted the focus for health, housing, and social care to prevention as demand for services is expected to increase.

4. Considerations: Key themes of the JSNA

4.1 There is a strong evidence base for the links between housing, health and wellbeing: good quality and appropriate housing is crucial to enabling people to stay healthy and well. Poor quality housing and homes which do not lend themselves to care at home can give rise to and exacerbate health and social care needs.

4.2 The JSNA makes a series of recommendations with a view to ensuring that the right services are delivered at the right time, with a focus on improving outcomes for those most in need. They have been drafted in consultation with key stakeholders to ensure the JSNA provides a number of levers for building strong partnership work.

Themes

4.3 There are a number of themes or 'foundation stones' which cut across and underpin the recommendations:

Joint commissioning and pooled budgets	Recognising the links between housing, health and social care, commissioners need to increase the use of pooled budgets as a way of enabling closer collaboration, with investment weighted towards 'upstream' prevention and earlier intervention.
IT data sharing protocols and information governance	Collaborative work to facilitate and enable information exchange between organisations, in a way that respects patient preferences and information governance protocols, is required if cost effective personalised prevention and early intervention are to be realised.
Smooth customer journeys supported by referral rights and referral pathways	Work building on existing best practice is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.

Quality services and facilities, appropriately tailored and targeted	This report seeks to highlight services which secure positive outcomes for some of our most vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.
Asset based approaches (for individuals and for communities)	This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.
Workforce development	Ensuring that staff teams are skilled up and supported to address the challenge is essential if positive outcomes are to be achieved.
Local intelligence	This foundation stone refers to securing greater understanding of the local landscape. Two specific areas highlighted are Fuel Poverty and those in severe and multiple disadvantage.

4.4 A more detailed explanation of the foundation stones can be found in Section 8 on p.87 of the full report.

4.5 **Recommendations**

Theme	Recommendation
Strengthening prevention and early intervention	Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability. Recommendation 2: Improve housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing. Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community. Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact. Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach.

Delivering personalised housing support and care	Recommendation 7: Establish data sharing appropriate protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents. Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care. Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.
Strengthening collaborative approaches to supporting carers	Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support.
Improving the offer for those in severe and multiple disadvantage	Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage.
Improving housing options in later life	Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and ensure their take-up.

4.6 The Health and Wellbeing Board is invited to consider the foundation stones and key recommendations arising from the Housing support and care JSNA (shown together in full in Section 7, p.82). Many of the recommendations include a range of opportunities for consideration by partners for local implementation.

5. Legal Implications

5.1 The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

5.2 Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

5.3 Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

5.4 JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

5.5 Implications verified/completed by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

6. Financial Implications

6.1 There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

6.2 Implications verified/completed by: Richard Simpson, Finance Manager – Public Health, 020 7641 4073.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Anna Waterman, Strategic Public Health Advisor

Email: awaterman2@westminster.gov.uk

Telephone: 0207 641 4651

APPENDICES:
Appendix 1: Adult Social Care response to the Housing support and care JSNA
Appendix 2: Housing response to the Housing support and care JSNA

BACKGROUND PAPERS:

Joint Health and Wellbeing Strategy consultation draft
North West London Sustainability and Transformation Plan

Appendix 1: Adult Social Care response to the Housing support and care JSNA

Adult Social Care endorses the recommendations of the Housing support and care JSNA. Officers were fully involved in the production of this JSNA and the recommendations align with the principles underpinning Adult Social Care as well as the current and proposed commissioning priorities.

Appendix 2: Housing response to the Housing support and care JSNA

Westminster's Housing Department welcomes the production of the JSNA and supports its recommendations. Officers were engaged in each stage of the report's development and played a key role in shaping the commentary as well as the recommendations.

The Department has provided a full response to the report which can be made available upon request. This provides commentary against the recommendations – offering further examples of local good practice and of innovative approaches to some of the most thorny challenges – which will be invaluable shaping implementation plans moving forward. The response demonstrates a willingness to work collaboratively to address the recommendations. Those with particular resonance include:

- Improving housing conditions (recommendation 2)
- maintaining independence (recommendation 3)
- maintaining and building on advice, information and outreach services (recommendation 5)
- addressing the challenges surrounding move-on accommodation (recommendation 9)
- support for those in SMD (recommendation 11), and
- improving housing options for older people (recommendation 12).

As with all stakeholders, Housing Department colleagues identify data sharing and making every contact count as having central importance.

Appendix 3: Response from the CCGs

Senior Personnel were engaged with the development of the commentary and key messages. West London CCG's Transformation Board and Central London CCGs Transformation and Design Group both formally received the report and the feedback (available on request) confirmed the following:

- Recommendations are well received and there is clear alignment with the North West London Sustainability & Transformation Plan
- Programmes already underway will both contribute towards delivery of the recommendations and be shaped by them
- Data sharing is of central importance
- Those recommendations which support delivery of the Like Minded Strategy are a particular priority.
- Improving housing options for people in later life has particular resonance.

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Westminster Health & Wellbeing Board
Work Programme
2016/17
DRAFT

KEY

FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date: 17 November 2016			
STRATEGIC ITEMS			
STP DELIVERY PLANING UPDATE	6 month post-implementation update	**NWL CCG**	**For discussion**
DISCUSSION ITEMS			
YOUNG PEOPLE'S MENTAL HEALTH NEEDS ANALYSIS	Consider service redesign and transformation	**ChS**	**For discussion**
SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16	Consider strategic alignment and lessons for integrated commissioning	**Independent Chair**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	Adoption of Joint Health and Wellbeing Strategy (TBC)	**ASC/CCG/PH**	**For discussion**
HEALTH HUBS			
PRIMARY CARE UPDATE	Comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			
Meeting Date: 19 January 2017			
STRATEGIC ITEMS			
BETTER CARE FUND PLANNING UPDATE + ALLOCATIONS 2017/18		**ASC**	**For decision**

JOINT HEALTH AND WELLBEING STRATEGY	Update on implementation plan and programme of performance monitoring	**ASC**	**For discussion**
DISCUSSION ITEMS			
HEALTH HUBS			
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			
Meeting Date: 23 March 2017			
STRATEGIC ITEMS			
HEALTH + SOCIAL CARE INTEGRATION PLANS	Update on planning for full integration by 2020	**CCG/ASC**	**For decision**
LEARNING FROM THE LONDON DEVOLUTION PILOTS	review learning from first year of London devolution pilots	**ASC**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	Discussion focusing on a particular aspect of the strategy (TBC)	**ASC**	**For discussion**
CCG OPERATING PLANS 2017/18	operating plans for 2017/18	**CCG**	**For discussion**
DISCUSSION			
HEALTH HUBS			
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			

KEY

STRATEGIC ITEMS – items concerning system level issues (e.g. health and care integration, devolution, primary care transformation)

DISCUSSION ITEMS – items of interest focusing on a specific part of the system such as a specific health condition, service or population group (e.g. JSNA deep dives)

BUSINESS ITEMS – items for the board's approval or information but which do not require a discussion (e.g. items that have been agreed offline but require formal approval by the Board)