WEST LONDON CCG - DRAFT 2016/7 CORPORATE OBJECTIVES

Strategic Priorities

- Enabling people to take more control of their health and wellbeing.
- Securing quality healthcare services and improved outcomes for the people we represent.
- Enhancing the organisation's culture - developing people, processes and systems to help deliver high quality commissioning.
- Establishing a collaborative and proactive culture with partners and the people we represent.
- Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes.
- Empowering staff to deliver our statutory and organisational duties.

Prog	WL CCG Annual Objectives 2016/17	Ref	Key Actions	Supporting Actions
1. Primary Care Transformation	Leading the development of high quality **primary care** services in West London, and supporting member practices to meet relevant challenges, both as providers and commissioners of services.	1.1	**Work collaboratively with the new GP Federation to increase its organisational capacity and capability, and support its development in line with the new organisational models identified in the Five Year Forward View.**	Support Federation in implementation of its Transformation Plan, ensuring that relevant investment contributes to organisational development priorities identified by the CCG.
				Embed Out of Hospital services delivery including effective cross-practice working, to ensure optimal service uptake.
				Achieve demonstrable improvement in quality of service delivery over time, via robust performance management of contractual KPIs.
		1.2	**Embed the new co-commissioning working arrangements in order to ensure effective decision-making which supports CCG progress towards achievement of its key strategic objectives.**	Working in close collaboration with NHSE, implement CCG Primary Care Development Plan, with a specific focus on quality of service provision, incorporating relevant outputs from the CQC inspection programme and intelligence from NHSE contract monitoring.
				Commence implementation of Primary Care Estates strategy using co-commissioning levers to facilitate rapid progress in premises development.
				Provide relevant support to practices affected by the PMS review, ensuring that the quality of frontline patient care is not detrimentally affected.
		1.3	**Manage an effective programme of practice engagement and development in order to support practices in their commissioning role and also in improving the quality of primary care provision.**	Implement an effective plenary and seminar programme throughout the year which maximises effective practice input to key CCG decisions , and offers on-going developmental and educative opportunities, including relevant areas identified in the 360 degree review.
				Embed Prime Ministers Challenge Fund initiatives to ensure on-going improvements to primary care access for local residents in relevant areas.
				Implement local improvement scheme (LIS), via the Commissioning Learning Set (CLS) Plan - which encourages increased practice input to CCG commissioning decisions, as well as improved clinical practice via peer review and implementation of best practice.
2. Integrating Care Out of Hospital	Implementing the North West London *shaping a healthier future* programme, through ensuring that patients receive **better care, closer to home**	2.1	**Transforming planned care and embedding real pathway change, through demand management reviews and collaboration with providers.**	Transforming planned care and embedding real pathway change, including Gynae/Urology and MSK service redesigns and full procurement of Wheelchairs services.
				Review the findings and develop a model for future children's hub provision, linked to wider CWHEE children's developments.
				Support the shift of activity through enhanced arrangements with the Chelwest and Imperial Transformational Boards and commission a system that supports appropriate primary care referral behaviour.
		2.2	**Transforming Urgent and emergency care in accordance with the NHS 5YFV plans.**	Commence full merger CIS into WS to reduce non elective admissions and work with providers to support reductions in DTOCs and improved discharge planning.
				Design and implement/procure new model of urgent and emergency care for St Charles UCC, CW UCC, A&E and GP OOH and support transition to a new NWL 111 service.
				Review and revise an effective integrated care pathway for falls which is adopted across all services with WL.
		2.3	**Develop an Intermediate Care strategy that balances bed-based, home-based and enabling services for long term provision of care for those with complex needs.**	Mobilise and embed the new intermediate care bed service and the new neuro rehab bed service from April 2016.
				Develop self-care admission prevention services that offer support for underlying causes of functional decline for under 65's.
				Develop an integration plan for the merger of care homes into WS with appropriate levels of workforce and medical support inclusive of "Skype" technology.
	Developing and implementing **Whole Systems Integrated Care,** centred around the holistic needs of the service users and their carers	2.4	**Refine and embed the Whole Systems Integrated Care for Older Adults model of care integrating health and social care needs and provision for over 65s**	Continue support to Wave 1 and 2 practices (28 practices). Recruit and train Case Managers and Health and Social Care Assistants to support Go Live with remaining WL practices (Wave 3).
				Refinement of WS Model of Care and service delivery through reflection and learning based on early outcomes and evaluation and monthly Whole Systems learning and development sets.
				Continually gather and embed service user feedback in the on-going development and delivery of the model of care.
		2.5	**Consolidate existing services and extend the range of services available from Integrated Care Centres at St Charles and Violet Melchett and drive implementation of VM Hub Business Case**	Co-design and agree with providers service changes to existing contracts and integrate existing services with WS Model of Care. Develop an outcome based specification for Whole Systems. The specification will integrate elements of existing services, including: CLCH Community Services contract, Community Independence Service contract and other contracts, as appropriate.
				Evaluate the Self Care pilot and procure longer term service.
				Gain approval for the Business Case for VM and initiate development process.
		2.6	**Implementation of WS OD plan to deliver phased progress towards ACP**	Develop patient centred holistic care through on-going workforce development and planning to migrate from existing services to WS model.
				Align ACP development.
				Develop and implement shadow capitated budget for subset of services and co-design with Provider Network defined stages and timescales towards ACP. Establish shadow ACP.
3. MH Transformation	Transforming **Mental Health** services to meet the needs of our diverse population, through commissioning integrated, personalised and responsive mental health & well-being services.	3.1	**Phased Implementation of the Whole Systems Integrated Pioneer for 'Community Living Well' with Long Term Mental Health needs, including employment and peer support/navigator services**	Establish SCH Hub & CCG-wide Core Service Go-Live (Q1).
				Develop integrated community spokes and 'asset map' (Q2).
				Phased plan to Q4 for safe transfer of all stable LTMHN cases from CNWL to CLW.
		3.2	**Implement 24/7/365 Crisis Home Assessment & Treatment Services; review acute in-patient services an continue re-patterning of care increasingly towards home settings**	Review implementation of SPA and 24/7/365 crisis home assessment and resolution against agreed contract targets and shift in activity from IP to community - Monthly
				Explore, under wider redesign plans, further re-patterning and right sizing of in-patient and community provision – Q2
				Ensure delivery of 95% 24/7/365 home assessment response standard by year end.
		3.3	**With Local Authority and other Partners, develop and deliver agreed integrated care initiatives (eg, employment, accommodation, complex individual placements, LD, dementia and physical health care)**	Ensure that Acute MH Care Pathway has appropriate adjustments for those with LD.
				Joint Dementia Action Plan, building on JSNA and NWL pathway declaration work.
				Review physical health input to LA commissioned care homes.
4. Enabling	Supporting our objectives through developing a strong culture of **enabling** patients, members and staff to deliver and realise the benefits of transformation	4.1	**Empowering staff and members to deliver our statutory and organisational duties**	Maintain organisational and statutory duties through improved focus on core activities while simplifying delivery through good governance, not increased bureaucracy.
				Support elected members and management team with targeted and focussed development.
				Election of Governing Body members.
		4.2	**Develop a Patient and Public Engagement Strategy for WL**	Develop PPE Strategy with clear structures for engagement in the CCG, including annual engagement plans and priorities.
				Use knowledge of the local population to identify less-heard groups or communities in order to promote engagement. Support PPG development to enable patient voice at practice level.
				Embedding the PPE toolkit to highlight and evidence the impact on service change and redesign for patients. In order to enable patients to be part of service change and redesign.
		4.3	**Supporting integrated working through improved information technology that supports patient care and good clinical commissioning**	Support delivery of the shared patient records.
				Develop business intelligence to support commissioning (WHYSE).
				Develop interoperability of system across providers.