PROGRESS PLANNING

# Sequential Test

217 High Street, Yiewsley, West Drayton, UB7 7GN

Erection of 5 and 6 storey buildings to provide a D1 Health Facility (approximately 10,000sqft) and 233 residential apartments with associated parking, communal podium garden, landscaping, pedestrian and cycle canal link and external works following the demolition of the existing buildings.

Prepared by Progress Planning on behalf of:

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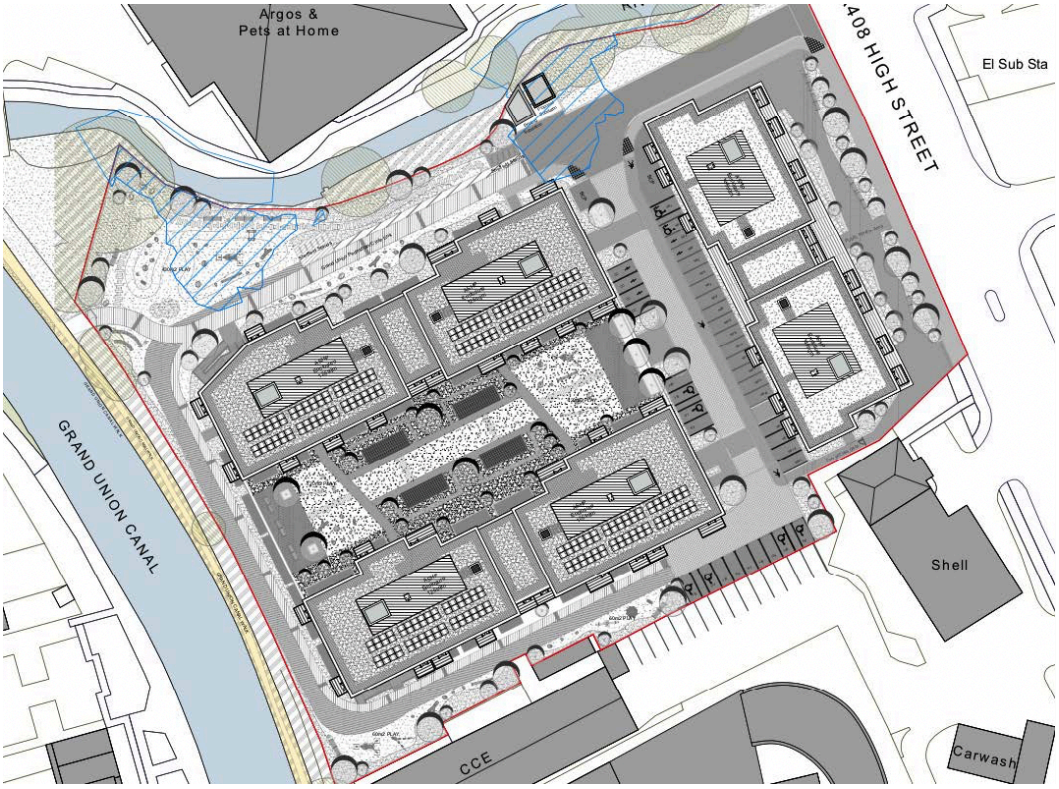
## 1. Introduction

1.1. Progress Planning have been commissioned by Taylor Wimpey Plc (The Applicant) to prepare and submit a Sequential Test to the London Borough of Hillingdon (The LPA) with an application for Full Planning Permission that seeks No. 233 residential dwellings and 10,000sqft (232.2sqm) of D1 (Health Facility) floorspace, with associated access, car parking, hard standing and landscaping. The Site, 217 High Street, Yiewsley, consists of a mix of A1 (retail) and B2 (Light Industrial). A limited portion (5.5%) of the application site is located within Flood Zone 3a (as denotated below), a greater portion of the site is in Flood Zone 2 with the rest in Flood Zone 1.

1.2.




*1.3. Figure 1 – Flood Zone 3 shown by blue hatching (Positioned to the north of the development)*

1.4. This Sequential Assessment has been informed by the Planning Practice Guidance, the West London Strategic Flood Risk Assessment, The Hillingdon Local Plan (part 2) and discussions with the LPA & the NHS. This Statement will also consider the LPA's five-year supply of housing, which has formed a discussion point with the LPA and the need for the new health facility for Yiewsley.

## 2. Policy Background

2.1. The National Planning Policy Framework (NPPF) states that inappropriate development in areas at risk of flooding should be avoided by directing development away from areas at highest risk, but where development is necessary, it should be made safe without increasing flood risk elsewhere. When considering new development, the NPPF is clear in stating that a sequential, risk-based approach to the location of

development should be taken to avoid where possible flood risk to people and property and manage any residual risk, taking account of the impacts of climate change, by:

- applying the Sequential Test;
- if necessary, applying the Exception Test;
- safeguarding land from development that is required for current and future flood management;
- using opportunities offered by new development to reduce the causes and impacts of flooding; and
- where climate change is expected to increase flood risk so that some existing development may not be sustainable in the long-term, seeking opportunities to facilitate the relocation of development, including housing, to more sustainable locations

2.2. The aim of the Sequential Test is to steer new development to areas with the lowest probability of flooding. The NPPF is clear in stating that development should not be allocated or permitted if there are reasonably available sites appropriate for the proposed development in areas with a lower probability of flooding. The starting point for the application of the test is the Strategic Flood Risk Assessment, and a sequential approach should be used in areas known to be at risk from any form of flooding. If, following application of the Sequential Test, it is not possible, consistent with wider sustainability objectives, for the development to be located in zones with a lower probability of flooding, the Exception Test can be applied if appropriate.

2.3. For the Exception Test to be passed it must be demonstrated that: -

- the development provides wider sustainability benefits to the community that outweigh flood risk, informed by a Strategic Flood Risk Assessment where one has been prepared; and
- a site-specific flood risk assessment must demonstrate that the development will be safe for its lifetime taking account of the vulnerability of its users, without increasing flood risk elsewhere, and, where possible, will reduce flood risk overall. Both elements of the test will have to be passed for development to be allocated or permitted.

2.4. Finally, specifically when determining planning applications, the NPPF states that LPA's should ensure flood risk is not increased elsewhere and only consider development appropriate in areas at risk of flooding where, informed by a site-specific flood risk assessment following the Sequential Test, and if required the Exception Test, it can be demonstrated that:

- within the site, the most vulnerable development is located in areas of lowest flood risk unless there are overriding reasons to prefer a different location; and

- development is appropriately flood resilient and resistant, including safe access and escape routes where required, and that any residual risk can be safely managed, including by emergency planning; and it gives priority to the use of sustainable drainage systems.

2.5. The development plan for Hillingdon Council consists of the following:

- The Hillingdon Local Plan: Part 1 – Strategic Policies
- The extant 2007 Saved Unitary Development Plan policies adopted as the Hillingdon Local Plan: Part 2
- The London Plan

2.6. Policies relevant to this Sequential Test are detailed below.

2.7. Paragraph 8.84 of the Hillingdon Local Plan: Part 1 – Strategic Policies states that development proposed in Flood Zones 2 and 3 (medium and high probability) will need to provide evidence of the Sequential Test outlined in the NPPF.

## 3. Planning Policy and the Five-Year Supply

3.1. The LPA have recently adopted the Local Plan Part 2, which, through the allocation of sites and Development Management Policies, sets out how the LPA will deliver the growth set out in the Local Plan Part 1 (Strategic Policies). During the assessment of Local Plan Part 2, the Inspector charged with assessing Soundness of the Plan, confirmed that the LPA have committed to an early review of the Plan, to account for the growth sought by the Intend to Publish London Plan. The commitment to an early review is recognition of both the length of time that passed between adoption of Part 1 of the Plan and Part 2 of the Plan and to take account of the Intend to Publish London Plan housing target for Hillingdon of 10,830 dwellings (1083 dwellings per annum). It should be noted, at this juncture, that the housing target should not be seen as a numerical cap for development, and exceedance of this figure, through sustainable development, is encouraged.

3.2. The LPA assert that, when considered against the annualized target of 1083 dwellings per annum, they are able to show 6.22 years of Housing Land Supply. The Supply is, in the main, made up of sites that have secured Planning Consent and subsequently been allocated in Local Plan Part 2. The nature of the allocations essentially front load the delivery to the first five years of the plan, given that the majority of sites benefit from consent are either under construction or indeed complete. This is a symptom of the retrospective nature of the Site Allocations in Local Plan Part 2, which sought to allocate consented sites.

3.3. The proposal provides the opportunity to further strengthen the LPA's five year supply of housing, which is likely to be delivered in monitoring year 22 / 23. This document does not seek to interrogate the LPA's five year supply position. Rather, the applicant considers that the five year supply of housing and the sequential test serve two distinctly different Planning Functions. The Sequential Test seeks to steer development to the areas of lowest flood risk, whilst the five year supply seeks to maintain a healthy

supply of new dwellings across the plan period. The NPPF does not reference the Five Year Supply position of the LPA in determining whether there are any reasonably available sites with a lower risk of flooding. Rather, paragraph 158 of the Framework confirms that "Development should not be allocated or permitted if there are reasonably available sites appropriate for the proposed development in areas with a lower risk of flooding". This confirms the scope of the Sequential Test, insofar as it confirms that:

- Sites must be reasonably available
- Sites must be able to accommodate the proposed development
- Sites must be in an area of a lower risk of flooding

3.4. There is no requirement for one to consider the five year supply of housing assessment in a Sequential Test and the status of the same is not a relevant consideration. The fact that the LPA does or does not have a five year supply of housing is not determinative in Sequentially Testing sites for development.

3.5. The following sets out the methodology for carrying out the assessment, specifying the criteria relating to the availability, comparability and consideration of flood risk of the application site when compared with other sites that make up the five year supply of housing.

## 4. The Development, Area of Search and Need for Enhanced Health Provision, and Flood Risk

### 4.1. The Development

4.1.1. The development, subject to this sequential test consists of: Redevelopment of the site to provide 233 residential dwellings, including 79 affordable dwellings (242 hab rooms, 38%), 232.2 sqm of D1 (Health Facility Floorspace), 181 parking spaces plus 4 car club spaces for the residential dwellings, 20 car parking spaces for the D1 Health Hub Facility, with associated access, hard standing and landscaping.

4.1.2. Both D1 and C3 uses fall within the More Vulnerable category, as such both 'elements' of the proposal must be considered as part of this assessment. The LPA, as advanced in Pre-Application discussions, originally considered that the residential development should be assessed separately to the proposed D1 floorspace. The Applicant disagreed with this approach, insofar as approval is sought for the C3 and D1 uses as part of the same proposal. It is important to understand that the quantum of residential development proposed (233 dwellings) enables a preferential rental rate to be agreed with Hillingdon Clinical Commissioning Group (CCG). Without this preferential rate the CCG would not be capable of delivering the new health facility or alternatively expanding services from existing sites. The crucial financial benefits facilitated through the enabling residential development and as set out in the Agreed Head of Terms (Appendix D) include a lower rent level for the new facility set at £240 per sqm with a further subsidised reduction of 50% for 15 years. This means that the NHS will be paying £120 per sqm for a facility which on the open market would expect to get £280 per sqm which is more than twice the rate agreed with the CCG for this new facility.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Apollo (Primary Care Property Specialists) have carried out a study (Appendix E) of the savings for the NHS CCG over a 25 year period with the reduced rent and 50% subsidy for 15 years. It shows a saving of circa £3.5 million, without which the larger health facility would not be deliverable. The agreed rent between the NHS CCG and Taylor Wimpey for 25 years is circa £5.5 million in comparison with the open market rent of circa £8.9 million. As such, both uses that comprise the development are intrinsically linked and therefore for the purpose of this Sequential Assessment, the Development being assessed is the delivery of 233 residential dwellings and 232.2sqm of D1 (Health Facility) floorspace. Both 'elements' of the proposal comprising the enabling development and health facility are inherently linked and as such, will be and need to be delivered together. Therefore, this assessment will consider sites that could accommodate the entire development which is the only way the health facility can be delivered. The Council has requested the inclusion of smaller sites that could potentially accommodate the health element on its own. This assessment has been carried out (set out in Appendix B) but for the reasons set out above, the delivery of the expanded and enhanced health provision is not viable without the enabling element of the development.

4.1.3. It is worth mentioning that the accompanying letters from Apollo and Clinical Commissioning Group (CCG) (Appendix C) sets out the aspirations of the CCG and how Health Facility will be utilised, including an expected delivery by 2024. The proposed facility as set out in the latest letter from Apollo dated 15th June 2020 explains that there are currently circa 27,000 patient places in this part of Yiewsley / West Drayton, provided by three GP practices operating from two independent buildings. The poposals seeks to combine two of the practices into a new hub facility that better meets the needs of their patients (including provision of car parking). The existing Yiewley High Street facility which would expand into this new hub is currently located in a building measuring 650 sqm and the new premises will be nearly 50% larger accommodating in excess of 10,000 additional patients. This proposal would cater for a significant uplift in patient places to over 37,000. Therefore, the proposal would deliver approximately a 37% increase in local primary health services. Also, the new health premises would be modern and fit for purpose and enable greater care provision by virtual / digital means and provision of 20 designated parking spaces. Although the current Yiewsley Medical Centre facility has been recently temporarily refurbished, this was a short-term fix which is acknowledged by Hillingdon and it does not achieve the medium to long term needs caused by the growing and ageing population.

## 4.2. Need for expanded health provision in Yiewsley - The Area of Search

4.2.1. When considering the Area of Search for this Sequential Test it is important to appreciate the specific need in Yiewsley for this facility in order to meet the increased needs for health care.

4.2.2. Yiewsley is located within the Hayes/West Drayton Growth Corridor and the Heathrow Opportunity Area forms part of the Elizabeth Line West area which is identified to deliver 13,000 homes. A significant number of new homes have been built in Yiewsley in recent years and many more are expected to be delivered.

4.2.3. Paragraph 92 of chapter 8 of the NPPF refers to 'Promoting healthy and safe communities' and it states that to provide the social, recreational and cultural facilities and services the community needs, planning polices, and decisions should plan positively for the provision and use of community facilities and take into account and support the delivery of local strategies to improve health, social and cultural well- being for all sections of the community. To support and evidence the need for this proposal, the Clinical Commissioning Group (CCG) has provided a suite of documentation setting out their wider health strategy for Yiewsley/Hillingdon which are appended (Appendices F-I). These include:

- Hillingdon Strategic Estates Plan (prepared by NHS CCG)
- Hillingdon Strategic Intensions (prepared by NHS Hillingdon Clinical Commissioning Group and dated September 2019)
- Better Care, Closer to Home – Our strategy for co-ordinated, high quality care (Prepared by NHS Hillingdon)
- Transforming the NHS in North West London – Five Year Strategic Plan
- Update Note: Strategic Estate Development prepared by Hillingdon Council in conjunction with Hillingdon Clinical Commissioning Group.

4.2.4. The Hillingdon Strategic Estates Plan provides a summary of the CCG local estate strategy review process and estate proposals within the context of the NWL Shaping a Healthier Future (SaHF) programme and the Hillingdon CCG Strategic Service Delivery Plan (SSDP) which both support the NHS 5 year forward view.

4.2.5. The SSDP has been developed to outline the local context in Hillingdon CCG within SaHF, the scale of change required to deliver an Out of Hospital (OoH) strategy and a plan for a hub service of between 2,700 and 3,600 $m^2$ split over three key locations across the borough. This new health facility would be one of these 3 key locations and would provide approximately 1/3 of the anticipated floorspace split need for the borough. This estates strategy explains that the main driver and challenged to the CCG is to meet an estimated increase in demand and complexity of care delivered in the community for out of hospital care across the area of **30-35%**. Given the location of the subject site in an Opportunity Area and Growth Corridor, the need is expected to be particularly intense in Yiewsley / West Drayton. The document further explains that there is to be a major shift in care from within a hospital setting to an out of hospital setting so more people are treated closer to their homes. The review of existing NHS estate land which formed part of this strategy found that primary care infrastructure was poor and that there was a need for placing GP practices in the right location and in fit for purpose accommodation. The SSDP sets out that due to expected population growth there is a need to develop clinical hubs in central and south Hillingdon where population is forecast to rise by the greatest.

4.2.6. The NHS has prepared a Strategic Service Delivery Plan (SSDP) which has been developed which (a) outlines the local context in Hillingdon CCG within SaHF, the scale of change required to deliver the Out of Hospital (OoH) Strategy and the model of care that is being developed at a national, regional and local level, and (b) considers the delivery implications of the new model.

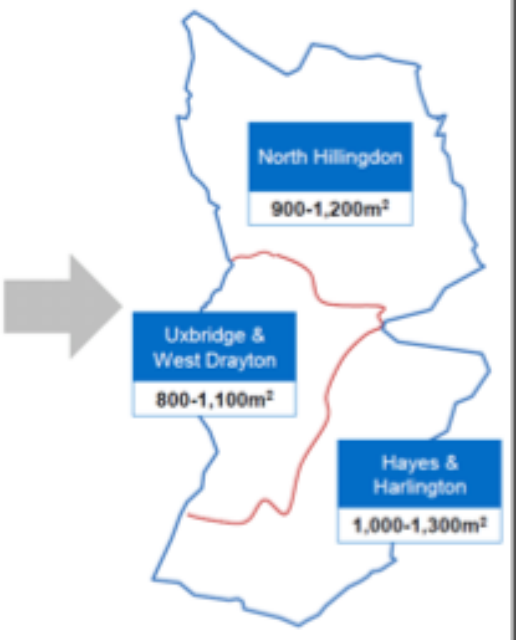
4.2.7. The primary challenges facing Hillingdon CCG that drive the aims of the SSDP are:

- meeting an estimated increase in demand for out of hospital care across the Hillingdon CCG area of 30%-35%
- delivering a major shift in care from within a hospital setting to an out- of-hospital setting so more people are treated closer to their homes
- transforming Primary Care to make more services available closer to home enabling the provision of accessible, coordinated and proactive care

4.2.8. The NHS CCG plan to address these challenges involves rolling out a hub service model comprising a total floor area of between 2,700 and 3,600 $m^2$ as illustrated by locality (map below), with a pipeline for investment and service identified for 60 treatment rooms across the borough shown in the table also below.

4.2.9.

| Service Type | Hub Delivery Type | Treatment | # Treatment Rooms required | 17/18 CCG Total Estimates GIFA (%) |
|---|---|---|---|---|
| Primary Care | Service delivery within a hub | GP Core | 21 | 35% |
| | | GP Enhanced | 11 | 18% |
| 'Hub' services | | OP | 10 | 17% |
| | | Minor surgery | 1 | 2% |
| | | Mental Health | 2 | 1% |
| | | Community LTC / Elderly | 7 | 12% |
| | | Under 5s | 1 | 2% |
| | | **Activity based total** | **53** | |
| | Workforce based service | Education and Training | 3 | 4% |
| | | ICP Case Management | 3 | 6% |
| | | Pharmacy | 1 | 2% |
| | | Grand Total | **60** | |




*4.2.10. Figure 2 - Hub Service Delivery Table / Map – Extract from Strategic Estates Plan*

4.2.11. Specific to the proposed new health facility, a letter from Apollo (Primary Care Property Specialists) dated 26th February 2020 (Appendix C) supports this application and sets out the specific need for this D1 health

facility. It states that the NHS in England, as part of the five-year plan are looking to deliver primary care at scale to bring a degree of robustness to the service they deliver. By creating Hubs of over 20k patients, the numbers of GP's, nurses and other health care professionals increase and allow for not only immediate cover in high demand times but also allows the delivery of additional services to patients. The subsequent creation of Primary Care Networks (PCN) creates even larger delivery hubs for between 30k and 50k patients in a particular demography.

4.2.12. Yiewsley Family Practice, The High Street Practice, Otterfield Medical Centre, the Medical Centre, West Drayton form part of the Colne Union Primary Care Network for Yiewsley. As explained, this new facility would allow the Yiewsley Family Practice and High Street Practice to expand care provision and provide enhanced facilities more efficiently from a hub location, further benefiting the wider Colne Union Primary Care Network (PCN)

4.2.13. The PCN's are made up of a group of GP practices who work together to deliver health. Quite often a Health Hub will be the focus for PCN enhanced activities such as Physiotherapy, mental health services, same day emergency care and pharmacy advice. The PCN need space to deliver these enhanced services which are essential for the new models of care and to reduce the pressures on the acute services.

4.2.14. Yiewsley PCN currently delivers services to almost 37,000 patents from 9 centres. The model becomes far more efficient when the Hub model is adopted to create delivery at scale. In Yiewsley town centre there are 3 practices, High Street Practice and Yiewsley Family Practice both operate from the Health Centre and Otterfield Practice operate from a converted house in Otterfield Road. The 2 practices in the Health Centre currently have circa 20,000 while Otterfield have 7200. The town centre practices therefore make up the majority of the PCN seeing circa 27,000 patients. This number is set to rise in the coming years with a high number of residential developments taking place and the improved interconnectivity to central London via Crossrail.

4.2.15. The CCG have already taken steps to address some of the immediate issues with a recent temporary refurbishment of the Health Centre site, however, this has been confirmed as a short term solution and it will not meet the needs moving forward. The medium to longer term solution will be to create a more centralised hub in Yiewsley centred around the PCN core delivery model. The CCG have confirmed they require a Health Facility to meet their medium-term aspirations.

4.2.16. Expanding the existing Yiewsley High Street Health Centre has also been explored as a means of delivering the health hub. However, this site is owned by NHS property services and therefore there is no opportunity for a subsidised rent or rate to enable the development. The condition of the existing building and site of this size (0.2 hectares) would make any extension or remodelling unviable. The only option would therefore be to demolish and redevelop which would require the decant and temporary relocation of the current practices while this work progressed. The cost associated with this decant and relocation would exceed over 500k alone. Therefore, this is not an alternative solution to what is being proposed.

4.2.17. The proposed development comprises the construction of a new 10,000sqft D1 health facility with an attractive public realm area to the front and 20 dedicated car parking spaces for staff and users. The proposed health facility would be able to accommodate circa 20 consulting/ treatment spaces plus admin and waiting spaces consistent with the NHS Strategic Estates Plan and as set out in the table/map earlier in this report.

4.2.18. The D1 Health Facility would be built at the same time as the 233 residential units on the proposed site and would be ready for use by 2024. This meets the medium-term plan for the CCG and in order to transform the service provided to a growing population of patients with increased demands and expectations of the NHS, new facilities need to be provided in key locations that meets this needs in this growth corridor.

4.2.19. The NHS CCG plan refers to the Yiewsley Pool site as a possible alternative location for the Yiewsley Health Centre which is linked to Kirk House. Mike Paterson (Head of Property and Estates) at Hillingdon Council confirmed by email dated 25th June 2020 (Appendix J) that this site is unavailable and as set out elsewhere in this report, it was not viable to develop this project.

4.2.20. Further supporting the need for the new health facility is the Hillingdon Strategic Intensions Report which includes enabling themes where E3 sets out the delivery of Strategic Estates Priorities for Hillingdon. The report incorporates key strategic actions which they seek to achieve:

- Delivery of a local service primary Hub in the Uxbridge and West Drayton Area by 2022/23.

- Provide additional primary care capacity in the Yiewsley Area by end of 2020, including delivering support to the Estates Technology Transformation Fund (ETTF) improvements to Yiewsley Health Centre.

4.2.21. The delivery of a local service primary Hub in Uxbridge and West Drayton Area by 2022/23 is a Strategic Intention of the NHS as set out by this document and their Strategic Estates Plan. There is significant housing and population growth in Yiewsley / West Drayton and there is clear need for improved and larger health facilities. The Update Note: Strategic Estate Development (Appendix I) prepared by Hillingdon Council acknowledged that a key point emerging from the Strategic Estates Plan is to secure a replacement site for Yiewsley Health Centre and build additional capacity to respond to local residential development. This statement prepared by Hillingdon Council recognises that a key challenge for health in the Borough is the estimated increase in demand and complexity of care delivered in the community for out of hospital care of 30-35%. Given the projected population growth for Yiewsley (it being an Opportunity and Growth Area), this area is likely to experience even higher need than some other parts of the borough. As set out in the previous development section, the proposed new health facility would without even including the efficiencies of working from one central hub location and using enhanced digital technology enabled by a modern fit for purpose facility, cater for an uplift of approximately 37% more patients, thereby addressing existing and quickly growing need. The NHS would retain their existing asset within the town centre which could

be used for further expansion if and when it is required. Nonetheless, it is important to reiterate that it would not be viable to expand health services without the subsidised rent referred to in the previous section of this Sequential Test. This is further supported through our discussions with Mike Patterson from the land department at Hillingdon Council who affirms that the CCG is in a challenging financial position that would prevent any significant improvements despite the housing growth in Yiewsley. The financial challenges and costs associated with expanding health care provision was the primary reason why the new development at the old Yiewsley Pool site was never delivered.

4.2.22. Policy 3.17 Health and Social Care Facilities of the London Plan states that development proposals which provide high quality health and social care facilities will be supported in areas of identified need, particularly in places easily accessible by public transport, cycling and walking. Also, the range of supporting NHS Health Strategy documents accompanying this assessment makes clear that a important aim of improving health care is to deliver the services closer to people's homes out of hospital locations. There is clearly an identified need for new and expanded local health care provision in Yiewley as evidenced by the strategic health reports prepared by the CCG and Hillingdon Council. Given the need for the new health facility to be accessible by public transport, cycling and walking, it is clear that the only appropriate location for the new facility would be in Yiewsley in order to provide local care for the residents of Yiewsley and as evidenced by Better Care, Closer to Home – Our strategy for co-ordinated, high quality care prepared by NHS Hillingdon. Hillingdon Council have recently accepted that it is reasonable to reduce the Area of Search for the new health facility and enabling development (233 residential dwellings) to Yiewsley as the proposal is seeking to address the specific need in this part of the borough. Therefore, the Area of Search will be focused on Yiewsley, particularly as it is envisaged that the existing Yiewsley High Street Practices would expand into this new facility along with their existing patients who live locally.

4.2.23. For reassurance, limiting the Search Area in the assessment to sites within Yiewsley is an established principle, as set out in the West London Strategic Flood Risk Assessment, which states:

*4.2.24. "**Search Area**: The default area should be the whole of the LPA area in question. This can be reduced where justified by the functional requirements of the development or..."*

4.2.25. More widely, chapter 11 Funding the London Plan refers to enabling infrastructure and specifically the need for Health Facilities. It states that the demand for health services in London is increasing due to a growing and ageing population and an increase in complex and long-term health conditions. The NHS has set out the need to undertake a higher proportion of healthcare in community rather than hospital settings. However, many hospital sites contain old, poor-quality stock and there is a need for both replacement and maintenance. Investment is also needed in the workforce and digital technology to deliver service change as evidenced and explained in Transforming the NHS in North West London – Five Year Strategic Plan. This new facility would enable a more efficient way of working and would incorporate enhanced technology that would improve health care experiences for local residents, specifically to address local need.

4.2.26. Across London, developer contributions are used to fund the capital costs of new or expanded primary and community care facilities in order to meet the increasing demand for services which arises from population growth in new developments. Boroughs should use the London Healthy Urban Development Unit Planning Contributions Model (HUDU Model) to calculate the capital cost of the additional health facilities required to meet the increased demand. Boroughs should also work with Clinical Commissioning Groups and NHS England to determine what investment is required by monitoring housing and population growth, keeping infrastructure plans up to date and working together to identify and develop projects towards which Section 106 and CIL contributions could be used.

4.2.27. Section 106 in-kind contributions can be used to support the provision of new health facilities, particularly in Opportunity Areas where there is little or no existing infrastructure. The subject site is located within a Growth Corridor and an Opportunity Area and the population has increased significantly and will continue to increase over the coming years. The subsidised health facility enabled by the quantum of residential development will address the health care needs for Yiewsley and provide significant public benefit to this growing local community. As explained above, there is clear appreciation by those involved in health delivery to residents in Hillingdon that there is a specific need for this new health facility.

4.2.28. London's Sustainability and Transformation Plans (STPs) were published in October 2016 to set out how health and care services would evolve and become financially sustainable over the 5-year period to 2020/21. The plans outlined a requirement to spend £4.8 billion on existing health infrastructure in London just to keep it operationally functional. Further capital investment in NHS infrastructure of £2.1 billion is needed to meet the costs of transforming health services in London and accommodating population growth. Therefore, a total 5-year investment of £6.9 billion is required. This application will deliver a significant contribution toward capital delivery of health provision to the local community (Yiewsley/West Drayton).

## 4.3. The Flood Risk

4.3.1. The site is located in areas of Flood Zones 1, 2 and 3(a). No part of the site is within Flood Zone 3(b). As detailed below, the site is considered to be both Low Risk and Very Low Risk in regard to Surface Water Flooding. The proposal, through the implementation of raised habitable floor levels, a comprehensive flood compensation scheme that delivers a net gain in flood storage and an appropriate sustainable drainage strategy including provision of green roofs, rain gardens, and rain water harvesting is likely to improve the risk of fluvial and surface water flooding both on and off-site.

4.3.2. Importantly, safe and dry pedestrian escape is ensured for all residents and users of the development.

4.3.3. During the development of the proposal, the Applicants undertook a Sequential approach within the site. The results of this assessment resulted in ensuring that the more vulnerable development (the C3 and D1 uses) were sited outside of Flood Zone 3. With landscaping being

provided in Flood Zone 3. Sequentially preferable sites will therefore have to be:

- Located within Flood Zone 2
- Located within an area of Low / Very Low Risk of Surface Water Flooding

4.3.4. A similar approach was utilised by the LPA in the development of the Strategic Flood Risk Assessment, which, in part, Sequentially Assessed the emerging Site Allocations contained within the Local Plan Part 2. In this assessment the LPA considered:

*4.3.5. "Therefore a sequential approach within the sites could be used to avoid areas at risk, and the built development permitted only in areas outside the floodplain. These sites therefore pass the Sequential Test".*

4.3.6. The LPA's Sequential Test passed sites that included parcels of land within Flood Zone 3, where there is sufficient space for the development to take place outside of the same.

4.3.7. The built development proposed by this application is outside of Flood zone 3, and as such the assessment will only consider sites within flood zones 2 as comparable and sites within Flood Zone 1 as preferable, subject to further consideration, as set out in the Search Criteria section of this report.

4.3.8. It should be noted that as the built development is not within Flood Zone 3 and that the development consist of more vulnerable uses, rather than highly vulnerable uses and exception test is not required. This is confirmed by the Planning Practice Guidance. Notwithstanding this, the application is accompanied by a detailed Flood Risk Assessment which sets out how the proposal complies with Part B of the exception test. The Planning Statement and the Sustainability Appraisal set out how compliance with Part A is found.

## 4.4. Area of Search and Comparable Sites

4.4.1. The Local Plan, Part 1 (whilst now aged), sets out that some 15% of the growth of the Borough should be accommodated within the Hayes / West Drayton corridor, which is a significant portion of growth within a relatively small area. Furthermore, the site is within the Heathrow Opportunity Area, as identified by the GLA. This reflects the sites sustainable location, close to the West Drayton Crossrail Station. This spatial strategy, which seeks to allocate growth to the most sustainable areas is relevant in the assessment of the Sequential Test.

4.4.2. The Development, as set out in the preceding, also includes 232.2sqm of D1 (Health Facility) floorspace. The catchment of such a facility is relatively narrow with a health narrative that requires the provision to be local and close to residents as set out earlier in this report. As explained above, Hillingdon Council have agreed that the Area of Search should be narrowed to Yiewsley given the specific need for health care provision at this location. Therefore, this assessment will review sites only in Yiewsley as outside of this area they would not be sequentially comparable.

4.4.3. An assessment will first be made to assess whether the development is sequentially comparable. The assessment of comparability is formed on the following:

4.4.4. To be considered comparable the development must:

- Provide at least 150 dwellings with potential for enhancement (minimum quantum considered necessary to subsidise delivery of the health facility – however this would be unlikely to deliver a policy compliant level of affordable on the lower end of the spectrum)
- Provide at least 800 sqm of D1 Floorspace (consistent with the minimum area set out in the NHS CCG's Strategic Estates Plan)
- Be located within Yiewsley

4.4.5. If a site is found to be sequentially preferable, an assessment will be undertaken as to whether the site is available for development. To be available for development the proposal must:

- Not be under construction / completed;
- Be available to purchase on the open market; or
- Receive confirmation from the landowner that the development site is available to purchase

4.4.6. Developments must be Sequentially Comparable, Sequentially Preferable and available. If a development is found that is both Sequentially Preferable and Available, then the proposed development, subject of this assessment would fail the Sequential Test. To test availability a Site Visit will be carried out to check commencement, a review of the LPA's Planning Register will be conducted to check pre-commencement condition submissions and phone survey of developer's / landowners. It should be noted that appeal decisions have confirmed that sites with Planning Permission are generally not available, however the criteria used by this Test seeks to include such sites which will only be discounted if they are under construction or completed.

## 4.5. Comparable Sites – Evidence Base

4.5.1. The core Sequential Test considers all sites in Yiewsley listed within the Council's Five- Year Supply of Housing, which is considered to form the most up-to-date evidence available. The test considers sites on a like for like basis, although seeks to provide some flexibility. Developments which provide 150 dwellings are considered to be a suitable baseline, as with enhancement, they may be able to deliver the quantum of development sought by this proposal.

4.5.2. Similarly, a pragmatic approach has been taken in consideration of the D1 use. Where a development proposes a similar level of D1 floor space, or provides flexible community / commercial uses, the development will be considered as comparable.

4.5.3. During the planning application process, Hillingdon Council also requested inclusion of sites capable of delivering the health facility on its own without the enabling residential element. Although this has proven to be unviable in the past including on projects between the Council and the CCG directly, we have undertaken a Part B sequential test for smaller sites in Yiewsley measuring 0.1-1 hectare in size which were not included in the core assessment (see Appendix B for full review).

## 5. Conclusions on the Sequential Test

5.1. The detailed Sequential Test is attached as Appendix A to this statement and a supplementary assessment for Smaller Sites (0.1-1 hectare in size) only capable of delivering the Health Facility without enabling element is attached in Appendix B. It is important to appreciate that the delivery of the expanded health care provision for Yiewsley would not be viable without the enabling development that would facilitate a subsided rate for the new health hub. Therefore, the commercial reality is that none of the smaller sites would enable the health provision required to address the specific need in Yiewsley.

5.2. A total of 52no. sites were considered as part of the assessment. The Council provided feedback following the submission of the original Sequential Test requesting that sites with consent that are not allocated also be included within the assessment. Unfortunately, there are no sites with consent that meet the parameters of being comparable as set out above. The supplementary assessment for smaller sites which are unable to accommodate the entire development including the enabling residential element has considered unallocated sites.

5.3. Out of the No. 52 sites assessed, no sites provided D1 (GP Practice) use within Yiewsley. As such no sites were considered to be Sequentially Comparable as they do not provide D1 uses to serve Yiewsley. On the assumption that a Health Facility to host the Local GP Practices are provided, the development Passes the Sequential Test.

5.4. Notwithstanding this, development sites considered have either commenced, part commenced or been completed on most. Feedback from planning policy sought further clarification on SA 39 Site A Trout Road. Ownership of this site was investigated subsequently and unfortunately it is not currently coming forward. The owner is not willing to release or sell the site to a 3rd party to deliver the much needed health provision for Yiewsley.

5.5. The methodology sets out that the area of search for the assessment is Yiewsley, therefore sites outside of Yiewsley would not be sequentially comparable. The approach taken demonstrates that the test is seeking reasonably available sites of a comparative type and quantum of development and provides a pragmatic approach to assessing the same. The methodology has been developed based on best practice as advanced through recent Planning Applications and indeed the LPA's own Strategic Flood Risk Assessment. It is therefore concluded that the methodology is robust.

5.6. No sequentially preferable sites were found in the assessment. The application proposal therefore passes the Sequential Test, confirming, in principle, that the development is acceptable within Flood Zone 2.

## Appendix A Sequential Assessment

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| *RAF Uxbridge, Uxbridge North | Allocation | 514 | Mixed | Flood Zone 1, 2 and 3<br>Very Low / Low Risk of<br>Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ Development commenced by Developer |
| 297 - 299 Long Lane, Uxbridge North | Allocation | 36 | N/A | Flood Zone 1<br>Very Low / Low Risk of<br>Surface Water Flooding | **Not sequentially comparable or available:**<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Grand Union Office Park, Uxbridge South | Allocation | 133 | | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available:**<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available – Development near completion |
| Waterloo Wharf, Uxbridge South | Allocation | 52 | N/A | Flood Zone 2<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available - Development Complete |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Randells, Uxbridge South | Allocation | 58 | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available – Additional Listed Building constraint |
| Bridge House, Riverview House & Waterside House, Uxbridge South | Allocation | 140 | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Dolphin Bridge House, Uxbridge South | Allocation | 41 | N/A | Flood Zone 1, 2 & 3<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available - Development completed |
| Weir House, Uxbridge South | Allocation | 16 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available:**<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available – Development Complete |
| Allport House, Uxbridge South | Allocation | 28 | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Woodbridge House, Uxbridge South | Allocation | 10 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available – Recently completed development |
| The Blues Bar, West Drayton | Allocation | 38 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Maple And Poplar Day Centre, Yeading | Allocation | 34 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available |
| *Padcroft Works Site A, Yiewsley | Allocation | 247 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ No D1 floorspace<br>➢ Not available – Development near completion |
| *Padcroft Works Site B, Yiewsley | Allocation | 104 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available:**<br>➢ No D1 floorspace<br>➢ Not available – Development near completion |

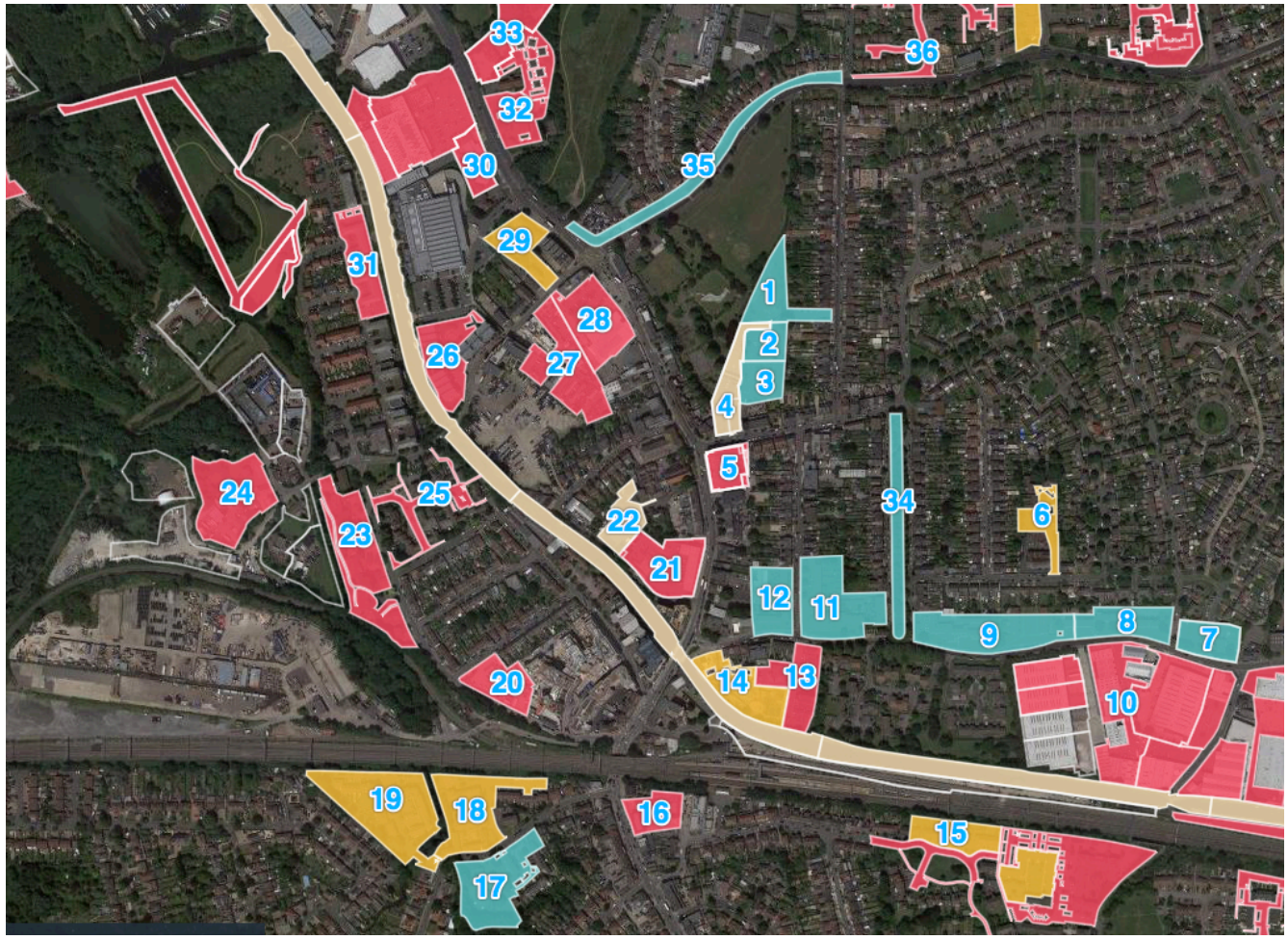
| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| *Trout Road Site A (Kirby and Rainbow Industrial Estates), Yiewsley | Allocation | 149 | A3 / B1(C) | Flood Zone 1 & 2 Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ No D1 floorspace<br>➢ Not available – Landowner approached – viable business operating from the site |
| Land to Rear of Horton Road, Yiewsley | Allocation | 87 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available – Development complete |
| Morrisons Supermarket 41-67 High Street, Yiewsley | Allocation | 144 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable**:<br>➢ No D1 floorspace<br>➢ Capacity too low |

| Site | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) |
|---|---|---|---|---|---|
| Packet Boat Marina, Yiewsley | Allocation | 25 | N/A | Flood Zone 1 & 2 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Outside Yiewsley<br>➢ No D1 floorspace<br>➢ Capacity too low<br>➢ Not available |

* Where sites were considered Sequentially Preferable, a detailed analysis was undertaken to assess whether they were available. This involved:

- Site visit to check commencement / completion, Review of Planning Register to check condition submission(s) & phone survey with landowners / developers to see if available.

**Appendix B Sequential Assessment for Smaller Sites (0.2-1 hectare) only capable of delivering the Health Facility without enabling element.**




*Map of smaller sites in Yiewsley*

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 1 | Yiewsley Swimming Pool, Falling Lane – Planning application ref: 18344/APP/2013/3564 in 2013 secured consent for a health centre and 12 supported housing/living flats. This application has now expired. Discussions with the Council and CCG have led to the understanding this was not viable. | Permission (Expired) | N/A | N/A | Flood Zone 1 Very Low - Very High Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low – Unviable to bring forward<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 2 | Northern section of car park | N/A | N/A | N/A | Flood Zone 1 Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low – Unviable to bring forward<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 3 | Southern section of car park owned by Hillingdon Council in Yiewsley | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low – Unviable to bring forward<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 4 | Yiewsley Methodist Church and Wilko land | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ Not available – viable operators / business |
| 5 | 92-104 High Street, Yiewsley | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 6 | Windermere Way | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 7 | 179-189 Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 8 | 1-26 Aspen Close | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 9 | 9-129 Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 10 | Horton Road Industrial Estate | N/A | N/A | N/A | Flood Zone 1<br>Very Low - Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – In viable industrial use. |
| 11 | Various on Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 12 | Various on Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 13 | Land on The South Side of Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 14 | Land Lying to The South of Horton Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 15 | 87 To 125 Odd Numbers And 124 To 132 Even Numbers Warwick Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low / Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Genesis Housing Scheme |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 16 | Land at The Rear of The Railway Arms Public House Station Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low - Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ 239 sqm A1 retail unit available but on the market for £850,000. Would not deliver the health hub benefits, nor would it be viable with this capital spend. |
| 17 | Hatton Grove Flats | N/A | N/A | N/A | Flood Zone 1, 2 & 3<br>Very Low - Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 18 | A2 Dominion Development at Humber Close | N/A | N/A | N/A | Flood Zone 1, 2 & 3<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – A2 Dominion Housing Scheme |
| 19 | Weirside Gardens | N/A | N/A | N/A | Flood Zone 1 & 2<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – A2 Dominion Housing Scheme |
| 20 | Land and Buildings on The South West Side of Bentinck Road and North East Side of Tavistock Road | Permission | N/A | N/A | Flood Zone 1<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently purchased by Redrow Homes and development has commenced. |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 21 | Morrisons Supermarket, High Street | N/A | N/A | N/A | Flood Zone 1 & 2<br>Very Low / Low Risk of Surface Water Flooding | **Please refer to core Sequential Test within Appendix A** |
| 22 | St Stephens County Primary Infants School St Stephens Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ Not available – Academy School |
| 23 | Land on The South West Side of Tavistock Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 24 | Trout Farm and Wingroves Cottages | N/A | N/A | N/A | Flood Zone 3<br>Very Low / Low Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Almost completely in Flood Zone 3<br>➢ Not available |
| 25 | Land at Peplow Close and Heathcote Way | N/A | N/A | N/A | Flood Zone 1<br>Very Low - Very High Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available |
| 26 | Land on The North West Side of Trout Road | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development by Aviva Investors |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 27 | Land Lying to The South-East of Trout Road | N/A | N/A | N/A | Flood Zone 1 & 2<br>Low – Very High Risk of Surface Water Flooding | **Please refer to core Sequential Test within Appendix A** |
| 28 | Aldi, 143 To 161 Odd High Street | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – viable operators / business |
| 29 | 197, 199 And 201 High Street and Land and Buildings on The North West Side of Trout Road | N/A | N/A | N/A | Flood Zone 1 & 2<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 30 | Shell Garage, 209 High Street | N/A | N/A | N/A | Flood Zone 1 & 2<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – viable operators / business |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 31 | Little Grebe House 130 Wraysbury Drive | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 32 | Land on The East Side of High Street | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available – Recently completed development |
| 33 | Yiewsley Grange | N/A | N/A | N/A | Flood Zone 1, 2 & 3<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low – Listed Building and Green belt<br>➢ No D1 use<br>➢ Not available |

| Site | Address | Allocation / Permission | Expected Delivery (first five years) | Other Development? | Flood Risk | Sequential Assessment (Delivery of a Health Facility to provide GP accommodation) without enabling element |
|---|---|---|---|---|---|---|
| 34 | Land at Colham Avenue | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 35 | Land on The North West Side of Falling Lane | N/A | N/A | N/A | Flood Zone 1<br>Very Low Risk of Surface Water Flooding | **Not sequentially comparable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available as confirmed by email from Hillingdon Council dated 25th June 2020. |
| 36 | Land and Buildings on The North Side of Falling Lane | N/A | N/A | N/A | Flood Zone 1<br>Very Low – Very High Risk of Surface Water Flooding | **Not sequentially comparable, preferable or available**:<br>➢ Capacity too low<br>➢ No D1 use<br>➢ Not available. |

**Appendix C – Letters from the NHS and Apollo (Primary Care Property Specialists)**

NHS
Hillingdon
Clinical Commissioning Group

The Head of Planning
London Borough of Hillingdon Council
Civic Centre
High Street
Uxbridge
Middlesex
UB8 1UW

Boundary House
Cricket Field Road
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Middlesex
UB8 1QG

Tel: 01895 203000
Fax: 01895 203010

http://www.hillingdonccg.nhs.uk

9 June 2020

Dear Sir/Madam

**RE: Application Reference 68663/APP/2020/705 - 217 High Street, Yiewsley, West London**

Hillingdon Clinical Commissioning Group (CCG) as commissioners of primary care services are responsible for ensuring service delivery to patients in the Yiewsley area. Hillingdon Council will be aware of the CCG's aspiration of finding fit for purpose premises in the long term as the existing estate in the area is ageing and requires replacement.

The NHS are entering a new era of delivery by adopting new methods of consultation through digitisation and a more heightened approach to infection spread and control. As we enter that new era, we are keen to support new schemes when presented if they make commercial sense and deliver value for money.

Taylor Wimpey West London Ltd have approached the CCG with a scheme at 217 High Street in Yiewsley which we understand is under consideration by the local planning authority. The scheme includes a circa 1050sqm gross internal area D1 Health Hub with 20 dedicated car parking spaces. We have recently agreed commercial heads of terms with Taylor Wimpey West London Ltd which we append for your information. Subject to planning and conditions within the heads of terms being met Hillingdon CCG support this application and we will work with Taylor Wimpey to deliver the new health hub when the unit becomes available.

The intention will be for existing GP practices within Yiewsley area to relocate into the new Health Hub along with consideration for more enhanced services. The efficiency of the new hub will allow the delivery of additional services linked to the Primary Care Network along with the continued services to their circa 20,000 patients plus future growth.

The location of the new hub will reduce the need for travel by a large proportion of new and existing patients and is ideally placed to cater for current patient journeys.

***Chair**: Dr Ian Goodman*
***Accountable Officer**: Jo Ohlson*
***Managing Director**: Caroline Morison*

HEALTHY WORKPLACE
MAYOR OF LONDON

Hillingdon CCG therefore support this scheme and subject to value for money assessments and commercial terms being agreed through the S106 obligation will relocate services into the new hub.

Yours faithfully



**Caroline Morison**
Managing Director
NHS Hillingdon Clinical Commissioning Group

***Chair**: Dr Ian Goodman*
***Accountable Officer**: Jo Ohlson*
***Managing Director**: Caroline Morison*

Apollo
The Primary Care Property Experts

Taylor Wimpey Plc
Form 1
17 Bartley Wood Business Park
Bartley Way
Hook,
Hampshire
RG27 9XA

Date – 26 February 2019

**Re – Proposed Development 217 High Street, Yiewsley, Hillingdon**

Apollo Medical (Apollo Capital Projects Development) have been asked to comment on a proposed 10,000sqft D1 Health Facility provision as part of a mix use residential / D1 development proposed by Taylor Wimpey at 217 High Street, Yiewsley in the London Borough of Hillingdon.

The NHS in England, as part of the five-year plan are looking to deliver primary care at scale to bring a degree of robustness to the service they deliver. By creating Hubs of over 15k patients, the numbers of GP's, nurses and other health care professionals increase and allow for not only immediate cover in high demand times but also allows the delivery of additional services to patients. The subsequent creation of Primary Care Networks (PCN) creates even larger delivery hubs for between 30k and 50k patients in a particular demography. The PCN's are made up of a group of GP practices who work together to deliver health. Quite often a Health Hub will be the focus for PCN enhanced activities such as Physiotherapy, mental health services, same day emergency care and pharmacy advice. The PCN need space to deliver these enhanced services which are essential for the new models of care and to reduce the pressures on the acute services. Yiewsley PCN current delivers services to almost 37,000 patents from 9 centres. The model becomes far more efficient when the Hub model is adopted to create delivery at scale. In Yiewsley centre there are 3 practices, High Street Practice and Yiewsley Family Practice both operate from the Health Centre and Otterfield Practice operate from a converted house in Otterfield Road. The 2 practices in the Health Centre currently have circa 20,000 while Otterfield have 7200. The town centre practices therefore make up the majority of the PCN seeing circa 27,000 patients. This number is set to rise in the coming years with a high number of residential developments taking place and the improved interconnectivity to central London via cross rail.

The CCG have already taken steps to address some of the immediate issues with a recent refurbishment of the Health Centre site, however, this has been confirmed as a short to medium term solution. The medium to longer term solution will be to create a more centralised hub in Yiewsley centred around the PCN core delivery model. The CCG have confirmed they require a Health Facility to meet there medium-term aspirations.

Taylor Wimpey's proposed development comprises the construction of a new 10,000sqft D1 health facility with an attractive public realm area to the front and 20 dedicated car parking spaces for staff and users and emergency drop off space to the side. The proposed health facility would be able to accommodate circa 15 consulting/ treatment spaces plus admin and waiting spaces as per the indicative layout shown on the floor plans. A Health Facility of this size would have circa 25 full time equivalent employees and a catchment of circa 5 square miles.

The D1 Health Facility would be built at the same time as the 235 residential units on the proposed site and would be ready for use in 2024. This meets the medium-term plan for the CCG and negotiations for the relocation could commence as soon as planning is approved. In order to transform the service provided to a growing population of patients with increased demands and expectations of the NHS, new facilities need to be provided in key locations that meets this need.

We are firmly of the opinion that this Health Facility / Hub is ideally located to protect the service of primary care in Yiewsley.

Yours Faithfully

**Rob James**
Managing Director
For and on behalf of
**Apollo Capital Projects Ltd**

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Apollo
The Primary Care Property Experts

Taylor Wimpey West London Ltd
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17 Bartley Wood Business Park
Bartley Way
Hook,
Hampshire
RG27 9XA

Date – 15 June 2020

**Re: Application Reference 68663/APP/2020/705 217 High Street, Yiewsley, West London.**

Primary Care in England is delivered by several different providers, these include GP's, dentists, pharmacies, and community providers. Doctors surgeries and GP's are not employed directly by the NHS but are small businesses with a contract with the NHS to provide GMS services. The GMS contract sets out a fee tariff for the provision of care plus elements of business that can be charged. These include some staffing costs, pensions, rates, and property costs. The property element is dealt with under the Premises Costs Directions.

Historically GP's set up their businesses in their own homes and then charged the cost of the mortgage as a notional rent back to the NHS. Over time and as populations grew, GP's started to form partnerships to create a more resilient service and to move away from the single-handed GP practitioner. This often-required GP's to then move away from practicing from their own homes and forming new partnerships in converted residential properties or purpose-built surgeries.

The GMS contract is open ended and is often referred to as a "contract for life". The GP or partnership can hand back their contract if they wish to retire or cease trading or the NHS can remove the contract should the GP or partnership be in breach of the conditions. However, more often than not the GP partnership will have a succession plan and bring on new partners to buy out the old. The new partners will often buy into the partnership by taking on the leaving partners property and GMS contract liabilities.

As the population of the UK continues to grow GP practices have had to employ new GP's as either partners or salary GP's (Employees) to deal with the increasing demands. Partnerships have increased in size and single-handed GP's are now almost unheard of. The larger partnerships are more efficient and create better service for patients and a better working environment for the GP's and staff.

No new GMS contracts have been issued in England in the past 5+ years. Any growth in population is taken up with existing partnerships, through existing GMS contracts and via an increase in contract value. If a new community is created outside of a current settlement, the local NHS will usually negotiate for a GP Practice to include this within their practice boundary. This could either be through the opening of a branch surgery or a sub partnership as part of a

group. If this fails, the NHS will then look to award an APMS contract which has similar tariffs for care but is only for between 5 and 10 years in length. This is not attractive for a new GP Partnership as it does not recognize the infrastructure costs and long-term commitment necessary.

In recent times, GP Practices have been working collaboratively to form Primary Care Networks (PCN). These are formed for areas of between 30k and 50k patients. These are groups of practices who collaborate to provide a more resilient service to patients. Its aim is to reduce admissions to hospitals by providing more services at a community level. The PCN's employ complementary practitioners such as physiotherapists, pharmacists, mental health nurses etc. These roles can be spread over several sites with these new professionals offering services to a wider patient community. The costs of these services are charged back to the NHS via the PCN contract.

So specifically, for Yiewsley, there are currently 3 practices in the centre, High Street Practice and Yiewsley Family Practice both operate from the Health Centre and Otterfield Practice operate from a converted house in Otterfield Road. The 2 practices in the Health Centre currently have circa 20,000 while Otterfield have 7200. The health centre currently has circa 650sqm net internal area for their 20k patients. The new heath facility will be nearly 50% larger than the existing premises with a total floor area of 232.2sqm. This will allow for the expansion of services to the current practice list and PCN patients and cater for an increase in population of over 10,000 new patients, possibly more given the changes to how patient care maybe delivered over the long term. The larger health hub facility would enable more efficient health care provision, fully compliant with current standards and post COVID guidance, allowing a wider and more flexible range of services to patients than available at their current smaller facility.

Therefore, the new, larger facility will be able to cater for more than just the 50% increase in patients suggested by the pro-rota amount of floorspace. This is why the CCG see the new development as a long-term solution. Although the proposals involve the expansion of existing practices, the net increase of patients would be equivalent or greater to the delivery of a new GP practice.

This strategy is being repeated throughout the UK and appears the most efficient way of dealing with the rising population numbers and levels of demand. Starting new GP practices in Yiewsley is unnecessary when there are already 3 in the town and a robust PCN delivering services from 9 centres in the region.

The new health hub as part of the Taylor Wimpey development on 217 High Street will provide much needed additional capacity for the rise in population and the additional services offered by the PCN and is fully supported by the CCG.

Yours Faithfully



**Rob James**
Managing Director
For and on behalf of
**Apollo Capital Projects Ltd**


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Tel: 02920 022 494

**Appendix D – Agreed Head of Terms for the D1 health facility between Taylor Wimpey and CCG (STRICTLY PRIVATE AND CONFIDENTIAL)**

Draft 9th June 2020 Subject to Contract

**HEADS OF TERMS**

**Proposed Development 217 High Street, Yiewsley, West London.**

| | | |
|---|---|---|
| 1. | Developer | Taylor Wimpey West London Ltd<br>Form 1, 17 Bartley Wood Business Park, Bartley Way, Hook, Hampshire, RG27 9XA |
| 2. | Developers Solicitor | Gateley Legal LLP<br>The Blade, Abby Square, Reading, RG1 3BE<br>RX4014 Reading<br><br>Contact – Tom Platt |
| 3. | Tenant | TBC |
| 4. | NHS Funder | Hillingdon Clinical Commissioning Group<br>Cricket Fields Road, Uxbridge, UB8 1QG<br><br>Contact – Craig Gibbard |
| 5. | Purchaser/Tenant Solicitor | TBC |
| 6. | Development | The D1 unit located on the ground floor of the residential development known as 217 High Street, Yiewsley, London. Along with 20 dedicated car parking spaces. |
| 7. | Services | The developer will contract to provide the following Services to the site:<br><br>• Gas Supply<br>• Electricity Supply<br>• Water connection<br>• Foul drainage connections<br>• BT / Virgin Media Ducts<br>• Connection into the site wide sustainable drainage system (SUDS) |
| 8. | Contracts / Terms | • 25-year lease with no breaks on full repairing and insuring Basis (FRI) |

- Rent £240p.s.m Subject to agreement with the District Valuer
- The initial 15 years of the term are subject to a 50% reduction of current market.
- Rent reviews to Retail Price Indexation with collar at 1% and cap at 4%
- Rent Reviews on a 5-yearly basis
- Rent reverts to full (100%) current market rent at year 16 and for the remainder of the term.
- The rent review will be conducted on the basis that full rent is being paid and the reduction applied post review.

9. Scheme

Developer will build a D1 health hub with a gross internal Area of 932sqm and a net internal area to be agreed subject to design development. The Health Hub will be fully fitted to comply with DVS Engineering Specification, ABC list for Primary Care Premises and HBN11-01 design for Primary Care.

The developer will provide 20no dedicated car parking spaces for the exclusive use of the medical centre staff and patients. All access roads and footpaths will be provided by the Developer.

10. Consideration

Head lease on shell unit to be held with 3rd party investor.

11. Planning / S106/ S278

The Developer is responsible for obtaining all necessary Planning and other statutory consents for the proposed scheme.

12. User

User of the property shall be Medical Centre Use class D1 with ancillary A1 Pharmacy and associated B1 office accommodation.

13. Special Provisions

None

14. Provisional Time Scale

Planning Application consideration – July 2020
Commence site works – October 2020
D1 unit shell complete – September 2022
D1 unit complete and handed to tenants – November 2022
The Developer will enter into an Agreement for Lease with [GP practice/s] or other NHS body subject to a 3 year Longstop from the date of the tenant entering into the agreement.
The target exchange date for the Agreement for Lease shall be [TBC]

15. Management Company

[TBA] Details Service charges to be applied appropriate to

| | |
|---|---|
| | The apportionment and area and use of the building. |
| 16. General | The Agreement for Lease will be subject to the approval of the District Valuer and Hillingdon CCG's approval process. |
| 17. Legal Costs | Each side will bear their own legal and surveyor costs |

Signed 

…….

**Daniel McDonagh – Land & Planning Director**
**Taylor Wimpey West London Ltd**

……

**Caroline Morison – Managing Director**
**Hillingdon Clinical Commissioning Group**

Dated 10th June 2020

**As per drawing HSY–AA–ALL–GF –DR–A-200**

# Appendix E – Yiewsley Health Hub Financial Benefits for Hillingdon CCG

**Yiewsley Health Hub - Financial benefits for Hillingdon CCG** **Jun-20**

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Agreed non subsidised rent** | **£240 per sqm** | £235,000.00 | £239,700.00 | £244,494.00 | £249,383.88 | £254,371.56 | £259,458.99 | £264,648.17 | £269,941.13 | £275,339.95 | £280,846.75 | £286,463.69 | £292,192.96 | £298,036.82 | £303,997.56 | £310,077.51 | £316,279.06 | £322,604.64 | £329,056.73 | £335,637.87 | £342,350.63 | £349,197.64 | £356,181.59 | £363,305.22 | £370,571.33 | £377,982.75 | £7,527,120.43 |
| Rent Review | | £4,700.00 | £4,794.00 | £4,889.88 | £4,987.68 | £5,087.43 | £5,189.18 | £5,292.96 | £5,398.82 | £5,506.80 | £5,616.94 | £5,729.27 | £5,843.86 | £5,960.74 | £6,079.95 | £6,201.55 | £6,325.58 | £6,452.09 | £6,581.13 | £6,712.76 | £6,847.01 | £6,983.95 | £7,123.63 | £7,266.10 | £7,411.43 | £7,559.66 | |
| **Agreed subsidised rent** | **£120 per sqm for initial 15 years** | £115,000.00 | £117,300.00 | £119,646.00 | £122,038.92 | £124,479.70 | £126,969.29 | £129,508.68 | £132,098.85 | £134,740.83 | £137,435.65 | £140,184.36 | £142,988.05 | £145,847.81 | £148,764.76 | £151,740.06 | £316,279.06 | £322,604.64 | £329,056.73 | £335,637.87 | £342,350.63 | £349,197.64 | £356,181.59 | £363,305.22 | £370,571.33 | £377,982.75 | £5,451,910.41 |
| Rent Review | | £2,300.00 | £2,346.00 | £2,392.92 | £2,440.78 | £2,489.59 | £2,539.39 | £2,590.17 | £2,641.98 | £2,694.82 | £2,748.71 | £2,803.69 | £2,859.76 | £2,916.96 | £2,975.30 | £3,034.80 | £6,325.58 | £6,452.09 | £6,581.13 | £6,712.76 | £6,847.01 | £6,983.95 | £7,123.63 | £7,266.10 | £7,411.43 | £7,559.66 | |
| **Current Market Rent** | **Rents being agreed on other health projects** | £279,000.00 | £284,580.00 | £290,271.60 | £296,077.03 | £301,998.57 | £308,038.54 | £314,199.31 | £320,483.30 | £326,892.97 | £333,430.83 | £340,099.44 | £346,901.43 | £353,839.46 | £360,916.25 | £368,134.57 | £375,497.27 | £383,007.21 | £390,667.36 | £398,480.70 | £406,450.32 | £414,579.32 | £422,870.91 | £431,328.33 | £439,954.89 | £448,753.99 | £8,936,453.62 |
| Rent Review | | £5,580.00 | £5,691.60 | £5,805.43 | £5,921.54 | £6,039.97 | £6,160.77 | £6,283.99 | £6,409.67 | £6,537.86 | £6,668.62 | £6,801.99 | £6,938.03 | £7,076.79 | £7,218.32 | £7,362.69 | £7,509.95 | £7,660.14 | £7,813.35 | £7,969.61 | £8,129.01 | £8,291.59 | £8,457.42 | £8,626.57 | £8,799.10 | £8,975.08 | |

**Notes**

Rent review based on RPI cap and collar compunded

Cap at 4% and collar at 1%.

Illustration based on 2% PA growth.

Heads of terms are based on £240 per sqm

Currrent regional CMR is circa £280 per sqm

| | |
|---|---|
| Saving between Agreed rent and 15 year reduced | £2,075,210.03 |
| Saving between CMR and agreed rent | £1,409,333.19 |
| **Saving to NHS on CMR and 15 year reduced** | **£3,484,543.22** |

# Appendix F – Hillingdon Strategic Intensions (prepared by NHS CCG)

NHS
Hillingdon
Clinical Commissioning Group




# Hillingdon Strategic Intentions

# 2020-2022

## 30th September 2019

NHS
Hillingdon
Clinical Commissioning Group

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# 1. Foreword

Welcome to our Strategic Intentions 2020–2022 for Hillingdon. This sets out our shared plans for NHS services in Hillingdon in partnership with our local health and care organisations to deliver high quality care and outcomes for our residents.

We are facing real challenges in delivering improved outcomes and high quality health care for patients, driven by increasing demand and constrained financial resources. We recognise that we can only achieve our ambitions by working together across NW London. We are moving ever closer to an alliance with our local Hillingdon health and social care partners to develop better and more "joined up" care for patients as part of an Integrated Care Partnership (ICP). We are also taking steps to more closely align to the NW London Integrated Care System (ICS).

Our shared goals are to keep our residents well, ensuring people that do need treatment get the right care and treatment at the right time, and have the right systems and functions in place to support when there is a life threatening or very urgent accident or emergency requiring swift treatment. These themes are reflected through these intentions as:

- **Keeping People Well**
- **Right Care, Right Time**
- **Managing in Times of Crisis**

## Keeping People Well

We have a strong prevention agenda to support early access to primary and community care. We have been implementing new models of care, including Neighbourhood Teams and community based clinics. These are being delivered by an empowered nursing and health care assistant workforce led by GPs and Consultants as part of multi-disciplinary teams to manage long term conditions. Conditions, that we have now long known, can and should be better addressed through supporting patients to proactively manage their condition at home. We are further developing our MyHealth programme, which has directly helped people to manage their own health with support and guidance from our healthcare professionals. These programmes are supporting people with identified needs avoid future health exacerbations, preventing their health from deteriorating, helping those with a life-long condition to plan and live better with their health status, and in these ways prevent hospitalisations.

## Right Care, Right Time

While the NHS is made up of a number of individual organisations, our goal is to deliver a seamless experience for anyone who becomes a patient. Through our developing ICP Hillingdon health and care organisations they have developed strong collaborative functionalities between our hospital, community, primary,

ambulance, 111 and social care services so patient treatment plans and care records are accessible by the multi-disciplinary teams that will support them.

We think that the best outcome we can pursue for our residents is to avoid ill-health and thereby avoid invasive treatments in hospital. However, when someone does have a diagnosis that leads to an invasive treatment, best practice indicates that the best outcomes happen from a planned care pathway to treatment and recovery.

Over the past year we have worked with NW London partners to update planned care pathways according to latest best practice and clinical guidance. Many years ago diabetes was treated in hospital. Now, diabetes can be managed at home by people themselves. The same developments have happened in a number of other areas and conditions. Not all can be treated at home yet, but many can be diagnosed and treated in primary care and the community, completely avoiding a hospitalisation. We have brought together our clinical workforce of GPs, clinicians, nurses and allied health staff to deliver community clinics led by the expertise our residents expect, but in a different setting. Our paediatric community clinics are a pioneering local example of this. Our ophthalmologists are working with high street optometrists to improve access to eye care. Our pharmacists in the high street too are able to answer questions about health and guide people to the right care. Into the future we will be looking to set up digital appointments to catch up to the technology revolution the rest of the world has experienced over the past decade. There is much to be done, and we have the enthusiasm and initiative to achieve it.

## Managing in Times of Crisis

We have worked very diligently together in Hillingdon and NW London to ensure that our residents can get emergency and urgent care help through our 111 telephone service as a first point of call.

In an urgent situation, our residents can call 111 for help. If the situation is a life-threatening emergency, 111 is able to call upon our ambulance services to send help immediately. If it is not immediately life-threatening, but does require immediate treatment such as a broken bone, 111 will advise going to hospital straight away. If the situation is urgent but not life threatening, 111 is able to book an urgent appointment with a GP as soon as possible. This appointment may be at a primary care practice, one of our GP Hubs, or on-site at the Urgent Treatment Centre, depending on which site has the earliest available appointment and the right person or equipment to treat the issue. At times the situation is found to be a fairly normal health issue that can be routinely treated by a GP, then it will be recommended that an appointment be made with your GP.

We have also created a Single Point of Coordination for people we know to have conditions that result in ongoing health emergencies. Our Neighbourhoods model means that multi-disciplinary teams can help people and put health care plans in place to manage these conditions and reduce the number of health emergencies a person

experiences. This means a better quality of life living with these conditions and fewer hospitalisations.

## The National Context

Critical to the priorities set out in our local Strategic Intentions is the publication of the NHS Long Term Plan in January 2019. The Plan builds on the work achieved since the NHS Five Year Forward View (5YFV) of the move towards place-based systems of care and to integrate are to meet the changing needs of the population who are living longer with more complex needs. The Plan sets this out in 7 chapters:

1. A new service model for the 21st Century
2. More NHS Action on Prevention and Health Inequalities
3. Further Progress on Care Quality and Outcomes
4. NHS Staff will get the backing they need
5. Digitally enabled care will go mainstream across the NHS
6. Taxpayers Investment will be used to maximum effect
7. Next Steps & Appendix: How the NHS Long Term Plan supports wider social goals

In reviewing the Plan we are assured that Hillingdon is already enabled to deliver many of these priorities through building on the work that has been done to enhance local services, access, systems and joined up working in recent years.

We are excited to share these Strategic Intentions, recognising that the goals and actions outlined here are not the end of the journey, but a fresh chapter continuing the good work begun at the birth of the NHS over 70 years ago. This is a living document that will evolve over time based on further engagement activities with the public, partners and providers, in line with current national, regional and local strategies to 2022. We will continue to develop, embed, and scale up commissioned services.

We would like to thank everyone who has contributed to the development of these intentions and look forward to delivering the best outcomes in healthcare for everybody in Hillingdon.



**Ian Goodman**
Clinical Governing Body Chair
Hillingdon CCG



**Caroline Morison**
Managing Director
Hillingdon CCG

# 2. The Strategic Context & plans towards working as an Integrated Care System (ICS)

In developing our local Strategic Intentions (SI) we are incorporating our local challenges and needs as well as those of the wider NW London health economy and national policy. This section outlines the national, NW London and local strategic context and response to challenges to take forward population health commissioning to deliver personalised and integrated care through our Integrated Care Partnership (ICP).

## 2a. The National Strategic Context

The NHS Long Term Plan' (the Plan) was published setting out the ambitions for NHS over the next ten years. The `*Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan*' 31 January 2019 was also published alongside the Plan.

The Plan builds on the work achieved since the NHS Five Year Forward View (5YFV) of the move towards place-based systems of care and to integrate care. This is to meet the changing needs of the population who are living longer with more complex needs and to improve care outside hospitals in primary care and the community. The Plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. Integrated Care Systems will be the main vehicle to achieve this and will focus on addressing population health needs. The Plan sets out in 7 Chapters:

1. A new service model for the 21st Century
2. More NHS Action on Prevention and Health Inequalities
3. Further Progress on Care Quality and Outcomes
4. NHS Staff will get the backing they need
5. Digitally enabled care will go mainstream across the NHS
6. Taxpayers Investment will be used to maximum effect
7. Next Steps & Appendix: How the NHS Long Term Plan supports wider social goals

Chapter 1 sets out the new service model to deliver joined up care. Key to this will be general practices joining together to form Primary Care Networks (PCNs), that will be expected to take a proactive approach to managing population health. From 2020/21 these Networks will assess the needs of their local population to identify people who would benefit from targeted, proactive support.

> *Over the next five years, every patient will have the right to online 'digital' GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments*
>
> *The NHS Long Term Plan (2019)*

Chapter 1 also commits to developing fully integrated community-based health care to support new urgent service channels and relieve pressure on A&Es. This will involve developing

multidisciplinary teams working across multiple sites. The long-term plan calls for a radical change in the way that the NHS works alongside patients and individuals. It highlights the need to create genuine partnerships between professionals and patients. As part of this shift, the plan focuses on personalisation. There is a commitment to rolling out the NHS comprehensive model of personalised care (supporting a whole population, person-centred approach).

Chapter 2 supports the prevention agenda to help cut smoking rates, manage weight loss, improve Diabetes Type 2 prevention, address alcohol-related A&E admissions, and support lowering air pollution.

Chapter 3 targets variation in health outcomes, extending the NHS Five Year Forward View focus from cancer, mental health, diabetes, multimorbidity and healthy ageing, to also include children's health, cardiovascular and respiratory conditions, learning disability and autism, amongst others.

Chapter 4 lays the foundation for addressing workforce pressures with a number of specific actions to be overseen by NHS Improvement as part of a national drive to train, retrain, and retain valuable NHS staff.

Chapter 5 promotes the use of technology and digitally enabled care across the NHS. This includes at home devices for patients, and access to Clinical Decision Support systems for GPs and clinicians.

Chapter 6 anticipates the need to continue to drive efficiency gains in the NHS in order that the NHS achieve financial sustainability, whilst also feeding through the 3.4% five year NHS funding settlement monies to enable transformation.

Chapter 7 provides a supporting framework for implementing the changes set out within the Plan, and key milestones and timelines for delivery to assist in priority setting.

*The NHS has been marking its 70th anniversary, and the national debate this has unleashed has centred on three big truths.*

*There's been pride in our Health Service's enduring success, and in the shared social commitment it represents. There's been concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population. But there's also been optimism – about the possibilities for continuing medical advance and better outcomes of care.*

*In looking ahead to the Health Service's 80th birthday, this NHS Long Term Plan takes all three of these realities as its starting point. So to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. This Plan sets out how we will do that*

*The NHS Long Term Plan (2019)*

## 2b. Plans to work towards a NW London Integrated Care System (ICS) and our local Hillingdon Integrated Care Partnership (ICP)

### The NW London Integrated Care System

Carrying forward the work founded in the System Transformation Partnerships (STPs), NW London NHS organisations are moving toward an Integrated Care System (ICS), as outlined in the national guidance and The Plan, with further detailed guidance still emerging as regional and local NHS organisations work together to deliver to the policy vision.

NWL CCGs in particular are working ever more closely together and toward a single CCG model, including shared and joint priorities with regional and local responsibilities for delivering high quality care and transformation. Further work is expected over the next two years to deliver this single model and provide population-based healthcare for the residents of NWL in partnership with Health and Care organisations, including our local borough council partners. This will be a complex process with many stakeholders involved, but all with the enthusiasm for the same goal – to deliver a better and more effective health and care system through integration and joined up care between services!

NWL organisations are currently drafting System Intentions 2020/21 to further inform and align local priorities across our patch. The NWL intentions will reflect the direction of travel for health and care partners to align working to deliver financial sustainability and quality health outcomes as we move towards an ICS in line with the Long Term Plan ambitions. Draft plans are anticipated by November 2019, in line with NHS England guidance shared with NWL CCGs.

### The local Hillingdon Integrated Care Partnership

Hillingdon CCG has been working with our health and care partners across Hillingdon to further develop our local Integrated Care Partnership. Hillingdon has been cited as leading the way with ICP development, taking the initiative to shape our future locally. It is therefore a critical part of our plans to ensure there is a credible Hillingdon ICP in place and operating, given that this is both a national and local requirement.

Our local partners (THHFT, CNWL, HPCC and Hillingdon4All) have come together to form a partnership called Hillingdon Health Care Partners (HHCP) to help enable the integration of services. The ICP will allow us to work as one whole system to implement population health and person-centred care models. Our focus for 18/19 (current year) is on the 18+ population with an emphasis on the following priority areas:

1. Extending active case management to the 15% of the adult population most at risk of a non-elective episode by optimizing the following programmes:

    a. Further development of Care Connection Teams (CCT) including self care
    b. Implementing a `High Intensity User Service' for the top 50 'Frequent Attenders' to A&E
    c. End of Life care pathway
    d. Falls Service and frailty pathway

e. Better support to care homes Including development of an Acute Home Visiting service that will be incorporated into the Care Home model (Care home & acute visiting service)

2. Transforming the MSK pathway
3. Intermediate Tier development – incorporating integrated HHCP and LBH urgent community response and follow up; same day emergency care at THHFT and integrated discharge from THH, Hawthorne Intermediate Care Unit (HICU) and Oaktree ward
4. `Local Neighbourhod Teams' aligned with PCNs comprised of integrated multi-disciplinary teams led by general practice as the basic delivery unit of integrated care.

During 2019/20 onwards we will be using this as an approach and vehicle to deliver the SI set out in this plan.

One of our key aims locally is to prioritise the System Transformation Programme to create a comprehensive plan to address the system deficit and operational performance issues either in full or in part - with each element becoming an additional chapter to the existing HHCP Integrated Business Case (IBC). This will involve expanding the current IBC to incorporate: planned care, mental health and Children & Young People which will therefore create a 'whole population IBC' that will be essential to meeting the requirements for ICP development. This will also require putting in place a Virtual Strategic Transformation Team from existing redeployed resources where possible to support the Transformation and Organisational Development Programme including Neighbourhood Development.

Proposed future forms of local teams/ICPs are currently being developed at NW London. The emergence of NWL ICS 'ways of working' is already requiring system accountability which developing a local ICP will enable and enhance.



***Neighbourhood Network Event 23rd January 2019***

Martin Hall (GP) & Kathleen Sadler (Chief Operating Officer) from the Confederation, Hillingdon CIC & Claire Eves (Head of Adult Services) & William Sakala (Assistant Director of Nursing) from CNWL

## 2c. The North West London Local Digital Roadmap

The NW London Local Digital Roadmap (NWL LDR) is critical to supporting the identified STP priorities and harnessing technology to accelerate change, as the NW London health care community moves towards greater digital maturity in delivering clinical services, and digitally connecting citizens and health and social care professionals. The main components of the LDR strategy are:

- To automate clinical workflows and records, particularly in secondary care settings, and remove the reliance on paper so organisations become paperless and transfers of care are supported through interoperability
- To build a shared care record across all care settings, through interoperability, to deliver the integration of health and care records that are required to support emerging and new models of care, including the transition away from hospital care to new settings in the community and at home
- Extend access to shared patient records to patients and carers, to help them to take an active role in their own care
- Provide people with tools for self-management and self-care, further supporting digital empowerment and the shift away from traditional care to new channels
- Use of dynamic data analytics to inform care decisions, and support integrated health and social care through whole systems intelligence.

To ensure the elements of the LDR deliver to best effect we need a continued focus on some of the underpinning principles of high quality IT including:

- Improved accuracy, timeliness and quality of data entered into clinical and non-clinical systems
- The mandated use of NHS number as patient identifiers by all providers
- To facilitate GP Practices to become GDPR (General Data Protection Regulation) compliant
- Ensuring data is safe and secure, by further embedding role-based processes for access
- Identification and mitigation of issues of non-compatibility across software packages
- Maximisation of the opportunities presented by mobile working to increase time for patient-facing activity for clinicians and staff
- To ensure that current and newly procured IT systems take into account the ease of accessibility for users and those with a physical/learning disability.

There is also a need to address how data is transmitted. In the last five years there has been a huge increase in the amount of data being transmitted to and from services. To allow for this growth to continue we will have to address the limits being imposed by the outdated technologies and systems across the patch. We will accelerate and strengthen the use of data by working with partners across the system and ensuring commissioning and contracting are aligned with these priorities.

## 2d: The North West London Transforming Care Partnership Plan

Transforming Support for people with Serious Mental Illness and those with Learning Disabilities: The NW London Long Term Plan focuses on improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with a Learning Disability (LD) and/or autism, who have mental health needs and / or display challenging or offending behaviour.

In delivering this plan locally, we outline below how we will keep those with serious mental health needs well, to provide them with the right care at the right time when they need it, and how we will respond in times of crisis when our residents urgently need our support and intervention.

### Keeping People Well

- Build up community capacity in neighbourhoods to support the most complex individuals in a community setting and avoid inappropriate hospital admissions
- Extend and develop a holistic and coordinated primary care mental health service that enables more people to recover and stay well in the community, including those with substance abuse
- Further integrate our LD service with the LBH LD services and provide a holistic community service response that supports people to remain safely in the community in the least restrictive environment
- Ensure that people with LD can access care and support to remain in the community, reduce hospital admissions and support the Stop Overmedication of people with a LD working with Medicines Management and providers
- Work with LBH, Primary Care, Hospital Trusts and providers to support introduction of reasonable adjustments for people with LD and/or Autism
- Work with LBH and schools to expand access to strategies to manage anxiety and depression for CYP and improve their overall health and wellbeing
- Increase support for CYP and their families who are experiencing emotional distress to build resilience and improve mental health and wellbeing
- Increase access for people who require Talking Therapies (Improving Access to Psychological Therapies) to support them with strategies to manage anxiety and depression and improve their overall health and wellbeing
- Review and improve the personality disorder pathway for patients with complex mental health needs
- Extend our co-commissioning with the local authority to support people with Mental Health, Autism and/or Learning Disability to access social networks and community support that contributes to a healthy lifestyle.

## Right Care, Right Time

- Develop an integrated community based model in partnership with LBH, CNWL and people who use services so that it provides: rehabilitation, promotes self-care, return to employment opportunities and access to education to support people to maintain mental well-being
- Key is the development of a NW London community strategy and the utilisation of more skilled staff to support people with complex and challenging needs in local communities
- Targeted work with individuals and services enabling others to provide person centred support to people with LD and their families/ carers
- Extend our co-commissioning to include Personal Health Budgets for people (adults and Children) entitled to section 117 aftercare
- Use information from Learning Disabilities Mortality Reviews to support earlier intervention for Persons with a Learning Disability around their ongoing conditions and acute healthcare needs
- Identify PwLD at risk of admission through Whole System Integrated Care (WSIC) data and risk registers – develop a stratification tool to support with identifying individuals and decisions around their care and support early in the LD pathway.

## Care at times of Crisis

- Ensure practitioners across primary care/secondary care services/social care and third sector partners, can respond effectively to people who may require a range of support, in order to avoid unnecessary admission to acute and crisis beds, and to ensure reasonable adjustments for people with LD and/or autism through development of PCNs across NWL (Neighbourhoods)
- Introduce active case management and personalised care plans for people with MH needs and ensure rapid access to treatment and support through joint working with our partners including LBH and police
- Improve access, quality and safety for people in mental health crisis to a Crisis Cafe/Safe Haven response service and Health Based Place of Safety (HBPOS) through joint working with partner organisations
- Provide coordinated care for CYP and Adults with a LD and/or autism to avoid an unnecessary admission to hospital
- Develop an all age at risk of admission register for LD/Autism cohorts
- Deliver a rapid response service for CYP and Adults with a LD and/or Autism when experiencing a mental health crisis and avoid unnecessary hospital admission.

## 2e. Our Local Joint Health and Wellbeing Strategy 2018-2021 and alignment with NWL STP Improvement Areas

Our local Joint Health and Wellbeing Strategy 2018-2021 (JHWBS) is a key strategic document informing our priorities for the next two financial years. It outlines what we have collectively agreed to do locally in Hillingdon CCG, in collaboration with health and care partners, and through consultation with Hillingdon residents. Our plans are built around the 10 Transformation Themes and 6 Enabling Themes contained therein. These Themes (Transformation & Enabling) are also aligned to the 22 Improvement Areas stated within the NW London STP.

### Hillingdon Transformation and Enabling Themes

| 10x **Transformation Themes** |
|---|
| T1. Transforming Care for Older People |
| T2. New Primary Care Model of Care |
| T3. Integrating Services for People at the End of their Life |
| T4. Integrated Support for People with Long Term Condition (LTCs) |
| T5. Transforming Care for People with Cancer |
| T6. Supporting People with Serious Mental Illness and those with Learning Disabilities |
| T7. Integrated Care for Children & Young People |
| T8. Integration across the Urgent & Emergency Care System |
| T9. Public Health and Prevention of Disease & Ill-Health |
| T10. Transformation in Local Services |
| 6x **Enabling Themes** |
| E1. Developing the Digital Environment |
| E2. Creating the Workforce for the Future |
| E3. Delivering Our Strategic Estates Priorities |
| E4. Delivering Our Statutory Targets Reliably |
| E5. Medicines Management |
| E6. Redefining the Provider Market |

## Hillingdon Alignment with NWL STP Improvement Areas

| NWL STP Improvement Area | Hillingdon Themes |
|---|---|
| 1. Enabling & Supporting Healthier Living | All 10 Transformation Themes |
| 2. Wider Determinants of Health Interventions | (T4) (T9) |
| 3. Helping Children To Get The Best Start In Life | (T7) |
| 4. Address Social Isolation | (T1) (T4) (T5) (T9) |
| 5. Improve Cancer Screening To Increase Early Diagnosis & Faster Treatment | (T5) |
| 6. Better Outcomes & Support For People With Common Mental Health Needs, With A Focus On People With Long Term Physical Health Conditions | (T4) |
| 7. Reducing Variation By Focusing On RightCare Priority Areas | (T2)(T4)(T5)(T9)(T10) |
| 8. Improve Self-Management & "Patient Activation" | (T4) |
| 9. Improve Market Management & Take A Whole Systems Approach To Commissioning | (T10)(E6) |
| 10. Implement Accountable Care Partnerships | (E6) |
| 11. Implement New Models of Local Services Integrated Care To Achieve Consistent Outcomes & Standards | (T1)(T2)(T3)(T8)(E4)(E5) |
| 12. Upgrade Rapid Response & Intermediate Care Services | (T1)(T8) |
| 13. Create A Single Discharge Approach & Process Across NW London | (T1)(T8)(T10) |
| 14. Improve Care In The Last Phase Of Life | (T3) |
| 15. Implement The New Model Of Care For People With Serious & Long Term Mental Health Needs To Improve Physical & Mental Health & Increase Life Expectancy | (T6)(E5) |
| 16. Address The Wider Determinants Of Health | (T1)(T4)(T9) |
| 17. Deliver Crisis Support Services Including Delivering The 'Crisis Care Concordat' | (T6)(T8) |
| 18. Implementing "Future In Mind" To Improve Children's Mental Health & Wellbeing | (T4)(T7) |
| 19. Specialised Commissioning To Improve Pathways From Primary Care & Support Consolidation Of Specialised Services | (T2)(T10)(E5) |
| 20. Deliver The 7 Day Services Standards | (T10)(E4) |
| 21. Reconfigure Acute Services | (T8)(T10)(E4) |
| 22. Deliver The NW London Productivity Programme | All Transformation & Enabling Themes |

## 2f. Hillingdon Financial Challenge

In June 2018 the government set out a new multi-year funding plan for the NHS, setting real terms growth rate for spending in return for the NHS agreeing a new long-term plan with the government later this year. The main elements of the funding package are as follows:

- NHS will receive an average 3.4 per cent a year real-terms increase in funding over the next 5 years starting in 2019/20
- Increased funding will support a new 10-year long-term plan the NHS will bring forward
- The long-term plan will help the NHS tackle waste and improve services

The NHS will receive increased funding of £20.5bn in real terms per year by the end of the five years compared to today. An average 3.4% per year overall. The increase will mean the NHS can regain core performance and lay the foundations for service improvements. The funding will be `front-loaded' with increases of 3.6% in the first 2 years, which means £4.1 billion extra next year. This long-term funding commitment means the NHS has the financial security to develop a 10-year plan. The plan will be developed by the NHS, working closely with government and be published later this year. The priorities include:

- To get back on the path to deliver agreed performance standards, locking in and further building on the recent progress made in the safety and quality of care
- Transforming cancer care so that patient outcomes move towards the very best in Europe
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- Better integration of health and social care, so that care is not compromised when patients are moved between systems
- Focusing on the prevention of ill-health, so people live longer, healthier lives.

It will be essential that every pound in the NHS budget is spent wisely. The government will set the following NHS five financial tests to show how the NHS will do its part to put the service onto a more sustainable footing:

- Improving productivity and efficiency
- Eliminating provider deficits
- Reducing unwarranted variation in the system so people get consistently high standards of care wherever they live
- Getting much better at managing demand effectively
- Making better use of capital investment

From 2019/20 it is expected that demand for services in Hillingdon will increase by circa 20%. This is made up of the expected growth in the population (called demographic growth) of c.7% and the growth in the prevalence of disease and ill-health through such things as increasing rates of diabetes (called non-demographic growth) of c.13%. In addition, the government agreed a pay increase for the majority of NHS staff of a minimum of 6.5% over three years, starting

in 2019/20 which will need to be financed from within this financial settlement.

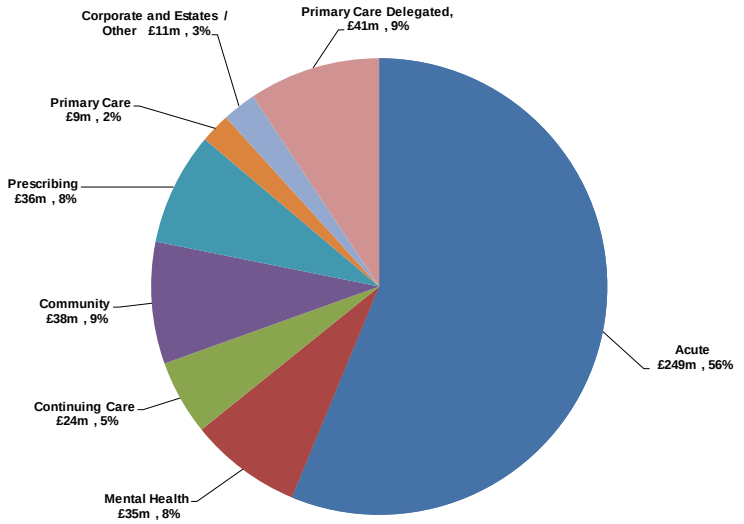
It is therefore essential that our plans include a range of approaches to address this growth in service demand and cost, including preventing people becoming ill in the first place. These approaches relate to: encouraging healthier lifestyles, ensuring that the services we commission are truly delivering the outcomes we expect, in a way that provides best use of resource, integrating where appropriate and reducing duplication and improving coordination of care.

The CCG's QIPP planned requirement for 19/20 is £9m which is c2% of the CCG's overall budget allocation. It is difficult to fully disaggregate the expenditure for e.g. Urgent & Emergency Care from the expenditure on Children & Young People as there is a significant overlap between transformation themes.

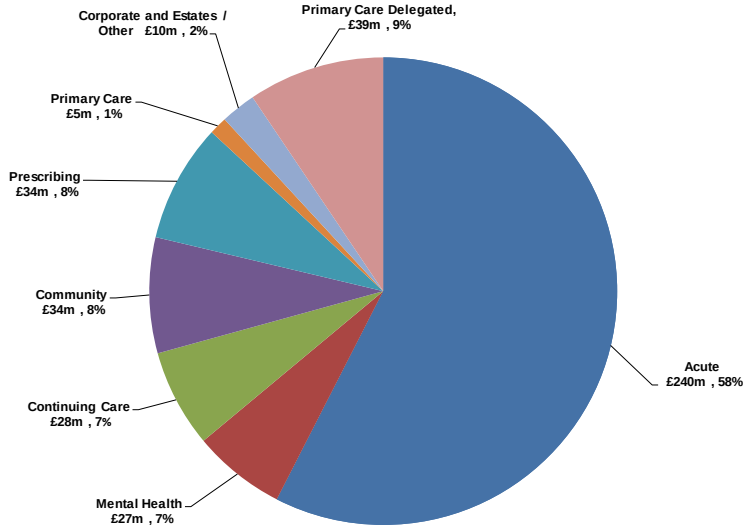
In 2019/20 the CCG has a £1.7m deficit plan against a control total of breakeven, and at M4 the CCG has reported on plan against this forecast outturn. As it is the CCGs statutory duty to breakeven, the CCG aims to get back into financial balance in 2020/21 and is currently working through various recovery actions in order to achieve this.



**Forecast outturn at M4 of 2019 /20 Net Expenditure by Service (£m)**




**2018/19 Net Expenditure by Service (£m)**



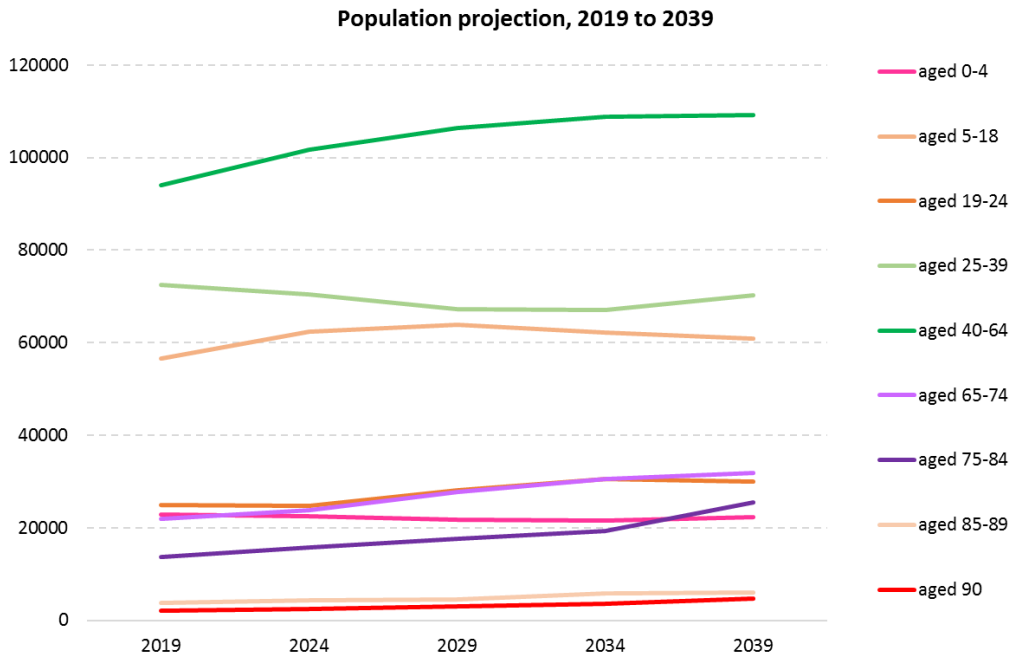
# 3. The Hillingdon Health Landscape

## 3a Population Demography

Hillingdon is the second largest London borough by area, located 14 miles from central London. It has the 12th largest population out of the 32 London Boroughs.

Using data from the Office of National Statistics' Mid-Year Population Estimates (2018) indicates Hillingdon population to be 304,850 with 22,490 (7.4%) aged 0-4 years, 40,690 (13.3%) aged 5-14 years, 201,030 (65.9%) aged 15-64 years, 21,420 (7.0%) aged 65-74, 13,460 (4.4%) aged 75-84, and 5,760 (1.8%) aged over 85. According to the same source, the proportion of men to women in the borough is 50.2% to 49.8%.

Population growth of approximately 14% is predicted for Hillingdon between 2019 and 2039. The larger proportion of this growth will be front-loaded occurring between 2019-2029 and slowing after this to 2039. Current estimates suggest a decrease in the 0-4 and 25-39 age bands (by 640 and 2,365 respectively) but a growth in all others age groups – the most pronounced of which will be the 40-64 age group (+15,189) and 75-84 (+11,764).




**The graph above shows the relative growth of the different age groups in Hillingdon between 2019-2039**

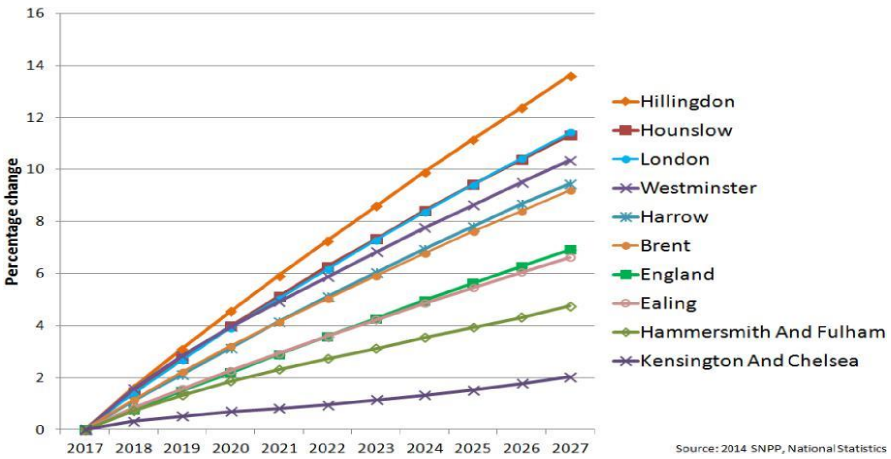
Comparatively, the population growth in Hillingdon is projected to be higher than any other NWL borough, and will be above the average for both London and England.

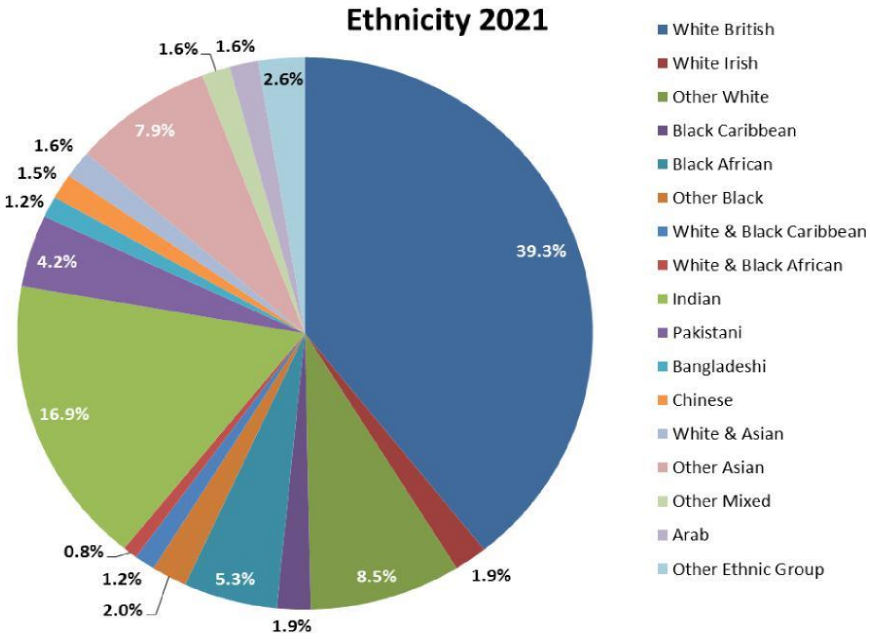
The age structure of the population in Hillingdon is intermediate between London and England, with a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England.

Hillingdon is an ethnically diverse borough with 46.9% of residents in 2017 projected to be from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021.

Christianity is the predominant religion in the borough with 49.2% from this faith. 10.6% are Muslim, 8% are Hindu, 6.7% are Sikhs, 17% have no religion and 6.4% chose not to state a religion. The preferred language in the borough is English with 81.2% residents stating this as their main language. Of the remaining 18.8% the majority speak English 'very well' or 'well'; 8,240 residents (16.8%) stated they cannot speak English well or at all. Apart from English, the most spoken languages in the borough are Punjabi (8,837 residents, 3.4%) and Polish (3,994 residents, 1.5%) (*Census, 2011).*

**Population Growth Projections**



## 3b. Health profile – Joint Strategic Needs Assessment

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies key health and wellbeing needs of people in Hillingdon. It is regularly updated with the latest available information to ensure our programmes and priorities are able to respond to the changing needs of our population. Our JSNA is available to read online at https://www.hillingdon.gov.uk/jsna. The JSNA is a key document informing the priorities and outcomes in this strategy. The JSNA underpins Hillingdon's JHWBS which is the overarching local strategy roadmap to addressing health and wellbeing needs and outcomes in Hillingdon.

The life at expectancy at birth in 2016 for males in Hillingdon is 80.8 years and for females is 83.8 years, and is higher than the England average. However, health status is not the same in all parts of Hillingdon, there are health inequalities, i.e. differences in life expectancy, depending on where people are living in the borough. There is a difference of around eight years in the life expectancy of people living in Botwell ward compared to people living in Eastcote and East Ruislip wards. Socio-economic circumstances have a complex relationship with health status and unhealthy lifestyle choices further increase the risk of ill-health, including smoking, poor diet, lack of physical activity, higher levels of alcohol consumption and/or binge drinking. The population is ageing and living longer due to which there will be a higher proportion of frail older people in the population. Over half of people aged 65 and over are diagnosed with multiple long term conditions, such as dementia, which increases dependency on care and support. The prevalence of long-term conditions is predicted to increase and years spent in good health are not increasing at the same rate as life expectancy. Therefore, it is important to maintain focus on keeping people well for longer.

Overall, our health outcomes in Hillingdon are varied when compared to the average for England. Hillingdon **compares well** against the England average in many areas, with some positive indicators being:

- Overall, people living in Hillingdon live longer lives compared to the average for England, but life expectancy varies within the borough
- Lower levels of prevalence compared to other boroughs nationally in London for learning disabilities, mental illness and cancer
- Adults in contact with secondary mental health services tend to live in stable and adequate accommodation
- levels of breastfeeding, which provides the best start in life for babies, and leads to a healthier life, are higher in Hillingdon than the national average
- Lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England
- Rates of teenage pregnancy in Hillingdon are similar to the England average
- Fewer people are admitted to hospitals in Hillingdon with an alcohol-related condition than the England average

- Early death rates (under age 75) from respiratory diseases are lower than the England average
- Lower rates of sexually transmitted infections compared with other London Boroughs, although higher than the England average
- The proportion of people killed and seriously injured in road accidents is significantly lower than the England average.

Hillingdon **compares less well** on the following indicators:

- According to Quality Outcomes Framework (QOF) measures 2016/17, the prevalence of the following health conditions are higher in the borough of Hillingdon compared to the London average:
    - Coronary Heart Disease (CHD), Atrial Fibrillation (AF)
    - Cardio Vascular Disease (CVD), Peripheral Arterial disease (PAD)
    - Stroke/Transient Ischaemic Attack (TIA)
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Asthma, Dementia and Depression

    While the overall detection of the former conditions are good, they could be improved.

- Rates of social isolation among social care users and their carers are too high
- Accommodation and employment needs of adults with learning disabilities are not being adequately met
- A higher proportion of children aged 10-11 are overweight / obese as compared to the national average
- Proportion of 5 year old children free from dental decay are significantly worse than the national average
- Rates of childhood vaccination are lower than the England average
- Higher rates of Tuberculosis (TB)
- Higher recorded prevalence of diabetes
- Proportion of adults who are physically active is lower than the national average
- Admission rates for alcohol related conditions for people aged 65 and over are higher than both London and England average
- Cancer screening rates are low
- The percentage of population being offered an NHS health check is low
- Lower birth weight for babies at term is significantly higher than the England average.

## Indices of Multiple Deprivation

Indices of Multiple Deprivation (IMD) are a group of measures of relative deprivation primarily for small areas (lower super output areas (LSOAs)) in England. They provide deprivation scores for each LSOA, ranked from 1 (most deprived area) to 32,844 (least deprived area).

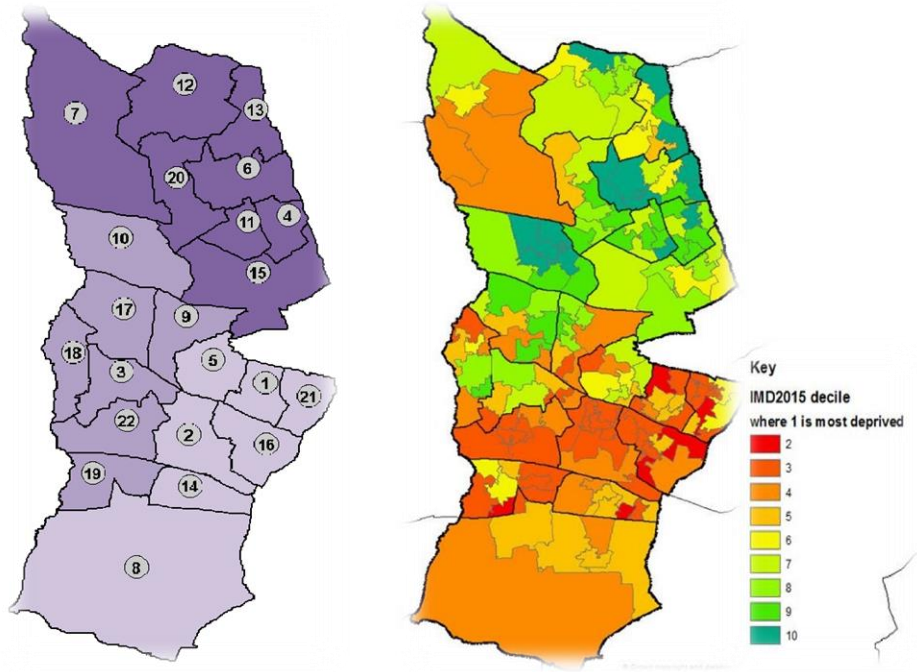
The scores are calculated from 37 indicators grouped under seven different domains or themes, each measuring a different type of deprivation to produce an overall indicator, the IMD.

These statistics are a measure of relative deprivation, not affluence, so not every person in a highly deprived area will themselves be deprived. Likewise, there will be some deprived people living in the least deprived areas.

Three in five (61 per cent) of the 326 local authorities in England contain at least one Neighbourhood which is in the most deprived decile nationally according to the Indices.

Hillingdon contains no neighbourhoods in the most deprived decile. Hillingdon is ranked number 23 out of 33 London Boroughs (including City of London), and number 153 out of all 354 authorities in England.

The graphics show variation in deprivation in Hillingdon by ward area.




| **Ruislip & Northwood** | **Uxbridge & West Drayton** | **Hayes & Harlington** |
|---|---|---|
| 4 Cavendish | 3 Brunel | 1 Barnhill |
| 6 Eastcote & East Ruislip | 9 Hillingdon East | 2 Botwell |
| 7 Harefield | 10 Ickenham | 5 Charville |
| 11 Manor | 17 Uxbridge North | 8 Heathrow Villages |
| 12 Northwood | 18 Uxbridge South | 14 Pinkwell |
| 13 Northwood Hills | 19 West Drayton | 16 Townfield |
| 15 South Ruislip | 22 Yiewsley | 21. Yeading |
| 20 West Ruislip | | |

## 3c. Hillingdon Local Health and Care Providers Landscape

### Primary Care

Primary Care services are predominantly those delivered by GPs in practices commissioned by Hillingdon CCG.

The CCG took on level 3 delegated commissioning of primary care in 2018/19. Hillingdon GPs have formed The Confederation, Hillingdon CIC (The Confederation) enabling general practice to work at scale and to provide a strong primary care voice within their organisation. Their specific aims are: `*to improve care for patients through further collaboration across general practice and will support practices to work together to deliver high quality services, release clinical time and develop the primary care workforce.'*[1] This is with the exception of two practices that we continue to engage with to ensure all patients in Hillingdon have equitable access to services and health initiatives. The Confederation is a key partner in Hillingdon's Integrated Care Partnership (ICP). Through The Confederation, Hillingdon CCG can continue to deliver priorities for primary care transformation including: extended access hubs, 24 hour blood pressure monitoring services, integrated paediatric clinics, Weekend Care Home Service and Care Connection Teams and work together in the future to deliver additional integrated care services. Our primary care services programmes also include working with other partners such as pharmacy, dentistry and ophthalmic.

### Hospital Based Acute Care

Our hospital based care is provided mostly by The Hillingdon Hospitals NHS Foundation Trust (THHFT), for which Hillingdon CCG is the lead commissioner on behalf of all CCGs who commission services from the Trust.

THHFT provide planned and unplanned care services, supported by an Urgent Treatment Centre on site at the front door of our A&E, which is managed by Greenbrook. The Hillingdon Hospital is the place where most Hillingdon patients have their in-hospital needs met. We work closely with THHFT to continuously improve the quality of acute care services and to transform care, where appropriate, in alignment with NW London and local strategic plans.

Hillingdon CCG is also the lead commissioner for some services with Royal Brompton & Harefield NHS Foundation Trust (RBHFT) who ae the largest specialist heart and lung centre in the UK. However, NHS England commissions the majority of services from RBHFT due to their specialist nature. In addition to being the leads on the contracts for THHFT and RBHFT, Hillingdon CCG is also an Associate Commissioner on the contracts for other acute trusts where our residents receive care. We work closely with the lead commissioners of those trusts to ensure that the SI intentions laid out here are applied across all providers from which our residents access care.

[1] http://www.hillingdonprimarycare.co.uk/page1.aspx?p=3&t=1

## Carers, Families and Patients

We are grateful for the valuable contribution made by carers and families of all types who support individuals of all ages and greatly add to their quality of life and the outcomes they experience. Partnership working across health and care partners has contributed to 30% of the estimated number of Adult Carers and 45% of the estimated number of Young Carers being registered with the Hillingdon Carers' Partnership, which is above the target of 24% for both groups. This is so important because the first step towards supporting Carers is identifying them.

The most important person in our health system is you. We aim to empower and support you so that you have the confidence to make informed decisions about your health and wellbeing. You are the author of your health story, and we aim to help you make it a good one!

## Local Authority Commissioned Services

The London Borough of Hillingdon (LBH) is responsible for commissioning many important aspects of the health and social care system in Hillingdon including: Public Health services, Health Visiting, School Nursing, Alcohol & Drug Addiction Services and Social Care to name just a few. In the increasingly interconnected world of health and social care LBH and Hillingdon CCG are working together to jointly develop, commission and manage a wide range of services.

## Community Services

Community services is a broad title covering a wide range of support that is delivered in a person's home, from District Nursing, Therapies, End-of-Life to Wheelchair services. For people who need additional support between home and the hospital, we also commission a range of services to support the transition back to their homes.

The vast majority of community services are delivered by our partner Central and North West London NHS Foundation Trust (CNWL) and Hillingdon CCG is the lead commissioner for CNWL's Community Services, acting on behalf of other Clinical Commissioning Groups who are party to the same contract with CNWL.

Other aspects of community services, such as the provision of home care and community equipment, are jointly commissioned by the CCG with the LBH through a shared funding arrangement called a Section 75 Agreement. Whereas items such as: Pressure Relieving Mattresses, Wheelchair and Non-Emergency Patient Transport, amongst others, are commissioned directly by the CCG from a range of other providers.

Throughout 2020/22 our providers as (THHFT, CNWL, H4All and The Confederation) will continue to work together as HHCP to deliver integrated care to deliver population based outcomes and personalised care as part of our ICP.

## RM Partners (RMP) West London Cancer Alliance

The RM Partners (RMP) is the West London Cancer Alliance hosted by The Royal Marsden NHS Foundation Trust and covers both North West and South West London of which Hillingdon CCG and THH are partners.

RMP as part of the Vanguard New Care Models Programme to redesign the NHS, as described in the NHS Five Year Forward View strategy, works collaboratively with partners to deliver the NHS national cancer strategy and to improve survival, quality and safety, patient experience and recruitment to clinical trials covering a population of 3.5 million people.

RMP pump primes a number of projects across the Alliance. For example, Hillingdon is one of the national pilot sites for the Lung Low Dose Computerised Tomography (CT) case finding projects which entails inviting specific patient groups at high risk of lung cancer for a lung health check and if needed a low dose CT scan to detect lung cancer early.

## Mental Health and Learning Disability Services

CNWL also delivers the majority of mental health services in Hillingdon. Hillingdon CCG also works with the mental health charity MIND to deliver community support and with a range of other providers to support people as part of their rehabilitation e.g. counselling, drop-in sessions, social prescribing and social outings. In the case of these services, Harrow CCG is the lead commissioner for the Mental Health Contract with CNWL and Hillingdon CCG is an Associate Commissioner.

Hillingdon CCG is an active partner in the NW London Mental Health Transformation Programme and works with other CCGs in NW London to develop joint standards and explore how we can adopt best practice and improve services locally. We also work jointly with LBH in a shared care management for some people with LD.

## Voluntary & Third Sector

Hillingdon's voluntary and third sector delivers a variety of services that are commissioned by Hillingdon CCG as well as a broad range of services that are commissioned through other routes including charitable donations. These organisations make a valuable contribution to the health and social care system in Hillingdon.

A key local partner is Hillingdon 4 All (H4ALL), a collaborative of local charities including Hillingdon Carers, Hillingdon MIND, Hillingdon Age UK, Dash (supporting domestic abuse) and Harlington Hospice. We also directly commission other charities to support our Seldom Heard patients and residents and our social prescribing programme, which empowers people with the tools to manage their own health.

## 4. Engaging with local residents, families and carers

NHS Hillingdon CCG is passionate about and committed to continuous engagement with local residents, families and carers in developing our SI.

We use a range of methods to tailor the way in which the CCG involve and engage its diverse population. This includes, but is not limited to community outreach, partnership working with local advocates and voluntary sector groups, close working with GP surgeries. This is further supported by a range of tools including online and paper based surveys, interviews (with trained interpreters where appropriate) and smaller focused group working. Our engagement is overseen by lay members of the Patient & Public Involvement & Equality (PPI&E) Committee and aligned to programme specific equality impact analysis where available.

We aim to continue an on-going dialogue and conversation with local people about NHS plans and proposals; the targeted gathering of feedback to inform these CCG's SI should be considered within this context.

The CCG's engagement activity includes the **co-production of new contract arrangements** with local people as part of our journey towards an **Integrated Care System**. We are also **empowering local people** to take **control of their own health** through our **MyHealth programme**.

Highlights from our engagement activity over the year include:

- Pro-active work with local advocates and groups to reach marginalised communities, and educate local people regarding the appropriate use of NHS services especially during the winter months
- Utilisation of Patient Activation Measure (PAM) to better understand the impact of the CCGs MyHealth Programme and identify areas for continued support to patients on the programme
- Consulted with patients and GP staff to gain a better understanding of their experiences and where improvements could be made with regards to the CCGs translation service in Primary care
- Continued work with primary schools to educate parents and their children on how to manage Asthma
- Working with GP practices and local voluntary sector groups to engage and encourage BAME women to take up cervical screening
- Educated approximately 3000 residents in 2018/19 as part of our MyHealth programme
- `Aggie the Alien' school assemblies to educate 5-11 year olds on how to stay well through the winter months, this included information on correct utilisation of NHS services
- Communicated to both members of the public and GP staff the introduction of Health Help Now App. Provided training

and demonstrations at the CCGs public roadshows as well as in GP surgeries

We intend to continue our engagement activities as part of the development of the CCG's CI through community outreach public events over the following months.

Our themes for engagement are:-

- **Keeping well**
- **Managing in times of crisis; and**
- **Appropriate stay in hospital / right care/ right place**

We are also improving our mechanisms for giving feedback to residents and participants to demonstrate how the CCG's commissioning activity continues to be shaped and influenced by the views and experiences of the local population in Hillingdon.




**Cervical Cancer Screening Event, Townfield Community Centre**
Anjumara Hussain (Communications and Engagement Officer) HCCG &
Marso Abdi from Family Care (Qoys Daryeel)

# 5. Our Local Quality Priorities and Principles

## 5a. Our Quality Priorities

NHS Hillingdon CCG believe that the people of Hillingdon are entitled to safe, high quality care services, that are based on best practice principles and guidelines and delivers a positive experience to all who use them. Listening to the users of the service is key to achieving continuous improvement and reduce variation in the quality of services that have been commissioned by the CCG.

The CCG Quality Team will continue to work closely with our commissioning colleagues to ensure new models of care are in line with the NHS Long Term Plan and in particular, the development of the Integrated Care Partnership (ICP) and the development and implementation of the Primary Care Networks (PCNs). In doing this, we will set clear outcome measures to monitor the new provision of care to ensure we are achieving the best models of care and patients are involved and satisfied. We intend to do this in conjunction with the ICP to create an integrated quality agenda which meets the needs of our population. We will do this by developing a joint Quality Improvement and Clinical Effectiveness based approach to reviewing the quality of existing and new services.

This model embraces the NHS definition of quality as defined under Section 1 of the Health and Social Care (safety and Quality) Act 2015 – Reducing Harm in Care, the NHS Outcomes Framework, and the Care Quality Commission (CQC) inspection protocol that has been further developed and refined since 2015.

***A PATIENT STORY***

***One of our patients was able to get advice and help from her local pharmacy when her son became ill.***

*A lady who had attended one of the MyHealth roadshow stalls explained to the team that her son had something wrong with his eyes.*

*She explained that, usually, she would go to A&E when something like this happened. But on this occasion she decided to seek advice from her local pharmacy as per the information shared from the roadshow.*

*The pharmacy told her that her son had conjunctivitis and needed some medication. The medication her son needed was available to buy then and there over the counter. She was able to buy the medication immediately to use for her son, and her son is now fine.*

*The lady explained to us that she was very impressed with the pharmacy and would definitely use them more for advice before going to the A&E in the future.*

## 5b. Our Quality Principles

The CCG Quality and Safety team apply the following principles to all of the work done within the CCG:

- Patients and their families/carers are at the heart of commissioning
- Promote continuous improvement in the quality of commissioned services
- Have systems and process to ensure that commissioned services are safe, effective and patients have a good experience
- Provide assurances to the CCG Governing Body that services are meeting their contractual quality outcomes and recommend action if this these are compromised
- Have open relationships with our Providers to share Quality Improvement work
- Learning from our quality and safety assurance processes is triangulated from a variety of sources, to inform what high quality, safe and effective care looks like across the London Borough of Hillingdon.

Hillingdon CCG will ensure the following principles are embedded within all quality and safety assurance systems and processes:

- Use of a systematic approach to monitoring and improving quality with the patient at the centre
- Use of Quality Improvement methodologies with Providers to improve quality of care
- Identifying and addressing any organisational barriers which hinder quality of care
- Fostering an open and transparent culture across the local health system
- Maintaining a systematic and proactive approach to early identification of service quality failures
- Robust links between commissioning priorities, the development of the Integrated Care Partnership and the Integrated Care System and quality
- Prioritise our quality assurance and improvement efforts, so as to develop an integrated approach with social care that reflects the Better Care Fund plans
- Drive effective engagement with key stakeholders across NW London to achieve the delivery of robust measurable outcomes that reflect “what matters most to patients”
- Joint meetings with providers to seek assurance and align learning from complaints, Serious Incident and Never Event, as well as feedback from quality assurance processes such as clinical quality assurance visits. This will involve the co-production of systems and processes to enable the timely sharing of such information.
- Maintaining commitment to gain feedback from patients, their families and carers to better inform quality indicators.

## 5c. Addressing Equality & Diversity in the Health System

The Equality Act requires all Clinical Commissioning Groups – as public bodies – to comply with the Public Sector Equality Duty (PSED). The PSED came into force in April 2011 and covers 3 key aims:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those that do not
- Foster good relations between people that have protected characteristics and those that do not share them

Hillingdon CCG, as a public body, has a specific equality duty under Regulation 2 of the Equality Act 2010; (Specific Duties) Regulations 2011, to provide information to our stakeholders and the public about how we deal with our general duties under Section 149 (1) of the Equality Act 2010.

The CCGs Governing Body Lay Member for Patient and Public Engagement has executive accountability for equality, supported by the Head of Communications and Engagement who holds operational responsibility.

The reporting and monitoring of equalities is embedded into the work of the CCG. All Commissioning staff take responsibility for the creation and continuous monitoring of Equality Impact Analysis's (EIAs).

The CCGs Equality Objectives (currently under review) provides further opportunity to focus on areas where inequalities to access / reach would benefit from a longer term commitment to make progress towards eliminating discrimination and advancing equality of opportunity for all in the borough. The CCGs equality objectives are supported by the NHS Equality Delivery System (EDS2).

Areas of focus for 2019 – 2024 will look to address inequalities in:

1. Cancer Screening – Increasing uptake of screening for patients with all protected characteristics
2. Patient access to Primary Care Services
3. Improving access to self-management / education for patients / carers e.g. Housebound patients; those with mental health issues, patients with language barriers and patients identified with another disability i.e. blindness
4. Supporting parents of children with LD/Autism and improve services for children and Young People with ASD/LD.

Advancing Equality and Diversity to a level that will make a notable difference in the reduction or elimination of inequalities also require the efforts and commitment of each Borough's Clinical Commissioning Group, providers, local authority, voluntary sector organisations as well as its patients, carers and residents.

Examples of recent achievements in this area include, but are not limited to:

- ✓ Targeted engagement with BAME women to increase the understanding and importance of cervical screening
- ✓ Community and General Practice engagement to understand how interpreting and translation services could be improved and accessed more by patients
- ✓ Collaboration with Uxbridge College and Arts for Life to work with young adults and teaching staff to manage anxiety and stress through art

The CCG will continue to work in collaboration with partners and the public ensuring a link between commissioning, engagement and equalities are embedded into the health economy.




**Young Healthwatch Hillingdon meeting held on Wednesday 10th June 2019**
**Hillingdon members**: Smriti is in the foreground and from left to right the others are Nicola, Rayyan and Aisha.

## 5d: Safeguarding

Hillingdon CCG has the required professionals, roles, systems and processes in place to protect and safeguard vulnerable children and adults. There are safeguarding strategy and policies available on the CCG website for further information.

The CCG's quality governance roles and committees oversee reporting and monitoring of compliance with safeguarding requirements. Hillingdon CCG will ensure the following principles are embedded within everyday safeguarding assurance systems and processes:

- Continue to be active members of Hillingdon Safeguarding Adults Board and Safeguarding Children's Boards and task & finish groups
- Continue to commit to our responsibility of working in partnership with the Local Authority and the Police in developing Safeguarding Children systems and processes in line with legislation
- Continue to work together with Quality and Safety colleagues to ensure valuable learning and triangulation of data is effectively utilised, alongside Safeguarding referrals and concerns
- Work closely with the Continuing Healthcare Team who manage and support some of the most vulnerable people in the community
- Participate in reviews relating to adults or children e.g. Domestic Homicide Reviews (DHR), Serious Adult Reviews (SAR) or Child Safeguarding Practice Reviews (CSRRs) and ensure that the CCG and Provider organisations complete all sections

.

## Our Safeguarding Priorities

| Priority Area | What We Will Do |
|---|---|
| **Listening to children & young people and adults at risk** | • Work with children's services to review the needs of all Hillingdon's Children & Young People (CYP) especially those with additional needs; looked after children, and those involved with the youth offending services.<br>• Make Safeguarding Personal (MSP) by involving adults at risk in safeguarding decision making.<br>• Ensure compliance with The Mental Capacity Act (MCA) 2005; The Deprivation of Liberty Safeguards (DOLS); and moving towards implementation of Liberty Protection Safeguards (LPS) due to come into effect Oct 2020 and The Care Act 2014.<br>• Ensure that this vulnerable group is consulted when new or changes in existing services are being considered/planned.<br>• Ensure compliance with Domestic Homicide Review (DHR) actions and NICE Guidance for anti-social personality disorder prevention and management. |
| **Safeguarding Education and Training g (Adults & Children)** | • Continue to monitor and challenge Providers of contracted services to comply with safeguarding responsibilities and achieve expected targets e.g. Training.<br>• Safeguarding Children and Adults training should also include Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Violence and Abuse, MCA, DOLS and `PREVENT.'<br>• CCG staff will also be compliant with the required safeguarding training.<br>• Gain assurance that lessons learnt from DHRs, SARs, LeDeR reviews and CSPRs, Incidents and complaints are disseminated throughout organisations.<br>• Support the Safeguarding Adult Board in the provision of a multi-agency training programme and continue to support further development of multi-agency Safeguarding Children training. |
| **PREVENT** | • Ensure training is delivered to staff that is commensurable to their level of responsibility as per the NHS England competency Framework.<br>• Ensure that both Commissioner and Provider organisations are compliant with the Counter Terrorism and Security Act (2015) and the related PREVENT Duty Guidance. |

| Priority Area | What We Will Do |
|---|---|
| **Domestic Violence and Abuse** | • Monitor compliance with NICE Guidance (2014/ph50; 2017) to ensure that staff are trained and that victims and families at risk are identified, assessed and referred for appropriate care.<br>• Monitor number of victims identified by all providers, ensure that a system is in place to flag high risk victims and ensure that their policy reflects locally agreed pathways.<br>• Work towards the implementation of better arrangements to support survivors of domestic violence. |
| **Child Sexual Abuse/Child Sexual Exploitation (CSA/CSE) and Emotional Wellbeing Service** | • Monitor newly established NW London CSA/CSE and Emotional Wellbeing service to ensure that this service is comprehensive and easily accessible to CYP who are at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM).<br>• Implementation of NWL Child Sexual Abuse (CSA) hub. |
| **Information Sharing** | • Continue to highlight responsibilities and importance of information sharing and support the CCG and providers to share information appropriately. Adhere to the Multi agency Safeguarding information sharing guidance and the relevant GMC Guidance. |
| **Young Offenders, Looked After Children and Children with Disabilities and Additional Needs** | • Work with children's services (Health and Social Care) to ensure their health needs are identified and met.<br>• Work with the providers to ensure they understand their roles and responsibilities. |
| **Reduce the incidence of Pressure Ulcers** | • Monitor compliance of the Department of Health and Social Care Safeguarding Adults Protocol – Pressure Ulcers and the Interface with a Safeguarding Enquiry. |
| **Ensure adults at risk are protected from avoidable harm.** | • Monitor Providers' adherence to the Care Act 2014 in relation to prevention of harm, promoting an outcomes approach to safeguarding and compliance with NHS England Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework 2015. |
| **Medication** | • Monitoring providers through Quality Review meetings, in relation to adult safeguarding concerns being considered for medication incidents. |
| **Learning Disability Mortality Reviews** | • Ensure providers have the correct processes in place to be compliant in carrying out a LeDeR.<br>• Monitor providers regarding NHS England LeDeR Programme and embedding any lessons learnt. |

# 6. Key Achievements in 2019/20

## Keeping People Well

- ✓ More support for carers in primary care with a Carer Lead identified in each GP practice, including a supporting information pack to increase awareness of carers' and their needs.
- ✓ GP Practices established Mental Health Registers and recall systems to facilitate Annual Physical Health Check appointments for people with Severe Mental Health needs.
- ✓ Developed a primary care mental health service that is enabling more people to recover and stay well in the community.
- ✓ Work with the LBH and schools to expand access to strategies to manage anxiety and depression for CYP to improve their overall health and wellbeing.
- ✓ Supported the establishment of Primary Care Networks (PCNs) that will support GP Practices to work together in groups to provide some services to residents in more efficient ways by pooling time and resources together.
- ✓ Established Neighbourhood Teams to deliver integrated and personalised care via multidisciplinary teams that have Primary Care and GP Practices at the centre of their approach so residents can access care closer to home through their GP Practice.
- ✓ The design and delivery of a prototype Improving Access to Psychological Therapies (IAPT) and multimorbidity clinic has commenced in one of the Neighbourhood Areas to test the concept. If successful, the service will be expanded over the next year to benefit more people.
- ✓ Increased capacity in the Community Heart Failure team, run by hospital consultants in collaboration with GPs, to help more people to have their check-up appointments in Community Clinics nearer to their homes rather than in hospital.
- ✓ Established a Cancer Survivorship Group working with cancer clinicians, sector partners and Macmillan to give people access to psychological support and help them have the information to understand and manage their health after cancer treatment.
- ✓ Rolled out the Faecal Immunochemical Test (FIT) to detect bowel cancer in low risk symptomatic groups of patients in primary care. Recent NICE guidance in this and other areas is helping to bring these types of tests out into primary care so that a diagnosis can be made faster.
- ✓ Conducted outreach work with Asian and Somalian groups to promote cervical cancer screening awareness.
- ✓ Four Primary Care Networks (PCNs have been successful in obtaining funding from Transforming Cancer Services Team (TCST) for London to participate in the National Cancer Diagnostic Audit (NCDA) to help practices improve pathways in primary care to diagnose patients earlier with cancer.
- ✓ Working with leads and pooling resources with Cancer Research UK, RMP Partners and NHS National Bowel Cancer Screening Programme at St Mark's Hospital at LNWHT to increase uptake of bowel cancer screening in primary care and to train staff.
- ✓ Joined up working with the THHFT Paediatric Asthma team to identify schools to host childhood Asthma workshops for children and parents.
- ✓ Developed a new Hillingdon Aggie the Alien self-care video – see direct link to the video on YouTube: **https://youtu.be/M_i-b7jKoK4**

- ✓ We have successfully recruited and trained 11 MyHealth facilitator Health professionals to deliver the MyHealth workshops, and achieved the accreditation of the Diabetes MyHealth Programme to help support people to self-care and self-manage their condition at home. Last year we helped 100 people to manage their health and avoid future A&E visits. This year we are helping over 2000 people with the MyHealth programme to manage their diabetes, childhood asthma, heart health, basic first aid for parents with young children, and seasonal wellness in the heat of summer and cold of winter. We are also looking to expand our programme to include respiratory/COPD support, dermatology, weight issues, and cancer wellness.

**MyHealth Hillingdon is a free patient education and self-management programme. Helping patients to take greater control of their own health. Patient feedback:**

*"The facilitator was caring and genuinely interested on my thoughts and what I wanted to learn, I'm looking forward to putting what I learnt into action and attending the advanced session." (**Borderline Diabetes Patient).***

*"I was surprised how much my daughter knew about her Asthma and how little I knew. The session has given me information so we can both keep on top of it."**(Parent of child with Asthma).***

## Right Care, Right Time

- ✓ Extended Primary Care Access Hubs so that there are more primary care appointments available for patients who urgently need to see their GP and avoid a visit to A&E when their condition is not life threatening – expansion to deliver an increased number of appointments based on a baseline of 14min/per 1000 residents to 30min/per 1000 residents.
- ✓ Promoted the use of shared care records in the Coordinate My Care platform and have one of the best and highest rates of use in London.
- ✓ Re-commissioned the Michael Sobell Hospice specialist palliative care service with providers that are accountable to local oversight offices to deliver Hillingdon standard care to Hillingdon residents after the service difficulties experienced last year.
- ✓ Established a community children's phlebotomy service so that children do not need to attend hospital for routine tests.
- ✓ Developed a new Integrated CYP's Therapy model co-developed with the London Borough of Hillingdon with input from families who use these services to support CYP with mild to moderate needs in relation to communication and mobility skills.
- ✓ Worked with local providers to develop a single point of access for musculoskeletal services, including physiotherapy in the community and primary care GP practices. Previously there were a number of services doing slightly different things and the refreshed model provides more joined up care out of and into hospital when needed. This includes First Contact Practitioners in primary care and self-referral into physiotherapy services.
- ✓ Worked with our ophthalmology team to develop a new and innovative model of care that will link hospital and community

care through an enhanced skill mix of practitioners with selected optometrist practices on local high streets.

- ✓ Specialist Neurology Nurses in the community have been appointed so that people with Parkinson's and Epilepsy can have help closer to home to manage their condition rather than needing to go into hospital. It is further hoped that by managing the condition closer to home, this will mean slowed deterioration and reduced episodes, which will mean a better quality of life and fewer visits to A&E.
- ✓ Clinical Decision Support software is being introduced to help GPs and consultants choose the best test or imaging (eg ultrasound and MRI) to confirm a potential diagnosis, and to know best when a person should be referred for these tests. These tests can be helpful, but they should be done only when necessary.

## At times of Crisis

- ✓ We have supported High Intensity Users (people who use our Urgent and Emergency Care services very significantly above the average visit to A&E, or call to our ambulance services) to know that they will be cared for with regular check-ins from staff to ease their concerns about their health. Our current services are highly equipped and qualified to help all patients, regardless of their level of need, be it for one call to our 111 line, an urgent GP appointment, or a visit to hospital. We consider it best practice that our patients have access to primary care and community support to prevent visits to A&E, except when an accident or an emergency occurs. Our programme of assistance around High Intensity Users calls on our current services to identify and support these patients into a normal package of care over a period of time.
- ✓ Introduced an Autism Register list to help proactively care for adults, CYP with autism to manage their condition with support, and prevent distressing hospital admissions.
- ✓ We continue to develop the Learning Disability Register list for CYP to align with our programme for the Adults Learning Disability Register.
- ✓ We have invested in additional community and primary care capacity to improve urgent access to clinician advice and help closer to home e.g. patients are able to call their GP or 111 out of hours and to get an urgent primary care appointment the same or next day. Patients are also able to rapidly access community support and care.
- ✓ We have invested in integrated discharge processes to help patients get home on time after an emergency visit to hospital that results in an admission. We have worked to bring together our hospital, community, primary and social care teams to form one working collaborative. They then respond so that those few patients who need extra support getting home have a swift response and can enjoy leaving hospital on time, rather than have an extended and unnecessary hospital stay after they have been treated.
- ✓ We have worked to improve our engagement and support to Care Homes to prevent unnecessary trips to A&E for our frail elderly population. We have also invested in a GP visiting service to care homes to deliver proactive care planning and prescriptions.

## Integrated Care Partnership

- ✓ We have implemented a Neighbourhood Team model that brings hospital clinics in the community, community care, social care and primary care services, including PCNs, together to focus a set of services around GP Practices. This means that our residents can expect to have their care managed and supported well before a visit to hospital is needed. This is our particular focus this year in addressing LTCs and older people's growing frailty and susceptibility to things such as falls resulting in a break or fracture, and common colds/flus during the winter.
- ✓ We have made progress toward implementing an Integrated Care Partnership with a number of key services working together on pathways of care (for example musculoskeletal and physiotherapy services as previously described, and end of life palliative care) with nominal shared budgets.
- ✓ We have rolled out the Commissioning Primary Care Outcomes Based contract in line with Integrated Care Partnership. This is intended to support practices to focus on the key population needs and to address some of our variation in health outcomes through a programme of targeted information and support. We have also rolled out the Diabetes Outcomes Based contract.
- ✓ We have launched the Primary Care Dashboard that contains a plethora of health and care information from a number of different, and previously separated reported sources, in the one place. Our practices have fed back that they have found it very useful to see the information in one place.
- ✓ We have procured a new `One Template' for coding of illness and conditions in computer records in line with national guidance to support in standardisation of coding in practices.

## Enablers

- ✓ We have successfully supported 100% use of the nationally rolled out eRS system (Electronic referral service). This has improved the use of GP2GP across GP Practices so that patient medical records can be transferred between practices in a timely way when patients move.
- ✓ We are reducing the use of paper and becoming more digitised and environmentally friendly.
- ✓ We have invested significantly in our IT data network to future proof the flow of digital information across its service as the number of records and detail of information we hold increases. The migration to a full fibre network across all sites is planned to be completed by summer end 2019.
- ✓ We have successfully recruited new staff in primary care: GP trainers (7), Nursing student placements (58), Independent Prescribing Pharmacists Students (9), Pharmacists (6) & Transitioned nurses (19) amongst others, to increase Primary Care capacity and the number of appointments available for residents.
- ✓ We have delivered over 50 training courses, forums, masterclasses this year with 1,500 attendees across all practices and staffing groups including the wider HHCP primary are teams practices. Education and training keeps our workforces' skills strong!!
- ✓ We have engaged independent Pharmacist Prescribers to manage the repeat prescribing systems and requests so patients get their medicines more quickly and reduce duplication.
- ✓ We have implemented the Medicines Optimisation in Care Homes programme so our elderly residents get their medication on time.
- ✓ We are piloting respiratory/COPD Virtual Clinics in GP practices.

# 7. 2020-2022 Strategic Intentions

## T1. Transforming Care for Older People

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2020/21 we will be delivering the following outcomes**:<br>• Fewer hospital admissions due to cold/flu related illness<br>• Improved dementia diagnosis and support<br>• Fewer emergency admissions due to falls<br>• Greater participation in screening programmes for 55 years and over<br>• Enhanced reablement outcomes and reduced need for long term care<br>• Fewer permanent admissions of older persons to care homes, enabling them to live independently and in the family home for longer<br>• Embedding use of LBH Connect to Support service<br>• Further reduce delayed transfers of care<br>• Reduced frequency of unplanned events, reduction in Non-Elective Admissions & ZLOS Admissions<br>• Community point of co-ordination implemented to simplify referral pathways<br>**Key strategic actions to achieve these include:**<br>• Coordinated Care for Older Peoples' planned & unplanned care needs<br>• Coordinated services for carers receiving respite and support<br>• Integrated Health & Social Care support for patients<br>• Improved Health Outcomes for LTCs and complex conditions<br>• Reduced frequency of unplanned events and rapid response to needs<br>**Key local aims to achieve by 20/21:**<br>• Improved health Outcomes and reducing unplanned care needs through focusing on LTCs and age related complicating factors such as frailty<br>• Integrated Health & Social Care support for those patients who need it<br>• Empowering people to plan for their own care.<br>• Diverse market of quality care providers maximising choice for local people who have complex needs covering both older people and other vulnerable groups | **Keeping People Well**<br>• Ensure access to advice, support and advocacy services so that informed choices can be made for older people, their carers and families<br>• Enhancement of support to care homes and extra care housing with SaLT and dietician support, taking into account any new resource allocated via PCNs<br>• Increased capability and efficiency within the Neighbourhood Teams for provision of preventative, social prescribing and case management interventions<br>• Continue to build on the offer to carers, consolidating GP Champions within GP practices and linking in with Neighbourhood assets developed via H4All<br>• Develop and implement collaborative care and support planning and shared care records in line with LTC management<br>• Further integrate and utilise predictive tools, such as those as part of WSIC, to identify and proactively manage health risks<br>• Proactively identify people at risk of falling and increase capacity in falls prevention services<br>**Right Care, Right Time**<br>• Embedding of integrated physical and mental health service provision at a Neighbourhood and network level, including access to IAPT and dementia diagnosis and follow-up post diagnosis, for patients and their families and carers<br>• To increase the number of shared cared records through the Coordinate My Care platform to help proactively manage developments in our older residents' frailty journey<br>**Care at times of Crisis**<br>• Build on the Single Point of Coordination integrated functions between hospital, community and primary care<br>• Support the implementation of Same Day Emergency Care pathway for when older individuals require a visit to Accident and Emergency<br>• Embed the two Hour two Day standards described in the local Intermediate Tier programme of work and NHS Long Term Plan |

## T2. New Primary Care Model of Care

| Key Strategic Health Outcomes and Actions |
|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Delivering services and increasing number of patients managed outside of hospital setting in the context of the broader ICS<br>• Reduction in the mortality gap<br>• Reduction in unplanned care events for vulnerable people, and those with a mental health condition or LD<br>• Greater access to integrated primary care services, with more appointments available<br>**Key strategic actions to achieve these include:**<br>• Proactive Case Finding in primary care, with a focus on those at risk of developing LTCs<br>• Supporting investment in primary care at scale for new models of care in place for all populations with integrated teams throughout the system, including social care, the voluntary sector and easy access to secondary care expertise<br>• Implementation of Neighbourhood Primary Care Models of Care, which includes the establishment of Primary Care Networks (PCNs) in 2019 and their ongoing development to deliver population-based health outcomes<br>• Premises development for out-of-hospital and GP Services in **h**ubs in Hillingdon in 2021 in the north/south and central Hillingdon<br>• Extended GP out of hours working implemented to support integration of urgent and primary care services so patients can access urgent GP advice and treatment without a need to visit hospital<br>• Support 111 direct booking into GP out of hours and hubs so patients can access urgent appointments without a need to visit hospital<br>• Expand access to and use of online digital technology information and advice for patients to make care more efficient and more effective for service users<br>• Explore opportunities for routine, low-complexity diagnostics in the community and primary care<br>• Implementation of a Neighbourhoods model, aligned with the PCNs and the Neighbourhood Teams, that will support whole-population health and care prevention and management through a place-based / local Neighbourhood model that will deliver individual care closer to home as well as enable some services to be delivered across a wider population with collaboration between multiple GP practices and community services<br>• Expand on personalised care & support creating a harmonised approach via holistic interventions in PCNs<br>• Increase practice capacity by improving the use of self-care and online consultations<br>• Build on partnerships working with voluntary sector, social prescribing link workers, public, patients and carers<br>**Key local aims to achieve by 2021/22:**<br>• Strengthened primary care provider landscape able to deliver new primary care models of care and services at scale through HPCC<br>• Increasing number of people cared for and supported outside of the hospital setting with integration across primary, community & secondary care services and social care<br>• Improved access to routine and unplanned services in primary care during the week, evenings and weekends<br>• Reduced variation in service and patient outcomes in primary care via outcomes based commissioning and contracting<br>• Sustainable primary care workforce<br>• Improved access to services for patients |

## T2. New Primary Care Model of Care (Cont'd)

| Strategic Intentions 2021/22 |
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| **Keeping People Well**<br>• Primary Care Networks (PCNs) to take a lead role in addressing the prevention of ill-health i.e. support for smoking cessation and addressing obesity and high alcohol intake<br>• To provide holistic management for patients through the roll out of multi-morbidity clinics to support patients with LTCs to manage their condition i.e. heart disease, respiratory conditions and diabetes<br>• Incorporate self- care and prevention programme principles in all models of care as appropriate to inform and enable patients to proactively engage in managing their health<br>• To roll-out social prescribing LINK workers in PCNs<br>**Right Care, Right Time**<br>• Develop a delivery plan to support PCNs to develop relationships with community provider partners via the PCN Directed Enhanced Services<br>• Identifying and addressing gaps in the GP Five Year Forward View with regards the provision of proactive, accessible and coordinated care to improve health outcomes<br>• To enhance and maximise the use of new dashboard-type approaches to evidence based clinical care in order to reduce unwarranted clinical outcomes via the PCNs (our current platform is the Whole Systems Integrated Care (WSIC) dashboard)<br>• PCNs Networks are established with the growing capability to assess and manage the health and social care needs of the whole population, as well as scoping, developing and implementing opportunities to collaboratively manage their populations' health needs<br>• Alignment of GP led PCNs to GP led Neighbourhood Teams, which will be cornerstone of the new ICP model with multidisciplinary/speciality working across a range of staffing and skill sets, including links into social and third sector support. These staff will include a core team of GPs, community nurses, community pharmacists, social care staff and integrated health and social care support-workers together with a wider team of mental health professionals, allied health professionals, Care Connection Teams, pharmacists, acute consultants, independent and third sector staff<br>• Local organisational development programme in place to support the development of the 8 Neighbourhoods<br>• To work with HPCC to develop a sustainable workforce to support PCNs and Neighbourhoods advancement<br>• Premises development of two further GP Hubs in north and central Hillingdon to support the local population by offering a number of integrated care services<br>• To review use of our estates and premises across the ICP organisations inform the Neighbourhood working model<br>• To further improve access to early diagnostics for patients and staff in primary care and the community. (We have begun to offer Irritable Bowel Syndrome (IBS) tests in primary care and are scoping routine tele-dermatology imaging in primary care, among other opportunities)<br>• To create a single outcomes based contract for multimorbidity management/Improving Access to Psychological Therapies to join up physical and emotional wellbeing health services<br>• To continue to expand access to routine primary care access for patients 7 days a week through use of our three locality extended access hubs<br>• To update referral pathways in collaboration with GP practices and secondary care consultants in line with national clinical and local best practice guidance<br>• To support practices in releasing capacity via the Increasing Clinical Capacity Contract (ICCPC ) contract<br>• Digitally enabling PCNs with infrastructure and clinical systems<br>**Care at times of Crisis**<br>• The implement Single Point of Coordination functionality in the Neighbourhoods for patients with a LTC who are at risk of an unplanned admission to hospital to manage their care at home and in the community<br>• Pre bookable primary care appointments accessible via the extended access hubs operating 7 days a week<br>• Supporting GPs to refer individuals directly to urgent community and hospital pathways where their condition or need cannot be addressed in primary care |

## T3. Integrating Services for People at the End of their Life

| Key Strategic Health Outcomes and Actions | Strategic Intentions to 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Helping a greater number of people to be able to die in their preferred place of death, which is usually in the comfort of their home/usual place of residence<br>• We will have embedded coordinated palliative services support for people at End of Life and their families/carers on a 24/7 basis and across all care settings<br>• We will have begun to identify more and more people who are at the end of life in order to better plan for their care and treatment preferences at a time when compassionate care to manage worsening symptoms is likely to be preferred over invasive treatment<br>**Key strategic actions to achieve these include:**<br>• Implementation of our End of Life Strategy and new integrated service model<br>• Increased access and use of the Coordinate My Care record Enhanced social support for those at end of life to continue our record as the locality with the best and highest use of the records platform<br>**Key local aims to achieve by 2021/22:**<br>• Reducing the number of admissions for people in the last 30 days of their life<br>• Improving access to information and anticipatory care plans in the Coordinate My Care platform for clinicians and professionals<br>• Supporting Hillingdon residents to come to terms with dying and to enable families and friends to support their loved ones in their last days. We need to start the conversation on what it means to die with dignity so people can plan ahead for their most vulnerable moments<br>• Improved consistency in management of patient care and coordination with services outside of Hillingdon but provided to Hillingdon patients.<br>• Improved access to patient care wishes for local authority and third/voluntary commissioned services to support integrated working across health, wellbeing and social care services<br>• Improved training and skills development to identify and support non-acute palliative needs at home and in care homes.<br>• Information/access to palliative drugs (list of pharmacies out of hours and in hours) | **Keeping People Well**<br>• To support people to prepare for dying and to enable families and friends to support their loved ones in their last days to die with dignity and have their holistic physical, mental and spiritual needs met<br>• To create shared care records with patients with palliative needs that express patient wishes, preferred care and treatment, and enable services to coordinate around patient needs<br>**Right Care, Right Time**<br>• Improved in-reach to care homes to help health and care staff to identify and support non-acute palliative needs<br>• For care planning to include preferred care at end of life through shared care records, including pre-planned and prescribed medications access and availability<br>• To support clinicians to identify patients with end of life and palliative care needs and to have difficult but necessary conversations with patients and loved ones about their best care.<br>• To continue to test and embed the Single Point of Access for End of Life care and a Palliative Overnight Nursing Service to support patients and clinicians with 24/7 expert palliative and last stage of life care and advice<br>**Care at times of Crisis**<br>• Ensure access to hospice and continuing care beds reflects local need<br>• To coordinate service response at times of crisis to ensure patients receive the right care at the right time. This may mean a visit to hospital, or urgent care provided at home<br>• To reduce unnecessary unplanned time spent in hospital at end of life when care could be better delivered in the comfort of home through improved care and capacity in the community, as well as in-hospital identification and a managed discharge pathway so that people who do need a visit to hospital can be swiftly supported back to the comfort of their home after being stabilised |

## T4. Integrated Support for People with Long Term Condition (LTCs)

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Reducing prevalence growth for core Long Term Conditions (LTCs) and significant progress made in closing prevalence gaps in respiratory, diabetes and cardiology LTCs<br>• Improved outcomes for people with multiple LTCs and complex needs<br>• Reduced mortality from cardiovascular and respiratory diseases<br>• Reducing unplanned care needs and events arising associated with LTCs<br>• Significant progress in patient activation and the numbers of patients self-managing elements of their care<br>• Increase access to and usage of Personal Health Budgets<br>• increase in people with an LTC who self-manage elements of their care<br>• Increase in people with an LTC who have an anticipatory care plan<br>**Key strategic actions to achieve these include:**<br>• Embed approach to tackling multimorbidities and complex needs<br>• Determine approach to close the gap between those who have diagnosed and un-diagnosed LTCs and by March 2019 show evidence of the gap closing<br>• New Atrial Fibrillation and stroke pathways and services targeting those with high need<br>• Expand the MyHealth programme (Empowered Patients Programme)<br>• To expand Personal Health Budgets in Hillingdon<br>• Expand the usage of Patient Activation Measures (PAMs) to gauge impact of support<br>• Mental health and well-being support to people with LTCs will be fully embedded within Hillingdon health systems<br>• Expand ICP to wider cohort<br>**Key local aims to achieve by 2021/22:**<br>• Improved outcomes and support for people with multiple LTCs and complex needs<br>• Reducing unplanned care needs arising associated with LTCs<br>• Reduced variation in care received by people with LTCs with a particular focus on variation in primary care<br>• Increasing focus on improved outcomes through preventative measures (primary, secondary and tertiary prevention)<br>• Pro-active and co-ordinated care for people with multimorbidities | **Keeping People Well**<br>• Increased uptake and capacity of Structured Education programmes and applying the learning to better manage their condition as informed patients e.g. via the MyHealth programme<br>• Diabetes remission prototyping to provide learning to inform implementation of remission at a wider scale across Primary Care Networks (PCNs)<br>• Provision of person-centred care through multimorbidity clinics<br>• Earlier diagnosis of COPD, asthma and hypertension through analysis of primary care data and use of the CVDPREVENT audit tool<br>• Improve uptake of pulmonary rehabilitation and smoking cessation services<br>• Ensure patients medications are optimised (Right Medicine, Right Time)<br>**Right Care, Right Time**<br>• People with LTCs are supported within Neighbourhoods to link their GP with primary care at scale services through the PCNs as well as community care services<br>• People with diabetes participation in remission prototyping programme<br>• IAPT and multimorbidity prototyping learning incorporated within the mobilisation of multimorbidity clinics for fast implementation<br>• Robust care planning with patients to have shared health goals<br>• To continue to enhance mental health integration within the LTC programme<br>• Optimisation and management of patients prior to referral to acute services<br>**Care at times of Crisis**<br>• Assessing and addressing the reasons for Diabetes Type 1 patients attending A&E to help prevent health exacerbations through a more managed approach<br>• The Integrated Respiratory service will provide a telephone advice service for patients with exacerbations of COPD<br>• Rapid Access Clinics will be available for acute exacerbation patients when they need consultant advice and support<br>• The Respiratory Specialist Team will work closely with generalist Rapid Response and Hospital At Home teams to ensure patients have a multidisciplinary response |

## T5. Transforming Care for People with Cancer

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Reduced mortality from cancer<br>• Improved screening coverage for breast, cervical and bowel cancer<br>• Greater proportion of cancers diagnosed at stage 1 or 2<br>• Holistic pathways covering both medical and non-medical care elements<br>• Integrated cancer rehabilitation programme<br>• SPA survivorship service model<br>• Reduction in unplanned events<br>• Early identification of cancer patients in primary care/community settings<br>• GP Direct Access and Straight-to-Test (STT) community diagnostics<br>**Key strategic actions to achieve these include:**<br>• To work with RMP West London Cancer Alliance to deliver evidence-based care<br>• On-going rollout of actions from our Hillingdon Cancer Improvement Plan leading to earlier diagnosis and improved treatment<br>• We will continue delivery of the National Cancer Vanguard Programme<br>• Roll-out clinical protocol for the follow-ups in community<br>• Develop Single Point of Access rehab model<br>• Implementation of Direct Access (DA) and STT<br>• Roll-out of outstanding actions from Cancer Improvement Plan<br>• Evaluation of cancer screening outreach programmes<br>**Key local aims to achieve by 2021/22:**<br>• Increasing rates of cancer prevented and increasing survival rates<br>• Reduction in the rates of reoccurrence<br>• Reduction in variation rates in the quality of care<br>• Improving patient/carer experience so that patients and their families better informed, empowered and involved in decisions around their care<br>• Improved health, wellbeing and quality of life for patients after treatment and at the end of life<br>• Increase in early diagnosis of cancer evidenced by reducing number of patients identified as having cancer following a non-elective presentation<br>• To deliver personalised care for patients to meet their psychological and health and wellbeing needs and improve their quality of life | **Keeping People Well**<br>• Improve cancer screening rates for vulnerable patients e.g. learning disabilities and in communities with lower rates of uptake, working with partners<br>• Continue work with partners to promote bowel cancer screening and early detection of bowel cancer through use of FIT in primary care, focusing on high risk groups<br>• Implement recommendations from RMP low dose CT lung screening programme<br>• Increase the number and quality of primary care Cancer Care Reviews in primary care for patients who have had cancer and are now managed in primary care<br>• Roll-out `C the Signs' Tool to help GPs identify and manage patients at risk of cancer at the earliest and most curable stage of the disease<br>• Support practices to participate in the National Cancer Diagnostic Audit to facilitate early diagnosis of cancer<br>• To work with THHFT to implement Macmillan `Right by You' programme to ensure patients who have cancer as a LTC receive personalised care<br>**Right Care, Right Time**<br>• Prototype Cancer MyHealth programme, working collaboratively with Harlington Hospice, to deliver personalised care support for patients in Neighbourhoods<br>• Work with THHFT and RMP partners to implement STT pathways for colorectal, prostate, oesophageal cancers and the national lung optimal pathway<br>• Work with our local hospital to facilitate the implementation of 28 day Faster Diagnostic Standard and meet the 62 day Treatment Standard<br>• Evaluate and expand Prostate Cancer Stratified Follow-up Pathway to enable patients who are stable to be managed in primary care<br>• Fully implement and enhance stratified follow-up pathways for colorectal, lung and breast cancer<br>**Care at times of Crisis**<br>• Reduce unplanned emergency admissions and identification in an unplanned care setting for those with cancer through symptoms management and early identification of patients via learning derived from local data, NCDA and NHSE RightCare analysis |

## T6. Supporting People with Serious Mental Illness and those with Learning Disabilities

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Greater 'Parity of esteem' through holistic care management approach for physical health, mental health and social care needs<br>• Improved support for people with an urgent mental health need<br>• Progress to closing the mortality gap for those with a Learning Disability (LD) and with a serious mental illness through annual health checks.<br>• Reduction in unplanned care for people with a known mental health condition and/or learning disability/autism<br>• Improved rates of adults with a LD or mental health need living in stable and appropriate accommodation<br>• Improved access to psychological therapies and maintaining the recovery rate<br>• Reduction in risk of harm to vulnerable CYP and adults<br>**Key strategic actions to achieve these include:**<br>• Expand integrated care delivery models to include adults, CYP with MH needs<br>• Full operational delivery of the strategy for adults and children with autism<br>• Re-modelled CYP mental health and emotional wellbeing pathway and further integration with mainstream children's support services<br>• Improve the LD and Autism pathway for Hillingdon residents, especially those with complex behavioural needs<br>• Invest in a new joint management model with our local council to develop and deliver a new integrated service and specification under Section 75 for people with a LD and/or complex needs<br>• Align mental health and physical health services within a multidisciplinary approach i.e. IAPT and primary care mental health | **Keeping People Well**<br>• Facilitate implementation of the `Ask Listen Do' Framework to support patients/carers with LD, autism or both to provide feedback and make a complaint more easily to services<br>• We will work towards Stopping the Over Medication of People with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the over-medication of people with a LD, autism or both<br>• Increase the number of available assessments to support adults with ASD (non-LD) to be diagnosed in a timely way to reduce backlog by 2020/21<br>• Embed annual physical health checks for people with a LD and/or autism and for people with severe mental ill-health<br>**Right Care, Right Time**<br>• Increase awareness of Personal Health Budgets for adults and children<br>• Increase access to mental health services for CYP with mental health disorders due to increase in prevalence rate from 102% to 119% to meet government Mental Health Data Set targets for Hillingdon by 2020/21<br>• Support enhancement of health checks and planning for those with LD in primary care as part of annual physical health review<br>• For people with severe mental illness to help GPs deliver outcomes based physical health through shared care arrangements<br>• Increase access to specialist perinatal wellbeing support allowing more women to receive evidence based treatment closer to home when they need it<br>• Reduce waiting times to two to four weeks for access to emotional well-being and physical health support for patients, including CYP<br>**Care at times of Crisis**<br>• Commission safe haven crisis services, including crisis cafés with a clinical component, and 24/7 CYP crisis services access<br>• Improve identification and support to those with emotionally unstable personality disorder and serious mental ill health to access 24/7 crisis care<br>• Targeted support to prevent and reduce suicides with a multiagency approach<br>• High intensity support available in primary care to step people down to appropriate crisis management services through a multidisciplinary approach |

## T7. Integrated Care for Children & Young People

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Early identification of issues and prompt intervention through integrated CYP services<br>• Coordination of care and support for CYP across health, social care and education services<br>• Reduction in unplanned hospital admissions for CYP with LTC (asthma & diabetes)<br>• Earlier identification and intervention for CYP requiring SaLT, and OT.<br>• Improved 0-4 year olds dental health to England average for dental caries.<br>• There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults. The KOOTH on line counselling service will be extended from 18- 25 year olds in 2019/20 as part of this development<br>• Reduce CAMHS waiting times for CYP to 2-4weeks via new early intervention mental health services and complete pilot and evaluation of the new model in a designated Neighbourhood with the view of scaling the model across Hillingdon.<br>• Achieve 2020/21 target of 95% of CYP with eating disorders accessing treatment within one week for urgent cases and four weeks for routine cases<br>• Stopping over medication of people with a Learning Disability (LD), autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the overmedication of CYP with a LD, autism or both<br>• Improve support for parents and children with Autism Spectrum Disorder (ASD)/LD and develop an annual health check for CYP with Autism / LD<br>**Key strategic actions to achieve these include:**<br>• Up-skilling of primary care staff though joint working and sharing of skills, knowledge and expertise with hospital staff.<br>• Delivery of wellbeing training programme for schools and implementation of the CAMHS national Link Training Programme in 2020.<br>• Establishment of multi- agency steering group to implement the STOMP/ STAMP programmes<br>• Introduce Single point of Coordination for CYP | **Keeping People Well**<br>• Fast access to joint GP / paediatrician assessment via Paediatric Integrated Community Clinics<br>• Signpost families to book appointment for childhood immunisations, that are not up-to-date, when children are seen at the Paediatric Integrated Community Clinics<br>• Improved dental health via supervised teeth brushing programme.<br>• Updated and refreshed CYP mental health model of care and specification aligned to the Early Intervention Service<br>• Ensure a robust system is in place for health checks for children with LD and autism with local GP`s in line with the NHS 10 year Plan<br>• Improve the time taken for children to receive emotional well-being and mental health /physical support in schools and community settings<br>**Right Care, Right Time**<br>• Development of early access and prevention services to deliver an integrated early intervention team to reduce waiting times and enhance specialist services with extended pathways (step up/step down) in collaboration with other local providers and voluntary sector to provide an equitable service in the community including schools and GP hubs<br>• CAMHS LD service specification revised and updated by 2020/21 to improve access and outcomes to services and make sure all local healthcare providers are making reasonable adjustments to support people with a LD or autism<br>• Extend children and adults mental health services from 0-18 to 18 -25 to enable a supportive transition period for those moving into adult services and address the gap<br>• Implement an all age Autism dynamic Risk Register to support proactive care that will help those with autism avoid an unexpected trip to hospital<br>• Continue to develop the all age LD Register to align with the LD Adults Register to support proactive and planned care<br>• Multi-professional clinics held in the community to review infants and children prescribed special milk formulas for suspected cow's milk intolerance |

## T7. Integrated Care for Children & Young People (Cont'd)

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **Key local aims to achieve by 2021/22:**<br>• Increasing support for people with an urgent mental health need<br>• Significant progress in closing the mortality gap between people with an LD and with a serious mental health illness and the wider population<br>• Full Implementation of plans for Mental Health & Future in Mind<br>• 100% of people with a LD and 60% of people with a serious mental illness receiving a full health check and appropriate on-going care<br>• Re modelled CYP's Mental Health end emotional wellbeing pathway and further integration with mainstream Children's support services<br>• Develop a local mechanism to reduce the over medication of CYP with a LD / ASD in line with national guidance<br>• Roll out new model of Integrated Therapies enabling CYP with mild to moderate needs to access support before issues escalate<br>• Practice nurse role modelling initiative to upskill in care for CYP rolled out to 15 practices<br>• Defined pathway in place for infants with suspected cow's milk intolerance.<br>• Achieve 2020/21 target of 95% of CYP with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases<br>• 35% of CYP in our population that are indicated to have a mental health illness, as estimated from national prevalence rates, will be receiving treatment and support to manage their concerns<br>• Revised ASD pathway and service specification with CAMHS specialist services will be included alongside work with CYP's mental health services to test and implement the most effective ways to reduce waiting times for specialist services | **Care at times of Crisis Continued…**<br>• Improve transition planning to better integrate the support provided to CYP people who need to transfer into adult services. Proposed improvements include: case management, key workers and service navigators<br>• Introduce health passports for Looked After Children (LAC) leaving care in order to support self-care and transition to adult services<br>• To commission a local review of crisis services toward a redesign of these services as part of our approach to expanding urgent 24/7 capacity and primary care and community services urgent access for CYP so they can get help when they need it. The review will ensure the delivery of 24/7 mental health crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions by 2023/24 |

## T8. Integration across the Urgent & Emergency Care System

| Key Strategic Health Outcomes and Actions | Strategic Intentions to 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Coordinated Urgent & Emergency Care services across system partners<br>• More patients having their unplanned care needs met before attendance and supported at home<br>• Increased community awareness to access urgent care services and advice<br>• Reduction in rate of growth for unplanned attendances at hospital<br>• Reduction in Zero-Length of Stay and Unplanned Admissions<br>• Reduction in Length of Stay following an unplanned admission<br>• Reduction in the number of emergency readmissions<br>**Key strategic actions to achieve these include:**<br>• Develop Integrated Urgent Care approach, aligning urgent care services across social, primary, community and acute settings<br>• Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines<br>• NHS 111 direct booking of appointments in GP Practices, as well as referral on to community pharmacy to support urgent care and patient self-management<br>• Robust monitoring of individuals discharged from hospital to monitor success in avoiding emergency readmissions<br>• Develop and enhance ambulatory care pathway services in out of hospital settings<br>**Key local aims to achieve by 2021/22:**<br>• Coordinated support across all urgent & emergency Care services<br>• Increased number of patients who have their unplanned care needs met outside of a hospital setting<br>• Increased awareness in the community about how to access appropriate services<br>• Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay<br>• Deliver the Ambulance Handover Time targets consistently<br>• Reduce the number of alcohol related presentations | **Keeping People Well**<br>• Health connectors will work with patients to refer them to the MyHealth Programme, where appropriate, to empower them with the information and support to manage their condition(s)<br>**Right Care, Right Time**<br>• Helping High Intensity Users to understand that they have wraparound care to address their ongoing health concerns<br>**Care at times of Crisis**<br>• Integrating early first response services to respond rapidly to patients in their home environment when they become unwell<br>• To undertake a review of the MIU at Mount Vernon Service to ensure it delivers in line with national quality standards.<br>• To standardise and improve the front door triage of patients in A&E to ensure patients are triaged and directed to the appropriate care service/setting, whether it is in hospital, in the community, primary care, or returned home with support and/or advice<br>• Continue to embed and scale same day emergency and ambulatory care in line with national standards to provide specialist support for patients who present at hospital requiring urgent acute intervention to avoid unnecessary hospital admission with planned discharge home with support arranged in a timely manner<br>• To commission an integrated community based urgent health care offer including NHS 111 and Clinical Assessment & Triage Service (CATS) enhancement, community primary care hubs, and pharmacy connection schemes<br>• Full implementation of Urgent Treatment Centre (UTC) model In line with national quality standards<br>• Opportunity to improve same day emergency care and ambulatory emergency care to support rapid stabilisation of patients<br>• Continue to build on work to support LAS to identify and refer patients to the right care where patients require urgent support but not emergency lifesaving intervention; including UTC, urgent primary care GP appointment, pharmacy, end of life advice and help, and rapid community response |

## T9. Public Health and Prevention of Disease & Ill-Health

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Integrated approach to addressing the wider determinants of health in the borough though the Early Intervention , Self-Care & Prevention Steering Group<br>• Improved rate of adults engaging in physical activity to England average<br>• Reduce obesity rates for children (10-11 years)<br>• Reduced suicide rate<br>• To reduce social isolation and increase access to the amount of social contact for adult social carers and care users<br>• Reduced admissions related to alcohol Increased numbers of patients successfully accessing and completing drug and alcohol rehabilitation courses and reduced deaths from drug misuse<br>• Better reporting and follow up of reported domestic abuse related incidents and crimes<br>• Reduced smoking prevalence in young people<br>• Supporting reduced air pollution levels in Hillingdon with partners<br>**Key strategic actions to achieve these include:**<br>• Joint Early Intervention and Prevention Services Plan<br>• Physical Activity Strategy<br>• Develop Suicide Prevention Strategy<br>• Address smoking prevalence in young people and adults<br>• Embed Patient Education Programme<br>• Review of Air Quality action plan.<br>**Key local aims to achieve by 2021/22:**<br>• Hillingdon wide self-management/education programme aligned to MyHealth programme for all patients regardless of their length of diagnosis for a number of conditions<br>• Reduction in rate of growth and prevalence gap for key LTC conditions<br>• Fully informed, engaged and activated patients taking control of the process of care for their own conditions<br>• Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcome | **Keeping People Well**<br>• To embed the six components of personalised care via Neighbourhood working so people have choice and control over the way their care is planned and delivered, and supports them to stay well for longer maximising use of available personal, community and social assets<br>• To enhance the offer of the MyHealth programme workshops to patients and work with the Primary Care Integrated care systems to offer bespoke packages of self-care workshops to their patient populations<br>• To increase the appointments offered in the MyHealth programme to 10,000 in 2021/22 Including an increase in self-referrals<br>• Continued monitoring of patients Patient Activation Measure (PAM) score through the MDT's (Multi Disciplinary Team) and aligning patients to the right level of self-care / prevention / support in accordance with their levels<br>• For cancer patients raising awareness of blood levels and neutropenia to avoid sepsis and potential delays in treatment as a result. Alongside this work to collaborate with Macmillan and Harlington Hospice to co-produce a holistic package of care that is tailored to the patients cancer journey and their activation level<br>• To work with QISMET to gain accreditation if all workshops within the MyHealth Programme. Work to start in 2019/20 with annual funding allocated to accredit courses that emerge as part of the continued expansion<br>• To reduce levels of obesity and smoking via access to digital and online support to enable 24/7 wrap around care<br>• Delivery of timely information and materials that link back to the patients record and condition to support 24/7 self-management outside of treatment and workshops<br>• Improved screening process and uptake to tests that pre-empt the patients likelihood of getting Health problems in the future i.e. cancer, dementia, breathing or heart problems etc. prevention courses / materials linked to these services<br>**Right Care, Right Time**<br>• Improved awareness of health services in Hillingdon, including how and when to access services for the condition of concern<br>• Better access to information in a range of languages and easy read for people with learning disabilities |

## T10. Transformation in Local Services

| Key Strategic Health Outcomes and Actions | Strategic Intentions to 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Reduction in prevalence gap for key conditions<br>• Reduction in the rate of growth in prevalence<br>• Reduction in the variation in management of conditions<br>• Reduction in the management of people with LTCs<br>**Key strategic actions to achieve these include:**<br>• Implement NWL Local Services Strategy<br>• Provide medical retina services at Mount Vernon hospital to treat macular degeneration<br>• Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016<br>• Full implementation of 7 Day Standards<br>• Enhanced progression of BHH RightCare Programme<br>• Rollout of Prevention Strategy<br>• Rollout of Proactive Case Finding in Primary Care<br>• Work to close prevalence gap<br>• Explore opportunities for diagnostics in the community<br>**Key local aims to achieve by 2021/22:**<br>• Reduced rate of growth in hospital attendances and admissions for people with planned care needs<br>• Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients<br>• Reduction in Length of Stay following a planned admission<br>• Increased use of alternative services to deliver planned care support<br>• Deliver the 4 Priority Acute Standards for 7 Day Services<br>• Enhanced progression of BHH RightCare Programme<br>• Rollout of Prevention Strategy<br>• Rollout of Proactive Case Finding in Primary Care<br>• Work to close prevalence gap<br>• Explore opportunities for diagnostics in the community | **Keeping People Well**<br>• Continue to commission best practice pathways to ensure health outcomes are optimised, and deterioration in health is avoided, reducing the future demand on care. e.g. reduce presentation for people with a flare up of persistent pain<br>• Integrating planned care pathways with MyHealth programmes to enhance prevention<br>• Review and develop the role of diagnostics within primary care including testing of Clinical Decision Software (CDS) software for feedback to GPs on the results of tests<br>• A greater focus on work to tackle the wider determinants of health, intended to identify and manage risk. Taking a population-approach to prevention to ensure more sustainable planned care provision in future years<br>**Right Care, Right Time**<br>• Support long term plan 'hot' and 'cold' site model development at THHFT as appropriate to local conditions<br>• Support and promote new approaches to planned care, including digital and e-clinics, as well as consultant led out-reach models that enable ongoing care in a non-acute setting to manage patients needing ongoing oversight of a consultant<br>• Work with the voluntary sector to fully embed the Patient Activation Measures for musculoskeletal services and other priority areas to support stratified pathways of care and improve health and wellbeing outcomes<br>• Continuing to commission shared care pathways to enable people with LTC to be seen closer to home in primary care, avoiding longer waits for specialist hospital services<br>• Demand and capacity planning and optimised utilisation of available capacity to support RTT recovery and ensure care is provided at the right time<br>• A greater focus on 'general surgery', in line with the NWL review of general surgery pathways, and colorectal procedures and treatments<br>• Develop co-working with ICP partners on personalised elective care as part of 'rethinking medicine', and as part of the THHFT Outpatient Transformation Programme |

## T10. Transformation in Local Services (Continued)

| Key Strategic Health Outcomes and Actions (from previous page) | Strategic Intentions to 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Reduction in prevalence gap for key conditions<br>• Reduction in the rate of growth in prevalence<br>• Reduction in the variation in management of conditions<br>• Reduction in the management of people with LTCs<br>**Key strategic actions to achieve these include:**<br>• Implement NWL Local Services Strategy<br>• Provide medical retina services at Mount Vernon hospital to treat macular degeneration<br>• Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016<br>• Full implementation of 7 Day Standards<br>• Enhanced progression of BHH RightCare Programme<br>• Rollout of Prevention Strategy<br>• Rollout of Proactive Case Finding in Primary Care<br>• Work to close prevalence gap<br>• Explore opportunities for diagnostics in the community<br>**Key local aims to achieve by 2021/22:**<br>• Reduced rate of growth in hospital attendances and admissions for people with planned care needs<br>• Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients<br>• Reduction in Length of Stay following a planned admission<br>• Increased use of alternative services to deliver planned care support<br>• Deliver the 4 Priority Acute Standards for 7 Day Services<br>• Enhanced progression of BHH RightCare Programme<br>• Rollout of Prevention Strategy<br>• Rollout of Proactive Case Finding in Primary Care<br>• Work to close prevalence gap<br>• Explore opportunities for diagnostics in the community | **Right Care, Right Time Continued**<br>• Support future planned care provision on a sustainable basis by implementing a unified referral access process for general practice and other referrers, ensuring referrals receive clinical triage and decision-making that supports the reduction of unnecessary appointments in specialist services<br>• Implementing digital initiatives to provide more care via a digital network of care and support improving access, and reducing unnecessary admissions<br>• Focus on outpatient transformation and best practice pathways to reduce unwarranted variation and maximise productivity and efficiency<br>• Work with provider hospitals, to roll-out of interactive face-to-face training for staff, in shared decision making programmes that will develop professional skills and behaviours around personalised care and support planning, across the ICP<br>• Embed effective mechanisms to enable people to exercise choice and control in elective care<br>**Care at times of Crisis**<br>• Enhancing access to MSK pathways through the introduction of the FCP service in PCNs in 2020/2021<br>• Working with the NW London MSK clinical network to enhance access to care for people with persistent pain when setbacks or flare-ups occur and improve care provided in general practice for this complex cohort<br>• Continuing to work with providers to identify opportunities to deescalate care from urgent care settings, redirecting suitable patients to planned care pathways<br>• Providing more care via PCNs to improve access for people who require a quicker response to health needs, thereby stratifying care and reducing escalation to urgent care pathways<br>• Planned care pathways will be designed to ensure that the drivers for urgent care attendances are understood via clinical audit and that alternate arrangements are made to avoid unnecessary hospital admissions |

## E1. Developing the Digital Environment

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Become paper free at the point of care across all services (subject to availability of sufficient capital funding from NHS England to automate systems)<br>• Digitally enabled transfers of care between all healthcare settings<br>• Improve access to Shared Care Records to support integrated care<br>• Make progress towards shared digital care and support plans (which meet the standards developed in 2018/19 by the Professional Records Standards Board in conjunction with NHS NW London and NHS Digital) to enable better integrated care across care settings, integrated with primary care clinical systems, and including EOL care planning and digitally enabled self-care<br>• Share and realise plans for use of real time data in decision making<br>• Promote assistive technologies e.g. telecare and telehealth<br>• Eradicate use of fax in care services<br>• Real time use of data used to inform patients<br>**Key strategic actions to achieve these include:**<br>• Relevant information safely and appropriately available from all clinical IT systems ,when needed, to coordinate care for people<br>• Clear information available to aid planning of services through BI and analytical systems fed by each provider<br>• High utilisation of Shared Care Record across settings by provider clinicians, and promotion to patients by providers<br>• Promote the use and sharing of information with the London Health and Care Information Exchange (CIE) to enable digital transfer of care between health care settings<br>• IT systems take into account the ease of accessibility for users and those with a physical/learning disability<br>**Key local aims to achieve by 2021/22**<br>• Effective and efficient integrated care services enabled by shared health and care records<br>• Relevant information, safely and appropriately available when needed to coordinate care for people<br>• Clear analytical information available to aid planning of services | We will:<br>• Support automation of systems through NHSE capital funding projects toward becoming paper free in our primary, community and acute care services<br>• Support services to embed digital technologies that enable transfer of care between healthcare settings, including ready access through user-interfaces to shared care records<br>• Enable home-based technology<br>• Improve access to shared care records to support integrated care<br>• Help our partners and GPs to align their digital operating structures and processes so that these integrated, or align, to support share digital care and support plans between multi-disciplinary and multi-speciality teams within health and care organisations<br>• Provide thought-leadership, planning and realisation for the implementation of real time data in decision making<br>• Identify new assistive technologies and enable their use and integration into digital systems<br>• Support development of Pan-London shared care records, whilst also deploying an interim solution to support emerging PCNs and ICIP/ICS to enable dataset read-ability between social services and healthcare settings and so enable more integrated care for patients<br>• Implement system to enable extended viewing of datasets between SystemOne and EMIS software in community, mental health and primary care settings<br>• Deploy an online consultation (triage & video consultation) offer in each practice working towards removing the need of up to a third of face to face visits<br>• Provide patients with digital self-care and management tools such as apps, to empower them in managing their health conditions and associated wellbeing<br>• Increase the use of digital tools to transform how outpatient service are offered, including more options for virtual appointments<br>• Make better use of data and Digital technology, first by providing convenient access to services and health information for patients by standardising on the NHS app as the digital front door to provide access to digital tools and patient records, and to clinicians to support population health planning through intelligence and live analytics |

## E2. Creating the Workforce for the Future

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• A workforce that meets the evolving needs of health and social care<br>• A service with the capacity and capability to meet our population needs<br>• Reducing sickness and absence rates<br>• Improving skills and competences within the workforce<br>**Key strategic actions to achieve these include:**<br>• Develop recruitment and retention strategy with multi-professional workforce plans<br>• Brunel University London (BUL) with THHFT, NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences<br>• Develop workforce plans with Buckinghamshire New University<br>• Roll-out recruitment and retention strategy and workforce plans<br>• Increase the training, mentorship and student placement capacity in general practice and to make this equitable across the borough<br>• Continue to provide staff forums, training and education opportunities to all general practice staff and others in the health and care arena<br>• Support consistent ways of working to improve and standardise processes in general practice (signposting, clinical correspondence)<br>• Working with our NHS partner organisations – we will implement a system workforce strategy that addresses shared values, behaviours and coaching approach to work as an ICP<br>• Develop a more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care<br>• Continue to properly evaluate and develop new workforce functions and competency frameworks with HENWL and HEIs<br>**Key local aims to achieve by 2021/22:**<br>• A workforce that grows new roles and skills to support patient care<br>• New systems and processes to release clinical time<br>• A sustainable primary care workforce that is competent and confident to work in new models of care delivery and new provider structures<br>• A supported workforce environment that promotes Hillingdon as an attractive place to work | We will:<br>• Create quality and consistent ways of working in general practice for The Confederation membership and support practice teams to find the space and time to work better together<br>• To transition local Vocational Training Scheme (VTS) GPs and nurses into primary care<br>• Ensure all programmes continue to increase figures, skills and joined up working<br>• We will share the workforce data with PCNs to support at scale collaboration to enable a more standardised offer that is easier to deliver at scale<br>• Resource local practice managers groups for peer support in IT, HR and general business sustainability<br>• We will package primary care roles in a standardised way, with recruitment material (on the Capital Nurse Portal) and wider portfolio offers that describe competencies, training packages and career pathway for staff<br>• Offer supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes (ST3s, GPNs)<br>• Target management skills at Practice Managers to lead the changes; upskilling nurses and HCAs to manage more of the patient caseload; upskilling 'medical assistants' and 'signposters' to deal better with the paperwork and non-clinical patient support<br>• Establish inter-professional, multi-organisational and multi-HEI packages of student placements and apprenticeships for joint learning, including training hubs and peer support for multi-disciplinary forums, training and education within The Confederation membership<br>• Create a targeted, multi-professional and multi-organisational pipeline of new staff for recruitment e.g. IPP pharmacists, physician associates and utilisation of regional apprenticeship programmes if and when required<br>• Establish the Transition Academy to coordinate these activities and engender quality and consistency of staffing and general practice offer<br>• The portfolio offers to include not just cross-practice, PCN and Confed roles, but also those that enable rotations of work with other HHCP partners where desirable |

## E3. Delivering Our Strategic Estates Priorities

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2020/21 we will be delivering the following outcomes**:<br>• Working with local authority and health partners to deliver a Local Estate Strategy for Hillingdon<br>• Support The Hillingdon Hospital acute estates approach<br>**Key strategic actions to achieve these include:**<br>• Better utilisation of existing estate taking into consideration triple integration of primary, community and mental health services delivered around Primary Care Networks (PCNs)<br>• Reduce / eliminate any void space that exists within NHS Property Services and health providers estate<br>• Dispose and reinvest into new fit for purpose premises<br>• Continue to support the hub programme delivery within North Hillingdon, Uxbridge & West Drayton and Hayes and Harlington localities<br>**Key local aims to achieve by 20/21:**<br>• An estate portfolio that meets the needs of our residents for accessing services and clinics that has regard to geography and transportation | We will:<br>• Deliver a local service primary care Hub in North Hillingdon by 2022/23<br>• Deliver a local service primary care Hub in the Uxbridge and West Drayton area by 2022/23<br>• Provide additional primary care capacity in the Yiewsley Area by end of 2020, including delivering support to the Estates Technology Transformation Fund (ETTF) improvements to Yiewsley Health Centre<br>• Undertake a capacity study within the Hayes and Harlington locality based on projected future growth and need to deliver a new health primary care focussed facility This work will consider existing estate including HESA Primary Care Centre and future opportunities with the Old Vinyl Factory and Nestle sites<br>• Deliver a new health primary care facility on a redeveloped Woodside development in 2020/21<br>• Invest in primary care infrastructure by supporting business cases made by practices for Improvement Grant applications and Estates Technology Transformation Fund applications<br>• Implement a primary care estates solution to Heathrow villages in 2020/21 to provide additional local services<br>• Support The Hillingdon Hospital strategic estates approach and the Long Term Plan hot/cold site opportunities, following the lead of partners<br>• Enable a Hillingdon-wide strategic estates programme to support best use of estates and unused space with our ICP organisations, HHCP, and NW London ICS |

## E4. Delivering Our Statutory Targets Reliably

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• Continued, consistent and sustained achievement of our mandatory and statutory targets for: 18 weeks RTT for elective care, cancer waits, A&E waits, and ambulance handover times<br>• Incorporate and performance manage any changes emanating from the NHS Review of Access Standards<br>**Key strategic actions to achieve these include:**<br>• Continued focus on improvement in A&E Performance to reduce demand and implementation of resilience plans<br>• To transform planned care elective services in line with ambitions in the NHS Long Term plan<br>• Robust demand and capacity study undertaken around RTT, Cancer and Diagnostic Targets<br>• Work with providers to achieve by 2020 the new 28 day faster diagnostic standard for cancer<br>• Development of diagnostic capacity to meet demands and targets for Cancer pathways<br>**Key local aims to achieve by 2021/22**<br>• Achievement of NHS Targets for Referral to Treatment (RTT), A&E and cancer waits and diagnostics as well as our other statutory targets associated with mental health, LD and community services<br>• Reduction in waiting lists and times in all specialities including cancer | We will:<br>• Ensure demand management programmes are robust and well-led for unplanned and planned care<br>• Seek assurance and accountability for delivering to national standards, offering support and proactive engagement to around matters arising as well as horizon scanning to mitigate risks to delivery of targets<br>• Work with stakeholders to come to a shared view of service delivery to deliver an integrated system response to shared challenges<br>• Agree trajectories and milestones for recovery where needed<br>• Apply robust, nuanced, contract and performance oversight and management<br>• Ensure the focus is on patient experience and quality of care outcomes<br>• Seek to promote patient choice and engage patients in decisions regarding their care pathways and experiences, actively listening and applying learning |

## E5. Medicines Management

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes**:<br>• More effective medicines expenditure per capita including reduced wastage, taking into account growth in costs<br>• Improved outcomes for people utilising medicines<br>• Supporting patients to self-manage their own care through greater awareness of the Over The Counter scheme<br>**Key strategic actions to achieve these include:**<br>• Focus on medicines optimisation and rollout of practice level pharmacy support with medicines reviews and repeat prescriptions<br>• Implement Prescribing Wisely<br>• Continue initiatives to ensure Antimicrobial Stewardship by prescribers in general practice and across the interface, including the implementation and delivery of the government's new 5-year action plan on Antimicrobial Resistance<br>• Continued support for prescribers regarding any national, local and NHSE prescribing guidance e.g. Items of low clinical value<br>• Supporting new pathway development for prevention initiatives and to reduce health inequalities<br>• Continued support for new pathway development for prevention initiatives and to reduce health inequalities.<br>• Further develop Integrated Care Partnership (ICP) pharmacy development – including workforce development and medicines management<br>**Key local aims to achieve by 2021/22**<br>• Support to reduce unplanned admissions related to medicines<br>• Increased use of skilled workforce e.g. specialised clinical pharmacists in GP practice setting<br>• Pharmacy connection schemes will be implemented as per national guidance as a result of the national pilot schemes ending in March 2020 | We will:<br>• Continue the Interface Pharmacy pilot project; phase 2 implementation<br>• Improve in and out-o-f hours end of life medication pharmacy provision<br>• Undertake domiciliary reviews by ICP pharmacy workforce<br>• Strengthen pharmacy workforce integration between partner organisations<br>• Deliver support and mentoring for clinical pharmacists in General Practice<br>• Reduce incidence of harm through implementation of the PINCER project<br>• Provide support for the STOMP/STAMP overprescribing for the learning disabilities programme<br>• Support the Enhanced Health in Care Homes Programme with Medicines Optimisation in Care Homes Pharmacist (MOCH)<br>• To reconcile medication of care home residents discharged from other settings to increase safety in prescribing<br>• Deliver training and education to care home staff to increase their understanding of the medications needs of residents<br>• When appropriate, promote reduction of drugs that are likely to cause kidney injury, antipsychotics in the elderly, anticholinergics, and harmful combinations of drugs, with a focus on care homes<br>• Support practice staff with the self-care agenda<br>• Continue to engage with CNWL and primary care to develop shared care protocols and guidance for prescribing mental health and learning disabilities medication<br>• Deliver medicines management support for COPD Virtual Clinics in practices, Independent Pharmacist Prescribers for patients with Heart Failure and the multimorbidity programme<br>• Support reduction in antidepressant prescribing in adults and increased referrals to IAPT<br>• Improved discharge and reduced readmission through established Interface systems and procedures<br>• Strengthen integrated pharmacy teams as part of the Integrated Care Partnership<br>• Continued engagement of Medicines Management work programme with community pharmacy colleagues and the LPC in supporting CCG and ICP priorities |

## E6. Redefining the Provider Market – Our Integrated Care Partnership

| Key Strategic Health Outcomes and Actions | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes:**<br>• A market capable of meeting the health and care needs of the local population within the financial constraints<br>• A diverse market of quality providers maximising choice for local people<br>• Significant proportion of care delivered through integrated delivery vehicles<br>• A high functioning and locally led Integrated Care system<br>**Key strategic actions to achieve these include:**<br>• Rollout and trial Integrated Case System model approaches and develop plans for future cohorts – including 0-16, 17-25, 26-64 and 65+ to address the needs, requirements and support models for those age groups<br>• Develop Neighbourhood and locality care delivery models that are primary care-led and working in multi-disciplinary approach with community assets, voluntary sector and health and care professionals<br>• Implement recommendation of THHFT master planning exercise<br>**Key local aims to achieve by 2021/22:**<br>• Improved capability across the system in meeting the health needs of the local population within the financial constraints<br>• Payment and risk share arrangements that incentivises innovation, quality and sustainability, based on delivery of defined patient-centred outcomes in order to improve quality and demonstrate system transformation<br>• Improvements in clinical quality, integrated care systems and financial sustainability<br>• System incentivised to work together to enable the needs of the whole person to be met | We will:<br>• Operationalise and embed the current ICP programmes to implement population health and person-centred care models for the over 18 population by:<br>○ Extending active case management to the 15% of the adult population most at risk of a non-elective episode<br>○ Transforming the MSK pathway to enable more people to receive care closer to their home<br>○ A transformed Intermediate Tier with an emphasis on better same day emergency care<br>○ The implementation of a new clinical model for integrated care based on 8 Primary Care led Neighbourhood Teams aligned to the new Primary Care Networks with joined up physical and mental health care and aligned social care<br>• Develop and Implement an agreed model of Integrated Care covering the whole population focusing initially on 2 key priorities; the redesign and implementation of new service models for Urgent and Emergency Care including Mental Health (building from the current partner approved HHCP IBC) and Planned Care. This will be enabled by the continued and accelerated development of 8 Primary Care led Integrated Neighbourhoods aligned with Primary Care Networks as the basic delivery vehicle for population health in Hillingdon. During 2020/21, we will also focus on the essential development work necessary to meet national requirements regarding CYP |

## E6 Redefining the Provider Market – Our Integrated Care Partnership (Continued)

| Key Strategic Health Outcomes and Actions (from previous page) | Strategic Intentions 2021/22 |
|---|---|
| **By 2021/22 we will be delivering the following outcomes:**<br>• A market capable of meeting the health and care needs of the local population within the financial constraints<br>• A diverse market of quality providers maximising choice for local people<br>• Significant proportion of care delivered through integrated delivery vehicles<br>• A high functioning and locally led Integrated Care system<br>**Key strategic actions to achieve these include**:<br>• Rollout and trial Integrated Case System model approaches and develop plans for future cohorts – including 0-16, 17-25, 26-64 and 65+ to address the needs, requirements and support models for those age groups<br>• Develop Neighbourhood and locality care delivery models that are primary care-led and working in multi-disciplinary approach with community assets, voluntary sector and health and care professionals<br>• Implement recommendation of THHFT master planning exercise<br>**Key local aims to achieve by 2021/22:**<br>• Improved capability across the system in meeting the health needs of the local population within the financial constraints<br>• Payment and risk share arrangements that incentivises innovation, quality and sustainability, based on delivery of defined patient-centred outcomes in order to improve quality and demonstrate system transformation<br>• Improvements in clinical quality, integrated care systems and financial sustainability<br>• System incentivised to work together to enable the needs of the whole person to be met | • Supporting the development of a SOC, OBC and FBC for a new local hospital in Hillingdon<br>• Maintaining sustainable local organisations through partners working collaboratively<br>• Develop a System Operational Plan (SOP) that addresses local priorities and the system deficit focussing initially on Urgent and Emergency Care and Planned Care<br>• Implement a new governance framework and approach to Integrated Management across our ICP that supports the new models of care and the implementation of system priorities<br>• Progressively implement a shadow 'ICP type' contract let in the first instance through a revised Alliance arrangement moving towards a Lead Provider model by April 2021<br>• Live within our means by moving towards a single budget for the Hillingdon system through the implementation of an agreed 'placed based' control total or another suitable alternative mechanism that will ensure the sustainability and viability of HHCP partner organisations going forward<br>• To work closely with NWL ICS to align NWL programmes in HHCP work programme to ensure joined up working and outcomes<br>• To pursue opportunity with NWL Health and Care Partnership to be one of the NHSE Innovation Accelerator sites for the Community Health and Ageing Well Programme. This relates to population-level frailty identification and stratification to help plan for future demand and to target ways to help people age well. |

# 8. NW London Clinical Commissioning Group

## 8a. NWL wide-work

Across NW London, over 30 NHS organisations and local authorities are working together to improve health and social care through the joint Sustainability and Transformation Plan (STP) which will form the ICS. This plan is focusing on five areas to make the biggest and quickest positive impact on our residents' health. These areas are: **improving health and wellbeing, better care for people with long-term conditions, better care for older people, improving mental health services and safe and high quality and sustainable hospital services.**

NHS and council colleagues are joining-up efforts to prevent illness, to improve care for people with diabetes and those with mental health needs. Teams are working hard to provide services in more convenient locations in local communities, and to give older people a better experience of using care services through integrated and coordinated care. Other staff are also helping to recruit and retain the professional staff we need, to use our resources more effectively and modernise our IT systems. These improvements will sometimes change how patients currently use services and some will make it easier for them to receive care more quickly and conveniently. Other changes are needed so our staff can work better together.

## 8b. Planned Procedure with a Threshold (PPwT) and Individual Funding Request (IFR)

The NHS is required to improve the health and care of local populations within a limited and increasingly challenging financial budget. There are some treatments that are therefore not normally available on the NHS and there are some treatments are only funded if certain clinical thresholds to warrant treatment are met. These are called **Planned Procedure with a Threshold (PPwT).** This means we have to:

- Review the clinical reasons in exceptional individual cases;
- Examine the evidence for the safety and effectiveness of any treatment; and
- Assess and evaluate the current services and treatments we provide in order to continue to give patients the greatest health gains from the resources available.

As part of ensuring the most effective use of resources, standardisation of clinical practice and equity in access for patients, the PPwT portfolio of policies are commissioned across the eight CCGs in NW London. During 2019/20 PPwT policies have been reviewed and updated. The **NW London CCG Policy Development Group (PDG**) will be reviewing a number of local treatments with limited clinical value with a view to develop policies with access criteria for implementation in year 2020/21. In addition, NHS England, both National and London Region, have identified a series of policies that will also provide commissioning guidance for local CCGs to consider through local governance arrangements. These may supersede existing PPwT thresholds or add new policies to the current PPwT portfolio. The access for treatment will continue to be through a clinical authorisation route (PPwT form), or if the procedure or drug is not routinely funded, through the completion of an **Individual Funding Request (IFR) form.**
For more information on PPwT and IFR please refer to the web link: https://www.hounslowccg.nhs.uk/what-we-do/individual-funding-requests-and-ppwt.aspx

# 9. List of Abbreviations Used

| Term | Meaning | Term | Meaning | Term | Meaning |
|---|---|---|---|---|---|
| A&E | Accident & Emergency | ED | Emergency Department | LA | Local Authority |
| AF | Atrial Fibrillation | EoL | End of Life | LAS | London Ambulance Service |
| BCF | Better Care Fund | ENT | Ear, Nose & Throat | LD | Learning Disability |
| BHH | Brent, Harrow, Hillingdon CCGs | FCP | First Contact Practitioner | LIS/LES | Local Incentive Scheme<br>Locally Enhanced Service |
| CAMHS | Children & Adolescent Mental Health Services | FCT | Faecal Calprotectin Testing | LBH | London Borough of Hillingdon |
| CCG | Clinical Commissioning Group | FIT | Faecal Immunochemical Test | LIS/LES | Local Incentive Scheme<br>Locally Enhanced Service |
| CHC | Continuing Health Care | FT | Foundation Trust | LNWH | London North West Hospitals NHS Foundation Trust |
| CHD | Coronary Heart Disease | FUP | Follow Up (Appointment) | LoS | Length of Stay |
| CIE | Care Information Exchange | FY | Financial Year | LTC | Long Term Conditions |
| CMC | Coordinate My Care | FYFV | Five Year Forward View | MDT | Multi-Disciplinary Team |
| CNWL | Central & North West London NHS Foundation Trust | GP | General Practitioner | MCA | Mental Capacity ACt |
| COPD | Chronic Obstructive Pulmonary Disease | GPN | General Practice Nurse | MH | Mental Health |
| COTE | Care of the Elderly | H4All | Hillingdon 4 All | MIU | Minor Injuries Unit |
| CQC | Care Quality Commission | HCCG | Hillingdon Clinical Commissioning Group | MMT | Medicines Management Team |
| CQG | Clinical Quality Group | HENWEL | Higher Education North West London | MSK | Musculo-Skeletal |
| CQRG | Care Quality Reference Group | HHCP | Hillingdon Health Care Partners | MS | Multiple Sclerosis |
| CRHTT | Crisis Response Home Treatment Team | HWB/HWBB | Health & Wellbeing Board | NEL | Non-Elective |
| CSE | Child Sexual Exploitation | IAPT | Improving Access to Psychological Therapies | NEPTS | Non-Emergency Patient Transport Service |
| CSPR | Child Safeguarding Practice Reviews | IBC | Integrated Business Case | NHSE | NHS England |
| CT | Computed Tomography | IBD | Irritable Bowel Disease | NICE | National Institute Clinical Excellence |
| CYP | Children & Young People | IBS | Irritable Bowel Syndrome | NWL | North West London |
| CVD | Cardio-Vascular Disease | IM&T | Information Management & Technology | OOA | Out of Area |
| DA | Direct Access | IPP | Independent Pharmacist Prescriber | OOH | Out of Hours or Out of Hospital |
| DES | Directed Enhanced Service | ICP | Integrated Care Partnership | PAD | Peripheral Artery Disease |
| DH/DoH | Department of Health | ICS | Integrated Care System | PCC | Primary Care Contract |
| DHR | Domestic Homicide Review | IT | Information Technology | PCN/s | {Primary Care Network/s |
| DNA/s | Did Not Attend/s | IUC | Integrated Urgent Care | PHB | Personal Health Budgets |
| DOLS | Deprivation of Liberty Standards | IV | Intravenous | PPE | Public & Patient Engagement |
| DTOC | Delayed Transfer of Care | JSNA | Joint Strategic Needs Assessment | PTS | Patient Transport Service |

| Term | Meaning | Term | Meaning | Term | Meaning |
|---|---|---|---|---|---|
| Pt/Pts | Patient/s | ZLOS | Zero Length of Stay | | |
| PYLL | Potential Years Life Lost | | | | |
| PH | Public Health | | | | |
| QIPP | Quality, Innovation, Productivity & Prevention | | | | |
| QOF | Quality & Outcomes Framework | | | | |
| RBH FT | Royal Brompton & Harefield Hospitals NHS Foundation Trust | | | | |
| RTT | Referral To Treatment | | | | |
| SaLT | Speech & Language Therapy | | | | |
| SAR | Safeguarding Adult Reviews | | | | |
| SCR | Shared Care Record or Summary Care Record | | | | |
| SI | Strategic Intentions | | | | |
| SPA | Single Point of Access | | | | |
| SSoC | Shifting Settings of Care | | | | |
| ST3 | (GP Registrar Year) | | | | |
| STT | Straight-To-Test | | | | |
| TB | Tuberculosis | | | | |
| TCST | Transforming Cancer Services Team | | | | |
| THH FT | The Hillingdon Hospital NHS Foundation Trust | | | | |
| TIA | Transient Ischaemic Attack | | | | |
| UEC | Urgent & Emergency Care | | | | |
| UCC | Urgent Treatment Centre | | | | |
| VTE | Venus Thromboembolism | | | | |
| WTE | Whole Time Equivalent | | | | |

## 10. List of Providers

1. Age UK
2. Ashford and St Peter's Hospitals NHS Foundation Trust
3. Barts & The London NHS Trust
4. BMI Healthcare Ltd
5. British Pregnancy Advisory Service
6. Buckinghamshire Healthcare NHS Trust
7. Camden & Islington Mental Health Trust
8. Care UK
9. Central & North West London NHS Foundation Trust
10. Central North West London Mental Health Trust
11. Direct Healthcare Services
12. East & North Hertfordshire NHS Trust]
13. Egton MIG Healthcare Gateway
14. First Databank Europe Ltd
15. Frimley Park Hospital
16. Great Ormond Street Hospital for Children NHS Foundation Trust
17. Greenbrook Healthcare
18. Guy's & St Thomas' NHS Foundation Trust
19. Harlington Hospice
20. Hayes Cottage
21. Healthshare Ltd
22. Hertfordshire Partnership University NHS Trust
23. H4All
24. Hillingdon MIND
25. Imperial College Healthcare NHS Trust
26. Kingston Hospital NHS Trust
27. Imperial College Healthcare NHS Trust
28. Kingston Hospital NHS Trust
29. King's College Hospital NHS Foundation Trust
30. Language Line Ltd
31. London Ambulance Service
32. London North West Healthcare NHS Trust
33. Marie Stopes International
34. Moorfields Eye Hospital NHS Foundation Trust
35. North Middlesex University Hospital NHS Trust
36. NUPAS (formerly Fraterdrive Ltd)
37. Omnes Healthcare General Practice Ltd
38. Opcare
39. Royal Brompton & Harefield NHS Foundation Trust
40. Royal Free London NHS Foundation Trust
41. Royal National Orthopaedic Hospital NHS Trust
42. Royal Surrey County Hospital NHS Foundation Trust
43. St George's Healthcare NHS Trust
44. South West London and St George's Mental Health NHS Trust
45. Tavistock & Portman NHS Foundation Trust
46. The Confederation, Hillingdon CIC (The Confederation)
47. The Hillingdon Hospitals NHS Foundation Trust
48. The Royal Marsden NHS Foundation Trust
49. The Whittington Hospital NHS Trust
50. Royal Trinity Hospice
51. University College London Hospitals NHs Foundation Trust
52. West Hertfordshire Hospitals NHS Trust
53. West London Mental Health NHS Trust

## 11. Hillingdon CCG Primary Care Networks

| Name of Primary Care Network | GP Practices |
|---|---|
| **HH Collaborative** | HESA Medical Centre, Hayes Medical Centre, Glendale House Surgery, Kingsway Surgery, North Hyde Practice, Kincora Doctor's Surgery, The Cedarbrook Practice, Townfield Doctor's Surgery & The Warren Practice |
| **Synergy** | The Belmont Medical Centre, Central Uxbridge Surgery & The Medical Centre Brunel University |
| **Celandine Health** | King Edwards & Swakeleys Medical Centre, St Martins Medical Centre, Southcote Clinic, Wood Lane Medical Centre, Lady Gate Lane Medical Centre & Wallasey Medical Centre |
| **Colne Union** | Yiewsley Family Practice, The High Street Practice, Otterfield Medical Centre, The Medical Centre West Drayton |
| **North Connect** | Eastbury Surgery, Harefield Heath Centre, Carepoint, Mountwood Surgery, Acre Surgery & Acrefield Surgery |
| **MetroCare** | Cedars Medical Centre, Devonshire Lodge Practice, Oxford Drive Medical Centre, The Abbotsbury Practice, The Medical Centre Queen's Walk and Walnut Way Surgery |
| **APPLICATION PENDING** | Acorn Medical Centre, Parkview Surgery, Hillingdon Health Centre, Oaklands Medical Centre, Shakespeare Health Centre, Willow Tree Surgery, Pine Medical Centre, Yeading Court Surgery & Heathrow Medical Centre |

** Two GP practices in Hillingdon are not part of a PCN; West London Medical Centre and Church Road Surgery.

NHS
Hillingdon
Clinical Commissioning Group



**Appendix G – Better Care, Closer to Home – Our strategy for co-ordinated, high quality care (prepared by NHS Hillingdon)**

NHS Hillingdon



# Better Care, Closer to Home

*Our strategy for co-ordinated, high quality care*

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# Foreword



As a GP, I see first-hand the way in which our community and hospital services are delivering care and the experiences of our patients and clinicians. Too often our care is fragmented and we have an over reliance on hospital care. It is now well recognised that many hospital admissions could be prevented or treated in a community setting which is better for patients.

The NHS also faces a time of unprecedented challenge. Demand is rising as our population gets older and lifestyle factors contribute to a greater prevalence of long-term conditions. The costs of new drugs and treatments are also increasing. The resources available to us are rising but at a slower rate. Indeed, if we continue with 'business as usual' we will face a funding gap of £35 million over the next three years.

We need to transform the way care is delivered to meet these challenges. Our vision is to ensure that the residents of Hillingdon can access high quality, evidence-based care in a setting appropriate to their needs. Moving care out of hospital is a key part of realising this vision. This strategy sets out the plan for how our system will come together and collaborate to prevent people becoming unwell and to offer effective alternatives to hospital when patients need it.

We have already made some real improvements such as launching a new free 'phone number for patients to find out about local services and receive advice 24 hours a day. We are just about to launch an integrated care pilot, joining up care for those most at risk of falling ill. This will help individuals to proactively manage their own conditions and provide access to help and clinical expertise when they need it so they are less likely to become acutely unwell.

However, there is still much more to do. We need to seize the moment and work together to transform our out of hospital care for the benefit of our local population.

**Dr Ian Goodman, CCG Chair, Hillingdon**

# Executive summary

This strategy sets out our plans to transform out of hospital care. Section one looks at the case for change. We need to transform how care is delivered because demographic changes are increasing demand on healthcare services and the resources available are not increasing at the same rate. Improving our out of hospital services will make care better and less expensive. By intervening earlier, joining up care and supporting patients at home, we will be able to improve outcomes and patient satisfaction, whilst delivering greater value for money.

In section two we outline what the changes will mean for patients, and in section three we describe how we will achieve this. We are using five themes to summarise the changes we intend to make:

1. **Easier access to high quality, responsive primary care**
   We will ensure our residents have easy access to primary care. GPs will work together to extend the range of services offered in primary care. The 111 telephone number will provide a single point of access for patients, carers and clinicians and our Urgent Care Centre will offer 24/7 primary care at Hillingdon Hospital.

2. **Simplified pathways for patients requiring planned care**
   GPs will strengthen the process we use to refer patients. This will ensure patients are placed in the most appropriate healthcare setting and, where possible, patients will be able to access more services, such as outpatients and X-ray, closer to their home.

3. **A rapid response to urgent healthcare needs**
   Where possible, we will avoid admitting patients into hospital. We will do this by creating 'virtual teams' who will be trained to respond and provide the required services without admitting the patient. We will also target patients with conditions where effective management and treatment should reduce emergency admission to hospital (often known as Ambulatory Care Sensitive (ACS) conditions).

4. **More integrated care for patients most at risk of becoming ill**
   Our strategy will identify and provide better care for patients most at risk of becoming ill. This includes people with long-term conditions (e.g. diabetes), the frail elderly and those at the end of their life. Working collaboratively with

GPs, clinicians, specialists and the patient, we will monitor and provide the best care for that individual at each stage of their condition.

### 5. Appropriate time in hospital and support after discharge

We will ensure patients admitted into hospital stay for right amount of time and continue to receive care in the community when discharged. By working collaboratively, we will ensure patients have joined up care plans when they are discharged from hospital and that they continue to receive care and support throughout and beyond their recovery. This will improve the patient experience and clinical outcomes.

## Working together to put patients in the centre of better health care

This will mean changing how we work together in Hillingdon. In section four we describe how we are organising ourselves and working with others to deliver better care. We have introduced six new clinical sub-groups (Northwood, Ruislip, Uxbridge, West Drayton, Hayes, and Harlington) across the Borough, which will coordinate key services around the patient (for example, integrated care for people with diabetes).

## Implementing the Strategy

Section five describes the key enablers that will support us in making these changes. These include patient and public engagement, leadership and workforce development, governance and information requirements. We will adapt and make best use of existing premises in Hillingdon to deliver more care out of hospital.

We will need to invest in our future; section six gives an overview of the investment we will make. In the coming months we will begin work to achieve our vision as outlined in this strategy, and will engage both clinicians and managers in how this will be delivered and funded. Section seven provides some more detail of our implementation plans and when we will make these important changes to how care is delivered.

# 1. The case for improving out of hospital services

This strategy sets out our plans to transform out of hospital care. We need to do this because demographic changes are increasing demand on healthcare services and the resources available are not increasing at the same rate. As the population ages and the number of chronic illnesses rises, the way we currently deliver care is becoming unsustainable.

Improving our out of hospital services will make care better and less expensive. By intervening earlier, joining up care and supporting patients at home, we will be able to improve outcomes and patient satisfaction, whilst delivering greater value for money. Better care, closer to home is an essential way to maintain the quality of care in the face of increasing demand and limited resources.

Exhibit 1 sets out reasons for transforming out of hospital care. Further details are provided in the North West London's *Shaping a Healthier Future* programme and the appendix to this document.

EXHIBIT 1

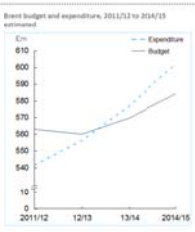
**There is a strong case for improving out of hospital services**

1



The residents of Hillingdon have **changing health needs**, as people live longer and live with more chronic and lifestyle diseases - putting pressure on social and community care. For example, the number of older people with dementia is expected to increase by 7% over five years to 2015[1]

2




Under our current model of care, **we can't afford** to meet future demand. Hospital is too often the answer and we need to have **more planned care and earlier** interventions outside of hospital

3



However, this needs a **transformation of primary, community and social care**. Currently there is variation in both **quality and access** and standards must improve.

1 Source: Hillingdon's 2012 Joint Strategic Needs Assessment sets out the health and well being needs of the local population over the next 5 years and beyond

# 2. Delivering quality care, differently

Our vision is to:

*'ensure that the residents of Hillingdon can access high-quality, evidence-based care in a setting appropriate to their needs'*

We will achieve this by working in constructive collaboration with patients, their carers, and providers of health and social care. In conjunction with our partners, we have identified five strategic goals that will make our vision a reality.

EXHIBIT 2



| | Hillingdon's five strategic goals | Specifically, this means |
|---|---|---|
| 1 | ▪ **Easy access** to **high quality, responsive primary care** to makeout of hospital care the first point of call | ▪ GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care |
| 2 | ▪ **Clearly understood planned care pathways** that ensure out of hospital care is not delivered in a hospital setting | ▪ Whenever possible, patients will have access to services closer to home |
| 3 | ▪ **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care | ▪ If a patient has an urgent need, a rapid clinical response will beprovided. |
| 4 | ▪ **Providers (social and health) working together**, with the patient at the centre to proactively manage **LTCs**, the **elderly and end of life care** | ▪ Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home |
| 5 | ▪ **Appropriate time in hospital** when admitted, with **early supported discharge** into well organised community care | ▪ Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care |

This section describes how care will be different for our patients.

EXHIBIT 3




## 2.1 EASIER ACCESS TO HIGH QUALITY, RESPONSIVE CARE

We are committed to improving access to primary care so it meets patients' expectations and needs. For patients this will mean:

- 24/7 telephone access (via the 111 number) for advice on local services, triage and booking urgent appointments.
- 24/7 access to primary care at the Urgent Care Centre (UCC) at the Hillingdon hospital.
- 9am-8pm access to the Minor Injuries Unit at Mount Vernon Hospital
- Greater use of email, text, video and 'phone for information and consultations.
- The opportunity to go to another GP to access a wider range of services.

## 2.2 SIMPLIFIED PATHWAYS FOR PLANNED CARE

An increasing number of patients will be seen in community facilities so they do not have to travel to hospital for outpatient appointments. For example, we are developing community based pathways for musculoskeletal (MSK) patients.

All patients will have access to the same planned care as a result of our Referral Facilitation Service (RFS). This will mean significantly more patients are referred directly to the most appropriate clinician first time.

## 2.3 IMPROVED RESPONSE TO URGET HEALTHCARE NEEDS

Where a patient has an urgent need, we will make sure that they are able to access timely alternatives to hospital. Our multi-disciplinary Rapid Response team will care for more patients at home, meaning they will not need to be admitted to hospital. Patients will be able to navigate the system easily via clear signposting, such as 111 and GP websites, as well as information from knowledgeable staff.

Any individual who is clinically assessed to be at risk of an admission to hospital that could be prevented by short term intervention and support will be seen within four hours. This includes access to expert advice, services, equipment and diagnostics. The Rapid Response Team will organise enhanced support for up to 10 days for those patients who need it to help them remain in their own home.

## 2.4 SOCIAL AND HEALTH PROVIDERS WORKING TOGETHER WITH THE PATIENT AT THE CENTRE

We will help patients to stay well. For patients most at risk of becoming ill, we will work with other providers to help individuals manage their conditions. This will mean developing integrated, evidence-based care pathways and coordinating care between providers. As a result, patients will experience more seamless care and know who to contact for help and advice. For example, patients with diabetes, or in the last 12 months of life, will have a care plan which they (and where appropriate their carer) will develop jointly with a clinician.

## 2.5 APPROPRIATE TIME IN HOSPITAL AND SUPPORT AFTER DISCHARGE

In future, following an admission to hospital, the patient's GP and other relevant providers will be actively involved in coordinating their discharge to support the transition from hospital to the community. As a result, we expect there will be fewer people staying in hospital longer than they need or wish to, due to lack of adequate supported discharge

Patients with care plans will maintain the continuity of their care throughout their admission to hospital For example; discharge can be delayed due to mental rather than physical health problems. Hillingdon Hospital is piloting a psychiatric liaison service on all wards which enables care plans to reflect mental health needs and support a smooth transition from hospital.

## 2.6 STANDARDS TO MAINTAIN THE QUALITY OF CARE

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and the wider care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. The out of hospital standards for care in NWL are shown below.

EXHIBIT 4

### STANDARDS: Local clinical leads have set providers high clinical standards of care to which they will be held

| Domains | The standards are covered in four key domains |
|---|---|
| Individual Empowerment & Self Care | ▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing |
| Access convenience and responsiveness | ▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:<br>▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling<br>▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hour |
| Care planning and multi-disciplinary care delivery | ▪ All individuals who would benefit from a care plan will have one.<br>▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care<br>▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists |
| Information and communications | ▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care<br>▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers<br>▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan |

Source: NWL Clinical Board and Programme Board, March 2012

# 3. How we will deliver better care, closer to home

This section describes the key initiatives that will enable us to deliver our five strategic goals. Some of these initiatives are already being implemented in Hillingdon, whilst others are new and are part of work taking place at a wider level, for example the North West London Integrated Care Pilot.

EXHIBIT 5



## 3.1 IMPROVING ACCESS TO PRIMARY CARE

### 3.1.a Improving access to GPs

- We will establish and offer the best mix of appointment (e.g. telephone appointments and emergency appointments booked for the next 48 hours). Online booking will also be available 24 hours a day.
- We will explore better ways to triage patients, getting the right people to focus on the right things. We will publish performance and ensure that practices are held to account to meet quality standards and patient expectations.
- GPs will work together to extend the range of services and hours of availability offered in primary care.

### 3.1.b 111 telephone number – a single point of access

- A new phone number, 111, now directs patients to the most appropriate service for all calls except emergencies and routine appointments with their GP
- The 111 team have detailed knowledge of Hillingdon's services. For example, they may provide clinical advice or direct patients to their GP or a local pharmacy.
- The 111 team is also trailing the direct booking of patients into GP appointments.

### 3.1.c convenient access to the Urgent Care Centre

- We are developing the Urgent Care Centre at the Hillingdon Hospital. This provides a 24-hour GP led service for dealing with minor illnesses and injuries. Mount Vernon Hospital also has a minor injuries unit open 9am to 8pm every day for patients in the north of Hillingdon.
- Our UCC will see approximately 80,000 patients each year. This will reduce usage of A&E by around 50,000 attendances allowing A&E specialists to focus on the most serious and life threatening conditions and reducing patient waiting times.
- The UCC will use the same system as the GP out of hours and 111 services. It will have links with each GP practice (e.g. sending discharge summaries by 8am the following day) as well as links into A&E's patient administration system (via scanning) for patients who require admission to acute care.

- The aspiration is that the UCC will use NHS Pathways, aligning its practice with the 111 service to ensure a consistent service at all points of access.

## 3.2 HIGH QUALITY PLANNED CARE

### 3.2.a Referral Facilitation Service

- The Referral Facilitation Service (RFS) will ensure referrals are directed to the most appropriate clinician and everyone has the same access to care.
- This will help ensure that patients are seen by the right clinician at the right time, reducing duplication and unnecessary appointments.

### 3.2.b Outpatients in a community setting

- We will aim to shift 10% of outpatient consultations into a community setting. We are developing community-based pathways of care for services such as musculoskeletal (MSK).
- Care will be delivered by consultants or other allied health professionals where appropriate (such as physiotherapists for MSK). We will also look at new ways of working such as tele-access to a specialist opinion.
- Consultants will play a key role in ensuring that out of hospital care is delivered to high standards. They will help ensure consistency and standards across the system: for example, by providing leadership to clinical networks (groups of local experts in a particular disease area), developing care pathways, and providing guidance and leadership on new developments in a disease area.

## 3.3 RESPONSIVE EMERGENCY CARE

### 3.3.a The Rapid Response team

- We are widening the scope and range of skills within the Rapid Response team. This will prevent avoidable admissions and provide enhanced support for people to remain independent at home following a crisis.
- This major investment in the Rapid Response will incorporate enhanced medical care access to step-up beds and health and social care professionals including mental health.
- The Rapid Response team will assess people within 4 hours.
- Patients with conditions known as Ambulatory Case Sensitive conditions (ACS), i.e. health problems which should not require hospitalization will also benefit from access to enhanced care if they experience a health crisis event.
- The Rapid Response team will work with other community services such as case managers and community nurses where community care is required.
- The team will provide a holistic assessment of needs and intensive multi-disciplinary support at home for up to ten days. In some cases, people may require a short admission to a community step-up bed (the Northwood and Pinner unit at Mount Vernon) for up to 3 days, to enable an enhanced level of medical support.
- After this initial phase of care, patients who need further support will be able to access other core community services, including a further period of rehabilitation or reablement, or community nursing support.
- This will be facilitated in part by reducing the number of people being admitted to hospital with a length of stay that is very short (under 1 day), and where only low-level care is required. This will help align incentives to the aim of treating more people in primary care and the community where possible.

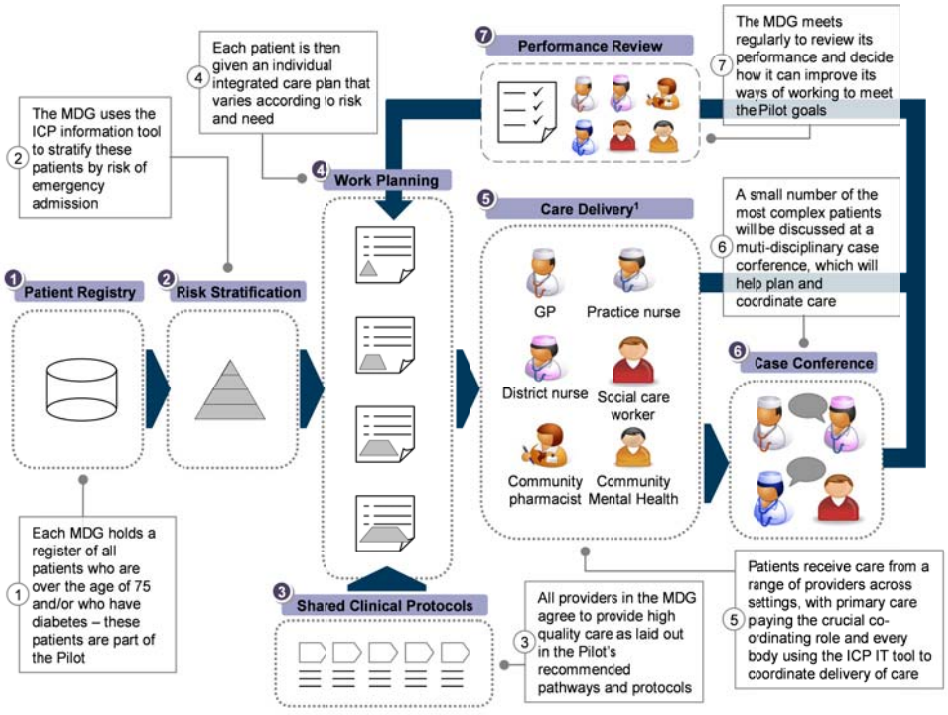
### 3.4.a Risk stratification, care planning and case conferences

- We will roll out the Integrated Care Pilot across Hillingdon. We are establishing six multi-disciplinary groups, which will work together to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients and the over 75s.
- GPs and other members of the multi-disciplinary group will identify the most complex patients who require integrated care from a number of professionals.
- The practice nurses will co-develop a care plan with the patient (and their carer where appropriate), ensuring all the services that the patient needs are working together.
- Case conferences will bring together hospital specialists, GPs, community health providers, social workers, mental health specialists and others to discuss how best to provide for complex patients. Case conferences will also develop clinicians' knowledge of conditions and the roles other services can play.

Exhibit 6 outlines how the integrated care model will work in practice

EXHIBIT 6

**How the integrated care model will work in practice**



- An IT tool is being procured across North West London which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers.
- The key benefit for patients will be improved outcomes since they will receive earlier and more coordinated intervention.
- This type of integrated approach will primarily support older people and people who have a range of long-term health conditions.
- We are exploring how this integrated approach can help people with mental health needs to be cared for in primary care without the need for more intensive settings

**The role of multi-disciplinary groups:**
Multi-disciplinary groups are made up of primary care, secondary care, social care and mental health staff. They share a database of patients which is used to identify the patients most at risk of hospital admission (known as "risk stratification"). The multi-disciplinary group has agreed clinical pathways of proactive interventions to keep people out of hospital and, through a regular process of work planning; each patient will have an integrated care plan, developed in consultation with them. High risk patient cases are discussed at monthly case conferences. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery.

### 3.4.b Proactive case management for frequent users of hospital services

All patients who have had three or more emergency admissions in the previous year will be offered case management by a dedicated team of community nurses. These patients will have care plans and support in primary care to reduce the number of avoidable health crises and hospital care or admission. This will be better for patients and for the health system. The community nurses will have a key role in the extended primary care health team and will work closely with GPs to ensure these patients have appropriate proactive care in place.

### 3.4.c End of life care

- We are committed to increasing the proportion of people dying in their place of choice. To achieve this we are:

  - increasing support to care homes;
  - providing a programme of education and workforce development;
  - Improving access to palliative care professionals.
- End of life patients will have a specialised care management plan, coordinated by the district nurses with specialist training.
- We are creating a borough-wide end of life Care register, which will include people's wishes on their preferred place of death. We will explore the use of IT tools to support end of life care so providers can understand and act upon the patients preferred place of care.

### 3.4.d Using technology to keep people healthy

We are working with social care to identify and develop how telehealth and telecare services can help keep people, such as those with respiratory conditions, healthy and in their own homes.

## 3.5 SUPPORTED DISCHARGE

Supported discharge enables people to leave hospital as soon as they are medically fit. At this stage of a person's care, some people require hospital, community and social services to work together and take a joint approach across health and social care. This is particularly important for older people to help them retain their independence as far as possible.

### 3.5.a Joined up discharge support and step-down care

We are working with partners to develop a new model of supported discharge that enables a seamless patient journey and a multi-disciplinary approach to care. This includes proactive in-reach and out-reach services, managing the transition from the acute to the community, and enhanced care at home. Services could include joined up intermediate care for up to 6 weeks at home or in a step-down bed, and access to supportive services such as equipment, telecare, rehabilitation and reablement. This will also help patients to return to their home rather than institutional care after discharge from hospital.

### 3.5.b Establish a psychiatric liaison service

Hillingdon Hospital is currently piloting a psychiatric liaison service. This service will help diagnose mental health problems while the patient is in hospital. This will enable care for patients with significant mental health needs to be addressed in acute settings (outside specialist mental health units), train other hospital staff to enable them to support mental health needs and provide integration with other parts of the health system including GPs.

The service will improve coordination with out-of-hospital care providers and housing services, meaning a higher proportion of patients can be discharged directly to their own homes or appropriate accommodation.

# 4. How we will work together

Earlier this year, we agreed some organising principles to guide the development of our strategy:

- We need to organise in a way that enables collaboration and co-ordination of care across Hillingdon
- We must avoid duplication of activity
- Activity should be delivered where it is most effective for the patient and most efficient financially
- Care will be GP-led, with primary care teams central to patient care
- We should design care around networks of practice populations which broadly reflect geographical boundaries
- Existing contracting arrangements should not constrain design

The changes proposed in our strategy will mean that providers need to work more closely together. In response to this we will:

1. Introduce networks of provision
2. Work with our partners to provide coordinated care
3. Develop three community 'hubs'

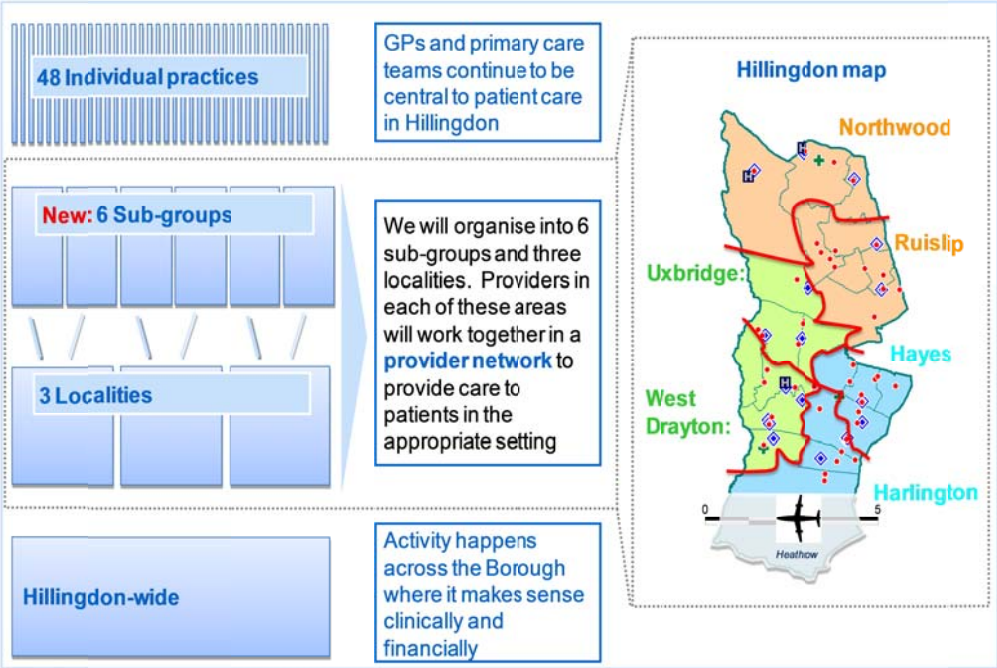
Another integral part of this is how we work with patients and carers; this is described in section 5.

## 4.1 NETWORKS OF PROVISION

Out of hospital care will be delivered at different four levels. This is because different types of services work better with different user population sizes. To coordinate and integrate care around the patient, the major healthcare providers will work together in networks. These networks will need to form between providers at the existing locality and the new sub-group levels. The four levels of care are described in turn from smallest catchment area to largest (Exhibit 10).

EXHIBIT 7

**In Hillingdon care will be delivered and managed at four levels**




GP practices will remain the foundation of care, providing routine care for minor conditions near where patients live. Overall accountability for a patient's health will remain with GPs. Practices will also continue to help patients with complex needs to navigate the healthcare system.

We are introducing six sub-groups, each of which will have a population of 50-70,000. These will play a key role in coordinating care and providing a greater range of services locally. Within each sub-group there will be services offering extended opening hours. District nursing and specialist primary care, such as our joint injections service, will be organised within these six sub-groups. Multi-disciplinary groups, which we are introducing as part of the Integrated Care Pilot,

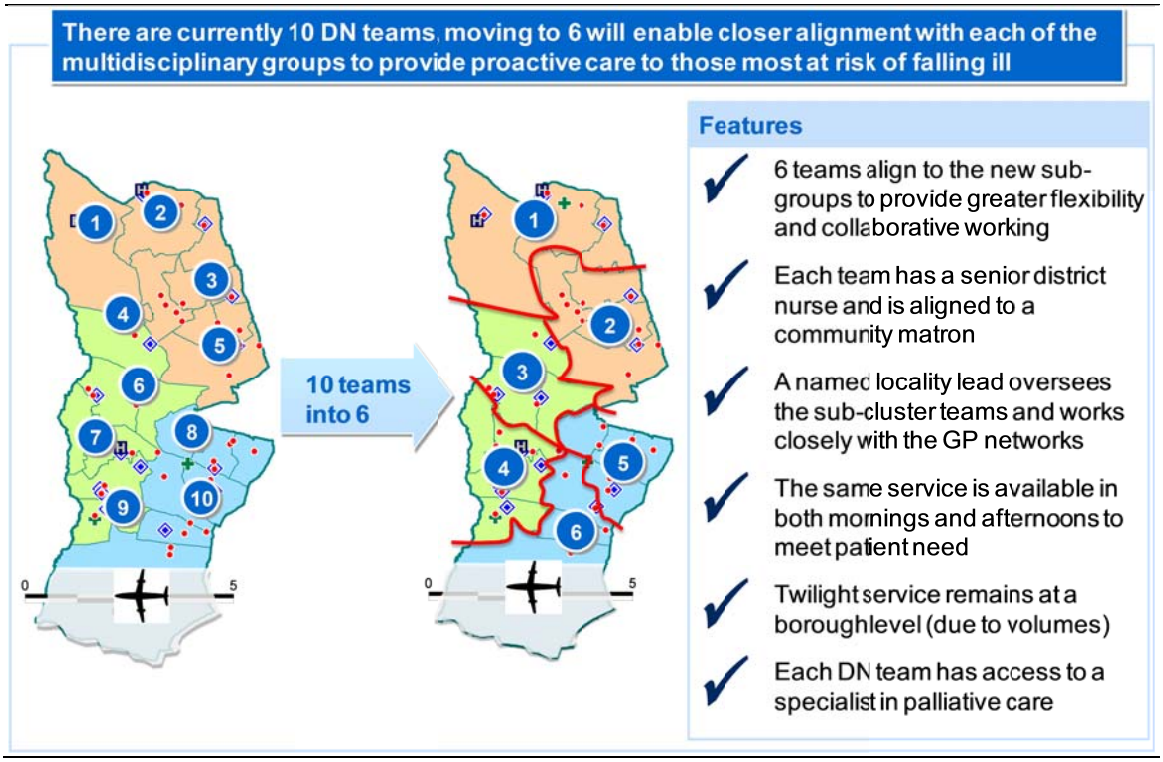
will increase the coordination of professionals within sub-groups through monthly case conferences.

The six sub-groups fit into three localities, which will provide more specialized care, such as community outpatient and elective procedures. Patients will travel to local centres for these services, which will be available during extended hours, seven days a week. Rapid Response teams that travel to the patient to provide discharge support and admissions avoidance will work within localities.

Other services which need to operate on a larger scale will function across the borough. Many will be provided around the clock, for example, the 111 urgent care phone number, GP out of hours services, community beds and acute hospitals services including A&E. Services such as Rapid Response, social care and telecare will be part of a borough level service which can be aligned to the networks.

In order to increase the coordination between different services, we are aligning them to our new boundaries. For example, we propose to reform district nursing (DN) teams into six teams that align to the clinical sub-groups as shown in Exhibit 8:

EXHIBIT 8



## 4.2 WORKING WITH OUR PARTNERS TO PROVIDE COORDINATED CARE

Given our aim to provide coordinated care for the residents of Hillingdon, the CCG commits to working closely with our partners. Some examples of how we will do this are included below.

### Acute trusts

- Co-design service developments with clinical teams including shared medical models and job-plans

### Hillingdon Health and Wellbeing Board (HWBB)

- Under the leadership of the HWBB, a joint health and wellbeing strategy is being developed.
- The HWBB will provide a framework for planning and commissioning care. It will describe how we will be more pro-active in preventing illness and reducing the impact of diseases. For example, it will describe plans to increase the number of people helped to stop smoking, increase the number of NHS health checks, tackle obesity locally and increase the uptake of screening e.g. to identify bowel, breast and cervical cancers.
- The HWBB will also give strategic direction to the actions local health services can take with the council to prevent ill health.

### Hillingdon Social Services

- We will develop an integrated service approach across the localities, ensure alignment with personal budgets, and enable people to remain independent at home. Examples of integrated working with health and social care include intermediate care, telehealth and integrated mental health services.
- Hillingdon social services can also provide information and signposting to individuals to support them to manage their own care.

### Hillingdon's voluntary sector

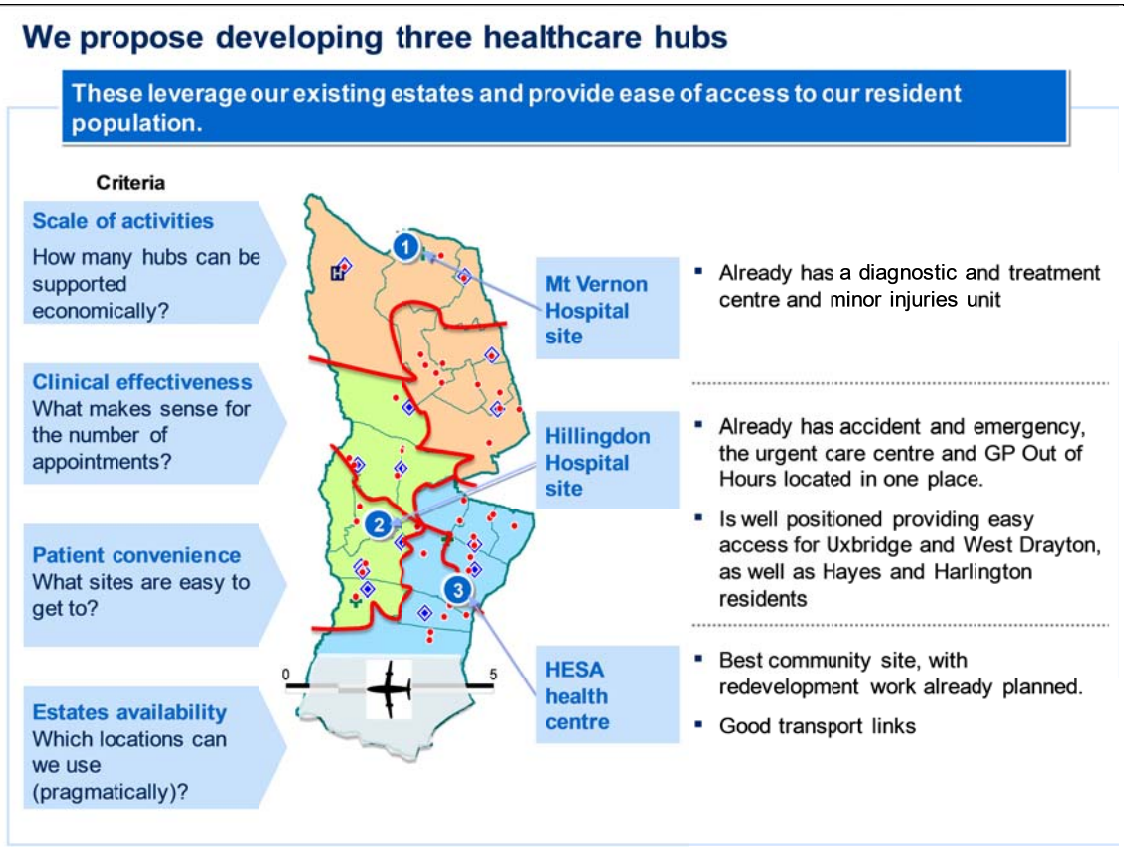
- The voluntary sector plays a valuable role in Hillingdon in both improving health and providing front-line services. The voluntary sector has a key role in co-developing services with patients to enable greater choice and control as well as promoting and supporting self-directed care.
- Voluntary sector services can also work collaboratively with each other and with statutory services, to innovate care to better meet service user needs.
- Their role in communities can also support the new networks with co-developing services and involving patients and the public.

## 4.3 THREE HEALTHCARE HUBS

This strategy aims to meet more healthcare needs in the community. To do this will require clinic space, procedure rooms, diagnostics and community beds. We will also need office space and meeting rooms to enable closer working between service providers.

With our partners, we have used a set of criteria to identify three healthcare hubs - Mount Vernon Hospital, Hillingdon Hospital and the HESA Health Centre – as shown in the exhibit below.

Exhibit 9




This approach will:

- Provide an integrated non-acute setting for care delivered by specialists, GPs, and AHPs;
- Serve as a base for consultants when they work in the community, and for mobile community providers;
- Provide space for regular meetings of multi-disciplinary groups, GPs and provider networks;
- Allow local access to advanced diagnostic equipment;

- Utilise existing facilities.

# 5. Enabling improved healthcare for Hillingdon

We have identified six key enablers for better care, closer to home:

- Patient and public engagement
- Leadership
- Workforce development
- Governance and variance management
- Information management and technology
- Contracts and incentives

## 5.1 PATIENT AND PUBLIC ENGAGEMENT

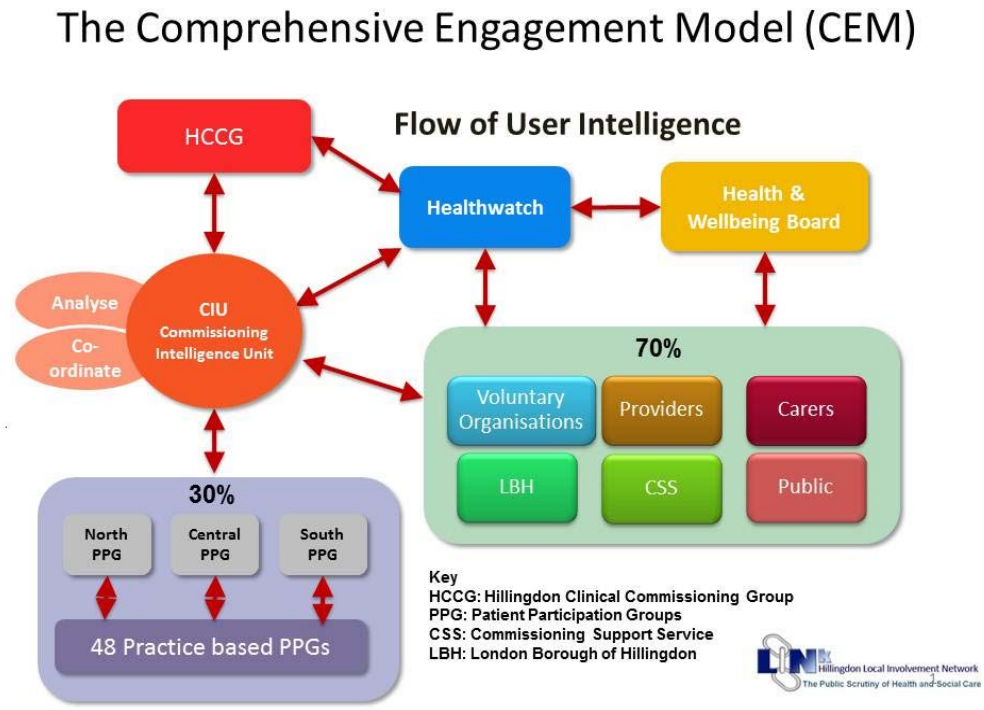
We are committed to engaging and involving patients and the public as set out in the NHS constitution:

*'You have the right to be involved, directly or through a representative, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'*

Our approach to patient and public engagement (PPE) is to create and sustain an on-going dialogue. This will ensure our population is aware of the changes proposed and have had the opportunity to shape the design.

We are adopting the PPE engagement model developed by our Local Involvement Network:

Exhibit 10




In practice, there will be three aspects to this engagement:

1. *Strategic planning:* patient representatives have already contributed to the development of this strategy and we will continue to seek views as we develop our plans
2. *Development of services:* we will involve patient representatives in service developments such as the community-based MSK pathways
3. *Wider communication:* we will use a range of channels to communicate with Hillingdon residents and specific groups on key priorities such as using 111 to access information on local services

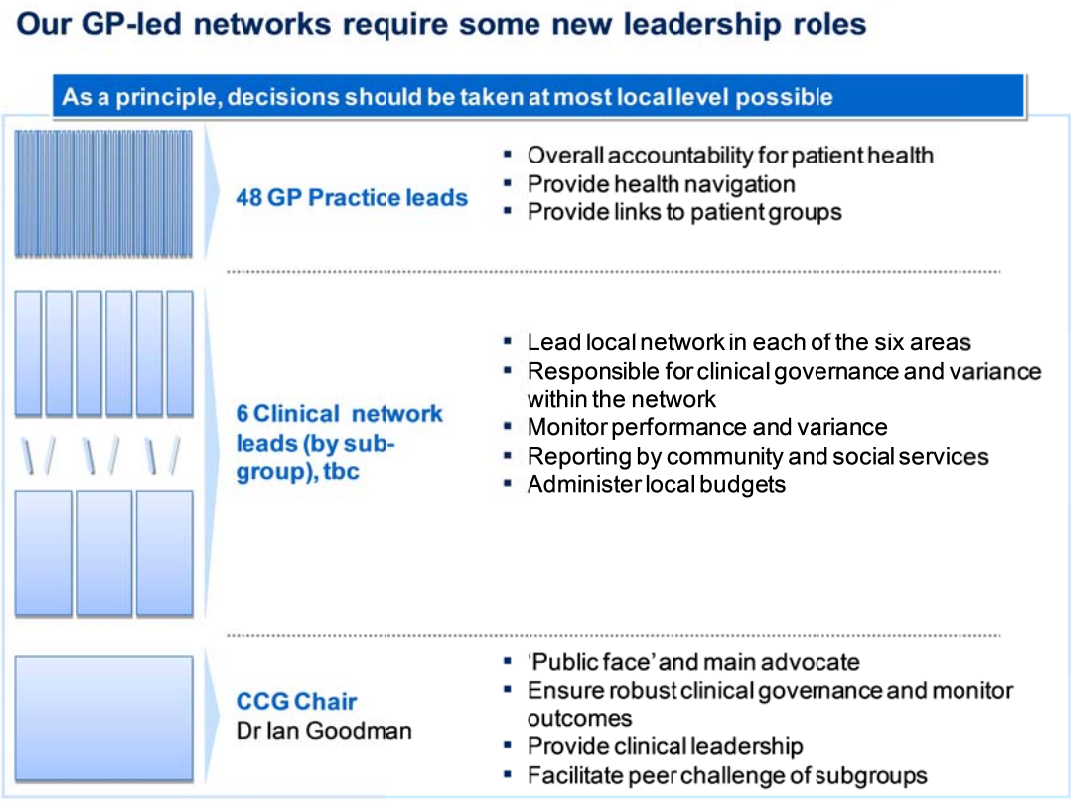
## 5.2 LEADERSHIP

This ambitious strategy can only succeed with the right clinical leadership.

We see developing GP leadership as an essential part of driving up standards of care. We will use our networks to provide peer-to-peer learning and challenge. Each clinical subgroup will establish its own structure with clear clinical leadership coming from the clinicians working within that geographic location. The potential for development of clinical leaders is significant and the CCG will provide the necessary resources to maximise this process.

In future, we will focus on the following key areas in order to increase the skills of our different professional groups to deliver enhanced out of hospital care:

Exhibit 11




SOURCE: Hillingdon OOH workshops

## 5.3 WORKFORCE DEVELOPMENT

Our workforce is critical to the delivery of the out of hospital strategy. Our plans to develop the workforce are as follows:

- We will support **GPs** to specialise where appropriate, increasing the number of GPs with a special interest.
- We will up skill our **practice nurses** so that they are able to carry out tasks that GPs have traditionally carried out (e.g. chronic disease management).
- We will build the capabilities of our **healthcare assistants** so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry).
- We will develop the skills of our **managers** so that they are effective at coordinating networks, monitoring outcomes and developing strong relationships with community services.
- We will work with the acute to adapt the job-plans of **consultants** and other medical staff to support working in the community.
- We will facilitate integration between health and social care through the introduction of **care coordinator** roles.

## 5.4 GOVERNANCE AND VARIANCE MANAGEMENT

Hillingdon CCG will put in place a robust means of managing performance to ensure patients experience improved care. We will:

1. **Establish clear targets and indicators to measure progress**

- Select key performance indicators (e.g. outpatient referrals and non-elective admissions for patients with a long term conditions).
- Bring our indicators together in a balanced scorecard with the following domains: clinical outcomes, patient experience, operations, and finance.

2. **Track performance effectively**

- Establish a transparent monitoring process to monitor performance against stated goals.

3. **Peer review of performance**

- Identify ways to spread strong performance.
- Establish a clear plan of action to address challenges.
- Report regularly on progress and consequences for poor performance agreed.

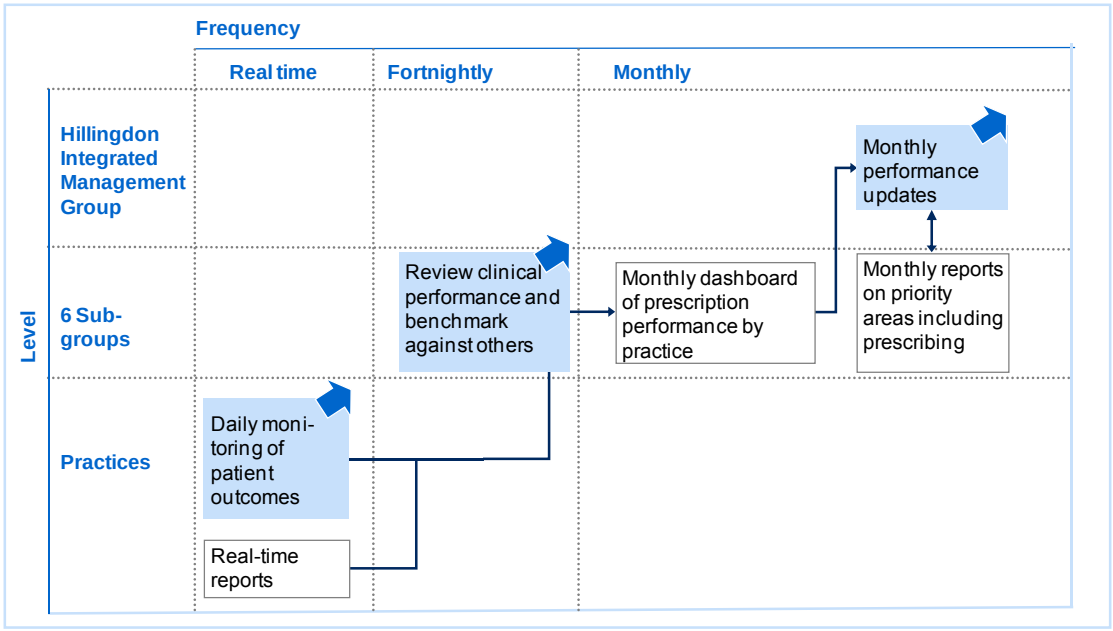
4. **Rewards, incentives and consequences**

- Explore payment to practices on achievement of targets.
- Agree consequences for continued under performance.

This is illustrated in exhibit 12

Exhibit 12

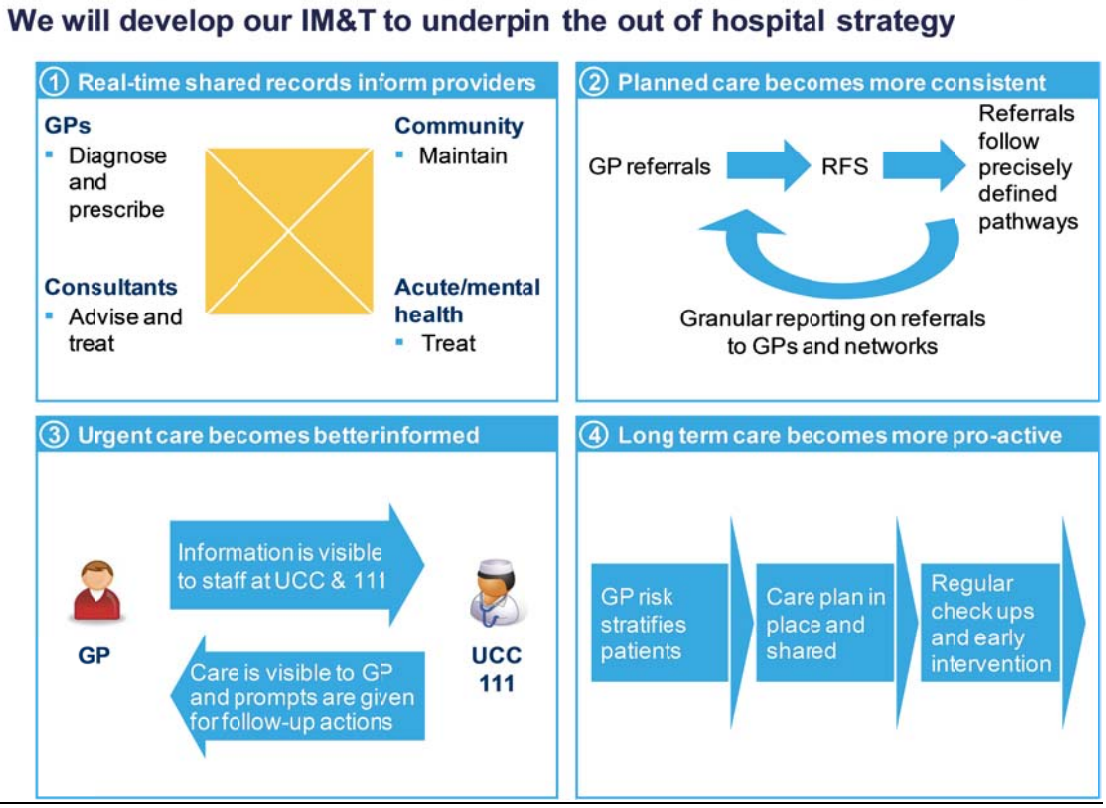
## We will develop a system to monitor and assure our progress



## 5.5 INFORMATION MANAGEMENT AND TECHNOLOGY (IM&T)

Better sharing of information will be central to achieving our vision. We aspire to have real-time shared records across GPs, community, acute and mental health teams as shown in the exhibit below. We will develop an IM&T strategy to support and enable the work to deliver more care out of hospital by autumn 2012. We plan to move to a common GP platform (EMIS Web). We will also develop an information governance approach and standards for the networks.

EXHIBIT 13



## 5.6 CONTRACTS AND INCENTIVES

As we introduce new services and ways of working, we need to ensure that the contracts and incentives that we have in place underpin these and reinforce the behaviours we want to see. Exhibit 14 shows some example targets that we will set for each of our five key goals and the new types of contracts, incentives and behaviours that will align with these.

EXHIBIT 14

**Incentivising out of hospital care**




| Hillingdon's five strategic goals | Example measures and incentives |
|---|---|
| ▪ Easy access to high quality, responsive primary care | ▪ Access times<br>▪ Patient satisfaction<br>▪ Shared incentives across networks |
| ▪ Clearly understood planned care pathways | ▪ Outpatient referral rates<br>▪ Adherence to evidence-based pathways |
| ▪ Rapid response to urgent needs | ▪ A&E attendance rates and conversions<br>▪ NEL admissions |
| ▪ Providers working together to proactively manage care | ▪ NEL admission rates<br>▪ Case conference attendances & outcomes |
| ▪ Appropriate time in hospital and supported discharge | ▪ Length of stay<br>▪ Readmission rates |

# 6. Investing for the future

This section summarises the investment we anticipate making to realise our strategy. To deliver our vision we will make significant investments in staff and estates across the different settings of care. Exhibit 15 outlines the broad investment we will make in services delivered at home, in GP practices, community health centres and community hospitals over the next three years as investment shifts from the hospital to the out of hospital sector.

EXHIBIT 15

Investment by 2015[1,2]

| Where you will receive care[3] | Services offered | Additional Investment | Additional workforce | Additional space |
|---|---|---|---|---|
| At Home[2] | ▪ Community care<br>▪ Elderly care<br>▪ Postnatal care<br>▪ Rapid Response | ▪ £3.0-3.5m | ▪ 50 – 55 WTE | ▪ Access to consulting rooms/ team room |
| At a GP Practice[3] | ▪ nGMS plus extended hours<br>▪ Core primary care services | ▪ £2.5-3.0m | ▪ 15 – 20 WTE | ▪ 200-300m²<br>▪ <3 consulting rooms<br>▪ Team room |
| At a Community Health Centre | ▪ ECG, possibly ultrasound<br>▪ Rapid access to blood tests<br>▪ Rapid access referral to hub/hospital | ▪ £6.5-7.0m | ▪ 65 – 70 WTE | ▪ 1,800-1,900m²<br>▪ <9 consulting rooms<br>▪ Team rooms<br>▪ <27 beds |
| TOTAL | | £12-14m | | |

Investment does not include estate cost implied from the figures above

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. "Outpatient at lower cost" initiative assumes re-provision cost of 1.0 GP appointment of 20 minutes & 1.0 Consultant appointment of 15 minutes per patient per year for 5% of total outpatient cohort
2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and Harrow Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews
3 Initiatives includes: "At Home"- e.g. Rapid Response (Nursing), Case Management, ICP; "ATa GP Practice"- e.g. Outpatient at lower cost, ICP; "In a community heath centre"- e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP
SOURCE: NHS NWL Team; Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

# 7. Next steps

In this strategy, we have set out an ambitious vision for transforming out of hospital care in Hillingdon. We need to move quickly to make early improvements for patients and to make the scale of the savings that are needed by 2014/15.

Work has already begun on developing business cases for the initiatives in this strategy. This includes detailing the investment required, how costs will be covered, the impact that will be achieved - both qualitative and quantitative - and mapping against other activities that may overlap. Exhibit 16 summarises the key next steps we will take:

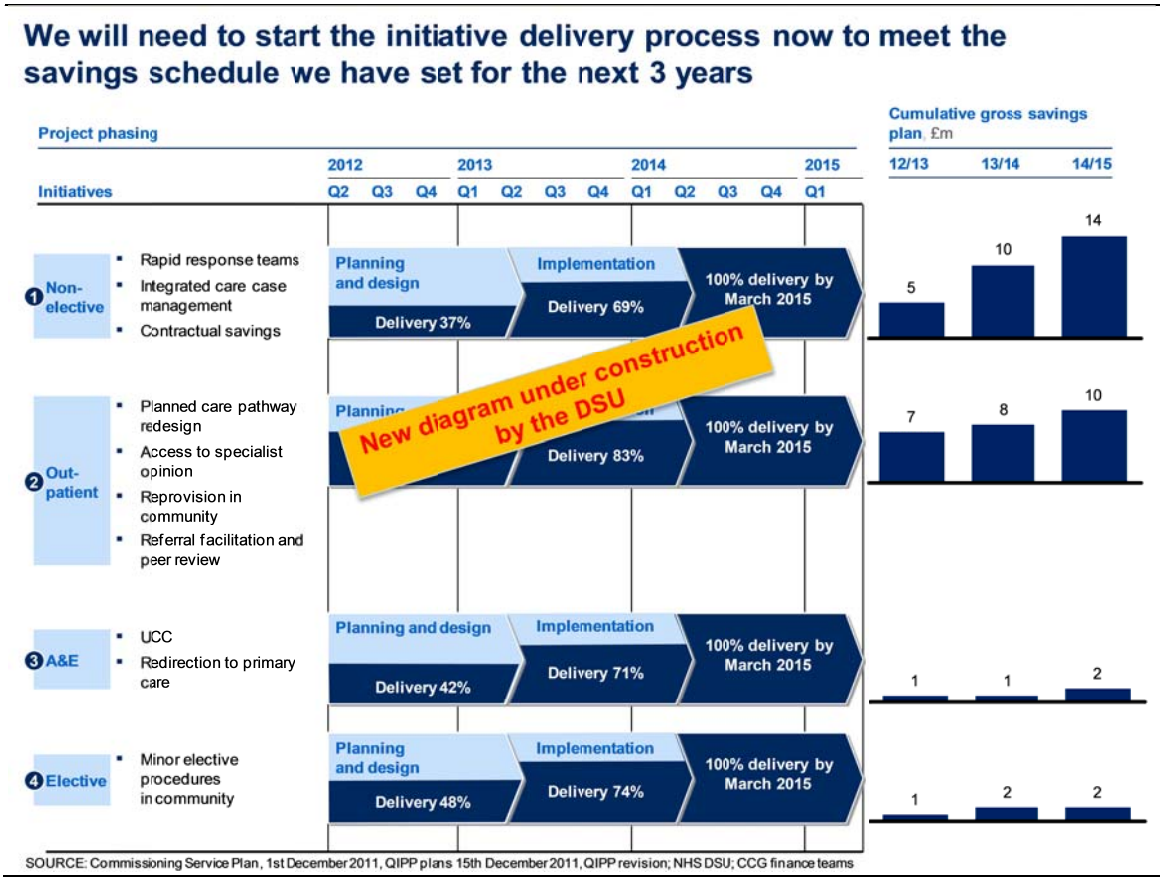
EXHIBIT 16



## 7.1 IMPLEMENTING OUR KEY INITIATIVES

We have already begun to implement a number of initiatives whilst others will be implemented over the next 12 months as shown below. The phasing of some of the key initiatives, along with the anticipated timing of when some of the more tangible benefits will be realized.

EXHIBIT 17

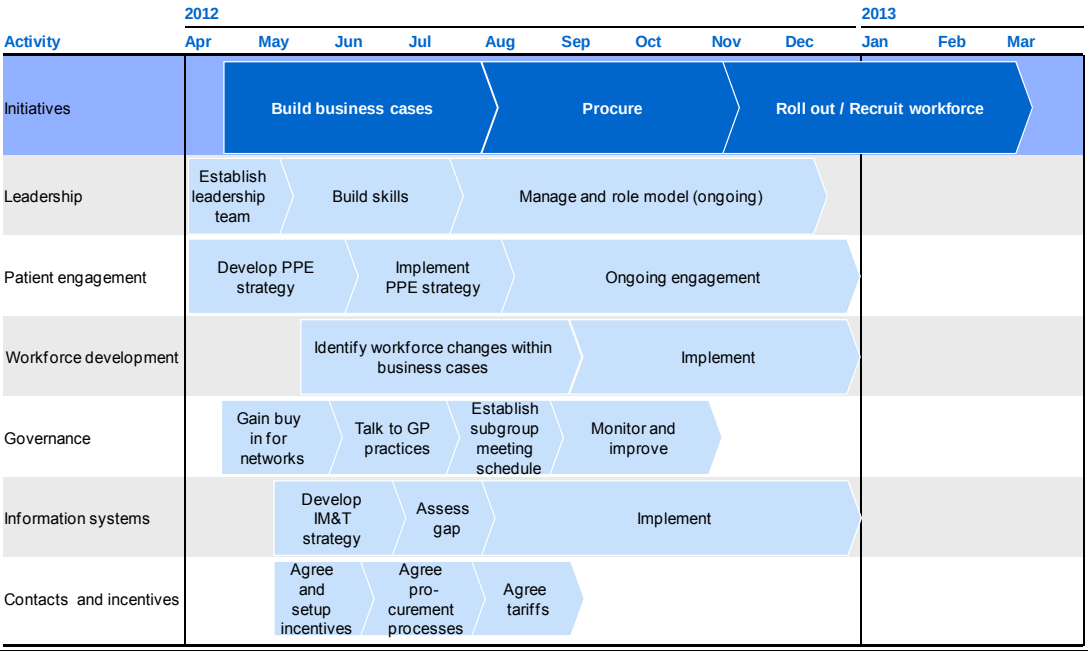


## 7.2 IMPLEMENTING OUR SUPPORT FOR CHANGE

Making large-scale, transformational changes to how care is delivered will require the development of a wider set of enablers as described in section five. The timeline for developing these underpinning changes is shown below.

EXHIBIT 18

### Successful delivery will rely on all enablers being addressed



**Appendix H – Transforming the NHS in North West London – Five Year Strategic Plan (prepared by NHS)**

# Transforming the NHS in North West London

Integrating health and social care with the leadership of local GPs and working in partnership with NHS England

*North West London - Five Year Strategic Plan 2014/15 - 2018/19*

*Draft –17th June 2014*

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# Executive summary

*Our five year strategic plan sets out how we will work collaboratively to transform the health and care landscape across NWL in order to achieve our shared vision, deliver improved outcomes and patient experience, ensure a financially sustainable system, and meet the expectations of patients and the public*

## Introduction

- Our vision for the future of North West London (NWL) health and care system is based on what people have told us is most important to them. We know that what people want is choice and control, and for their care to be planned, helping them reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.
- It is in support of this person-centred vision that our NWL five year strategic plan sets out the collective plans and priorities of the eight Clinical Commissioning Groups (CCGs) of NWL, working in partnership with NHS England. This Plan sets out the vision and ambitions against which NHS England and each CCG's detailed two year operational plans have been set.
- Our plan is consistent with NHS England's vision, outcome ambitions, service models and essentials, and this alignment is articulated throughout the document.

## Our shared vision and outcome ambitions for North West London

Our overarching vision, co-produced with the people of NWL, is:

> *"To improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

Four overarching principles underpin our whole system NWL vision – that health services need to be:

1. **Localised** where possible
2. **Centralised** where necessary;
3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless person centred care. Individuals will be enabled to work with

frontline professionals, their carers, and their families to maximise health and wellbeing and address their specific individual needs.

4. The system will look and feel from a patient's perspective that it is **personalised** - individuals will be enabled and supported to live longer and live well.

In addition, commissioners will recognise our broader role in society (both as employers and commissioners), and address the wider determinants of health, working with our partners, including local authorities.

The health needs of the people of NWL are changing, the demands on our health services are increasing, and the way we have organised our hospitals and primary care in the past will not meet the needs of the future.

Each NWL CCG has considered the current state, and set levels of ambition against the following strategic objectives[1]:

1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring that people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Our other strategic objective is to ensure a financially sustainable health system for future generations.

All of the programmes and plans set out in our five year plan have been developed to achieve these strategic objectives.

### The essentials: quality and innovation

Patient Safety is at the heart of the NHS agenda, treating and caring for people in a safe environment and protecting them from avoidable harm.

The CCGS of NWL are responsible for the quality assurance of provider organisations they commission from, ensuring they are held to account for delivery of quality standards and contractual obligations. NWL has developed Quality Strategies that set out approaches to embedding quality into every part of the commissioning cycle. We also recognise that clinical leaders are at the heart of delivering high quality care. Key plans include:

1. **Response to Francis, Berwick and Winterbourne View:** the overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people at the centre of the NHS. The NWL CCGs have developed actions plans to address key identified issues, including responding directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff.
2. **Patient experience:** the CCGs are committed to ensuring both the continuous improvement in patient experience, as part of the overall quality of care that is provided locally.
3. **Compassion in practice:** '*Compassion in Practice*'[2] is a national three year vision and strategy for nursing, midwifery and care staff - The strategy sets out the 6 "Cs", i.e. the values and behaviours to be universally adopted and embraced by everyone involved in commissioning and delivering care

[1] For further detail on the NHS Outcome Ambitions, see 'The NHS Outcomes Framework, 2014/15', Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf

[2] *Compassion in Practice – Nursing, Midwifery and Care Staff*; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, December 2012: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

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4. **Staff satisfaction:** NWL will strengthen our review of data and information regarding staff experience and satisfaction as part of our overall quality and safety monitoring and improvement processes.
5. **Safeguarding:** key priorities include the quality of local Care Home provision, and sexual exploitation, missing children and Female Genital Mutilation (FGM).

North West London has a world class research infrastructure, but navigating innovations through the healthcare sector can be difficult and complex. Anecdotal evidence suggests that the lag time between research and adoption is around 17 years.

In addition, there is significant variation in healthcare at almost all levels, including in the management of long-term conditions. The gap between what we know and what we do is unsustainable if we want to improve the value of care provided in the NHS, as well as make the UK the place of choice for industry and academia.

Each CCG therefore has a duty to promote innovation in the provision of health services, and to promote research and the use of evidence obtained from research.

This duty represents two distinct roles:

- To ensure the consistent uptake of existing good practice, including national guidance issued by the National Institute for Clinical Excellence (NICE); and
- To support developments in the pipeline of innovation, leading ultimately in turn to their uptake as recognised good practice.

NWL works closely with a number of partners in the promotion of both innovation and adoption.

### Our key transformation programmes

While each CCG is leading its own set of initiatives to address local priorities, including respective Health & Wellbeing Strategies and Quality, Innovation, Productivity and Prevention (QIPP) plans, a number of shared transformation programmes have been jointly developed to address the key themes identified in our Case for Change, NHS England's '*Call to Action*'[3] and through NWL's patient engagement and public consultation:

1. **Health promotion, early diagnosis and early intervention**: This programme of work is fundamental to achieving our outcome ambitions, particularly with regards to securing additional years of life for the population of NWL.

   Effective delivery will require close partnership working between Local Authorities, CCGs and NHS England.

2. **Out of Hospital strategies, including Primary Care Transformation:** NWL has embarked on a major transformation of care, from a system spending the majority of its funding on hospitals to one where we spend the majority of funding on services in people's homes and in their communities, i.e. "out of hospital".

   Significant transformation in primary care is planned to support integrated out of hospital service delivery:

   - Primary care will change to deliver out of hospital care;
   - Primary care will change to meet expectations for access; and
   - Primary care will change to meet rising quality expectations.

   In order to deliver these commitments, individual GP practices will build on the progress they have already made towards delivering services as networks – this will enable GP practices to provide the additional capacity, flexibility, limited specialisation and economies of scale needed to deliver to deliver the new model of care in a sustainable way.

   Delivering our vision requires us to invest in and to use our estate differently. Hubs, one of the configurations that we are

[3] http://www.england.nhs.uk/2013/07/11/call-to-action/

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exploring, are flexible buildings, defined as those that offer a range of out of hospital services and/or host more than one GP practice.

To support the transformation of primary care, we are working with NHS England to test ways we can co-commission primary care services.

3. **Whole Systems Integrated Care**: The whole plan is underpinned by our Whole Systems vision, which places the person at the centre of their provision and organises services around them. This includes our 'embedding partnerships' approach to the genuine co-design of services with patients and carers. Our vision for integrated care is supported by three key principles:
    1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
    2. GPs will be at the centre of organising and coordinating people's care.
    3. Our systems will enable and not hinder the provision of integrated care.
4. **Transforming Mental Health Services**: Achieving parity of esteem for mental health is a national and NWL priority – NWL will provide excellent, integrated mental health services to improve mental and physical health.
5. ***Shaping a healthier future*** **(SaHF) acute reconfiguration:** A key principle that underpins the acute reconfiguration programme in NWL is the centralisation of most emergency specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care) into five major hospitals, as this will lead to better clinical outcomes and safer services for patients.

    Agreed changes will result in a new hospital landscape for NWL – the SaHF programme will see:

    - The existing nine hospitals of NWL transformed into **five Major Acute Hospitals**.
    - On the remaining sites there will be **further investment with Local hospitals**, developed in conjunction with a patients and stakeholders, at Ealing and Charing Cross;
    - There will be **a Specialist hospital** at Hammersmith; and
    - There will be **a Local and Elective Hospital** at Central Middlesex.

### Cross-cutting plans: Urgent and Emergency Care and Cancer Services

While the key transformation programmes are being implemented on a pan-NWL basis, urgent and emergency care plans are centred around acute trusts, with local Urgent Care Working Groups overseeing the implementation of changes across the continuum of emergency care from primary through to acute care.

In addition, cancer is one of the top priorities for outcome improvement across London, and NWL aims to achieve significant, measurable improvements in outcomes for patients, working with the London Cancer Alliance and London Cancer to localise and implement the Cancer Commissioning Strategy for London 2014/15 – 2019/2020.

### Challenges and Enablers

The ambition of the North West London strategic plan is enormous. No other health economy has managed to achieve this level of agreement on the scale of the changes and to deliver this scale of change with their acute providers. A huge amount of work has been carried out to get to the point where commissioners were able to make the necessary decisions on the future of providers in NWL and for this decision to be robust so that it successfully withstood the inevitable legal challenges. Now it has done so, it faces the equal challenge of implementation. At the same time, the out of hospital services and

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whole systems integrated care work, including through the Better Care Fund and QIPP plans, needs to be delivered, to ensure that patients receive high quality care and only go to hospital when they need to.

A number of enabling workstreams have been developed to ensure successful implementation of the strategic plan, including Informatics and Workforce.

### Programme Investment Costs

Programme investment costs are based on the *Shaping a healthier future* Decision Making Business Case (DMBC) financial analysis produced in February 2013. This is in the process of being updated to reflect latest CCG and Trust plans and this work is due to be completed by the end of June.

Over the next five years, we will be investing in specific services to transform care across NWL. These investments will result in more staff and better facilities to deliver it.

- In five years, we will be spending **£190 million more a year on out of hospital services** including integrated care, planned care and more access to general practice.
- In addition, we plan up to **£112m of capital investment in hubs**, offering a range of services closer to patients' homes, including outpatient appointments, general practice and care for patients with long-term conditions.
- Up to **£74m of capital investment in primary care** to ensure all our primary care services are offered in high-quality buildings that are accessible to the public.

### Programme Implementation Timeline

The high-level programme implementation timeline illustrates the timescales by which each of the programme's key milestones will be achieved, including:

- Sustainable network-based GP model in place by in 2015/16.
- Roll-out of Whole System approaches to commissioning and delivering services from April 2015.
- Consistently high standards of clinical care achieved across all days of the week by 2017/18.
- The full transition to the new configuration of acute services complete by the end of 2017/18.

### How We Work: embedding partnerships at every level

A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, service users, families and carers, building on the co-design approach developed through the Whole Systems Integrated Care programme. We will also continue to work collaboratively across the eight CCGs of NWL.

We also recognise that we will not achieve our outcome ambitions through internal actions only, but will need a concerted programme of change with our statutory and community partners, including local authorities and community groups (including through the Health and Wellbeing Boards). Effective partnership working will, amongst outer outcomes, reduce demand on the NHS by enabling residents to manage their own health, support one another, and improve their health and wellbeing in the community.

### What our Five Year Plan will achieve

Our five year plan will deliver two key outcomes: (1) improved health outcomes and patient experience (along with reduced health inequalities), as set out in our outcome ambitions; and (2) a financially sustainable health system for future generations.

- The CCG projections are to ensure that a sustainable position is attained, one that is consistent with NHS England Business Rules (i.e. a 1% surplus) and includes contingency (at 0.5%) to respond to risks.
- The NWL CCGs' financial plans include the outcome ambitions.

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- Non-recurrent implementation costs are assumed to be funded through the NWL financial strategy agreement to pool CCG / NHSE non-recurrent headroom (2.5% in 2014/15).
- All organisations aim to have clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks - there is a clear link between service plans, financial and activity plans.

A detailed Finance Appendix is included in this Plan that sets out the relationship between the financial and activity modelling underpinning the *Shaping a healthier future* programme and Out of Hospital strategies, the CCG's two year operational plans (including QIPP), and the Better Care Fund plans.

Our five year strategic plan has set out how we will work collaboratively to transform the health and care landscape across NWL in order to achieve our shared vision, deliver improved outcomes and experience within a financially sustainable system, and meet the expectations of our public and patients.

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# 1. Introduction

*The purpose of this five year strategic plan is set out the collective priorities of the eight CCGs of North West London, working in partnership with NHS England, over the next five years, in order to achieve our vision and outcome ambitions. It is developed in line with NHS England planning guidance 'Everyone Counts – 2014/15 – 2018/19'.*

### Purpose

Across the eight boroughs of North West London (NWL), the NHS comprises eight Clinical Commissioning Groups (CCGs), ten acute and specialist trusts, four community and/or mental health trusts and 400+ GP practices.

NHS England is also one of the largest commissioners of services in North West London.

The purpose of this North West London Five Year Strategic plan is to set out the collective plans and priorities of the eight CCGs of NWL, working in partnership with NHS England. This Plan sets out the vision and ambitions against which NHS England and each CCG's detailed two year operational plans have been set. The eight CCGs of North West London have been working closely together (and with local authorities) for several years to develop a shared strategic vision and plan, and this document reflects the latest iteration of these plans, along with the aspirations of NHS England for the services it is responsible for commissioning. It summarises the full range of plans that have been developed across NWL, from how we will ensure patient safety in all settings of care, to how we will support research and innovation, through to how we will design and implement new models of joined up, person-centred care to address the fundamental challenges facing our health and care system.

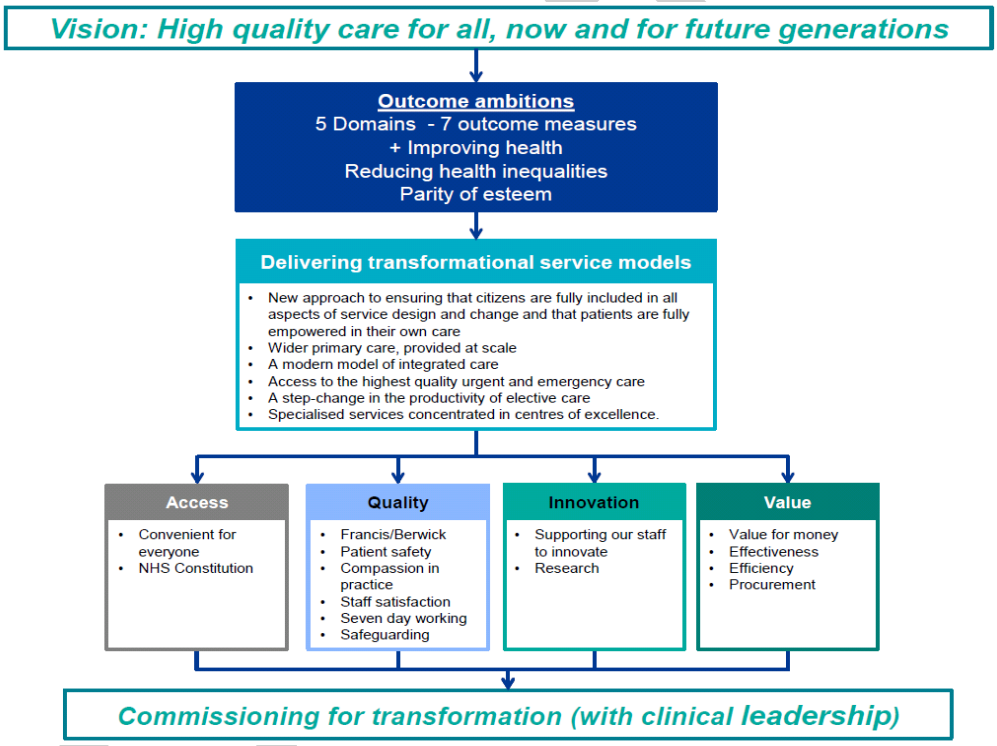
The Plan also articulates how we will work more closely than ever with patients and the public, building on work to embed and sustain co-production as a first principle, and seeking to enable and empower patients to maintain independence and to lead full lives. The Plan builds upon the significant strategic planning that has taken place over the past couple of years across NWL, including as part of the *Shaping a healthier future* programme, and articulates how the various workstreams and programmes fit together into a clear vision for the future that is sustainable and that tackles the challenges identified in NHS England's 'Call to Action'.

The Plan is also intended to demonstrate to NHS England that our plans are robust, comprehensive and fit-for-purpose.

Therefore, the document reflects the latest planning guidance as published in *Everyone Counts: Planning for Patients 2014/15 to 2018/19*[4], including 21 fundamental national planning requirements.

The NWL Plan is consistent with NHS England's vision, outcome ambitions, service models and essentials, as is articulated throughout the document:

NHS England vision for the NHS[5]




[4] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

[5] Please note within the 'Quality' box that "Francis" refers to the implementation of recommendations set out in the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf), chaired by Robert Francis, QC; while "Berwick" refers to the recommendations within the *Berwick review into patient safety* (https://www.gov.uk/government/publications/berwick-review-into-patient-safety)

## North West London - context

### Population

North West London is a population of approximately 1.9 million people living in the boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The population is expected to grow to 2.1 million by 2021 (which represents 7.46% growth between 2011 and 2021)[6].

[6] North West London SPG planning document, November 2013 (Monitor, TDA, NHS England),

The area covered is densely populated, and there is wide variation in household income. Inner North West London has a higher population density than outer North West London. Some sections of the population are highly transient and there are sections of the community who are not counted in official statistics nor registered on GP patient lists.

The Joint Strategic Needs Assessments (JSNA) covering North West London all identify cardiovascular disease, cancer and respiratory disease as the most common causes of death, but as a result of earlier diagnosis and improved treatments, fewer people are dying prematurely from these diseases. These improvements mean that people are living longer and, therefore, the population as a whole is getting older. Over the last ten years, life expectancy in North West London has increased by about three years to 80 years for men and 84.5 years for women.

The population is relatively young: 3.7% of the male NWL population are over the age of 75, as are 5.8% of females – both of these figures are both below the national and London rates (although Harrow and Hillingdon rates are higher than London averages).

The percentage of males and females under the age of 19 (23.9% and 22.1% respectively) are in line with both England and London averages, although Kensington, Chelsea and Hammersmith & Fulham populations are below average[7].

Each of the eight London boroughs has a significant ethnic community with different communities in different areas. There is great breadth and depth of population diversity in our communities, which must be considered in ensuring equality of access to services and in our work to reduce health inequalities.

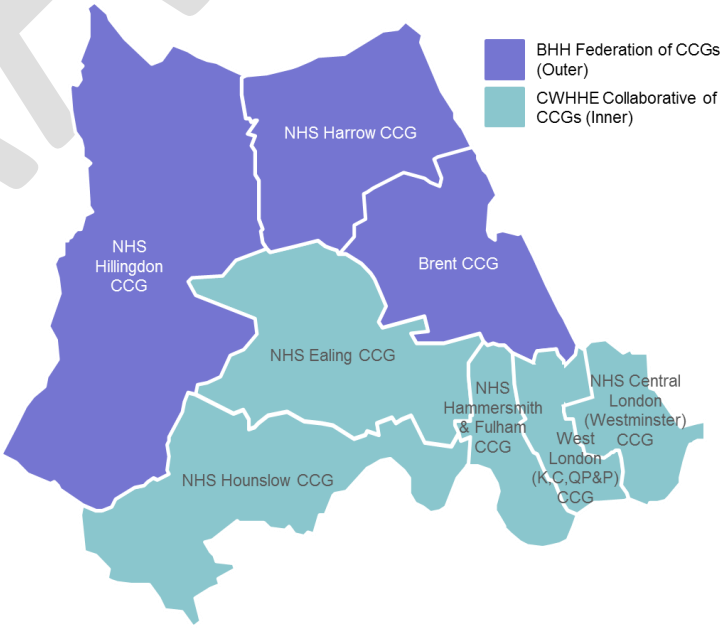
**Commissioning**

North West London (NWL) is comprised of eight Clinical Commissioning Groups (CCGs), 10 acute & specialist trusts, 4 community and/or mental health trusts, 400+ GP practices, and eight Boroughs. The three CCGs of Harrow, Hillingdon and Brent work jointly in some areas (and have a shared senior management team), as a 'federation', while the remaining CCGs operate similarly as a 'collaborative'.

NHS England is also one of the largest commissioner of services in North West London, and is responsible for commissioning all specialised services, early years including childhood immunisations, health visiting, child health information systems and family nurse partnerships; screening, including cancer screening, adult non cancer screening, and antenatal and newborn screening (in collaboration with CCGs); health in the justice system; military health; and primary care contracts (417 GP contracts, 390 dental, 484 ophthalmic and 515 pharmacy providers).

The NHS in NWL consists of eight CCGs that, with one small exception[8], are coterminous with the eight local authority boroughs.

<u>NWL Clinical Commissioning Groups</u>




based on GLA 2012 Round Demographic Projections, 2013

[7] North West London SPG planning document, November 2013 (Monitor, TDA, NHS England)

[8] The area of Queen's Park and Paddington in the Borough of Westminster forms, with all of the Royal Borough of Kensington & Chelsea, NHS West London CCG. The remainder of the Borough of Westminster forms NHS Central London CCG.

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It is a relatively self-contained health economy, within which over 90% of spending on providers for the NWL population is with providers located in the sector.

The CCGs work closely with their Local Authority partners in a number of areas, and have made a commitment to work co-productively with patients, service users, carers and the public.

**Providers**

The providers that the CCGs primarily use are categorised according to service type below.

Acute providers:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust. This includes Charing Cross Hospital, Hammersmith Hospital (including Queen Charlotte's Hospital), St Mary's Hospital and Western Eye Hospital)
- The Hillingdon Hospitals NHS Foundation Trust. This includes Hillingdon Hospital and Mount Vernon Hospital
- The North West London Hospitals NHS Trust. This includes Central Middlesex Hospital and Northwick Park Hospital
- West Middlesex University Hospital NHS Trust
- Ealing Hospital NHS Trust

Community providers:

- Central London Community Healthcare Trust (CLCH), covering Hammersmith and Fulham, Kensington and Chelsea and Westminster
- Hounslow and Richmond Community Healthcare (HRCH), covering Hounslow
- Central and North West London NHS Foundation Trust, incorporating Hillingdon Community service provider, covering Hillingdon
- Ealing Hospital Trust, incorporating Ealing Integrated Care Organisation, covering Brent, Ealing and Harrow

Mental health providers:

- West London Mental Health NHS Trust, covering Ealing, Hammersmith and Fulham and Hounslow
- Central and North West London NHS Foundation Trust, covering Brent, Kensington and Chelsea, Harrow, Hillingdon and Westminster.
- In addition there are three specialist trusts located in NWL (The Royal Marsden NHS Foundation Trust, The Royal Brompton and Harefield NHS Foundation Trust and The Royal National Orthopaedic Hospital NHS Trust).

Emergency ambulance services are provided by the London Ambulance Service (LAS), a London-wide NHS Trust that is the busiest emergency ambulance service in the UK to provide healthcare that is free to patients at the time they receive it.

The benefits of being coterminous with local authority boroughs and being self-contained means that NW London as a whole is a logical level at which to effect strategic change.

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# 2. Our shared vision and outcome ambitions for North West London

*NHS England, in setting its ambition of "high quality care for all, now and in the future", has challenged commissioners across England to make substantive improvements across seven outcome ambitions.*

*Our vision and ambition in NWL is to improve the quality of care…empower and support people…to lead full lives".*

### Introduction

Across North West London service users, clinicians, commissioners, and providers know that by working together across the region we can transform the quality and effectiveness of services provided to our local population. Importantly, by adopting this collective approach we can ensure consistency of service where demand is common and balance this with local enhancements where demand is specific.

We have defined a vision that responds to and aligns with the national challenges laid out by NHS England, encompassing NHS England' *Call to Action*, Seven Day Services and the vision for Urgent and Emergency Care.

Our overarching vision, building on that set out by NHS England and developed in consultation with the people of North West London, is:

> *"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

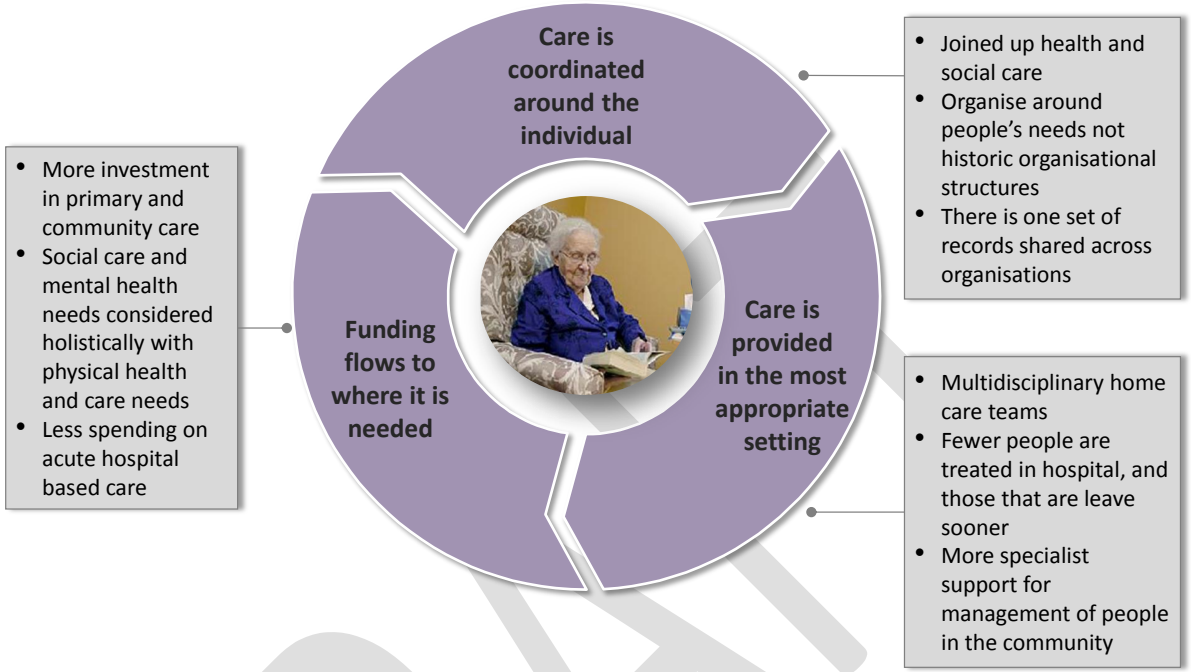
Four overarching principles underpin our whole system NWL vision – that health services need to be:

1. **Localised** where possible;
2. **Centralised** where necessary;
3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless person centred care. Individuals will be enabled to work with frontline professionals, their carers, and families to maximise health and wellbeing and address their specific individual needs.
4. The system will look and feel from a patient's perspective that it is **personalised** - empowering and supporting individuals to live longer and live well.

In addition, commissioners will recognise our broader role in society (both as employers and commissioners), and address the determinants of health.

NWL's vision for the health and care system is represented in the figure below:

NWL's vision for personalised care




The health needs of the people of NWL are changing, the demands on our health services are increasing, and the way we have organised our hospitals, community-based services and primary care in the past will not meet the needs of the future.

NWL, having developed our vision and the principles that underpin it in 2012, NWL initiated a strategic planning process to understand the challenges that our future plans need to address, and documented these in a NWL 'Case for Change.'

In addition to the findings of the original NWL Case for Change, NHS England has recently published a new report, '*The NHS belongs to the people: a call to action',* which sets out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The report states that the NHS must change to meet these demands and to make the most of new medicines and technology, and that it will not contemplate reducing or charging for core services.

NHS England wants to see a greater focus on preventative rather than reactive care; services matched more closely to individuals' circumstances instead of a one size fits all approach; people better equipped to manage their own health and healthcare, particularly those with long term conditions; and more done to reduce invest admissions to hospital and avoidable readmissions, particularly amongst older people.

NHS England recognised that thinking strategically about how we use our resources and commission services over a five year period presents us with an opportunity to truly put outcomes at the heart of our commissioning plans.

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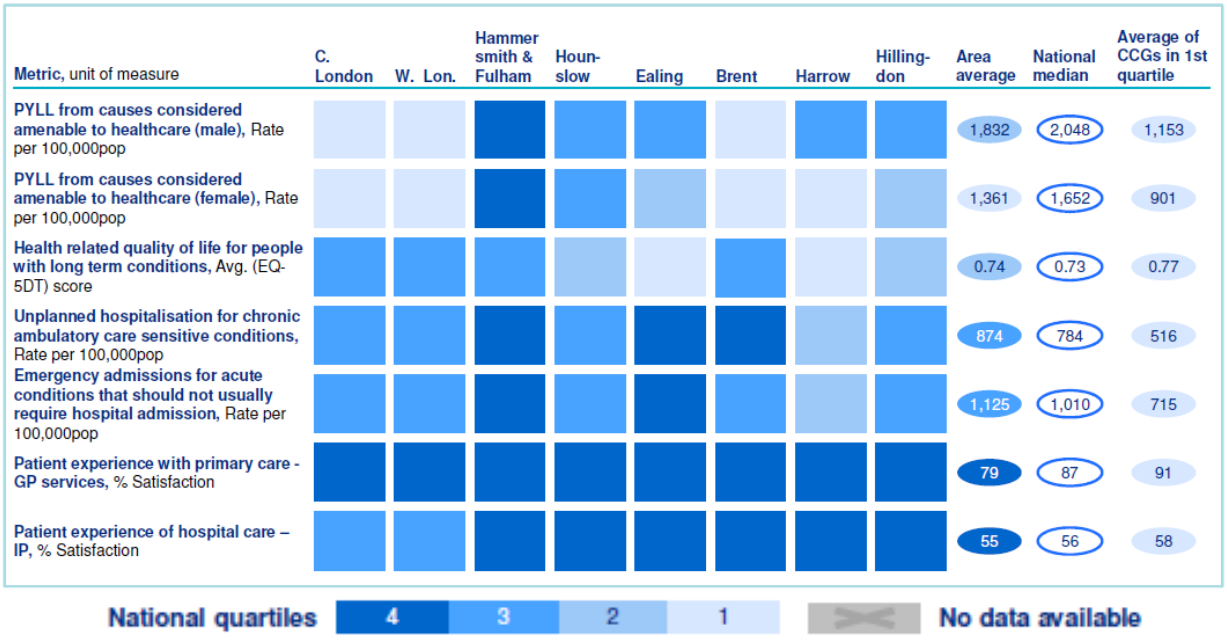
All CCGs have therefore been asked to set levels of ambition against the NHS' five national strategic objectives and our NWL plans have been developed to achieve these objectives, which have also been mapped to national outcome ambitions/indicators (see the NHS Outcomes Framework for further details[9]):

1. Preventing people from dying prematurely (i.e. people living longer and not dying prematurely)
2. Enhancing quality of life for people with long-term conditions (i.e. people with LTCs maximising their quality of life)
3. Helping people to recover from episodes of ill health or following injury (i.e. people recovering from illness or injury resuming their lives)
4. Ensuring that people have a positive experience of care (i.e. people having a positive experience of care)
5. Treating and caring for people in a safe environment and protecting them from avoidable harm (i.e. people experiencing a safe care environment)

The baseline position across the NWL CCGs against the associated national indicators is summarised in the figure below.

Selected National Outcome Framework indicators – NWL[10]




(Note that the first quartile represents the best performance against the indicator).

Our Case for Change has therefore been set in the context of our current performance against these important outcome ambitions. We recognise that the wider determinants of health have an impact on achievement of all of these ambitions, and have noted specific examples of these in the following section where possible.

[9] *The NHS Outcomes Framework 2014/15*, Department of Health, November 2013 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf ); *Setting 5-year ambitions for improving outcomes: A how-to guide for commissioners*, NHS England, December 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/12/stra-op-how-to-guide1.pdf)

[10] North West London SPG Planning document, November 2013 (Monitor, TDA, NHS England)

### Ambition 1:
### Securing additional years of life for local population with treatable conditions

As a region, NWL is currently performing slightly above the national average in relation to the indicator for this ambition: *Potential years of life lost (PYLL) from causes considered amenable to healthcare.* However, there are areas of real opportunity to improve – for example*, c*ancer is the biggest cause of premature death in London, and every hour three more Londoners are diagnosed with cancer. However, in 2009, a number of challenges facing London's cancer services were identified, including late diagnosis of cancers with many cancers diagnosed at a late stage when successful treatment is less likely; variability in cancer outcomes across London for common cancers; and variability in cancer outcomes across London for rare and more complex cancers.

Other causes of death considered amenable to healthcare include cardiovascular disease, respiratory disease and some maternal/infant deaths.

The baseline performance of each CCG, along with the national quintile this represents, and the target for improvement over the next five years, is provided in the table below[11]:

Targeted reduction across NWL CCGs in 'Potential years of life lost from causes considered amenable to healthcare'

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 1,929.9 | 3 | 2,060.8 | 1,640.0 | 15.02 |
| **Hammersmith & Fulham** | 1,998.2 | 2 | | 1,698.0 | 15.02 |
| **Ealing** | 2,018.4 | 3 | | 1,715.5 | 15.01 |
| **West London** | 1,822.7 | 2 | | 1,549.1 | 15.01 |
| **Central London** | 1,800.2 | 1 | | 1,530.0 | 15.01 |
| **Hillingdon** | 2,102.0 | 3 | | 1,787.0 | 15.03 |
| **Brent** | 2,516.0 | 5 | | 2,135.0 | 15.14 |
| **Harrow** | 1,987.9 | 2 | | 1,689.0 | 15.00 |
| **Aggregated** | **16,174** | | | **13,743** | **15.04** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

[11] Note: Top quintile is 1, lowest quintile is 5.

NHS England has suggested a minimum of 3.2% improvement per year and all of the NWL CCGs are targeting improvements in lines with this figure.

### Ambition 2:
### Improving the health related quality of life for those with long term conditions

There is a variable patient experience and support for people with long-term conditions across NWL. For example, when people are worried about their health, their first point of call is often NHS primary care – usually their GP. But patients in some parts of NWL cannot get a GP appointment, or access their GP and related services, very easily. When people need support from a number of different services their overall experience of care can feel disjointed and fragmented. Each person providing care may be doing a good job, but taken as a whole the individual and their family often experience care that is poorly coordinated and confusing. The growing number of people living with long-term conditions requires services to work together in different ways to meet rising and changing patterns of demand. People and their families should be supported to manage their own condition as far as they are able, drawing on the support of their community and local services to meet their personal outcomes and aspirations. Wider determinants of the quality of life for those with long-term conditions include social isolation and the availability of assistive technology.

Despite the challenges, the majority of CCGs within NWL are currently above the national average in relation to the indicator for this ambition: *Health-related quality of life for people with long-term conditions*.

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Targeted improvement across NWL CCGs in the health-related quality of life for people with long-term conditions

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 75.2 | 2 | 72.9 | 76.0 | 1.06 |
| **Hammersmith & Fulham** | 74.6 | 2 | | 76.1 | 2.01 |
| **Ealing** | 75.8 | 2 | | 76.1 | 0.40 |
| **West London** | 70.8 | 4 | | 76.1 | 7.49 |
| **Central London** | 73.3 | 3 | | 76.0 | 3.68 |
| **Hillingdon** | 75.2 | 2 | | 79.1 | 5.10 |
| **Brent** | 73.4 | 3 | | 77.2 | 5.09 |
| **Harrow** | 75.6 | 2 | | 79.5 | 5.1 |
| **Aggregated** | **594** | | | **616** | **3.71** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

The NWL CCGs have set a range of targets against this outcome, depending on their starting position.

### Ambition 3: Reducing the amount of time people spend avoidably in hospital

In NWL, too many people are admitted to hospital and this is shown in our below national average indicator score. Like other areas in the country, rather than relying on reactive, siloed and episodic units of care, across NWL we need to take a more preventative, personalised approach. Providers need to work with each other, other local services and communities to promote the long-term, sustainable wellbeing of the whole person, taking into account wider social determinants of health and wellbeing as well as personal circumstances and capacity for self-care. Our aim must be to prevent people going into hospital in the first place and when people do go in, we need to support them to regain independence and wellbeing at home as quickly as possible. Providing care closer to home will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals. Doing so could result in 20-30% of patients who are currently admitted to hospitals in NWL as emergencies being more effectively cared for in their community. Wider determinants of the amount of time people spend avoidably in hospital include the availability of housing and of social care services.

The baseline performance of the CCGs ranges from the second to the fifth quintile nationally in the related indicator for this ambition, a composite measure capturing the rate of avoidable emergency admissions per 100,000 of the population:

Targeted reduction across NWL CCGs of avoidable emergency admissions to hospital

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 1,890.9 | 2 | 2,053.7 | 1,645.0 | 13.00 |
| **Hammersmith & Fulham** | 2,308.4 | 4 | | 2,008.3 | 13.00 |
| **Ealing** | 2,310.3 | 4 | | 2,010.0 | 13.00 |
| **West London** | 1,896.6 | 2 | | 1,650.0 | 13.00 |
| **Central London** | 1,781.2 | 2 | | 1,549.6 | 13.00 |
| **Hillingdon** | 2,064.0 | 3 | | 1,962.0 | 4.94 |
| **Brent** | 2,734.0 | 5 | | 2,600.0 | 4.90 |
| **Harrow** | 2,714.8 | 5 | | 2,582.0 | 4.89 |
| **Aggregated** | **17,700** | | | **16,007** | **9.6** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

As our 18/19 targets demonstrate, we have strong ambitions to address this and as is set out in future chapters, already have significant transformation programmes underway to make it a reality.

### Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital

While there are currently no measurable outcome indicators available nationally against this ambition, NWL's primary and community services for the terminally ill are variable; too often working in silos, access complicated by multiple referral approaches.

The National Voices narrative sets out patients' expectations of person-centred coordinated care; however, interviews with London community services have identified significant limitations in meeting such expectations.

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Whist there are pockets of excellence in some service models, work so far highlights:

- **Standards of community nursing care are variable** resulting in postcode variation to clinical practice.
- **Patients want joined-up care, yet there is limited uptake of technology** to help people manage their care at home or improve continuity of care between providers - community nurses, GPs, social care, carers, GP out of hours, acute, etc.
- **Community nurses report low morale and spend less time with patients**.

To support people to live independently at home, care needs to be coordinated around the needs of the individual. GPs should be at the centre of bringing together a comprehensive network of support which responds to a person's total physical, psychological and social needs, drawing on what they can do for themselves as well as the contribution of their families, communities and public services. Personal budgets for both health and social care spend are a key mechanism to enable people to assume choice and control over how their needs are best met, taking a planned, proactive and personalised approach in collaboration with care professionals. Consistent and high quality support for carers will mean better outcomes for both the individual being cared for and carers themselves, enabling people to remain at home and independent for as long as possible.

Wider determinants of the proportion of older people living independently following discharge from hospital include the availability of housing and of social care services. Maintaining the health and wellbeing of carers is a key component of delivering care in the community.

### Ambition 5:
### Increasing the number of people having a positive experience of hospital care

When it is necessary for residents of NWL to be admitted into hospital we want to ensure that they have the best experience possible whilst receiving important and often lifesaving care.

Patient perception is that the hospital care they receive in NWL hospitals is below the national expectation, as reflected in the baseline figures below. We know that people there are big differences in the quality of care patients receive depending on which hospital they visit and when they visit.

As the table below demonstrates, all of the CCGs in NWL are below the national average in relation to the indicator for this ambition: *'Poor' patient experience of inpatient care*[12].

Targeted improvement across NWL CCGs in patient experience of inpatient care

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 164 | 4 | 142 | 142 | 13.41 |
| **Hammersmith & Fulham** | 158.1 | 4 | | 150 | 5.12 |
| **Ealing** | 173.1 | 5 | | 161 | 6.99 |
| **West London** | 159.3 | 4 | | 143 | 10.23 |
| **Central London** | 149.5 | 3 | | 139 | 7.36 |
| **Hillingdon** | 164.7 | 5 | | 157 | 4.92 |
| **Brent** | 167.1 | 5 | | 159 | 4.91 |
| **Harrow** | 171.6 | 5 | | 163 | 4.90 |
| **Aggregated** | **1,307** | | | **1,213** | **7.20** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

### Ambition 6:
### Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community

When people are worried about their health, their first point of call is often NHS primary care – usually their GP. But patients in some

[12] This national indicator is constructed based on responses to 15 'experience of inpatient care' questions within the national inpatient survey (a sub-set of potential responses have been selected as representing 'poor' experience of care). Note that the national inpatient survey is collected at provider level. NHS England has used the algorithm from the Quality Premium to attribute provider-level data on patient experience to a geographical CCG footprint.

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parts of NWL cannot get a GP appointment, or access their GP and related services, very easily. Patients report low levels of satisfaction with primary and acute (both bottom quartile, nationally) across all CCGs[13]. NWL has also carried out its own street survey, as part of a broader review, in order to understand patient priorities for primary care.

As the table below demonstrates, all of the CCGs in NWL are below the national average in relation to the indicator for this ambition: *'Poor' patient experience of primary care*.

Targeted improvement across NWL CCGs in patient experience of primary care

| CCG | Baseline | Quintile | National average | 18/19 target | % change |
|---|---|---|---|---|---|
| **Hounslow** | 8.9 | 5 | 6.1 | 6.1 | 31.46 |
| **Hammersmith & Fulham** | 8.5 | 5 | | 7.4 | 12.94 |
| **Ealing** | 11 | 5 | | 8.5 | 22.91 |
| **West London** | 7 | 4 | | 6 | 14.29 |
| **Central London** | 7 | 4 | | 5.9 | 15.71 |
| **Hillingdon** | 8.4 | 5 | | 8.0 | 4.88 |
| **Brent** | 10 | 5 | | 9.5 | 4.91 |
| **Harrow** | 8.2 | 5 | | 7.8 | 4.88 |
| **Aggregated** | **69** | | | **59** | **14.24** |

*[The outcome ambitions are currently being reviewed so attainment targets may be updated]*

### Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

While there are currently no measurable outcome indicators available nationally against this ambition, recent analysis across London has shown that those people attending and admitted to hospital during evenings, nights or at the weekend are more likely to die than people admitted at times when more senior staff are available. Around 130 lives could be saved in NWL every year if mortality rates for admissions at the weekend were the same as during the week.

If the NHS is to provide more consistent high quality hospital care in NWL, it needs to ensure that senior doctors and teams are available more often, seven days a week, 24 hours a day. Much progress has been made – for example, in centralising heart attack care, major arterial surgery and stroke care in hospitals. This new approach to stroke care has already saved about 100 lives over the last year in NWL – but more needs to be done.

### Financial challenge

In addition to the health outcome and patient experience objectives we have set, NWL has a number of financial challenges that our five year plan will also address:

- **Population changes**: the population of North West London is facing major changes in its health needs and these are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia. The demand for health services in NWL will continue to grow.
- **Financial challenges:** from a commissioner perspective, if we do nothing we estimate we would need £365m more to keep pace with demand. Hospitals in NWL will also face significant financial challenges even if they become as efficient as they can be. This means services need to be redesigned to be more affordable.
- **Estates:** The physical condition of hospital buildings needs to improve. Good quality care environments improve the quality of care provided, as well as improving the working conditions of staff. Despite having three relatively newly built hospitals (Central Middlesex, Chelsea and Westminster and West Middlesex), NHS buildings in NWL are generally in a poor state.
- **Productivity:** NWL also has more hospital floor space per head of population than

[13] North West London SPG planning document, November 2013 (Monitor, TDA, NHS England)

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in other parts of the country, and uses a greater proportion of the NHS budget on hospital care than average – but the productivity of NWL hospitals is lower than in other regions. This is not the best use of resources – resources which could be better used to help people to stay well in the community – and makes it even more important to change hospital services.

### Summary

The North West London baseline against the five measurable ambitions varies across CCGs. This mirrors the, in places, vast variance in affluence, deprivation and health that is characteristic of a large urban centre such as London. Whilst the region performs well against Potential years of life lost and *health related quality of life for people will long term conditions*, NWL is below the national average for the other three measures; avoidable hospital admissions and patient experience.

We therefore know that there is scope for improvement and have set ambitious targets to make improve across all CCGs as well as levelling out the imbalance between some localities, so that residents in every borough can expect a similarly high standard of care.

Where indicators don't currently exist to quantify our ambition we still have bold plans to make improvements to these outcomes across North West London and have set these out in the sections that follow.

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# 3.The essentials: Quality, Safety, Access, and Innovation

*While NWL is implementing an ambitious set of transformation programmes, at the CWHHE collaborative and BHH federation level essential work continues to improve quality and performance through the commissioning cycle*

### Introduction

While the eight CCGs of North West London are collaborating to implement an ambitious set of shared transformation programmes, significant work to support improvements against the outcome ambitions also takes place at the CWHHE Collaborative (CCGs of Central London, West London, Hounslow, Hammersmith & Fulham and Ealing) and the BHH Federation (Brent, Harrow and Hillingdon). Both the Collaborative and Federation have chosen to work together in a number of areas, including Quality, safety, performance and delivery. These areas are essential to NWL's ability to achieve its outcome ambitions in terms of population health, clinical effectiveness, patient experience, and financial sustainability.

### Quality and Safety

Patient Safety is at the heart of the NHS agenda, treating and caring for people in a safe environment and protecting them from avoidable harm. The findings and recommendations of the Francis report have raised the national and political profile of safety issues. We recognise that clinical leaders are at the heart of delivering high quality care.

The CCGS of NWL are responsible for the quality assurance of provider organisations they commission from, ensuring they are held to account for delivery of quality standards and contractual obligations.

Both the BHH federation and the CWHHE collaborative have developed Quality Strategies that set out their respective approaches to embedding quality into every part of the commissioning cycle, ensuring that quality is at the heart of everything we do.

Ensuring patient safety is integral to all of our work as commissioners, and NWL has robust approach to understanding and measuring the harm that can occur in healthcare services.

The quality and safety governance structure in NWL includes:

- Commissioning Quality Group (CQG) meetings: these are held on a monthly basis with all key acute, community and mental health providers, and are the primary mechanism through which quality, safety and patient experience indicators are monitored, remedial action plans are developed, and from which significant risks are escalated to CCG Quality and Safety Committees for further action.
- CCG Quality and Patient Safety Committees: these meetings are convened as sub-committees of each of the Governing Bodies. These sub-committees discuss local quality issues, oversee and gain assurance on provider quality and performance issues, and escalate issues to the Governing Body or take other action where appropriate.

In addition, a CWHHE Collaborative Quality Committee meets to share potential areas of quality concern that are raised by individual CCG Quality and Patient Safety Committees.

A range of information inputs are triangulated for review and analysis within the established governance process.

Key performance indicators associated with harm and untoward incidents, including quarterly trend reports, are monitored by NWL CCGs with all key providers at a monthly CQG (Commissioning Quality Group).

### 6. Response to Francis, Berwick and Winterbourne View

How NWL addresses the outcomes of the government's final report on Winterbourne View and the Francis Report on Mid Staffordshire NHS Foundation Trust is a critical test of our ability to make a real difference to improving patient safety and to caring for some of the most vulnerable people in society.

The overarching lesson from events at both Mid-Staffordshire and Winterbourne View is that a fundamental culture change is needed to put people at the centre of the NHS. This is about everything we do. Both BHH and CWHHE have developed actions plans with to address the issues raised within the Francis and Berwick[14] reports, including:

- Listening to and involving patients and carers in every organisational process and at every step in their care.
- Commissioning for quality standards, and monitoring the quality and safety of care constantly, including variation within the organisation.
- Responding directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff.
- Embracing complete transparency, including being recognisable public bodies, visibly acting on behalf of the public we serve and with a sufficient infrastructure of technical support.
- Training and supporting all staff all the time to improve the processes of care.
- Joining multi-organisational collaboratives, i.e. networks, in which teams can learn from and teach each other.

The NWL Quality and Safety teams are working with the NWL Academic Health Science Network (AHSN) to create a culture of continuous improvement and learning across the sector, adopting and implementing the recommendations of the Berwick Report. This will also provide the basis for the Collaborative for Patient Safety in NWL as part of the national initiative to be rolled out by NHS Improving Quality (IQ).

In addition, each individual CCG has developed an action plan in response to the Winterbourne View Review of services provided to people with learning disabilities.

[14] A promise to learn – a commitment to act; Improving the Safety of Patients in England; National Advisory Group on the Safety of Patients in England (August 2013): (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)

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The Winterbourne plans address the following areas:

- Numbers of patients still cared for in an inpatient setting (with a view to reducing these where appropriate).
- Strengthening the operational, governance and oversight arrangements by which transfers from inpatient care are monitored.
- The frequency and robustness with which on-going care needs are assessed.
- The development of new services, with partner Local Authorities, to support these patients.
- Identification of future need for local provision of care for learning disability clients.
- Transition planning for children with learning disabilities.

**7. Patient experience**

The NWL CCGs are committed to working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population. More specifically, the CCGs are committed to ensuring both the continuous improvement in patient experience, as part of the overall quality of care that is provided locally.

The CCGs have therefore been working with patients and wider stakeholders to develop a patient experience strategy to inform decisions for commissioning person-centred care that is compassionate, safe and effective.

The definition and framework were created collaboratively by patients, carers, the wider community as well as Health and Social Care staff.

The strategy also sets out that from a patient's perspective - when I have a 'good experience' of care, I feel:

- Confident of receiving an accurate diagnosis
- Positive about receiving high quality, evidence based care
- Respected, safe, comfortable, peaceful and cared for
- Listened to and understood
- Informed and involved in decision making
- Able to take responsibility for and contribute to my own health as a partner in care
- Assured of having full access to all available resources

A *'good experience'* of care is enabled when:

- My care is planned with me and centred on my needs and is inclusive of my family and carers
- My care is co-ordinated across health, social and third sector services
- I have easy access to comprehensive services that are responsive, offer choice and provide me with timely treatment and care
- Equipment and resources are available to meet my needs and requirements
- I receive consistent and continued care which helps me to build relationships with staff promoting holistic approaches
- Staff have good communication skills and use clear and appropriate language, providing me with time to talk, ask questions, discuss issues and options, and to be given explanations and information
- Staff are effective at communicating and sharing information with me and also with other staff within and across health, social and third sector services
- I have access to information about services (what services are available, how services work and what they can expect), support, care, illness and health promotion that is relevant, useful, sensitive, up-to-date and available in different formats
- I, my family and carers have access to volunteers and the opportunity to learn and gain support from other patients
- I am provided with opportunities to get involved in shaping and influencing the service and the organisation as a whole

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- The environments where I receive care are appropriate, accessible, clean, welcoming and enable my privacy and dignity to be maintained
- The staff/services/organisations are committed to learning and improving - a no blame culture in which people take complaints seriously, respond quickly and learn from mistakes
- Staff have a positive experience of work
- Services are valued and used responsibly by both patients and staff
- Staff:
    - Are professional, honest and accountable
    - Are approachable, kind, compassionate and empathetic
    - Maintain my confidentiality, privacy and dignity and treat everyone with respect
    - Are prepared and informed about me, my care needs and other services
    - Have the right knowledge, attitude and skills and adhere to policies
    - Work in partnership with me, my family and carers and other professionals
    - Are culturally aware and sensitive to my needs and state of mind, and those of my family and carers
    - Are willing to work across services and to connect with communities

A number of subsequent steps have been identified to ensure that patient experience is embedded into the commissioning process. To this end, the following Strategic Contracting Principle has been developed and is currently incorporated in CCG Commissioning Intentions:

> *"We expect all providers to work with us to ensure that patient experience is used to inform the provision of services that are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public"*

In the context of the commissioning process, the ***ultimate purpose of capturing the patient experience is to achieve excellence in care*** by using these experiences to create services that put patients at the heart of decision-making and improving quality and outcomes for physical and mental health through improving services so that they are compassionate, safe, effective and responsive to meet the clinical, social and personal needs of patients, carers and the wider public.

NWL has identified a series of actions to take forward linked to the patient experience enabling factors, including:

- Deliver a Series of Seminars and Learning Events for Staff and Governing Body Members on *'Effective Leadership to enhance Patient Experience'.*
- Deliver a programme of training for CCG Lay Reps and Patient Champions to enable them to promote patient perspective at decision making levels and in considering CCG plans and proposals.
- Establish a NWL Patient Experience Leads Network whose aim will be to act as a Forum for:
    - Agreeing integrated patient experience reporting and evaluation mechanisms for inclusion in CQG meetings. Feedback from patient and service user representatives including Healthwatch has recommended that a range of tools are used to present the patient experience data by providers.
    - Deliver quarterly patient experience learning events themed around a specific service or issue across health and social care
- Map out the current data gathered on patient experience data against key themes associated with good patient experience, to enable the development of a pre-populated dashboard.
- Provide information and feedback on actions arising from patient experience reports from providers to patients, carers

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and the wider community both at CCG Level and across North West London.

The measurable improvements in patient experience that are targeted through our patient experience strategies are reflected in the outcome ambition targets (see sections 2 and 12).

### 8. Compassion in practice

'*Compassion in Practice*'[15] is a three year vision and strategy for nursing, midwifery and care staff developed by the NHS Commissioning Board and Department of Health in 2012.

The strategy sets out the 6 "Cs", i.e. the values and behaviours to be universally adopted and embraced by everyone involved in commissioning and delivering care:

1. **Care**: Care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life.
2. **Compassion**: Compassion is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care.
3. **Competence**: Competence means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.
4. **Communication**: Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike.
5. **Courage**: Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working.
6. **Commitment:** A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead.

In NWL, each provider has developed an action plan to implement the *Compassion in Practice* strategy, and from 2014/15 these will be reviewed on a quarterly basis as part of the standard contract management process. The six action areas to be taken forward by each provider organisation are:

- Action area #1: Helping people to stay independent, maximise well-being and improving health outcomes
- Action area #2: *Working with people to provide a positive experience of care*
- Action area #3: *Delivering high quality care and measuring the impact*
- Action area #4: *Building and strengthening leadership*
- Action area #5 *Ensuring we have the right staff, with the right skills, in the right place*
- Action area #6: *Supporting positive staff experience*

### 9. Staff satisfaction

The importance of staff, capabilities and culture is very clear in the learning from Mid-Staffordshire NHS Foundation Trust and Winterbourne View Inquiries. As part of the NWL CCGs' assurance frameworks we carry

[15] *Compassion in Practice – Nursing, Midwifery and Care Staff*; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, December 2012: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

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out site visits to services in order to test the culture that exists within the service, using our agreed quality visit process.

Staff satisfaction across NWL providers is variable, and historically has been understood based on annual staff surveys, GMC surveys, and engaging with staff as part of Clinical Visits to providers. Building on the recommendations of these key reports, we will strengthen our review of data and information regarding staff experience and satisfaction as part of our overall quality and safety monitoring and improvement processes, routinely collecting (as part of the Integrated Performance reporting and monitoring process) a wider range of workforce indicators, including sickness, absenteeism and turnover rates, and staff feedback, in order to triangulate with other quality measures, including patient experience data, in order to assess the performance of organisations. Other key sources of information that we will review together include:

- Staff satisfaction surveys
- Staff training information
- Workforce/patient dependency – skills and capabilities
- Whistleblowing information.
- Soft and hard intelligence from Local Education Training Board
- Responses and implementing of workforce related policy such as 'Compassion in Practice'
- Local Education and Training Board (LETB) and General Medical Council (GMC) training survey

**10. Safeguarding**

The NWL CCGs have safeguarding plans in place to ensure that NWL meets the requirements of the accountability and assurance framework for protecting vulnerable people, as follows:

- The CCGs seek assurance that providers have arrangements in place to safeguard and promote the welfare of adults and children in line with national policy, guidance and locally identified areas of concern.
- Providers identify safeguarding issues relevant to their area and we challenge providers to demonstrate that policies and procedures are in place and implemented.
- We review staff training to ensure staff are appropriately trained, supervised and supported and know how to report safeguarding concerns.
- The CCGs require providers to inform them of all incidents involving children and adults including death or harm whilst in the care of a provider.
- We monitor our own staff training.
- Full details are captured in CCG Safeguarding policies.
- We work closely with our partners to participate in Serious Case Reviews and Domestic Homicide Reviews and ensure findings are included in our triangulation of data.
- We lead institutional safeguarding investigations for health funded clients within nursing care homes and those receiving domiciliary packages of care.

The safeguarding plans include the need for seven day services, i.e. access to information to support decision-making with regards to safeguarding adults and children seven days a week. The systems are being put in place to ensure that the needs of vulnerable people are met, regardless of when they present within the health system.

<u>Safeguarding adults</u>

Implementing our safeguarding plans will ensure we continue to improve safeguarding practice in NWL, reflecting our commitment to prevent and reduce the risk of abuse and neglect of adults.

In 2014/15, the CCGs will assess what the training needs are across the health economy with regards to applying the Mental Capacity Act, and will develop a training plan

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accordingly. NWL will also develop and implement a campaign of awareness in primary care and care homes, to ensure that the Act is consistently applied across all care settings.

A key priority for the CCGs is to improve the quality of the Care Home provision locally.

- The CCGs are engaged in the Better Care Fund work in conjunction with the Local Authorities.
- The CCGs are working with partners to monitor the quality of the provision and identify areas for improvement.
- Safeguarding advice is available for all contracts and quality monitoring.
- CCG Safeguarding Leads contribute to LA safeguarding investigations to assure the CCGs of the safety of their patients.

The *Prevent* Strategy is a cross-Government policy that forms one of the four strands of CONTEST – the Government's counter terrorism strategy. With over 1 million contacts with patients every 36 hours, the NHS is key to the support and delivery of the Government's Prevent Strategy and will work hard to embed it fully into everyday safeguarding activity, including mandatory training.

The *Prevent* agenda requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation and making safety a shared endeavour.

In NWL, providers report on delivery of the *Prevent* agenda standards as part of regular CQG meetings.

Safeguarding children

The CCGs are committed to supporting the development of national and local initiatives to improve outcomes for children. This is achieved through working with partners via the Local Safeguarding Children Board and ensures that learning is taken forward within commissioning actions.

Key areas include sexual exploitation, missing children and Female Genital Mutilation (FGM).

For FGM the CCGs are working with Local Safeguarding Children Boards and providers to improve the recording of FGM cases to enable clear identification of risk to girls. This will provide a more cohesive multi agency response to the preventing FGM and supporting the victims.

### Access

NWL will deliver good access to the full range of services, including community, mental health, and general practice, through achievement of the out of hospital and primary care standards. NWL has developed out-of-hospital quality standards across a number of domains, including the following standards for access, convenience and responsiveness:

**Access, convenience and responsiveness**:

- Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:
  - Individuals whose health needs are assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling.
  - For individuals whose health needs are assessed as not urgent and that cannot be resolved by phone, they will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours.

In primary care, the expectations with regards to access are that it will include:

- The principle is that care will be responsive to patients' needs and preferences, timely and accessible.
- This may be differentiated depending on patient types: urgent needs may be dealt with by GPs at a network level, whereas patients with long-term conditions may continue to only see their named GP.

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As the detailed primary care standards are developed and agreed for London, these will be reviewed and adopted for implementation in NWL.

Each NWL CCG's operating plans are consistent with commissioning sufficient activity to deliver the NHS Constitution right and pledges for patients on access to treatment as set out in Annex B.

**Equality of access**

NWL Quality leads are working to incorporate additional Equality indicators into standard provider contracts, in order to measure how different groups may be treated at different stages of treatment and care, including uptake and use of services.

### Research, Innovation, and the Diffusion of Best Practice

North West London has a world class research infrastructure, but navigating innovations through the healthcare sector can be difficult and complex. Anecdotal evidence suggests that the lag time between research and adoption is around 17 years.

In addition, there is significant variation in healthcare at almost all levels. The gap between what we know and what we do is unsustainable if we want to improve the value of care provided in the NHS, as well as make the UK the place of choice for industry and academia.

Each CCG therefore has a duty to promote innovation in the provision of health services, and to promote research and the use of evidence obtained from research.

This duty consists of two distinct roles:

- To ensure the consistent uptake of existing good practice, including national guidance issued by the National Institute for Clinical Excellence (NICE); and
- To support developments in the pipeline of innovation, leading ultimately in turn to their uptake as recognised good practice.

NWL works closely with a number of partners in the promotion of innovation and adoption.

If we can overcome these barriers to delay between research and uptake, North West London would improve clinical outcomes, increasing life expectancy and reducing avoidable mortality, in line with our outcome ambitions. NWL could also become a UK-wide leader in commercial and non-commercial studies.

**Innovation, Health and Wealth**

In 2001 the Department of Health published '*Innovation, Health and Wealth – Accelerating Adoption and Diffusion in the NHS*'[16], setting out plans to support development and adoption of innovation in the NHS.

Innovation, Health and Wealth (IHW) set out a delivery agenda for spreading innovation at pace and scale throughout the NHS. It included a number of actions that are delivering significant improvements in the quality and value of care delivered in the NHS. NWL is adopting innovative approaches using the delivery agenda set out in this document as follows:

- **Reducing variation and strengthening compliance**: the NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals (recommendations on the use of new and existing medicines and treatments within the NHS). Innovation Health and Wealth identified the need to reduce variation and strengthen compliance of uptake of NICE Technology Appraisals.

  NWL is committed to achieving full compliance with NICE Technology appraisals – each CCG will therefore

[16] *Innovation, Health and Wealth – Accelerating Adoption and Diffusion in the NHS* (Department of Health, 2011): http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

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continue to track its own compliance, including through the innovation scorecard[17]. Academic Health Science Networks (further details available within this section) have been set up to support providers and commissioners to accelerate the adoption and diffusion of best practice. NWL is therefore working with Imperial College Health Partners as well as NICE to identify NICE Technology Appraisals (TAs) and other established best practice that generate the greatest value in the local context, and that cannot simply be addressed through traditional commissioning levers. This will build on the existing NHS England Innovation Scorecard but also take into consideration the impact on health and fiscal indicators, as well as the size of the population that would benefit from the adoption. Following the prioritisation of TAs and other best practice using this approach, NWL and Imperial College Health Partners will look to develop a clear rationale and business case for uptake of the most beneficial TAs and work together with health system partners to develop an adoption programme.

- **Creating a system of delivery of innovation**: the North West London ASHN and CLARHC are the key bodies through which innovation is both identified and disseminated.
- **Developing our people**: one of the Health Education NWL funding priorities for 2014/15 includes 'Innovation, such as clinical simulation' (see the Workforce section in chapter 11 for further detail).
- **Leadership for innovation**: CCGs have a duty to seek out and adopt best practice, and promote innovation. The NWL CCGs are actively promoting innovation in the provision of health services, as demonstrated in our key transformation programmes, including:
    - Whole Systems Integrated Care (see chapter 7)
    - Primary Care Transformation (see chapter 6)
    - Transforming Mental Health Services (see chapter 8)

<u>NWL Policy Development Group</u>

While the NICE Technology Appraisals (TAs) are mandatory for implementation, not all other best practice guidance published by NICE is implemented, as it needs to be considered in the context of the wider commissioning priorities (for example, as adopting all recommendations is not affordable).

North West London CCGs have therefore established a Sector Wide Policy Development Group (PDG). The PDG group ensures there is a robust framework that supports evidence-based policies and that this provides equity in access of treatment provision across the North West London population.

The PDG uses commissioning intelligence gathered from Individual Funding Requests (IFR) to identify patterns of referrals that are no longer exceptional and therefore necessitate a policy appraisal. The PDG look at published evidence, both from NICE and other evidence based bodies, and more importantly, provide an innovative approach in the appraisal of evidence gathered from local clinicians, through a range of clinical workshops. The PDG also review current policies to ensure they reflect the most up to date published evidence, including NICE guidance, and ensure that recommendations provide sufficient information to enable CCGs to make decisions in the context of the wider commissioning priorities.

**Research and Innovation partners**

NWL works closely with its research and innovation partners, including the Imperial College Health Partners (the Academic Health Science Network) and NIHR CLAHRC, who are leading the research and innovation agenda in

[17] http://ccgtools.england.nhs.uk/innovation/ISCCGMedTechT22/atlas.html

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NWL. The relationship between these bodies is summarised as follows:

- Academic Health Science Centres (AHSC)/Biomedical Research Units (BRUs)/Biomedical Research Centres (BRCs): identify best practice through research and discovery.
- Collaboration for Leadership in Applied Health Research and Care (CLAHRC): studies and applies the translation of research into practice.
- Academic Health Science Network (AHSN): promotes diffusion and consistent adoption of best practice and innovation across the sector.

Further detail about how each of these organisations contributes to and promotes research is provided in the following sections.

Imperial College Health Partners - Academic Health Science Network (AHSN)

Imperial College Health Partners is a partnership organisation bringing together the academic and health science communities across North West London. It is also the designated Academic Health Science Network (AHSN) for North West London.

The AHSN partnership includes representation from academia, primary and community care, mental health, secondary and specialist care and the NWL CCGs. In addition to its partners, the AHSN works closely with local government and social care, technology and pharmaceutical industries, opinion leaders, research bodies and patients and the public.

The AHSN is intended to deliver demonstrable improvements in health and wealth for the people of North West London and beyond through collaboration and innovation. As a partnership organisation and an AHSN, it will act as a driving force for collaborative working across NWL.

The core strategic objectives of the AHSN are:

- Enable the discovery of best practice
- Adopt best practice systematically
- Support wealth creation in the sector and beyond

The core strategic objectives act to form a work programme space in which the projects undertaken fit into one or more of these objectives. The priority programmes of the NWL AHSN are well-aligned to the NWL strategic priorities and key improvement interventions, and are as follows:

- **Alignment and dissemination of research**: to standardise a path for 'ready-to-go' research to get to the patient as fast as possible as well as identify opportunities for greater collaboration and innovation in research across the sector.
- **Cancer:** to oversee (with the South London AHSN) the London Cancer Alliance's extensive programme of work that covers 20 themes.
- **Cardiovascular Rehabilitation**: to evaluate the MyAction programme - the CVD prevention and treatment initiative used in Westminster – to help decide whether it should be rolled out across NWL, and to establish the best practice for cardiovascular rehabilitation and the management of patients at high risk of cardiovascular disease.
- **Chronic Obstructive Pulmonary Disease (COPD):** to work with partners across the sector to identify and overcome remaining barriers to the uptake of COPD best practice and to support the CLAHRC in developing a care bundle for primary care while refining the secondary care bundle. This includes the development of an outcome based commissioning model for the provision of community based best practice services to ensure comprehensive access to high quality care across the population.
- **Collaboration with industry:** to help the NHS work better with industry by developing a "matchmaker" infrastructure for our NHS partners to systematically articulate their needs to industry, enabling industry to respond to this need in a standardised and transparent form.

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- **Intelligent use of data:** to develop intelligent applications to the linked health data to ensure that maximum benefit is realised from it to drive further improvement in services, high standard observational and follow up research studies, and population surveillance for unexpected health issues.
- **Mental Health:** the partnership will build on previous and current work done across North West London and in particular work with the sector's Mental Health Programme Board. It will undertake a strategic profile of mental health need and care in North West London. It will create a forum that brings together academic and clinical experts to advise on service development and the implementation of research and innovation.
- **Overseas development:** to work with United Kingdom Trade and Investment (UKTI) organisation and some commercial partners to develop a comprehensive and systematic commercial offer for clients in a number of countries, and to develop a philanthropic offer on behalf of our partners
- **Patient safety:** to create a culture of continuous improvement and learning across the sector, adopting and implementing the recommendations of the Berwick Report. This will also provide the basis for the Collaborative for Patient Safety in NWL as part of the national initiative to be rolled out by NHS Improving Quality (IQ).
- **Supporting Whole Systems:** the AHSN has been asked by its members to support the Whole Systems programme by providing information on best practice from around the world and bring together thought leaders to enable partners to co-design the model effectively. In addition, the AHSN will develop, partly fund and manage an independent evaluation process to ensure the investment provides value for money and leads to measurable outcomes.
- **Neurorehabilitation:** to undertake a comprehensive review of neurorehabilitation services across the system (at the request of NWL CCGs). Note that this is consistent and aligned with the work of the London Neuroscience SCN.

<u>NIHR CLAHRC for North West London</u>

The National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care for North West London (CLAHRC NWL) is an alliance of academic and healthcare organisations working to develop and promote a more efficient, accelerated and sustainable uptake of clinically innovative and cost-effective research interventions into patient care.

CLAHRC has had a five year multi-method programme, working across primary and secondary interfaces of care, which has now been renewed for another 5 years, with a long term strategy of building capacity through improvement methodology and small cycle change. CLAHRC involves multi-disciplinary, including at its heart patient/public engagement, working amongst and across teams. While new research and innovation are always necessary, CLAHRC recognises that more can be done by effectively implementing existing evidence.

CLAHRC's overall goal has been to improve health outcomes and patient experience - delivering value within NWL and across the wider NHS through research and implementation. To achieve this goal CLAHRC developed a systematic approach to encourage better and faster uptake of clinically-proven, innovative and cost-effective care, closing the so-called second translational gap.

CLAHRC has support from all healthcare organisations within NWL to develop, implement and spread good practice across the sector with the aim to lead and influence the broader health and social care agenda.

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Biomedical Research Units

The NIHR Biomedical Research Units (BRUs) undertake translational clinical research in priority areas of high disease burden and clinical need.

The BRUs are based in leading NHS organisations and Universities enabling some of our best health researchers and clinicians to work together to develop new treatments for the benefit of patients.

In NWL, there is a BRU based at the Royal Brompton & Harefield NHS Foundation Trust.

Biomedical Research Centres (BRCs)

NIHR Biomedical Research Centres (BRCs) drive progress on innovation and translational research in biomedicine into NHS practice. The Centres are leaders in scientific translation. They receive substantial levels of funding to translate fundamental biomedical research into clinical research that benefits patients and they are early adopters of new insights in technologies, techniques and treatments for improving health.

In NWL, there is a BRC at both Imperial College Healthcare NHS Trust and Royal Marsden NHS Foundation Trust.

Academic Health Science Centres (AHSCs)

An academic health science(s) centre (AHSC) is a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

In NWL, there is an Imperial College Healthcare AHSC.

North West London Research Hub

A North West London Research Hub has been created, which includes acting as host site for the London (North West) Comprehensive Local Research Network (CLRN) and National Research Ethics Service (NRES), and supportive site for the NWL CLAHRC, Primary Care Research, Patient Representatives, Trust R&D Pharmacy Unit and support for Intellectual Property.

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# 4. Our key transformation programmes

*The North West London portfolio of transformation programmes is the basis by which will we collectively deliver our vision and ambitions*

### Introduction

While each CCG is leading its own set of initiatives to address local priorities, including respective Health & Wellbeing Strategies, Quality and Patient Experience strategies, and Quality, Innovation, Productivity and Prevention (QIPP) plans, a number of shared transformation programmes have been jointly developed to address the key themes identified in the Case for Change, the 'Call to Action' and through NWL's patient engagement and public consultation.

The core principles and values of NWL's strategy are that services and care be:

- Localised;
- Centralised/specialised;
- Integrated; and
- Personalised

These principles are embedded in and reflected across NWL's programmes. The initiatives are designed to improve health outcomes in NWL, in line with the seven NHS Outcome Ambitions, and to achieve a financially sustainable health system.

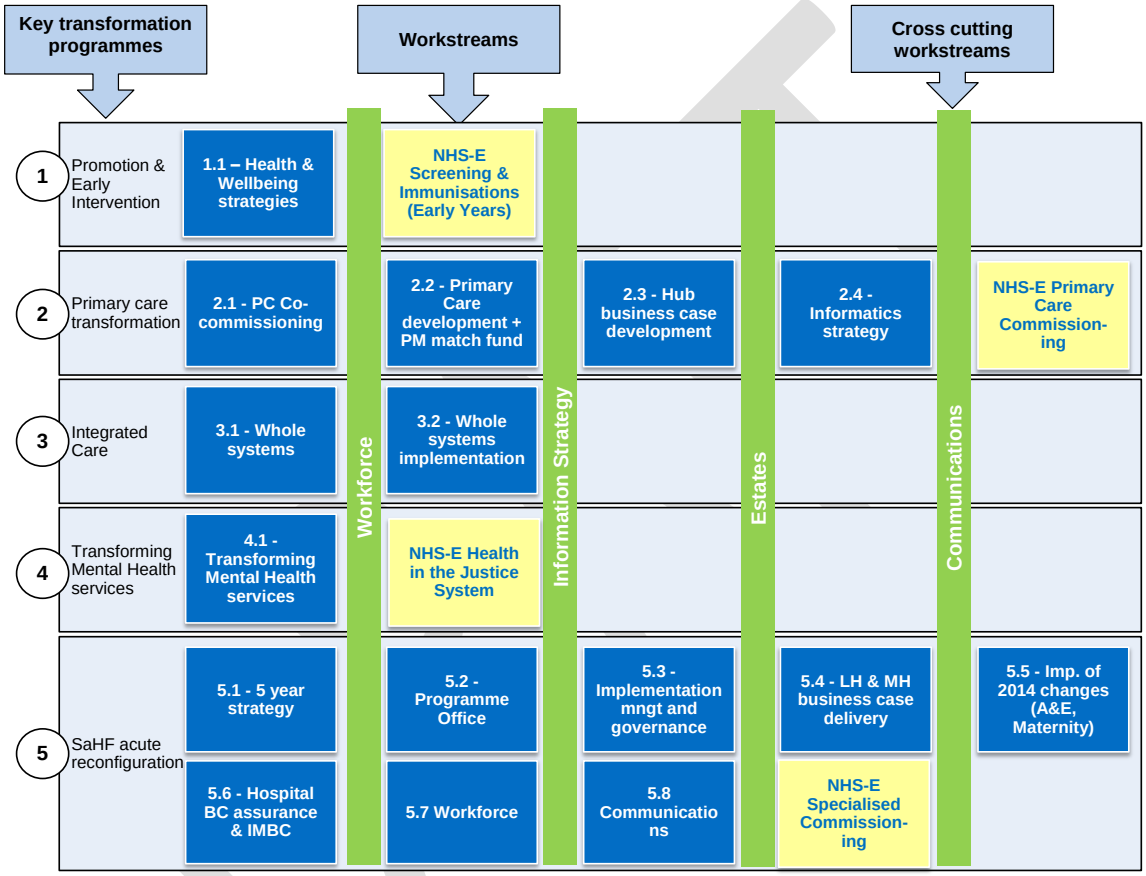
The delivery of the NWL vision is managed through a portfolio of programmes that are grouped into five themes, as depicted in the figure below:

1. Health Promotion, Early Diagnosis and Early Intervention
2. Out of Hospital strategies, including Primary care transformation
3. Whole Systems
4. Transforming Mental Health services
5. *Shaping a healthier future* Acute reconfiguration

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

In addition to the NWL transformation programmes described below, London's Strategic Clinical Networks (SCNs) focus on priority services areas to bring about improvement in the quality and equity of care and outcomes of their population both now and in the future. The networks aim to reduce unwarranted variation in health and wellbeing services, to encourage innovation in how services are provided, and to provide clinical advice and leadership to support CCGs in their decision making and strategic planning. The networks will support developing all characteristics and improvements against all outcome ambitions.

Key NWL transformation programmes




*Note: blue boxes represent NWL's workstreams, while the yellow boxes represent areas of direct NHS England commissioning.*

Further detail about each transformation programme is provided in the following section, followed by further information about overall programme investment costs, the implementation timelines, programme risks and key enablers. Each of the SCN's plans has been included in the relevant transformation programme section, as have the associated NHS England direct commissioning plans.

**Our transformation programmes address our local case for change and align with the national outcome ambitions and transformational service models.**

In developing our plans we have considered in depth both the needs and views of our local population, as well as the national direction set out by NHS England and other leading bodies.

The NWL transformation programmes are supported by and reflected in the joint Medium Term Financial Strategy (MTFS) for NWL. This financial strategy, including the

pooling of some financial resources, will ensure that the strategy is successfully implemented across all eight Boroughs of NWL. It will also ensure that delivery of the NWL strategy has the financial impact required across the health economy.

The MTFS, along with the key improvement interventions, are approved and monitored by the CCG Collaboration Board (see Governance section in chapter 13).

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# 5. Health Promotion, Early Diagnosis, and Early Intervention

*Health promotion, early diagnosis and early intervention are fundamental to achieving outcome ambitions, particularly with regards to securing additional years of life for the population of NWL.*

*Effective delivery will require close partnership working between Local Authorities, CCGs and NHS England.*

### Introduction

Health promotion, early diagnosis and early intervention are fundamental to achieving our outcome ambitions, and are the foundation of our transformation in NWL.

There are many partners involved in providing effective prevention and screening programmes across NWL, including Public Health teams within Local Authorities, NHS England Direct Commissioners for screening and early years (immunisations), Public Health England, and CCGs.

At the Local Authority and CCG level, each NWL Borough has worked with its local partners to develop a Health and Wellbeing strategy, building on each Borough's Joint Strategic Needs Assessment (JSNA).

The JSNA and joint Health and Wellbeing Strategies are the foundations upon which each Borough's Health and Wellbeing Boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education.

They enable the NWL commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes.

While each Borough's Health & Wellbeing strategy reflects the specific priorities of the Borough there are some key themes which are reflected across a number of strategies, including:

- Early Years –giving children the best start in life
- Childhood obesity
- Mental health and well-being (see chapter x for further detail)

See Appendix D for a summary of the key themes and priorities within each CCG's Health and Wellbeing Strategy, along with links to the full strategy documents.

In addition to the work of the Health & Wellbeing Boards, NWL CCGs work

collaboratively with its other partners in health promotion, prevention, early diagnosis and early intervention.

It is important that all partners take a proactive approach to managing future demand for healthcare services by working together to implement a multi-faceted and multi-partner approach to prevention and early intervention.

CCGs have a role to play in encouraging health promoting services as well as an improved focus on preventative approaches such as smoking cessation, healthy eating and exercises for frail elderly people to prevent falls. Health promotion requires a multi-faceted approach to improving people's health – key to this will be an improved focus on primary and secondary prevention and working towards wide-scale behaviour change that is sustainable in the longer term. For example, a number of the NWL Boroughs are working to develop a "making every contact counts" approach, and would be keen to explore how this approach can also be embedded across NHS services and culture.

Please see Chapter 10 for further details about North West London's plans to improve services across the continuum of cancer services, including prevention and early diagnosis.

### Screening: an integrated approach to screening and symptomatic services

While NHS England commission the majority of screening programmes, up to referral for treatment, CCGs commission all treatment arising from screening, as well as Antenatal and Newborn screening programmes (as part of the maternity tariff).

NHS England and NWL CCGs will therefore work collaboratively to meet the vision to commission screening programmes that provide a high quality, patient focussed service, meeting or exceeding national standards and targets, for all communities in NWL.

An integrated approach to screening and symptomatic services in NWL will result in:

- Increased screening coverage and uptake, including of cervical cytology.
- Ensuring all CCGs commission along the best practice commissioning pathways for the earlier detection of ovarian, lung and colorectal cancer to ensure patients a cancer diagnosis as quickly as possible.
- Supporting all GPs to be able to understand cancer referral patterns through the use of practice profile data as provided by the National Cancer Intelligence Network.
- Consolidation of screening services to achieve higher quality assurance, improve patient access and experience, increase accountability, and increase cost-effectiveness – this may include Diabetic Eye programmes, and a core administrative service for breast screening.
- High quality programmes that deliver the national standards, including reduced variation in performance.
- Service integration within the pathway and at hand off points (including treatment services, commissioned by CCGs).
- An improved antenatal/maternity pathway across NWL.

While there will be a national review of pathology laboratories, but there are not expected to be many implications in NWL as these are laboratories are in line with national requirements.

[*Placeholder for further detail from NHS England's direct commissioners of screening services*]

### Early Years - Immunisations

NHS England commissions immunisations services for NWL to reduce vaccine preventable diseases, ensuring individuals' risk is reduced and effective levels of herd immunity are reached. These services

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contribute to securing additional years of life, by reducing the incidence of vaccine preventable diseases; improving the health related quality of life for those with long term conditions and the reduction of avoidable admissions to hospital such as that demonstrated by the flu vaccination programme.

NHS England (working with NWL) will ensure that every child has a complete clinical record across the health system, including immunisation regimes, so infants are ready for school and teenagers are ready for employment. NHS England will create Public Health Action Plans for each programme across the CCG, Local Authority, Public Health England and NHS England partnership to ensure London achieves, or exceeds the national target for uptake and coverage, especially in the non-registered and most vulnerable cohorts. NHS England will work to eliminate vaccine-prevented diseases from London by 2020.

Priorities for Early Years:

- Child Health Information System **(CHIS) will be linked** for all children's records across London by 2015 and nationally by 2018
- Health Visiting and Family Nurse Partnership commissioning be will via Local Government by 1st October 2015 and the **integration of these services into early years delivery by 2018**.

Priorities for Immunisation:

- An **integrated model** of vaccinations and immunisation, reflecting the technology changes within vaccinations delivery.
- **CHIS-to-GP-to-Other Provider** secure data transfer for COVER (0-5) and all immunisation regimes
- Implement an integrated delivery model of immunisations, involving all providers and the timely and secure sharing of clinical data from August 2014.
- Initiate the funding of new regimes, including annual Seasonal Flu for 7-8 year olds

NHS England is also taking forward work on immunisation to:

- Improve information and data flows.
- Improve uptake in specific communities where we know uptake is poor.
- Widen access by commissioning a range of alternative providers to complement existing GP practice and Community Health Service delivered immunisations: NHS England will work with CCGs to ensure an extended range of providers are delivering the national regimes, whilst send clinical data back to the registered GP for them to update the prime-clinical file. Focus of work with Community Pharmacists seen as a way to effectively increase uptake, especially as new methods of delivering move from injections, seen as more effective models. This will require strong partnership working in order to be effective.

[*Placeholder for further detail from NHS England's direct commissioners of immunisations*]

### Children's Services

Services provided to children and their families both in the early years and up to the age of sixteen are a key priority for all of the North West London CCGs and Boroughs, as reflected in the Health & Wellbeing Strategies. Considerable work is underway to strengthen services provided to this cohort at the local level, both to address the needs of children in general as well as specific cohorts of children who tend to have higher levels of need and benefit from an integrated approach. Key populations from a Children's Services perspective include children with disabilities as well as looked after children and care leavers. Meeting the needs of looked after children and care leavers is additionally complicated by the need for them to often be placed away from their "home" borough.

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North West London will work to consider how and where a more joined-up and coordinated approach to caring for these cohorts of the population may further improve their outcomes. For example, a sub-regional plan could be an opportunity to ensure that the physical and mental health needs of children placed away from their "home borough" are better coordinated and met.

Early intervention for children with low level mental health difficulties is a particular issue for Children's Services, where significant proportions of children requiring early help, a child protection plan or needing to be looked after have parents who have a range of mental health difficulties.

Specific key initiatives to improve services provided to children in North West London also include the Child GP Hub, which is a major project that will, amongst other outcomes, reduce demand for acute services.

### Cardiovascular Disease

Cardiovascular disease is a significant cause of premature disease, and a priority for a number of CCGs, from prevention and early intervention, including supported self-management. The priorities of the Priorities for the London Cardiovascular SCN over the next five years include:

- Maximise opportunities across the whole patient pathway to **identify and manage people at risk** of developing CVD by ensuring that NHS Health Check Programme is offered everywhere.
- **All patients, pre and post diagnosis are offered education and information** on opportunities to access interventions, rehabilitation and support that decreases risk of developing CVD and/or CVD progression.
- Ensuring patients and carers have **appropriate access to psychological support** (in line with the Improving Access to Psychological Therapies (IAPT) work that is underway across each NWL CCG - see chapter 8, Transforming Mental Health Services).
- **Empowering patients** to be involved in decision-making, care planning and self-management of their CVD to improve health outcomes.
- London's CCGs to collaboratively commission some **tuberculosis services on a 'once for London basis'** and significantly reduce the London tuberculosis rate.

Specific programmes within this SCN are: cardiac and vascular, stroke, renal, diabetes, and tuberculosis.

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# 6. Out of Hospital strategies, incl. Primary Care Transformation

*North West London has embarked on the biggest transformation of care, from a system spending the majority of its funding on hospitals to one where we spend the majority on services in people's homes and in their communities, i.e. "out of hospital".*

### Introduction

Successful achievement of the North West London vision for whole systems, including the principles of services being localised where possible and centralised where necessary, will rely on reducing demand for acute services.

In order to make this work, we need to strengthen our out-of-hospital services. There are many different types of out-of-hospital services in place already providing different aspects of out-of-hospital care. Many are excellent, but there needs to be more consistency. NWL has embarked on a major transformation of care to move from a system spending the majority of its funding on hospitals to one where we spend the majority on services in people's homes and in their communities, i.e. 'out of hospital'.

Our 'Our of Hospital' strategies aim to meet these changing needs by developing:

- Better care, closer to home
- A greater range of well-resourced services in primary and community settings, designed around the needs of individuals and reducing unwarranted clinical variation, including in the management of long-term conditions

For this reason, NWL has developed out-of-hospital quality standards. Achieving these standards will mean that patients can be confident in the standard of the care received out-of-hospital – these standards cover six domains:

1. Individual empowerment and self-care
2. Access, convenience and responsiveness
3. Care planning and multidisciplinary care delivery
4. Information and communications
5. Population and prevention-oriented
6. Safe and high quality

## Standards for out of hospital care[18]

| Domain | Out of Hospital Standards |
|---|---|
| A Individual Empowerment & Self Care | ▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing |
| B Access convenience and responsiveness | ▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:<br>▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling<br>▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours |
| C Care planning and multi-disciplinary care delivery | ▪ All individuals who would benefit from a care plan will have one.<br>▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care<br>▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists |
| D Information and communications | ▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care<br>▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers<br>▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan |
| E Population- and prevention-oriented | ▪ The provider has a responsibility to pro-actively support the health and wellness of the local population. This includes prevention (e.g. immunisation, smoking cessation, healthy living), case-finding (e.g. diabetes, COPD, cancer) and pro-active identification and support for patients from hard to reach groups |
| F Safe and high quality | ▪ Patients experience high quality, evidence-based care and clinical decisions are informed by peer support and review. Clinical data are shared to inform quality assurance and improvement |

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[18] Note that where standard 3 references GPs working within multi-disciplinary groups, these groups also includes acute clinicians.

Each NWL CCG has developed its own 'Out of Hospital' strategy to support the require shift of activity from acute to community and primary care settings, and to ensure that all services meet these standards for out of hospital care. Each of the NWL CCGs has its own individual plan to achieve this, which has been tailored to meet the population's needs. However, there are a common set of initiatives working to similar objectives.

Primary Care has a significant role to play in providing out of hospital services.

### Primary Care Transformation

The scale of change that is required in primary care to achieve our quality, patient experience and financial objectives is truly significant, and our CCGs and GPs are determined to translate this vision into reality. In 2012, NWL commissioned a comprehensive review of patient priorities for primary care. The four stage process involved:

1. Literature review (October 2012)
2. Workshops (10/11 November 2012)
3. Street survey (late November 2012)
4. Final list of patient and public priorities (December 2012)

Additional engagement was carried out with CCG patient groups, patients with learning disabilities, non English speakers, patients from a variety of BME groups.

The report has already provided evidence to underpin the need to design new models of primary care that will support the delivery of the SaHF out of hospital strategy. The top three patient priorities were:

1. *I can quickly get an emergency appointment when I need one.*
2. *I have enough time in my appointment to cover everything I want to discuss.*
3. *I can rely on getting a consistently good service at my GP surgery.*

Based on this survey and other inputs, including our baseline position on the related Outcome Ambition measures, a key element in our case for change is the need to increase the overall quality and consistency of primary care across our eight boroughs.

The future model for primary care will be increasingly patient-centred, with networks as a central organising point. GPs are the centre of organising and co-ordinating people's care, and a new model of General Practice is emerging in NWL to build on the existing strengths of Primary Care. This new model of General Practice will also help to deliver the vision of *Shaping a healthier future* and Whole Systems Integrated Care.

We have an expectation that primary care will change in three ways to improve care for patients:

1. ***Primary care will change to deliver out of hospital care:***

The CCGs' Out of Hospital strategies (and the associated Delivery Strategies) are clear about the growing role for general practice in delivering improved, integrated care.

Central to this will be GPs working together in networks to deliver some of the innovations included in CCGs' plans for Out of Hospital care, including differentiated access and additional support for patients with long-term conditions.

While the overall model of care varies by CCG, there are some common principles that will be met. Based on the feedback of patients in North West London, our vision for primary care transformation is to offer:

- **Urgent**:
  - Patients with urgent care needs provided with a timed appointment within 4 hours.
  - Patients with non-urgent needs offered choice of an appointment within 24 hours, or at their own practice within 48 hours.
  - Telephone advice and triage available 24/7 via NHS 111.

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- **Continuity**:
  - All individuals who would benefit from a care plan will have one.
  - Everyone who has a care plan will have a named 'care co-ordinator'.
  - GPs will work in multi-disciplinary networks.
  - Longer GP appointments for those that need them.
- **Convenience**:
  - Access to General Practice 8am-8pm (Mon-Fri) and 6hrs/day during the weekend.
  - Access to GP consultation in a time and manner convenient to the patient.
  - Online appointment booking and e-prescriptions available at all practices.
  - Patients given online access to their own records.
  - Online access to self-management advice, support and service signposting.

Note that increased online access will not replace face-to-face and other channels of information and support.

***2. Primary care will change to meet expectations for access:***

Our work with patients indicates an expectation of better access to primary care and including better continuity of care for people released from custody settings.

- The principle is that care will be responsive to patients' needs and preferences, timely and accessible.
- This may be differentiated depending on patient types: urgent needs may be dealt with by GPs at a network level, whereas patients with long-term conditions may continue to only see their named GP.
- Alongside this, NWL is promoting 7-day working across the system, which includes GPs. Again, this may be addressed at a network level.

***3. Primary care will change to meet rising quality expectations:***

- NHS England expects improvements in the quality of the core primary care they commission.
- This will include support for practices to improve but also contract management of poor quality practices across NWL.
- Alongside this, CQC has a range of expectations of quality and safety, including the safety and suitability of premises. We will therefore need to address any estate that does not meet these standards and manage the consequences.

Whilst the details may change as they are developed, this combines to suggest that the direction of travel is towards:

- GPs will deliver a wider range of services and lead the integration of care for patients with long-term conditions.
- Networks will support their member GPs to deliver services collectively and manage urgent demand.
- Other providers will deliver large-scale services across the CCG.

***In order to deliver these commitments, individual GP practices will build on the progress they have already made towards delivering services as networks.***

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## General Practice Networks

North West London has made significant progress towards establishing GP practice networks, with every practice now part of a network for peer review purposes, and some networks already coming together to deliver services. However, getting networks to work properly is no small thing. Significant changes are needed in ways of working, workforce, organisational form, service design, capacity planning and IT/telephony infrastructure. Building this capability takes time but we will also deliver tangible service improvements for patients earlier.

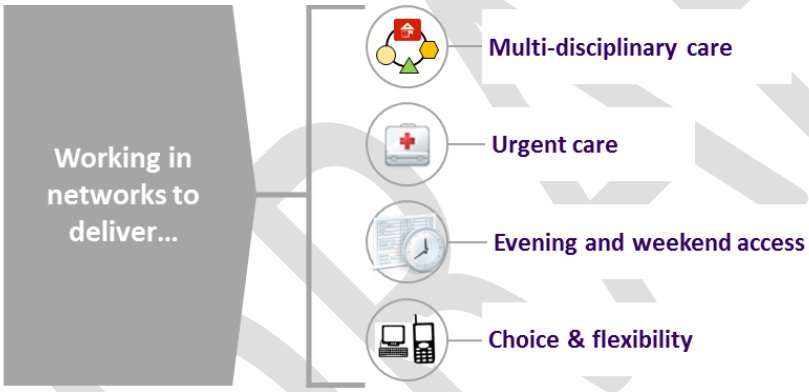
**We have done detailed work to understand General Practice Staff's ambitions for future working** *(From Good to Great* NWL workforce engagement, 2013*)*:

*"Networks will create new career routes…allowing for progression; they will facilitate proper extended hours; [and] strategic planning for training & development", **GP***

*"The range of services we provide will expand: more minor surgery, mental health services…LTC services",* **GP**

*"When we pool resources together in networks, we can reduce inequities in provision…bringing all practices up to the standards of the best now",* **GP**

GPs will work in networks to deliver:




## Out of Hospital Care Settings

Delivering our vision requires us to invest in and use our estate differently. Hubs, one of the configurations that CCGS are exploring, are flexible buildings, defined as those that offer a range of out of hospital services and/or host more than one GP practice. Hubs will focus on delivering services that ensure patients' medical, social and functional stability. Investment in hubs and General Practice estate will help us deliver better care in North West London.

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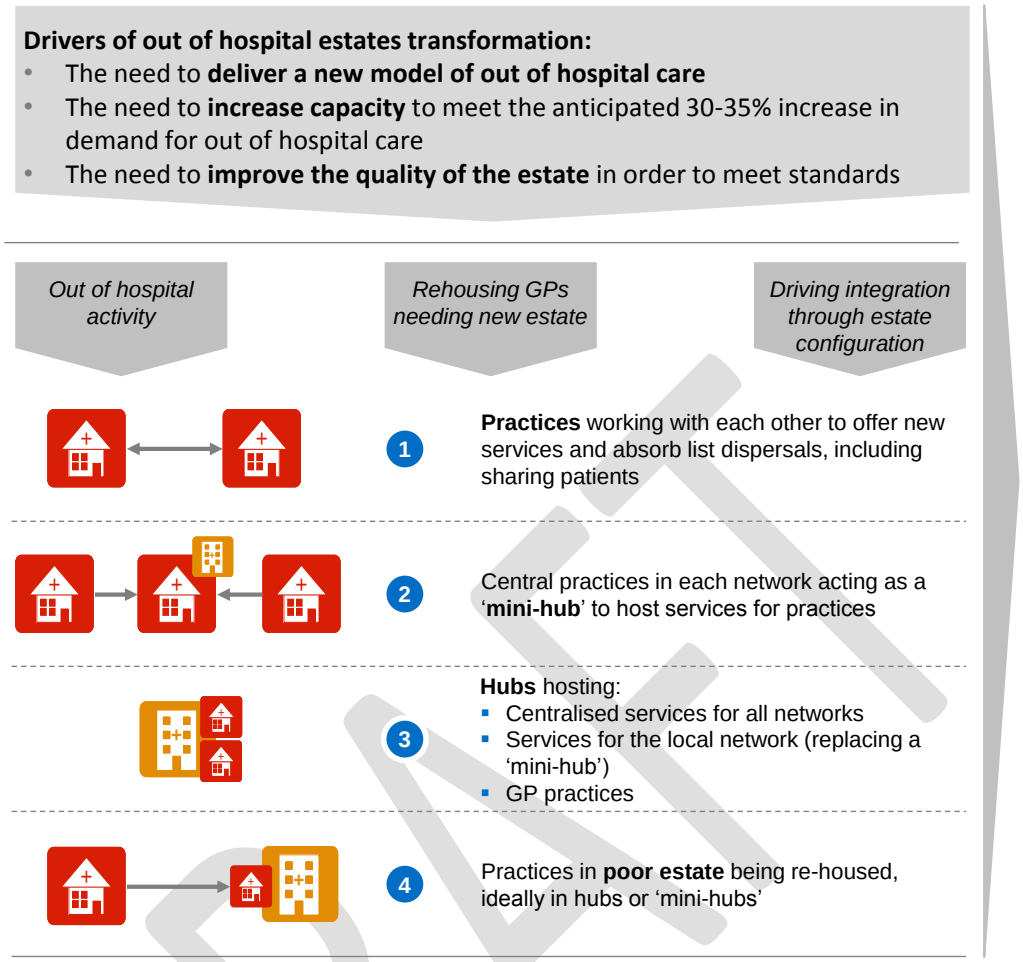


Through our estates transformation will ensure we can:

- **Deliver a greater volume of care in out of hospital settings** by utilising our current estate to maximum effect and by providing new hub spaces for care delivery.
- **Deliver improved access** by supporting networks to offer extended access and differentiated access models.
- **Deliver better planned care** by offering spaces for diagnostic equipment and community outpatient appointments.
- **Deliver whole systems integrated c**are by offering space for care co-ordination, multi-disciplinary working and sharing of key services.
- **Support the meeting of relevant standards** for access and integration of care.

The Primary Care Transformation programme is fundamentally linked to the other key transformation programmes, as GPs will be at the centre of organising and coordinating people's care (through the Whole System Integrated Care programme), while a key enabler of the successful realisation of the benefits of the *Shaping a healthier future* (SaHF) acute reconfiguration will be the effective implementation of the NWL 'Out of Hospital' strategies and associated reduction in demand for acute services. Supporting people in the community will require an integrated approach from both health and social care staff.

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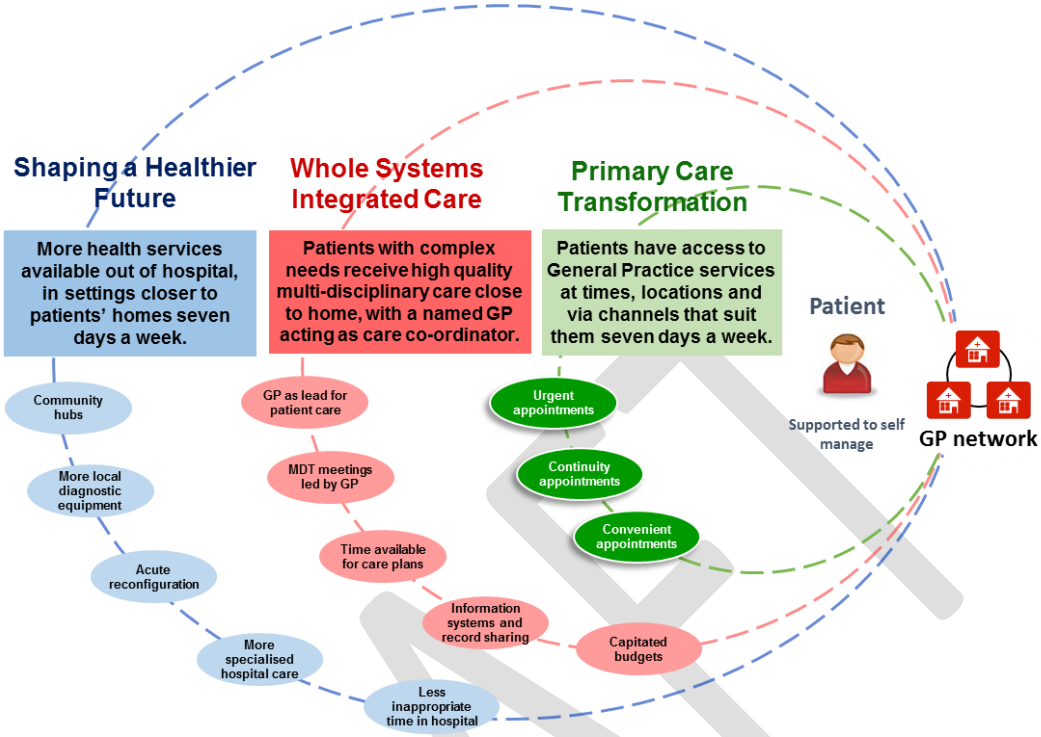
These important relationships are depicted in the following diagram:

Relationship between Primary Care Transformation and other transformation programmes

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### NHS England's Primary Care programme in London

NHS England commissions many primary care services. It is responsible for primary care contracts and has a duty to commission primary care services in ways that improve quality, reduce inequalities, promote patient involvement and promote more integrated care. CCGs have a role to play in driving up the quality of primary medical care but will not performance manage primary-care contracts.

NHS England's priorities for the primary care programme in London include:

- **Maximise every opportunity to improve GP outcomes**: through an established and effective QIPP programme.
- **Developmental standards for Primary Care**: London's vision is underpinned by development standards that describe the potential service that could be offered by general practice in the future following a period of redesign, development and investment.

**Primary Care Co-Commissioning**

As described earlier the Plan, the NHS in NWL is facing a range of clinical and financial pressures and challenges, and doing nothing is not an option.

Primary care will play an increasingly important role, with general practice at the centre of coordinating people's care. NWL London is committed to significant additional investment in out of hospital care to make this vision a reality, including £190 million investment to support a re-distribution of activity from the acute hospital to out-of-hospital sector as part of *Shaping a healthier future* (SaHF). A significant proportion of this investment will be in general practice.

As commissioners, NW London CCGs and NHS England are aligned in their thinking about how to support primary care transformation and their strategies demonstrate this alignment. Both agree that care should be more responsive to patients' needs, and that this will require certain key factors such as a central role for primary care, GPs working in networks, and multidisciplinary teams for some patients.

Despite this, both NWL CCGs and NHS England are constrained in their ability to drive transformation in primary care. CCGs are unable to shift funding from other parts of the health system to primary care, or invest in enablers such as estates and IT. NHS England does not have the local management resource to drive change or proactively manage performance.

By commissioning together, NWL CCGs and NHS England will be able to:

- **Develop and implement a pan-NWL commissioning strategy** that delivers a consistent level of service from general practice and other out of hospital services (e.g. out of hours services).
- **Collaborate effectively with the LA at the borough level** as one unified health commissioner, to co-commission whole systems integrated health and social care.

In a number of areas, co-commissioning could allow specific changes, enabling NW London's vision for primary care to be achieved. For example:

- **Operating model**: NWL CCGs and NHS England could invest in the development of networks, allowing GPs to realise the benefits of scale associated with network working.
- **Contracts and money**: NWL CCGs could influence the PMS review, aligning it with their vision and ensuring that savings are reinvested in NWL.
- **Performance:** CCGs could be given a well-defined and active role focusing on improving outcomes at the practice and network level.

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- **Estates:** NWL CCGs and NHS England could pool available estates funding and develop a clear five year investment pipeline.

For practices that are interested in exploring new ways of working, NW London and NHS England are proposing to develop a new, optional "opt in" service specification for general practice, defining services and additional payment more clearly.

Co-commissioning is about helping general practice to secure greater levels of investment, providing greater flexibility to innovate, and supporting practices to improve quality of care. It is not about reduced CCG control or CCGs taking on the role of managing poorly performing practices.

The exploration of co-commissioning takes place in the context of several programmes already underway in NWL to support general practice, which aims to improve the consistency of primary care across NWL, support GPs to work effectively in GP networks, and to enable these networks to collaborate with other providers. For example:

- Designing **new whole systems models of care** that deliver an enhanced range of services to meet the needs of specific patient groups in their homes and general practice.
- Standardising the range of **enhanced services** that CCGs commission and ensuring their availability to all patients (Central, West, Hounslow, H and F, and Ealing CCGs only).
- **Organisational development** for practices to support collaborative working, through the Prime Minister's Challenge Fund.
- Developing a **primary care estates strategy** for each CCG to support the delivery of new whole systems models of care.
- Developing a joint strategy with Health Education NW London (HENWL) to improve **training and career opportunities** for the primary and community workforce.
- Investing in **GP IT** to establish a common IT platform across each CCG.

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# 7. Whole Systems Integrated Care

*The North West London five year plan is underpinned by our Whole Systems vision, which places the person at the centre of their provision and organises services around them.*

### Introduction

NWL's five year plan is underpinned by our Whole Systems approach, which places the person at the centre of their care provision and organises services around them.

Across the eight boroughs of North West London, 31 partner organisations have agreed to work together in pursuit of a shared person-centred vision for integrated care. Achieving this vision will require a five year change programme to develop entirely new ways of working. The name given to this vision and change programme is 'Whole Systems Integrated Care'.

The Whole Systems Programme is built on strong foundations, drawing on progress and learning from various local initiatives across our boroughs. In particular, the NWL Integrated Care Pilots and the Tri-borough Community budget pilot have looked at bringing people and professionals together in support of a more coordinated, proactive approach.

Building on these foundations, NWL partners have agreed to work together to go further and faster, developing plans to design and deliver joined up, person centred care across the system and wider community. Having made this collective decision, it was therefore timely that the Government subsequently announced its intention for all local areas to develop Better Care Fund plans, bringing together health and social care resources to deliver personalised, integrated care is a fundamental component of the Whole Systems approach and as such, BCF plans for each of our boroughs provide an important stepping stone in the journey to long term transformation.

Equally, the vision, principles and co-design work undertaken to date across NWL as part of this programme have been fundamental to the development of the Better Care Fund plans in each Borough, and to the further development of our out-of-hospital strategies, including for primary care.

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The shared vision of the Whole Systems Integrated Care (WSIC) programme is:

*"To improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community"*

This vision is based on what people have told us is most important to them. Through holding workshops with patients, people who use services and carers, and conducting interviews and surveys across NWL, we know that what people want is choice and control, and for their care to be planned with people working together to help them to reach their goals of living longer and living well. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

Our vision is therefore supported by three key principles:

The vision and principles for Integrated Care in NWL:

**Our shared vision of whole systems integrated care…**

"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community

**… supported by 3 key principles**

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Our systems will enable and not hinder the provision of integrated care.

Fundamentally, Whole Systems Integrated Care is a plan for a radically different way to provide care for people. This is different both in the nature of the care people receive and how the system is organised to deliver it. A Whole Systems approach means health and social care provider organisations forming new integrated care teams around the person - one co-ordinated team to deliver care. This care will be directed by the people receiving it, where they define the outcomes they want and are empowered to achieve them. General practice will be at the centre of co-ordinating these teams which will make innovative preventative interventions, often social care based, to prevent unnecessary deterioration of people's health and admission to hospital, as well as reducing variation in the management of long-term conditions based on best practice. Local authorities, CCGs and NHS England will pool budgets such that providers have collective responsibility for outcomes and for the budgets to deliver them. This collective responsibility will incentivise the integrated working of staff for the benefit of people, so they receive a seamless and efficient service. This new way of working will require major changes in cultures, behaviours and

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system structures to achieve change. The sections below describe some of the efforts to date to provide support to local areas to make these difficult but worthwhile changes.

While the focus of our NWL integration work is WSIC, this aligns with and supports the implementation of changes for particular conditions and pathways (e.g. Cancer), and these are detailed in this section as well.

### Pioneer

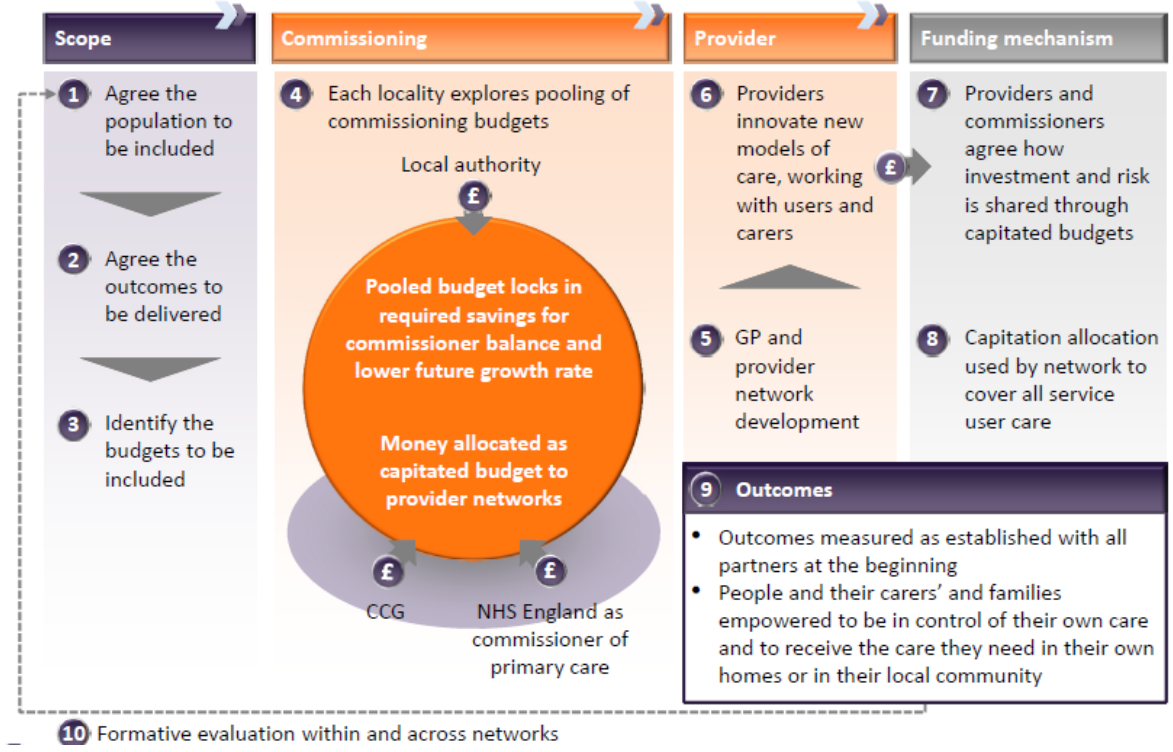
In June 2013, 31 partners across the eight boroughs of North West London submitted a joint pioneer application under a single vision. NWL was one of only 14 areas nationally to be awarded Pioneer site status. Pioneer areas will be provided bespoke and tailored support from government and national partners in order to move further and faster towards integrated care. In return, pioneers will share their learning with each other and other local places, including participation in a national evaluation.

### Approach - co-design with people and partners as our guiding principle

Through the NWL WSIC programme, local authorities, GPs, local hospitals, community care services, mental health services and the voluntary sector are working together to turn best practice, innovative care into 'business as usual' day-to-day care. These organisations have come together as partners to tackle organisational barriers, reduce duplication, and provide a more seamless care service for local people, many of whom have long term conditions, and are part of a population which is also getting increasingly older.

The high-level approach to achieve the vision and principles of Whole Systems is as follows:

Ten-step plan to achieve Whole Systems vision




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

considered some of the difficult questions that this vision raises through the Whole Systems Integrated Care programme. Implementing Whole Systems Integrated Care in NWL will only be successful if it keeps the person who uses services at the centre of all decisions and design processes. To this end, from September 2013 to January 2014, over 200 people from across our health and care system came together in regular working groups to discuss the challenging design questions that we need to resolve in order to achieve our vision of integrated, person-centred care.

In our context, co-design means an inclusive and collaborative process with a breadth of stakeholders who can represent the varied interests of patients, people who use services, carers, their families, and their communities. This process has not only facilitated reaching a solution that everyone supports, but has also inspired more creative and effective ideas for the future of the system.

Whole Systems Co-Design Working Groups

**Embedding Partnerships**

**Population and outcomes**



- Instead of organisations or diseases, which groups of **people** should we organise care around?
- What are the opportunities to improve care for these people?
- What goals do people in these groups want to achieve?

**GP networks**



- What services could groups of practices provide better for people if they work together?
- How can these GP groups work with other care providers to deliver better services?

**Provider networks**



- What services could groups of providers provide better for people if they work together?
- How can incentives for providers make the right thing to do the easy thing to do?
- How do different providers of care decide to spend money in new ways without damaging existing care?

**Commissioning and finance**



- How can people get better care by not having different organisations paying for care with separate budgets?
- If there were one pot of money how do different commissioners make sure that people are getting the care they want?

**Informatics**



- What information is needed to provide better services to people?
- What information do commissioners need to make sure people are getting the care they need?
- What do we have and what is missing today?

**Embedding Partnerships'** is a cross-cutting workstream of the NWL WSIC programme. Its purpose is to support effective partnerships among professionals and with patients, people who use services, carers, and members of the local population, to ensure that changes are co-produced. There are over 100 lay partners involved in the Lay Partner Forum, reflecting the diverse demographic and spectrum of need level across the NWL population.

In order to support all programme partners with their development around working co-productively and what it means in practice, the WSIC lay partners worked collaboratively to produce a **co-production touchstone**. The lay partners also agreed a set of "I" statements to help keep the focus on all work on-going throughout the programme on how best to enable person-centred, accessible and proactive high-quality care. In effect, the lay partners act as the guardians of the programme's vision.

***Agreed NWL 'I' statements for people who use services and carers:***

- I can access my own health- and social-care data and correct any errors
- I can discuss and plan my care with a professional, focusing on my goals and concerns

- I know what I can do to keep myself as well and active as possible
- I know whom to contact and where to go when I need extra support
- I can make sure that the professionals who support me have access to my up-to-date health records and care plan
- I am regularly asked what I think about the care I am getting, I know that my feedback is listened to
- I know that when changes are being planned to services, my interests and those of people like me will be taken into account because we have been part of the planning process from the start

These are consistent with the "I" statements developed by National Voices, the national coalition of health and social care charities in England that works to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. These "I" statements provide a narrative for person-centred coordinated ('integrated') care[19].

*Our commitment to working co-productively in North West London means:*

1. Co-production for the Whole Systems programme starts with co-design, through which we can then embed co-delivery. This is the core of our programme and is embedded throughout the whole process.
2. We are dealing with new relationships for which we need a new language of inclusion: we will avoid "consultation" and aim at all times to have "conversations" for a genuine partnership.
3. We are people driven: we will actively reach out to those whose voice is rarely heard.
4. We are all responsible for driving progress and educating each other along the way.
5. We recognise the political and social context in which the programme sits.

**North West London Care Journeys**

Over the course of a month at the end of 2013, a small number of service users and carers with a range of different health and care needs worked with Ipsos Mori to document and reflect on their experiences of integrated care.

This insight is an integral component of the Whole Systems Integrated Care Toolkit, enabling NWL partners to better understand:

- Areas of good practice
- What people value most from integrated care
- Particular areas of need for certain groups
- How all aspects of a person's life can affect and be affected by their care and support needs

The method used to undertake this research included:

Research methods

[19] http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

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**An initial in-depth filmed ethnographic interview which lasted a whole day**



**Capturing everyday experiences using photography**



**Diary writing over the course of a month**



**Bringing it all together**

*"The material in this ebook, put forward by individuals themselves, is the most powerful form of evidence about what it feels to live with a long-term condition or to be a carer. It shows the importance of coordination and continuity of care, as well as time, understanding and compassion from every health and social care professional.*

*Most importantly, it shows how whole systems means considering every aspect of a person's life, and all the clinical, statutory, voluntary and community support they receive. "*

*Lay Partners Advisory Group*

The learning from the co-design process, which has engaged over 200 individuals across NWL, as well as the results from the ethnographic (care journeys) research has resulted in a North West London Whole Systems Integrated Care Toolkit, a practical how-to guide to support health and care partners as we move to local implementation.

### Whole Systems Integrated Care Toolkit

NWL has embedded its collective knowledge together into a living toolkit available to everyone across NWL. This toolkit distils the work of these groups into a web resource that is intended to be of use to commissioners, providers, voluntary organisations and communities, to help them design new and innovative models of care within North West London and elsewhere.

The toolkit is a living web-based resource and will be updated frequently as local areas implement their plans for integrated care and lessons are learned and shared.

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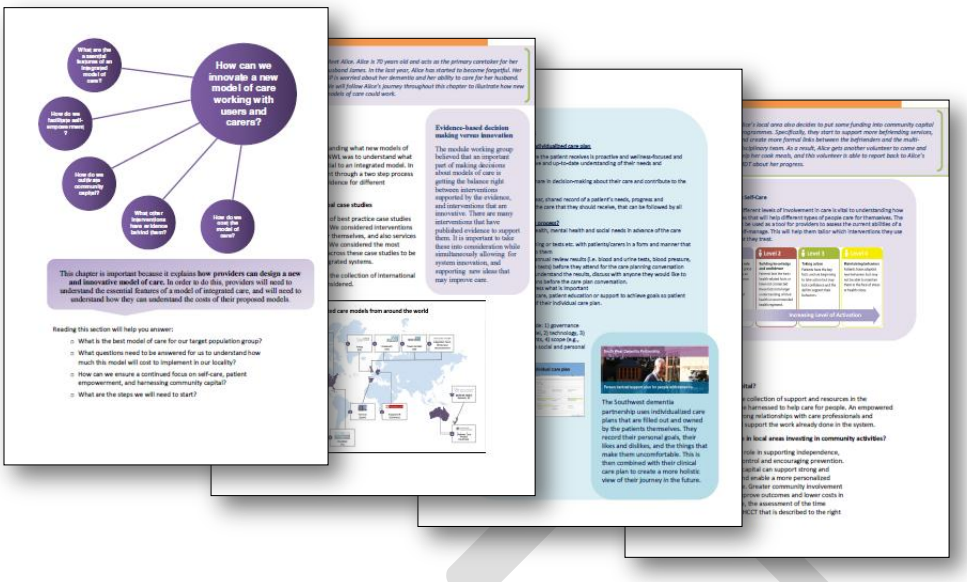


Further information regarding the findings from the population segmentation co-design process is provided in the following section.

**Population segmentation - what population groups do we want to include?**

The toolkit explains why commissioners should organise care around people and their needs and lays out the Whole Systems proposals regarding thinking about people with similar needs. This grouping has been co-designed by professionals across health- and social-care, as well as lay partners.

In carrying out the grouping, the working group used three complementary methods. First, they gathered the judgement of multiple professionals and lay partners from across North West London. Then, they did an in-depth analysis of a fully integrated example data set gathered from Hammersmith and Fulham to test the hypotheses. Bringing together data from across acute, primary, community and social-care helped us to understand levels of service utilisation and cost for each group, which helps build a picture of population needs. Finally, they also looked at how populations had been grouped in other health systems both nationally and internationally. Using these three approaches, they reached consensus in the working group around how to group the population of North West London.

There are ten proposed groups that cut across health and social-care, and represent the holistic needs of the individuals that fall into those groups (see figure below). As such, a model of care surrounding the serious and enduring mental illness group would address all care needs of the people in that group, whether they are mental, physical or social, and would address these needs across organisations. The idea is to address the needs of individuals, rather than the specific conditions or the specific type of care.

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Description of population segments

| | *Description of group* |
|---|---|
| 1 Mostly healthy adults <75 | ▪ People aged between 16-75 that are mostly healthy and do not have LTCs, cancer, serious and enduring mental illness, physical or learning disabilities and advanced stage organic disorders<br>▪ Includes those that have a defined episode of care, e.g. acute illness with full recovery, maternity |
| 2 Mostly healthy elderly (>75) people | ▪ Same as group 1 but for those that are above the age of 75 |
| 3 Adults (<75) with one or more long term conditions | ▪ People aged between 16-75 that have one or more long-term conditions, e.g. HIV, COPD, diabetes, heart disease<br>▪ Includes common mental illnesses, e.g. depression, anxiety |
| 4 Elderly (>75) with one or more LTCs | ▪ Same as group 3 but for those that are above the age of 75 |
| 5 Adults and elderly people with cancer | ▪ People aged above 16 that have any form and stage of cancer |
| 6 Adults and elderly people with SEMI | ▪ People aged above 16 that have a mental health problem (typically people with schizophrenia or severe affective disorder) that experience a substantial disability as a result of their mental health problems, such as an inability to care for themselves independently, sustain relationships or work |
| 7 All with advanced stage organic brain disorders | ▪ People aged above 16 who have a decreased mental function resulting from a medical disease rather than a psychiatric illness. Includes dementia as well as other conditions such as Huntington's and Parkinson's disease |
| 8 Adults and elderly people with learning disabilities | ▪ People aged above 16 who have a difficulty learning in a typical manner that affects academic, language and speech skills<br>▪ Excludes mild conditions that does have an impact on social relationships or work |
| 9 Adults and elderly people with severe and enduring mental illness | ▪ People aged above 16 who have a FACS eligible physical disability<br>▪ Excludes physical disabilities, including sensory disabilities, that are not FACS eligible<br>▪ FACS eligibility includes an inability to perform 3 or more household tasks |
| 10 Socially excluded | ▪ People aged above 16 who have chaotic lifestyles who often have limited access to care<br>▪ Includes the homeless, alcohol and drug dependency |

The next step in establishing the grouping is to understand how individuals will be assigned to groups. Commissioners and providers will need to agree on this step because it is important for the capitated payment system to understand the process for moving in and out of groups. In order to deal with this issue, a preliminary categorisation was created for providers and commissioners to use to assign people to groups.

The groupings presented previously represent the primary organising logic. Within each of these groupings sit a set of cross-cutting themes or lenses to help us prioritise needs within the groups. These include age-related frailty, levels of economic well-being, behaviour, social connectedness, utilisation risk, presence of a carer, and a person's own caring responsibilities. In addition to people's clinical and social care needs, these lenses can have a significant impact on a person's capacity and willingness to manage their condition as well as their reliance on statutory services. These lenses should therefore also be taken into account to help target individual services to best meet those needs.

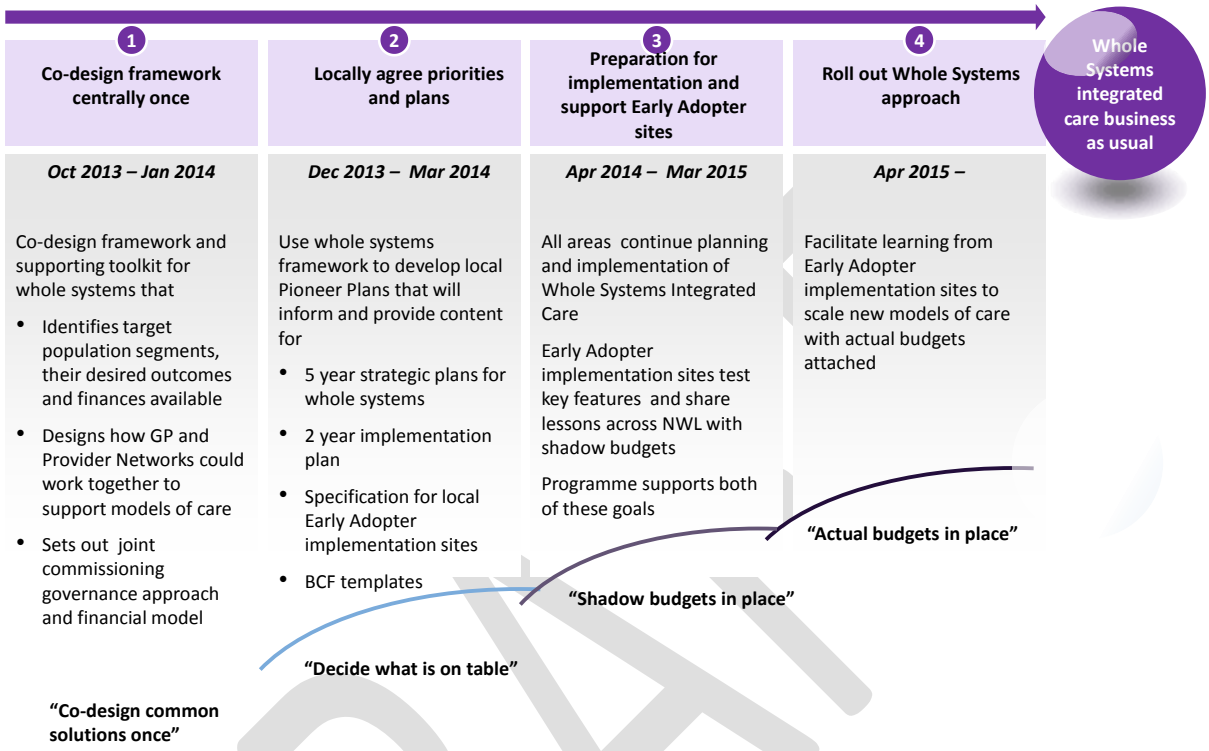
There are three factors which will need consideration when choosing a group: (1) potential financial opportunity; (2) potential impact on individual outcomes; and (3) implementation readiness.

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

Note that while the population group of children has not been included within the Whole Systems Integrated Care programme in its first stage, many of the principles of integration also apply to these chorts of patients – please see the Children's section within the

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

Whole Systems implementation timeline




The next step is to work with a number of Early Adopter sites, who will move further and faster and share learning across NWL**.** Across NWL, groups of commissioners and providers have expressed interest in becoming 'Early Adopters' of Whole Systems Integrated Care through defining a segment of their population for whom they wish to commission and provide health and social care in a new and integrated way.

Early Adopters must plan to implement the following criteria for Whole Systems:

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Criteria for Whole Systems and "Early Adopters"

**Criteria for Whole Systems and "Early Adopters"**

| | |
|---|---|
| Embedding Partnerships | ✓ Use co-production to develop plans<br>✓ Commitment to move to personalisation, self care and use of community capital |
| Commissioning governance & finance | ✓ Pool health and social care budgets<br>✓ Operate shadow capitated budgets<br>✓ Generate significant savings to system<br>✓ Agree binding performance management |
| Population and Outcomes | ✓ Organise care models around people with similar needs<br>✓ Identify outcomes to be delivered |
| Provider networks | ✓ Establish governance for networks, bringing together different types of providers around a GP registered population<br>✓ Reallocate money across a care pathway to fund innovative models of care regardless of setting<br>✓ Agree binding performance management |
| Information | ✓ Ensure the flow of information to support care delivery, performance management and payment<br>✓ Information governance to support this across all providers |




Selected Whole Systems Early Adopter site's plans will be developed, building on the toolkit, and will address in more detail the criteria set in the co-design phase which include:

- Co-production with lay partners to develop Early Adopter Plans
- Commitment to personalisation, self-care and use of community capital
- The pooling and capitation of health and social care budgets
- The organisation of care models around people with similar needs and the identification of outcomes for those groups
- The development of provider organisations around groups of registered GP populations and governance, resource allocation and performance management processes to support this
- Ensuring the flow of information to support care delivery, performance management and payment and the appropriate governance arrangements to support this

The Whole Systems Early Adopter Plans will be developed until October 2014, with an interim checkpoint in June to assure levels of ambition against the above criteria.

Whole Systems will be rolling out to become part of business as usual across NWL from April 2015, as per the high-level implementation timeline.

All eight boroughs across NWL are strongly committed to driving real change for the benefit of people using services. Each of the eight localities will retain their own approach to delivering services specific to the needs of their local population, taking strategic direction from their Health and Wellbeing Board. However, working together across eight boroughs will enable us to pool our collective time and expertise to tackle the common barriers to integrated care. It will also ensure

that where there are opportunities for closer, joint working this will happen, across borough and other boundaries, where this is in the best interests of the local population.

Localities can adopt and adapt the co-production touchstone, which was designed to serve as a set of behaviours against which actual group behaviour will be monitored, and will be a key tool underpinning the ways of working agreed by WSIC Early Adopters.

### Patient self-management and self-care

One of the three key strands of Whole Systems is self-care, i.e. that people will be empowered to direct their care and support and to receive the care they need in their homes or local community.

We have significant local evidence through our patient journey feedback that patients want to be in control of their condition and treatments and this project will support them to do so. As part of the Early Adopter and wider roll-out of Whole Systems, each NWL CCG will ensure that patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services they commission. This will be achieved through:

- Existing Expert Patient Programmes and patient user groups.
- The roll-out of Personal Health Budgets from April 2014 (building on learning from existing users to ensure they are deployed as effectively as possible).
- Online access to self-management advice, support and service signposting (also part of Primary Care Transformation – see chapter 6).
- The roll-out of care plans, developed with patients as part of Whole Systems Integrated Care.
- Self-management initiatives to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in and out of a hospital setting, including peer mentoring and local champions.

It is important that WSIC aligns with the proposals set out in the jointly agreed BCF plans with regards to self-management, patient experience and personal health budgets.

### Transforming end of life services in London

NWL will develop and implement effective end of life care integrated care models of commissioning and delivery which translate into a better end of life care experience for individuals, carers and their families.

As part of NWL's roll-out of NHS 111 services, NWL supported an electronic end of life care planning platform Coordinate My Care (CMC). CMC as a single electronic end of life care planning platform accessible to 111, GP Out of Hours (OOH) and London Ambulance Services (LAS) can enable a joined up approach to care at the end of life, particularly in crisis and out-of-hour periods.

Priorities for transforming end of life services in NWL include:

- To **maximise uptake of CMC** across all NWL CCGs, and to ensure it is used as part of an integrated care pathway.
- To **commission coordinated care**, centred on patients and planned between services who work together to understand patients and their carers.
- To **improve interfaces/joint working** between services including primary care, secondary care, social care, LAS and NHS 111.
- To support the **End of Life Care Alliance** sharing good practice and dialogue across London. The End of Life Care Pan-London Alliance was launched in 2013 to promote patient-centred, coordinated care commissioning and delivery across

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London. The End of Life Care Pan-London Alliance is an inclusive membership group and is supported by an Executive Steering Group who will provide oversight and prioritise activities. The founding members are ADASS (London) Directors of Adult Social Services, Marie Curie and NHS England (London).

- To identify **issues and barriers to local success** such as workforce and training which require national and regional input, and agree approaches and activities to address.

### Transforming Community Services

The Community Health Services programme in London aims to support London's leadership in re-commissioning or redesigning community health services, maximising their contribution to delivery of integrated health and social care services where care is based on continuous healing relationships, personalised, proactive and patient driven, and where services provide high quality and safe care in the home, across all seven days of the week.

Priorities for the community health services programme in London include working with key commissioning and provider stakeholders to define **community health service principles and system design objectives** that contribute to personalised, proactive and patient driven care, and include:

1. Service responsiveness and access for both 'steady state' and 'crisis response'.
2. The extent to which people with complex needs can be appropriately cared for through the provision of intensive support in community.
3. Interfaces/joint working with other services including primary care, secondary care, social care, London Ambulance Service (LAS) and NHS 111.
4. Organisational and workforce development.
5. New contracting models, performance and quality monitoring.

The work of the Community Health Services programme in London will be taken forward in NWL as part of the Whole Systems Integrated Care programme and through the Better Care Funds. It is important that the Transforming Community Services guidance is applied to the integrated operational services being developed within the BCF.

In the Tri-borough CCGs (Central London, West London, and Hammersmith & Fulham), joint homecare provision with social care is believed to be one of the key enabler to wider health and social care integration and to supporting the vision for Whole Systems Integrated Care. The anticipated benefits of joint homecare provision include greater alignment of health and social care provision at home, closer working between professionals and greater continuity of care for residents.

A joint homecare procurement exercise is now underway, led by the Tri-borough CCGs and Tri-borough Local Authority, to establish joint/hybrid homecare provision.

Homecare providers will be required to perform both standard Adult Social Care tasks and low-level health tasks (bands 1-4) that may previously have been conducted by Community Nurses. This approach is intended to align homecare provision to the Multidisciplinary Function (MDT) function and to release case management time for Registered Nurses. The health tasks identified will not require nursing qualifications, and homecare providers will be supported by clinical staff in their local MDT, aligned to the intentions of Whole Systems Integrated Care led by GP's.

### London Neuroscience SCN

Priorities for the London Neuroscience SCN over the next five years include:

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- Increasing the **priority of service developments and pathways** for patients with neurological conditions.
- Including patients with **long term neurological conditions** who are at high risk of unplanned care in local integrated care developments.
- Developing **local pathways** with local providers.
- Commissioning appropriate capacity for **community rehabilitation.**

NWL CCGs have asked the NWL Academic Health Science Network (ASHN) to undertake a comprehensive review of neurorehabilitation services across the system, in line with the priorities of the London Neuroscience Strategic Clinical Network (see chapter 7 (Neuroscience) for further details).

### North West London's Better Care Fund plans

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

The vision, principles and co-design work undertaken to date across NWL as part of this programme have been fundamental to the development of the Better Care Fund plans in each Borough.

In addition, as external factors such as poverty and a lack of affordable housing may prevent delivery of our Plan, it is important the local Better Care Fund plans are aligned with both the wider transformation programmes, including *Shaping a healthier future* and Out of Hospital strategies, as well as with wider local authority priorities including the regeneration of key areas to improve housing, health and wellbeing.

The BCF plans set out how each borough/CCG will progress the vision and principles for Whole Systems developed through the WSIC programme, including:

***People will be empowered to direct their care and support, and to receive the care they need in their homes or local community***

- Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.
- Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, and self-management to maximise their independence and wellbeing.
- The clinically-led *Shaping a healthier future* programme, describes what success in this area will require of, and mean for, our hospitals, with services adapting to ensure the highest quality of care is delivered in the most appropriate setting.
- The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and community provision, will mean we will eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.
- We recognise that there is no such thing as integrated care without mental health.

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Our plans therefore are designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

- By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

***GPs will be at the centre of organising and coordinating people's care.***

- Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.
- We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

***Our systems will enable and not hinder the provision of integrated care.***

- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.
- Our CCG and Social Care commissioners will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities.
- In partnership with NHS England we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.
- In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.
- This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so live healthy and well lives.

Fundamentally, through each the CCG/Local Authority Better Care Fund plans we aspire to

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tackle fragmentation across providers and across settings in order to ensure the best outcomes and noticeable improvements to patient experience, with CCG developing its local plan to achieve this with its respective Local Authority and through its Health and Wellbeing Board. The majority of the NWL BCF initiatives are part of the Whole Systems Integrated Care will therefore support delivery of the NWL and National Voices' "I" statements[20], as well as the key ingredients for integrating care identified by NHS England (see Appendix E).

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20 http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf

# 8. Transforming mental health services

*Achieving **parity of esteem** for mental health is a national and NWL priority – the NWL vision is to provide excellent, integrated mental health services to improve mental and physical health.*

### Introduction

Approximately 160,000 people with mental health problems are in treatment across North West London, almost 90% of who are in Primary Care. *Shaping Healthy Lives* (2012) set out a vision and actions to deliver:

- Care closer to home (*Shifting Settings*) – returning out of area placements to NWL, more resilient community 'hospital at home' services to reduce reliance on beds and promote recovery, transfer of patients from secondary to enhanced GP or primary care management.
- Liaison Psychiatry Service piloted in 4 acute hospitals pending roll out to all 10, to provide expert mental health services into A&E and wards, supporting colleagues in acute hospitals to better manage the pathway and avoid preventable admissions due to mental health issues.
- Better physical/mental health service integration, to reduce the excess morbidity and mortality associated with serious mental illness, and support treatment concordance among those with a long-term physical health condition.

Building on this, the Mental Health Programme Board[21] has developed the following draft vision statement for the development of mental health services across North West London:

[21] The Mental Health Programme Board is a partnership collaboration board of the 8 CCGs, Local Authorities, Police, NHS Provider Trusts and Academic Health Science Network.

Vision statement for the development of mental health services across North West London:

> Excellent, **integrated** mental health services to improve mental and physical health, secured through **collaboration** and determination to **do the best for the population** of North West London. Services that:
>
> - Are **responsive**, focussed on the **person**, **easy to access and navigate**;
> - Provide care as **close to home** as possible, with **GPs at the heart**; where and **when it is needed**.
> - Improve the lives of users and carers, promoting **recovery** and delivering **excellent health and social care outcomes**, including employment, housing and education.

Our Mental Health transformation strategy sets the framework for the significant re-patterning of mental health services across North West London.

### Shifting Settings of Care

Building on the success of initial work to shift settings of care to the least restrictive possible, efforts to secure a transformational step change will be made over the coming years.

Priorities for the community health services programme in London include working with key commissioning and provider stakeholders to define **community health service principles and system design objectives** that contribute to personalised, proactive and patient driven care and include:

**Access to Urgent Mental Health Services**

NWL is working with partners to ensure that those in mental health crisis have appropriate mental health community services on a 24/7/365 basis, to help them stay at home wherever possible, wherever they present in the system. Phase 1 of the Urgent MH Care Pathway Review set access standards, a single pathway and point of access, shared care principles and shared paperwork and IT solutions to smooth access to urgent mental health assessment and care. Core hours for community mental health are being extended to 8:00 – 20:00, which better matches GP working hours, pending a fuller transformation towards 24/7/365 and a single system-wide pathway.

Ahead of the launch of the *Mental Health Crisis Care Concordat (HM Government, February 2014),* NWL had already moved into the second phase of pathway redesign. All stages of the pathway, from referral prevention, through advice/support, referral, treatment and transfer/recovery are being mapped and the flow understood. Under the aegis of an Expert Reference Group established for this purpose by the Mental Health Programme Board, with Police, Ambulance, Housing and Third Sector alongside health, social care, users and carers, working on the pathway, its standards and support to providers for implementation.

Within the justice system, NHS England will (in alignment with CCGs) improve mental health liaison and diversion in police custody and court settings with robust referral pathways integrated into mental health, acute and community services.

**Quality and availability of urgent care services**

Building on the initial pathway focus of access and referral, a programme to ensure the quality, impact and availability of urgent mental health care services, securing balance between in-patient and community to reflect national and local policy and support greater independent living in the community by intervening earlier with intensive community support and robust crisis plans. Excellent

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services, delivering high impact outcomes, value for money with the organising principle of care in the least restrictive setting possible, promoting independent living and self-efficacy.

See chapter 10 – Urgent and Emergency Care plans.

**Residential Rehabilitation Services**

A review of out of area placements, local provision, and pathway management to secure care close to home wherever possible, and better value for money and stability through a shift to locally commissioned services.

**Improving Learning Disability Services**

A programme to ensure that mental health services are appropriately accessible and responsive to those with learning disabilities, and to develop common pathways and standards for the future commissioning and delivery of services across NWL.

**Primary Care Enhanced Services**

Work to ensure a standardised GP-based service, targeting those with the highest SMI incidence, with support from primary-care based services where this is needed to support continued recovery and prevent crisis escalation where possible. It is recognised that supported housing, pathways to employment and social inclusion services for people with mental health services are also key to the delivery of the recovery model.

**Improving Access to Psychological Therapies (IAPT)**

All CCGs and its providers are committed to delivery of national standards for access to, and recovery within, its IAPT services. NHS England will also increase access to IAPT in prisons, immigration referral centres and sexual assault referral centres.

**Liaison Psychiatry in Acute Hospitals**

Bridging the gap between physical and mental health care is essential, and in acute settings liaison psychiatry plays a vital role. Liaison psychiatry teams see A&E attenders, as well as people referred from inpatient wards and outpatient clinics. They respond to the needs of the acute hospital and must be flexible enough to manage a diverse range of mental health problems.

Following successful piloting of models across four sites (West Middlesex, Ealing, Northwick Park and Hillingdon), services were evaluated and benchmarked for quality, efficiency and impact. A common service specification, with a comprehensive 'scorecard' of key indicators will be rolled out to all 10 sites in 2014-15.

### Whole Systems Transformation

Initial co-production work underway focuses on two key groups: (1) severe and enduring mental illness (SEMI) and (2) those with a long-term condition and a mental health co-morbidity.

For the former group, an Expert Reference Group, reporting to Mental Health Programme Board, has been established, and is working on defining the target population, the benefits being sought from such a radical service delivery change and proposed models of care. Consideration is being given to new service models to assertively engage with groups, for example, those with more chaotic lifestyles, those with LTCs whose mental health may mitigate against treatment concordance, and people with dementia whose needs can only effectively and efficiently be met by a range of providers working in an integrated manner and providing a range of 'social integration' initiatives (housing, training, employment, social networks) effectively 'wrapped round' the service user and their carers. The organising principle is around the GP and primary care. This will also provide an opportunity to address 'parity of esteem' between mental and physical health, for those with severe mental health problems as well as common conditions such as depression.

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For those in Group 2, the emphasis is on ensuring the necessary expertise in mental health is integrated into care models and interventions for those target groups (as, for example, it is in Liaison Psychiatry Services in acute hospitals).

### London Dementia Strategic Clinical Network (SCN)

Priorities for the London Dementia SCN over the next five years include:

- Two-thirds of the estimated number of people with dementia in England to have a **diagnosis by March 2015**. Better identification of people with suspected dementia in primary care and acute settings and referring to robust memory services.
- Improve **access to post diagnostic support**, so that timely diagnosis includes improvement on the condition and referral to local services which are already available.
- **Use of technology**, systems such as *This is me* and embracing standards to be proposed by the network so that all services work together to ensure patients and carers are supported to manage the impact of their condition and avoid crisis.

NWL CCGs are developing Dementia strategies to address improve diagnosis rates and provide a fully integrated pathway of care for patients diagnosed with dementia.

### London Mental Health Strategic Clinical Network (SCN)

Priorities for the London Mental Health SCN over the next five years include:

- **Resilience in younger people**: the need to tackle mental ill health early has been noted and this is an area that the SCN is working in partnership with UCL Partners and Public Health England and the London Health Board.
- **Primary care: a** quarter of full time GP patients will need treatment for mental health problems in primary care, making it essential that mental health problems can be competently managed by the primary health care team, working collaboratively with other services, and with access to specialist expertise and a range of secondary care services as required. The SCN aims to develop principles, values and outcomes in mental health for primary care transformation across the commissioning landscape – including improved access to services and reduced waiting times for patients with mental health difficulties.
- **Psychosis/urgent care**: an improved response is needed when people are in urgent mental health need. This includes achieving consistency and clarity of urgent mental health care services and addressing the problems in prevention, response, treatment and support provision. The SCN is working to develop a standardised approach for urgent care in London - forming an improvement collaborative to share learning and transform services to enable easier access, improve quality and outcomes.
- **Integrating mental and physical health**: mental health is the commonest comorbidity and raises costs in all sectors. We are taking forward a piece of work to promote the integration of mental health support within physical health pathways. There will be an initial focus looking at access for mental health interventions for patients with diabetes, to act as a model for further conditions.

Other principles for mental health commissioning include:

- Ensuring there is a clear focus on **improving the physical outcomes of mental health patients** and reduce the inequalities and poor outcomes experienced by mental health patients, develop an approach that looks at the **whole care pathway or cycle of care** rather than fragmented aspects, fully

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supports the **recovery model**, supports horizontal **integrated care** across primary care, social care and voluntary sector, as well as vertical care between primary and secondary care, and **involving people** with lived experience.

- Working with UCL Partners and GP leads, the SCN supports a **mental health CCG GP network** to share and develop good practice in mental health commissioning, and a second stage of the leadership programme is under development.

*[Placeholder for content from NHS England with regards to plans for commissioning Children and Adolescent Mental Health Services (CAMHS – a range of CAMHS services are required to address to address the wide continuum of need]*

### Health in the Justice System

Services commissioned by NHS England in NWL include the healthcare services in the justice system, including:

- Prisons (including Feltham Prison, Wormwood Scrubs Prison)
- Police Custody and Courts – Mental Health Liaison and Diversion
- West London Forensic Service: Westminster Magistrates Court Diversion team; Central & NW London NHS Foundation Trust (5 sites) and Uxbridge Magistrates Court Diversion Service
- Police Custody (transfer of commissioning): including Ealing (Acton), Hounslow (Chiswick, Hounslow), Hammersmith & Fulham (Hammersmith), Kensington and Chelsea (Notting Hill), Westminster (Belgravia, Charing Cross), Hillingdon (Uxbridge)
- Sexual Assault Referral Centres - Havens: St. Mary's Hospital, Imperial College Healthcare NHS Trust
- Immigration Removal Centres: Harmondsworth, Colnbrook
- Initial Accommodation for people seeking asylum

NHS England (London) is also responsible for children and young people in secure homes and training centres.

NHS England (London)'s joint vision, working with the Mayor's Office, is ***"working together to achieve excellence in Health in Justice outcomes for Londoners"***.

Priorities for Health in the Justice System services include:

1. ***Equivalence and parity of esteem for Mental and Physical Health in NWL strategies by***:

- Co-commissioning integrated pathways including London s136 protocol and transport, secondary care, and improved access to IAPT.

2. ***Reduce re-offending by***:

- Assuring continuity of care from prisons: increase GP registration rates of prisoners (as currently only approximately 25% of prisoners are registered with a GP); develop onward referral pathways to mental health services where required.
- Earlier interventions and improved prevention: co-commission with NWL CCGs' Mental Health referral pathways to Liaison and Diversion schemes.

3. ***Strengthen leadership to improve efficiency, clinical-and cost-effectiveness from better co- commissioning*:**

- Develop a single multi-agency London performance dashboard for local use: to improve local outcomes for Borough Community Safety Partnerships and Health and Wellbeing Boards
- Co-commission improved integrated care for victims:
    - CAMHS, Paediatric and therapeutic support for raped/sexually assaulted children
    - Reduce Female Genital Mutilation (FGM): improved support and include FGM issues in safeguarding training, data collection and reporting, in line with NWL quality and safeguarding plans.

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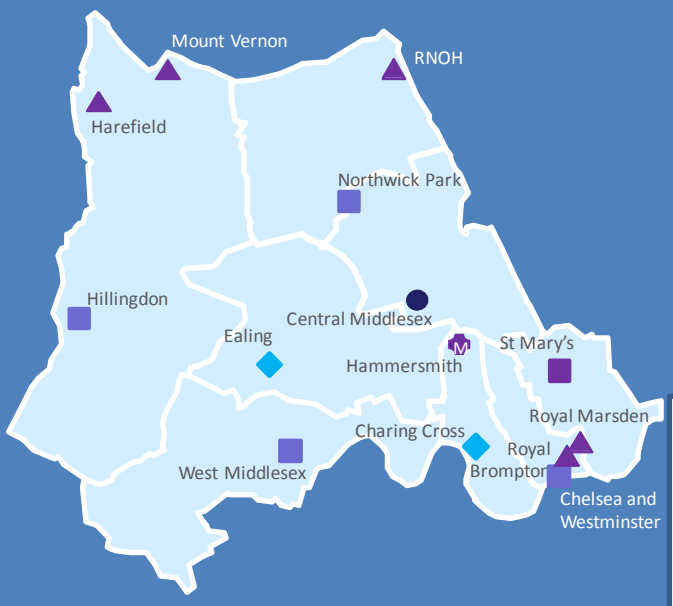
# 9. *Shaping a healthier future* (SaHF) acute reconfiguration

*Our new Local Hospitals will help ensure that where possible, care can be provided closer to home.*

*By consolidating our hospital services onto five Major Hospital sites we are ensuring that services are centralised where necessary to provide the best care.*




## Introduction

*Shaping a healthier future* (SaHF) is a clinically led, significant transformation programme to improve clinical outcomes and the quality of services by reshaping acute and out-of hospital health and care services across the region. It is driven by a number of NWL principles. A foundation principle that underpins the reconfiguration programme is the centralisation of most specialist services (such as A&E, Maternity, Paediatrics, Emergency and Non-elective care), as this will lead to better clinical outcomes and safer services for patients.

The SaHF acute reconfiguration proposals have been subject to consultation and more recently, in mid-2013, review by the Independent Reconfiguration Panel (IRP). The IRP report, accepted by the Secretary of State, concluded that the "programme provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services."

The proposed changes will result in a new hospital landscape for NWL – the SaHF programme will oversee:

- The emergency services currently provided by nine existing hospitals in NWL will be concentrated on to **five Major Acute Hospital** sites.
- On the remaining sites there will be **further investment with Local hospitals**, co-developed with patients and stakeholders to deliver a new and innovative model of care, at Ealing and Charing Cross;
- Hammersmith will continue as a **specialist hospital** with a **24/7 UCC;** and
- Central Middlesex Hospital will host a **24/7 Urgent Care Centre, an elective centre and other community services.**

- Specialist hospital
- Local and Specialist hospital with obstetric -led maternity unit and UCC
- Local and Elective hospital with UCC
- Local and Major hospital with A&E and UCC
- Local and Major hospital and specialist eye hospital and Hyper Acute Stroke Unit with A&E and UCC
- Local hospital with A&E

The SaHF reconfiguration of NWL acute hospitals was defined in the Decision Making Business Case (DMBC), subject to consultation and finally agreed by the Joint Committee of PCTs in February 2013. The DMBC directly aligns to service model #6, specialist services concentrated in centres of excellence.

The SaHF acute reconfiguration also directly supports service model #5, a step change in the productivity of elective care, through the development of new Elective Hospital at Central Middlesex that, among other benefits, will deliver increased productivity as there will be no cancellations due to emergency activity.

Following the development of the DMBC trusts have been working with the SaHF programme to develop the more detailed Outline Business Cases (OBCs). It is the results of this work that are described in this chapter. To reflect the changes to the individual hospital solutions identified during the OBC stage, the SaHF programme is developing an Implementation Business Case (ImBC) to maintain that collectively the refined solution for North West London remains aligned with the clinical vision and remains affordable.

The anticipated benefits associated with each of the hospital solutions as proposed in the Trust OBCs are summarised below:

**Major hospitals**

- Saving at least 130 lives per year by having more specialist consultants on duty at all major hospitals at the weekend.
- Centres of excellence in emergency care which copy the way stroke and trauma has been centralised across London – something which was controversial at the time and now acclaimed by clinicians and politicians alike proving to save hundreds of lives every year.
- Meeting 4-hour A&E waiting time targets consistently, at all major hospitals across NWL, throughout the year.
- Dedicated senior medical cover present in critical care units 24/7, so that seriously ill patients always receive expert care.
- More obstetric consultants on duty 24/7 in labour wards (168 hours per week), reducing the number of serious complications during birth, and one to one midwifery care for women during established labour.
- More trained and experienced doctors on site 24/7 in A&E departments with a consultant presence 16 hours per day, seven days per week.
- More trained and experienced emergency doctors on site 24/7 in A&E departments ensuring patients are seen by senior specialist staff early in their treatment.
- Investment in mental health so psychiatric liaison services can better co-ordinate 24/7 care for vulnerable, mentally ill people.

**Local Hospitals**

- All nine key hospitals across NWL will have an Urgent Care Centre open 24/7 to see 70% of existing A&E activity, with a guaranteed waiting time of no more than hours.
- New custom-built, locally-tailored hospitals at Ealing and Charing Cross, delivering an innovative new model of care to deliver the specific services most needed in those local communities, ensuring we are responding to changing health care needs.

**Elective Hospitals**

- Safe, clean and modern facilities for planned operations like hip replacements and pre-planned procedures.
- Zero cancellations of planned operations due to facilities no longer having to be shared with potential emergency cases.
- Zero infection levels due to better, more modern buildings and no risk of cross-contamination from emergency cases.

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**Chelsea and Westminster Hospital will redevelop adjacent land to create the maternity and non-elective capacity required under SaHF to meet increased demand**




**Chelsea & Westminster's solution delivers a number of benefits:**

- Establishes Chelsea & Westminster as a Major Hospital for North West London.
- Improves and expands maternity services.
- Expands the emergency department to handle demand more effectively.
- Adds theatres and imaging to handle the additional activity that will transition to the hospital.
- Enables achievement of SaHF clinical standards.

**Chelsea & Westminster Hospital continue to offer its full range of existing services to patients. Improvements include:**

- **ED**: provision of additional space to double existing capacity to 120,000 attendances p.a.
- **Wards**: Additional 68 acute beds on site, 60 intermediate beds off-site.
- **Theatres**: 2 additional theatres (1 elective, 1 non-elective).
- **Imaging**: Additional CT scanner, ultrasound facility & and mobile image intensifier.
- **Maternity**: MLU to increase capacity by 1,000 births and 2 HDU beds.
- **Neonatal**: 4 additional NICU cots.

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**Northwick Park Hospital will develop the required additional capacity through internal re-configuration and some new build**



**Northwick Park's solution delivers a number of benefits:**

- Establishes Northwick Park as a Major Hospital for North West London.
- Expands and improves efficiency of maternity services.
- Creates additional critical care capacity.
- Adds capacity to already stretched support services to meet increased demand.
- Enables achievement of SaHF clinical standards.
- Increased capacity to enable transfer of acute services from Central Middlesex Hospital.

**Northwick Park Hospital will continue to offer its full range of existing services to patients. Improvements include:**

- *Ward stock*: Additional 117 beds of accommodation.
- *Critical care*: 28 bedded high acuity unit; 24 bedded theatre recovery unit.
- *Maternity*: Increase in triage facilities to increase bed utilisation; Additional delivery suite and ultrasound room; Reconfiguration of post-natal, NNU and paediatric beds.
- *Support services*: Reconfigured mortuary, MRI and pharmacy.
- *Backlog maintenance*: Replacement of boilers and HV ring main.

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## Hammersmith Hospital will concentrate on its primary role as a specialist hospital



**Hammersmith's solution delivers a number of benefits:**

- Hammersmith will concentrate on its primary role as a specialist hospital providing a variety of services for North West London and nationally.
- Transitions the current Emergency Unit activity to alternative sites that provide a 24/7 service.
- Maintains specialist expertise on the Hammersmith site.
- A 24 hour Urgent Care Centre.

**Services/improvements that Hammersmith Hospital will offer post reconfiguration:**

- Hammersmith will become one of North West London's specialist hospitals.
- It will not have an A&E but will offer highly specialised care in areas such as cardiothoracics and cancer.
- Obstetrics and midwifery will be retained at Queen Charlotte's and Chelsea Hospital.

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**Hillingdon Hospital will establish a co-located Midwifery Led Unit and undertake a theatre and recovery space reconfiguration programme to generate additional capacity**



**Hillingdon Hospital's solution delivers a number of benefits:**

- Creates capacity for 6,000 births in a mixture of midwife-led and consultant-led specialist care.
- Delivers maternity clinical services in accordance with agreed quality standards
- Implements changes to increase non-elective capacity to meet SaHF requirements.
- Addresses over £17m of backlog maintenance.

**Services/improvements that Hillingdon Hospital will offer post reconfiguration:**

Hillingdon Hospital has already established an expansion of its A&E with a co-located Acute Medical Unit and it will continue to offer its full range of existing services to patients. Improvements include:

- Additional Midwifery Led Unit to work alongside consultant-led service.
- Additional recovery space to achieve greater theatre throughput.
- Re-allocation of Hillingdon and Mt Vernon theatres and refurbishment of one Hillingdon theatre.
- Additional A&E majors cubicles.

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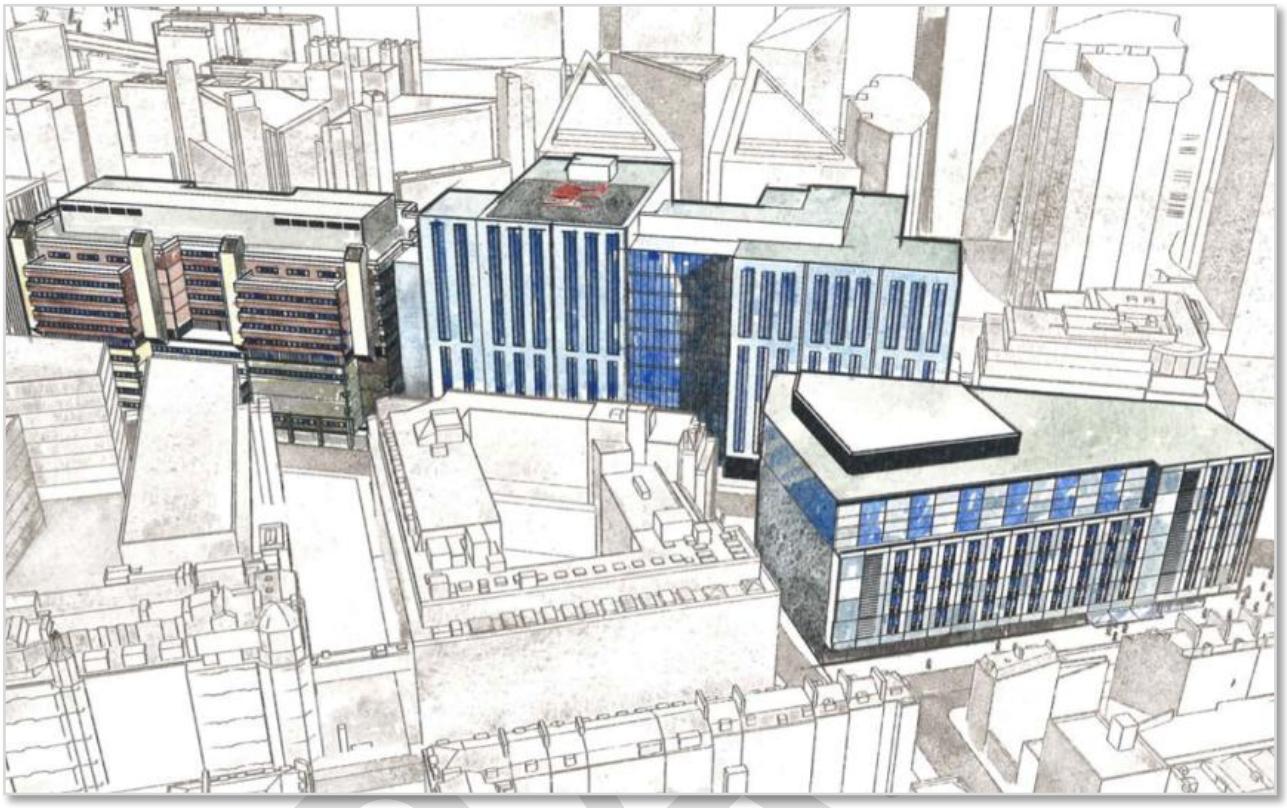
**St. Mary's will become Imperial's 'hot' site with HASU/Major Trauma Centre and a focus on emergency care**



**The St. Mary's solution delivers a number of benefits:**

- Alignment with the Clinical Model.
- Co-locates the primary care & community Hub with the UCC and A&E.
- Consolidates major trauma services.
- Addresses significant maintenance issues.

**Services/improvements that St. Mary's will offer post reconfiguration:**

Services will include:

- A&E
- Urgent Care Centre & primary care hub
- Primary care front-end
- Trauma care
- Emergency surgery and intensive care
- Obstetrics & midwifery unit
- Inpatient paediatrics

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**West Middlesex University Hospital will deliver 21st century maternity care through a new maternity unit and expand its non-elective capacity to meet increased demand**




**WMUH solution delivers a number of benefits:**

- Provides the additional capacity required to absorb displaced activity.
- Enables modern maternity healthcare standards to be met.
- Maintains Emergency Department standards with increased activity.
- Co-locates maternity unit with main building improving quality of care and patient experience.
- Increases efficiency of delivering maternity and related services (such as paediatrics), which share staff.

**Services/improvements that WMUH will offer post reconfiguration:**

WMUH will continue to offer its full range of existing services to patients. Improvements include:

- New maternity building to replace the aging Queen Mary maternity building.
- Reconfiguration of the ED footprint.
- Additional adult inpatient and paediatric beds.

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**Central Middlesex Hospital will provide a suite of services to meet the needs of Brent residents and utilise the facility**




**The Central Middlesex Hospital solution delivers a number of benefits:**

- Provides the best range of health services for residents whilst maximising site use.
- Improved quality.
- Increased primary care and community services.
- Improved direct access to diagnostics.
- More out-patients clinics.
- Improved mother and baby unit.
- Dedicated planned/elective care with proven model of care.
- Moving lab services allows Northwick Park to expand major hospital services.

**Services/improvements that Central Middlesex Hospital will offer post reconfiguration:**

- *Hub Plus for Brent* – major hub for primary care and community services including additional out-patient clinics and relocation of community rehabilitation beds from Willesden.
- *Elective Orthopaedic Centre* – a provider joint venture (Ealing Hospital Trust, North West London Hospital Trust, and Imperial College Healthcare Trust) delivering modern elective orthopaedic services.
- *Brent's Mental Health Services* re-located from Park Royal Centre for Mental Health.
- *Regional genetics service* relocated from Northwick Park Hospital.

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**Ealing Hospital will transform delivery of health care for residents and will be a platform for community led services**



**The Ealing Hospital solution delivers a number of benefits:**

- Reduced morbidity rates
- Reduced admission and readmission rates
- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved care planning that is centred around the patient and carers needs
- Improved clinical outcomes
- Centre of excellence for diabetes and re-ablement
- Improved patient and carer satisfaction
- Improved integration between health, community and mental health services
- Improved health and wellbeing across the Borough

**Services/improvements that Ealing Hospital will offer post reconfiguration:**

- Primary care led services
- 24/7 Urgent Care Centre
- Care assessment, coordination and delivery:
  - Outpatients/ access to specialist opinion and services
  - Diagnostics & Therapies
  - Social care
- Transitional and rehabilitative care:
  - Assessment / observation beds
  - Active post-surgical rehab beds
  - Transfer beds
  - Palliative care beds

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**Charing Cross will transform health and care services in the borough as Imperial's new local hospital and centre for non-complex elective surgery**



**The Charing Cross solution delivers a number of benefits:**

- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved access to multiple diagnostics and care professionals in a 'one stop' service model
- Improved care planning that is centred around the patient and carers needs
- Centre of excellence for re-ablement
- Improved patient & carer satisfaction
- Improved integration between health, community and mental health services
- Improved health and wellbeing across the Borough through greater

**Services/improvements that Charing Cross will offer post reconfiguration:**

- Primary care led services
- 24/7 Urgent Care Centre
- Outpatient and diagnostics
- Ambulatory surgery and medicine services (including cancer)
- Access to additional step-up/step down community beds
- Day case/23 hour elective centre for non-complex surgery[22]

[22] Proposals place other post-reconfiguration elective surgery across Imperial's other sites with some orthopaedic elective surgery being undertaken at Central Middlesex Hospital.

## Provider transactions

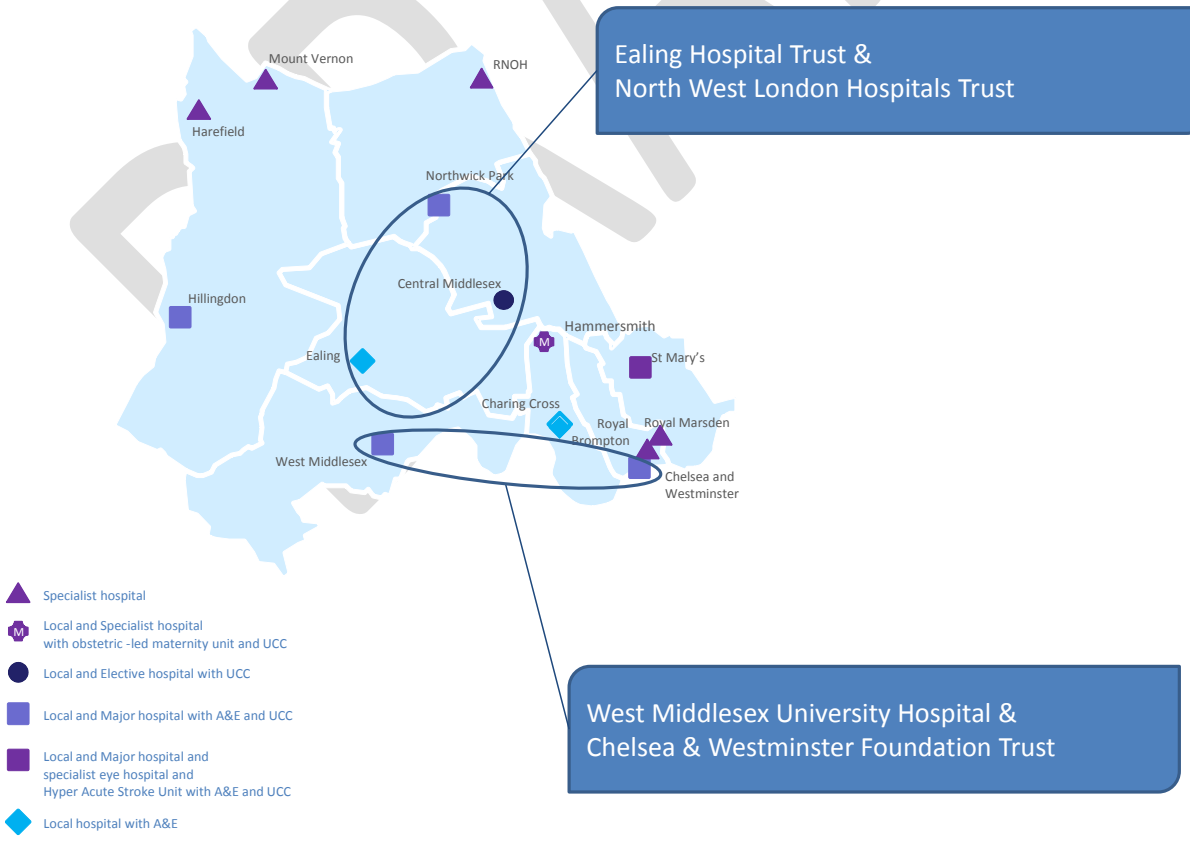
Alongside the pan-NWL acute services reconfiguration, two significant provider transactions are proposed to further strengthen the financial viability of the NWL provider landscape: a merger between North West London Hospitals Trust and Ealing Hospital Trust, and a merger between Chelsea and Westminster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

### North West London Hospitals Trust & Ealing Hospital Trust

The merged NWLHT/Ealing Trust will be a large scale Integrated Care Organisation with acute and community services co-terminus with its three local authorities. This places it in a unique position to respond to the drive for more streamlined patient pathways with a greater emphasis on local service provision at home and in the community, as well as access to the highest quality acute and specialist in-patient services.

### Chelsea & Westminster Foundation Trust and West Middlesex Hospital Trust

To secure its future financial sustainability West Middlesex Hospital Trust are exploring the opportunities to merge with Chelsea & Westminster Foundation Trust. This would create opportunities for organisational restructuring of services to provide economies of scale and improved quality of care.

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### Planned Care Pathways

In addition to the major shared Primary Care Transformation initiative, each NWL CCG is redesigning its local planned care pathways as part of Out of Hospital Strategies. There will be a significant change in that outpatient services are delivered, so that:

- **Services are patient focused**, recognising the cost to the patient of the time and emotion involved in engaging with health services.
- **Clinical decisions are made as quickly** as possible while minimising the time that the patient has to spend in contact with NHS services and the number of times they need to attend a hospital.
- **GPs are able access specialist advice** to enable them to avoid referrals for a second opinion.
- **Hospitals utilise alternatives to outpatient clinics, including technological solutions**, and run one stop shops where patients can have diagnostics and a decision at the same time.
- **Patients are able to book appointments easily** and have a clear point of contact when they have questions.
- **Clinicians in outpatients have full access to the GP patient record** and enter data into it, providing real time updates for the GP.

Improving the planned care pathway – transforming the way in which outpatient services are provided to patients to reduce the number of trips and amount of time that patients spend in contact with secondary care – will lead to step-change in the productivity of elective care and a reduction in the use of acute Outpatient services.

In addition, the strategy to concentrate key elective services onto fewer elective centres of excellence will provide evidence based opportunities for productivity improvements. There are three organisational proposals: the development of a new elective and regional orthopaedic hospital at Central Middlesex; the development of an elective centre for Imperial at the Charing Cross site and Chelsea and Westminster's plans to concentrate certain elective activity at West Middlesex (should the acquisition be successful). The benefits from this concentration of elective work are well recognised; with no unplanned care to cut across planned work there should be fewer cancellations, lower infection rates, enhanced productivity through standardisation, and the concentration of services that supports learning and development, all of which contribute to less waste, reduced length of stay and greater utilisation of facilities.

### NHS England's Specialised Commissioning strategy

Specialised services are those services which are provided from relatively few specialist centres. Conditions treated range from long-term conditions, such as renal (kidney services), mental health care in secure settings and neonatal services, to rarer conditions such as uncommon cancers, burn care, medical genetics, specialised services for children and cardiac surgery.

They are commissioned nationally through 10 of NHS England's 27 area teams, including NHS England (London), and account for approximately 10% of the overall NHS budget.

While NHS England is the direct commissioner for the majority of the services, the delivery of specialised services involves the whole health system, as CCGs and local authorities are also responsible for commissioning parts of the pathway, and delivering, elements of care. Many of the conditions treated in specialised services are highly debilitating, life-long and demand the advice of experts, as well as responsive access to care locally when needed.

The strategic objectives for specialised services in NWL include:

- **Quality** - specialised services will be consistently in the top decile for

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outcomes across all providers, including through:

  - Consistent achievement of service specifications
  - Benchmarked outcomes
- **Patient experience** – continuous improvement of patient experience, including through:
  - Engaging patients in service and pathway development
- **Integration** – maintain the integrity of care pathways for patient with specialised services, including through:
  - Co-commissioning with NWL CCGs and Local Authorities
  - Development and implementation of best practice pathways for individual services
- **Value for money** – contain the cost of specialised services, including through:
  - Understanding the cost of services commissioned
  - Convergence of prices
  - Alignment of incentives
  - Contract management

In order to achieve this overall set of objectives, the strategy for specialised commissioning is to provide services from fewer sites, supporting improved quality, patient experience, and value for money, while maintaining integrity of care pathways.

NHS England will work closely with the CCGs of North West London to ensure that any changes to specialised services in NWL are aligned with the *Shaping a healthier future* acute reconfiguration.

*[Placeholder for additional planning detail from NHS England - NHS England and NWL would like to work together with regards to specialised cancer, cardiovascular and children's services, considering their inter-relationships with the plans under Shaping healthier future. NHS England and NWL would also like to further explore how we might better collaboratively commission specialised services].*

<u>National specialised service reviews</u>

There are three specific national reviews which may impact upon specialised services in NWL over the next five years:

- **Children's Congenital and Adult Cardiac services:** this review will be carried out in 2014, and will focus on the number of surgeons and the number of procedures each surgeon undertakes, together with the co-dependencies required on site, e.g. Paediatric Intensive Care Unit (PICU).The review could result in a consolidation of services, with fewer providers nationally and within London.
- **Burn Centre services:** all Burn Centres (treating critically ill children with Burns injuries) must have on-site access to a PICU. NHS England therefore intends to carry out an urgent review of current services prior to the development of long term proposals to address this issue, with a view to moving the small number of children with severe burns who don't currently have access to PICU, to services that provide this facility.
- **Paediatric Oncology Shared Care Units (POSCUs):** NHS England will lead a review of Paediatric Oncology Shared Care Units (POSCUs) in order to develop a new model of care, consolidating existing services to create larger facilities that will enable more shared care to be provided outside of the Principle Treatment Centres. The Principle Treatment Centres (PTCs) are currently based on Great Ormond Street Hospital and the Royal Marsden (the latter of which is in NWL). PTCs are staffed by doctors and nurses with specialist qualifications and training in cancer whereas POSCUs are staff by those with a special interest in cancer. The PTC can deliver a comprehensive service while depending upon the level of care (1-3)

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they are designated for deliver some aspects of the service.

This review is intended to be complete by September 2014, with the new model of care becoming operational from April 2015/16.

Cancer services

NWL will develop and implement the following aspects of the London Cancer Commissioning strategy, working collaboratively with NHS England specialised services commissioners:

- chemotherapy commissioning strategy
- radiotherapy commissioning strategy

### Clinical standards, including London Quality Standards and Seven Day services

As part of the original development of NWL's vision, NWL clinicians developed a set of clinical standards covering three service areas:

- Maternity
- Paediatrics
- Urgent and Emergency Care (with a focus on Emergency Departments and Urgent Care Centres)

The purpose of these standards is to drive improvements in clinical quality and to reduce variation across NWL's acute trusts. The London Quality Standards were subsequently published in 2013, many of which are consistent with the SaHF clinical standards – these were also adopted by NWL. Together the SaHF standards, London Quality Standards and now the national Seven Day standards, will underpin quality within the future configuration of acute services, including along the urgent and emergency care pathway.

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

In November 2013, NWL was selected as one of 13 areas in England to lead the way in delivering seven-day NHS services for patients. Being an Early Adopter of Seven Day Services is important to NWL as it creates the opportunity to accelerate existing commitments to seven day working (through SaHF) and to implement improvements at scale and pace.

Achieving the national clinical standards for seven day services will improve patient care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway. The Seven Day Services programme in NWL is working across the whole health and care system to achieve our shared vision for seven day working:

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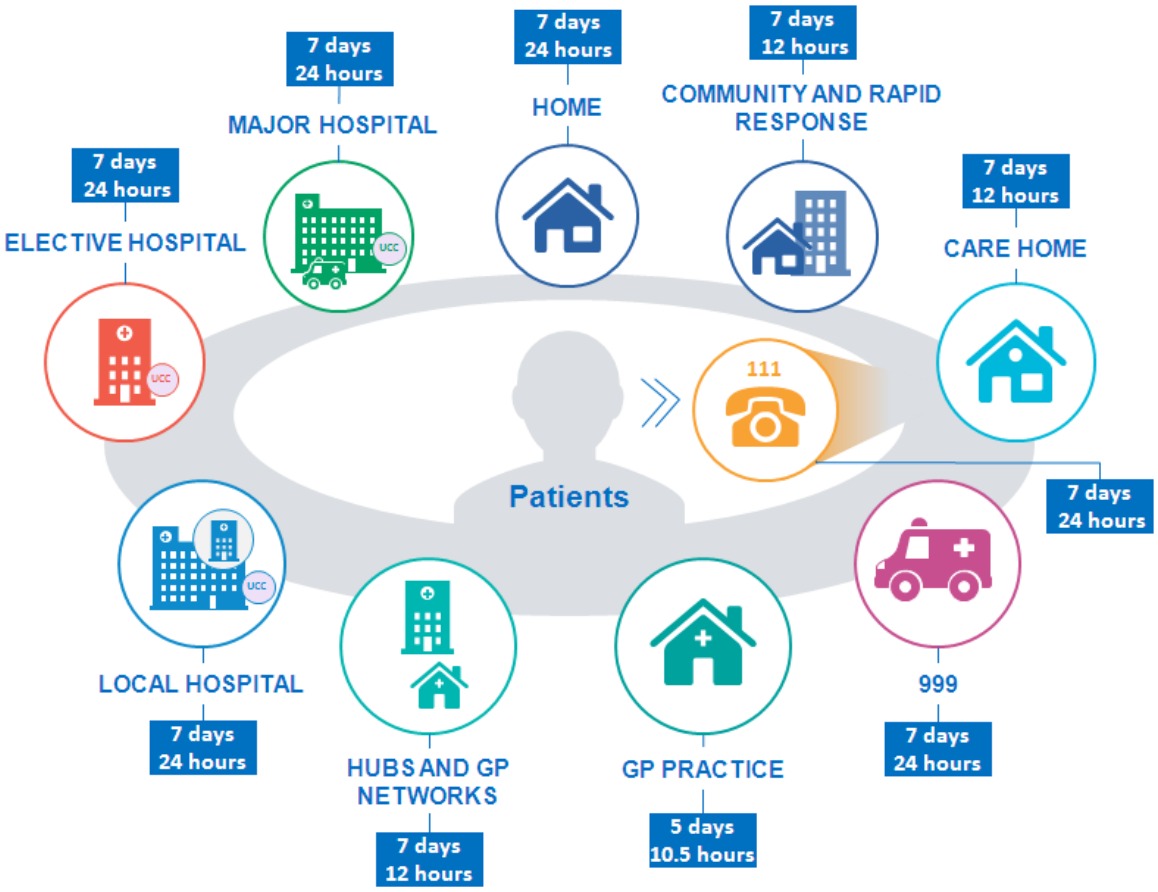
NWL vision for seven day services




The Seven Day Services programme has two key roles:

- To align, coordinate and support North West London providers, commissioners and other stakeholders to improve the quality, safety, and efficiency of services by collectively achieving agreed standards for seven day services.
- To provide a programme of support for acute providers and other partners to work at pace and scale to implement seven day services and meet the clinical standards, and to learn from and share with NHS colleagues as part of the NHS IQ Seven Day Service Improvement programme.

Acute providers and their partners from across the whole system will be working as part of the NWL Seven Day services programme to develop action plans to achieve all ten of the Seven Day Service Clinical Standards by 2016/17. Better Care Funds include plans for 7 day working in social care by April 2015, and the development of these plans will be done in collaboration with acute and other partners across the emergency care pathway.

### London Children's Strategic Children's Network

Priorities for the London Children's SCN over the next five years include:

- The network is currently developing a proposal to establish **three children's networks** based on the three Local Area Teams/Academic Health Science Networks (AHSN) and Local Education and Training Board (LETB) footprints. Note

that this suggests that a children's network will be established in NWL.

- **Children's healthcare standards**: numerous standards currently exist for children's healthcare, but are located in different organisations such as the Royal College of Paediatrics and Child Health and the National Institute of Health and Care Excellence. The network is gathering these standards together into one cohesive document to enable commissioners to **see all the standards in one place** and to commission against them.

The SaHF clinical standards and London Quality Standards, which include a set of Paediatric standards that the NWL acute trusts are working to implement, will be reviewed once this review of the full set of children's healthcare standards has been gathered together.

### London Maternity Strategic Clinical Network

Priorities for the London Maternity SCN over the next five years include:

- The network is working with CCGs to implement **funded maternity networks** across five areas of London.
- The network will be providing tools and support to enable **reduction in maternal mortality**, a **reduction in still birth rate** and to **improve women's experience of care**. A pan-London commissioning group will be established to enable delivery of these improvements across CCGs.

The SaHF clinical standards and London Quality Standards, which include a set of Maternity standards that the NWL acute trusts are working to implement, will be reviewed by the Maternity Clinical Implementation Group (CIG) once the pan-London commissioning group has published its recommendations with regards to reducing maternal mortality, reducing the still birth rate, and improving women's experience of care.

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# 10. Cross-cutting plans: Urgent & Emergency Care, and Cancer Services

*While the key transformation programmes are being implemented on a pan-NWL basis, urgent and emergency care plans are coordinated at a provider level, with local Urgent Care Working Groups overseeing the implementation of changes across the continuum of emergency care*

### Urgent and Emergency Care

Through the *Shaping a healthier future* (SaHF) acute reconfiguration process, North West London has undertaken an intensive review of urgent and emergency care across the health economy, based on the core principles of localisation, centralisation and integration. In addition, each local health economy has developed Urgent Care Improvement Plans in 2013 through their respective urgent care governance structure. Membership of these Working Groups is being refreshed, and the resilience plans will be continue to be reviewed and refined. Urgent Care Working Groups (UCWGs) will also be the vehicle for reaching agreement on the investment plans to be funded by the retained 70 per cent from the application of the marginal rate rule. UCWGs remain a valuable opportunity to bring together local providers and commissioners to deliver practical solutions as NHS services are reconfigured.

The NWL Urgent and Emergency Care plans cross-cut all of the key improvement interventions in NWL, including acute reconfiguration, whole systems integrated care, and primary care transformation, and are consistent with the findings of the phase 1 findings of the *Urgent and Emergency Care Review*[23].

The NWL vision is consistent with the vision set out in the Urgent Care review - i.e. that care be delivered as close to people's homes as possible, and that for those with more serious or life threatening emergency needs that they are treated in centres with the very best expertise and facilities. The NWL plans are also in line with five proposals set out in the Urgent and Emergency Review Phase One Report.

### Alignment to the vision set out in the Urgent and Emergency Care Review

[23] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

The Urgent and Emergency Care Review sets out five proposals for urgent and emergency care in the NHS. These proposals, along with how NWL's plans will deliver them, are set out in this section.

In addition, as a 24/7 pan-London healthcare provider, the London Ambulance Service (LAS) are often the first point of contact for people who want medical help, whether it is an emergency or a less serious condition. Their response may determine whether patients get the right treatment to meet their needs. Over the next five years LAS intends to improve the quality of care in a number of ways.

***Proposal #1: we must provide better support for people to self- care***:

**Self-treatment information**: see chapter 7 (Whole Systems Integrated Care) and chapter 13 (Citizen Empowerment and Patient Engagement section) for details on how NWL CCGs will provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.

**Care planning**: comprehensive and standardised care planning is one of the out-of-hospital standards, and will be achieved through the Whole Systems Integrated Care programme, including supporting initiatives in the Better Care Fund plans.

***Proposal #2: we must help people with urgent care needs to get the right advice in the right place, first time*:**

**NHS 111**: NHS 111 is now nationally available, including across NWL. NHS England will now be revising the NHS 111 specification and core vision ahead of the re-procurement of NHS 111 contracts in 2014/15. London has made twelve recommendations covering proposed changes to 111 contracts across London, including changes to the service operating model. Priorities for 111 in London include:

- A series of pilots are planned within the national Learning & Development programme to test specific elements of 111 service specification and impact across healthcare systems:
  - '111 Smart Call to Make' reviewing the impact of targeted marketing the 111 service on walk-in attendees to UCCs and Emergency Departments
  - Earlier intervention of specialist clinicians, including GPs and specialist nurses within the 111 patient journey for a defined subset of callers e.g. complex callers, children under 5 years old, older callers with Special Patient Notes as crisis records.
  - 111 Digital – building on the successes of Coordinate My Care (CMC) electronic end of life care plans, developing Special Patient Notes as crisis records and sharing across the Urgent and Emergency Care system.
  - 111 Digital – developing online access to 111 assessment and appropriate onward referrals to GPs both in and out of hour GPs.
  - Reviewing **the impact of 111 on GP out of hours (OOH) providers** including direct booking into GP OOH.
  - Reviewing **the impact of 111 on Emergency Departments and UCCs.**
  - Improving **integration and referral mechanisms to community health services.**
  - Reviewing **the impact of 111 on ambulance services.**

  Pilots will report to London and National Programme Boards to influence the final revised specification in September.

The intention is to greatly enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service.

In North West London, there have been other particular concerns, including ensuring the local Directory of Services are regularly maintained and updated, and the need to resolve current Information Governance issues preventing commissioners from

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reviewing calls which might have an impact on patient safety.

In addition, NWL CCGs are looking to review how 11 can best be integrated with local plans ahead of the re-procurement.

**Access to data and information about health and services:** NWL, working with national partners, will ensure that the population is well served by access to transparent and accessible data and advice about health and services. This will include a clear avenue for accessing up-to-date local clinical and operational service information for patients, GPs and other providers.

***Proposal #3: we must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E*:**

When individuals have urgent needs, it is important that they can access the advice or care that they need as rapidly as possible. In the new system of out of hospital care, people will be able to access services through a number of routes. These include community pharmacy, extended GP opening hours, such as weekends and evenings (within an individual practice or the practice network), greater availability of telephone advice from the practice or through 111, and GP out-of-hours services. These will be designed to ensure they address equality issues, ensuring that urgent care services meet the needs of all services users, including protected groups.

The CCG Out of Hospital strategies, including Primary Care Transformation, will improve access to primary care, including on weekends, while Rapid Response and Care at Home will reduce demand on A&E services.

Changes in primary care that will help deliver out of hospital urgent and emergency care services include:

- Patients with urgent care needs provided with a timed appointment within 4 hours.
- Access to General Practice 8am-8pm (Mon-Fri) and 6 hours/day during the weekend.
- Access to GP consultation in a time and manner convenient to the patient.
- Online access to self-management advice, support and service signposting.

The Mental Health Urgent Assessment Pathway (part of Transforming Mental Health Services programme) will improve access to local mental health teams, including on weekends.

Commissioners will continue to ensure that Out of Hospital strategies are on the correct trajectory when preparing for acute service changes.

**London Ambulance Service**: LAS recognises that for many of their patients, many can get better, more appropriate care somewhere other than at hospital. People who call LAS will not automatically receive an ambulance response, and those who do will not necessarily be taken to hospital. In their efforts to ensure patients get the right care for their needs, they may refer these patients to their local GP or pharmacist. Alternatively LAS may take or refer them to an urgent care centre or somewhere similar for treatment. If patients call LAS with a minor problem, their specially-trained clinical advisors will provide medical advice over the phone or may refer them to NHS 111 for help. LAS will work more closely with health and social care organisations in London to ensure that there are other places people can go to get medical help. It is also important that LAS staff have the right skills to be able to assess patients with less serious conditions and refer them to the right place for help.

***Proposal #4: we must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery***

As agreed through the SaHF review and consultation, which was informed by working with key partners and informed by a detailed understanding of NWL, the current existing nine acute hospital sites in NW London will

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not be able to deliver the desired level of service quality. The SaHF Clinical Board determined that delivering safe and effective A&E services on a 24/7 basis requires rapid access to emergency surgery and expertise for complex medical cases on a 24/7 basis as well as level 3 critical case (intensive care).

Therefore, through the SaHF acute reconfiguration, in NWL there will be:

- **Five Emergency Departments** (EDs) located at Major Acute hospital sites in NWL: Major Acute Hospitals will provide a full range of acute clinical services - they will have sufficient scale to support a range of clinically interdependent services and to provide high quality services for patients with urgent and/or complex needs. At their core they will be equipped and staffed to support a 24/7 A&E with 24/7 urgent surgery and medicine and a level 3 ICU.
- **Nine Urgent Care Centres** (UCCs) in NWL, operating on a 24/7 basis: the UCCs will be fully integrated with the wider integrated and coordinated out-of-hospital system to ensure appropriate follow up. They will have strong links with other related services, including GP practices and pharmacies in the community. They are also networked with local A&E departments, whether on the same hospital site or elsewhere, so that any patients who do attend an UCC with a more severe complaint can quickly receive the most appropriate specialist care at another NWL A&E. As part of SaHF, all Urgent Care Centres in NWL will operate based on a common specification and to a common set of clinical standards. The UCC specification will also ensure that future care meets the needs of all service users but particularly those protected groups and hard to reach communities affected by A&E transition.
- **London Health Programme's London Quality Standards** covering Emergency Surgery and Acute Medicine and UCCs will be adopted across NWL for Major Acute Hospitals.

The London Quality Standards are in line with the national clinical standards, and NWL will be at the forefront of commissioning and providing standards of high quality care, seven days a week. On-going implementation of the London Quality Standards for acute emergency services will be commissioned from April 2014 (see chapter 9 for further details, including about the NWL Seven Day Service programme).

**London Ambulance Service**: LAS has seen major developments in the quality of care that is provided to patients who are critically ill or injured, with patients suffering a heart attack, cardiac arrest, stroke, or life-threatening injuries now taken to specialised centres for treating these conditions, improving chances of survival.

LAS aim to build on this good work so that critically ill and injured patients get the best possible care.

***Proposal #5: we must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts**:*

Building on the success of major trauma networks, we will develop broader emergency care networks. It is essential that GP practices and out-of-hours providers, as well as all those who deliver other community and mental health services, are fully involved.

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## Transforming Cancer Services

### Introduction

Alongside the rest of London, NWL aims to achieve significant, measurable improvements in outcomes for patients, including the saving of additional lives currently lost to cancer, improved patient experience and effective use of financial resources. This will be achieved through a collaborative, clinically-led**,** patient-centred approach, maximising the effectiveness of pan-London strategic leadership.

Cancer is one of 4 top priorities for outcome improvement across London and represents one of the top three causes for premature mortality across NWL CCG's. Survival rates, which although are good in places across NWL relative to England, the UK survival rates are still some way behind international and European best[24]. It is the ambition of NWL to achieve European best survival rates equating to 355 lives saved per year.

In London, cancer services are being transformed through work with the London Cancer Alliance and London Cancer – NHS, academic health science centres, the Pan London Transforming Cancer Services Team (TCST) and voluntary sector partnerships – and a Cancer Commissioning Board.

Priorities for the cancer programme in London include localising and supporting the implementation of the Cancer Commissioning Strategy for London 2014/15 – 2019/2020[25], which was produced in partnership between NHS England (London), London's CCGs, Public Health England, the Integrated Cancer systems and charity partners, which sets out a plan to boost cancer services enhance patient experience and raise survival rates.

Key sections within the Cancer Commissioning Strategy include:

- Prevention
- Cancer screening
- Early diagnosis and awareness
- Reducing variation and service consolidation
- Chemotherapy
- Radiotherapy
- Patient experience
- Living with and beyond cancer
- End of life care

Further details about these areas of work in NWL are provided below.

### Prevention

CCGs and Local Authorities will commission well-evidenced prevention programmes to tackle factors such as smoking, unhealthy diets, alcohol and excess weight, which cause one third of all cancers diagnosed in the UK each year.

### Cancer screening

Commissioners will improve the take-up of national screening programmes through closer working with the screening hub. Screening uptake rates across London are all below the England target of 60%. The highest Borough for uptake in London is Harrow at 47%. The lowest uptake across the capital is NWL CCG's. Commissioners, GPs and the screening programmes will all need to work closely together if uptake rates are to improve. Commissioners will also support the roll-out of Bowel Scope – the new bowel cancer screening for those on or around their 55th, and join-up the pathway from screening to treatment. In addition, we will consider potential opportunities over the lifetime of the strategy for the co-commissioning of screening if appropriate.

### Earlier detection of cancer in the community

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf

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

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Implementation of an early detection and population awareness strategy, reducing the number of patients diagnosed when their cancer is at a late stage when successful treatment is less likely as the cancer is more likely to be at an advanced stage. More GPs will be trained to spot the signs of cancer early, for example, using a Macmillan decision support tool that flags up combinations of symptoms that could be caused by cancer. The one year survival for a newly diagnosed cancer patient is significantly reduced if the cancer is diagnosed through an emergency route.

The most recent data from the national cancer intelligence network (NCIN) data demonstrates there is still work to be done across NWL to reduce this cohort.

| CCG | % of new cancer diagnosis through an emergency route Jul-Dec 2012 |
|---|---|
| Ealing | 23.2% |
| West London | 19.6% |
| Hillingdon | 23.1% |
| Harrow | 17.1% |
| Central London | 24% |
| Hounslow | 21.9% |
| Hammersmith & Fulham | 25.6% |
| Brent | 22.9% |
| All England | 20.5% |

*Source: NCIN Cancer commissioning toolkit*

Recently published early detection reports by the Pan London Transforming Cancer Services Team (TCST) for NWL CCG's provide a good baseline for NWL to work with practices to develop plans as part of the NWL early detection & population awareness strategy.

For patients to benefit from the impact of having an earlier stage diagnosis of their cancer, there needs to be a focus on developing prepared patients (aware of the key signs of cancer) and prepared, alert professionals. The community of professionals that can signpost people to their GPs includes nurses, dentists and pharmacists among others.

NWL will aim to build on the Cancer Awareness Measure data of their patient populations, using this information to identify groups and geographies at higher risk. Linking with evidence based national cancer awareness campaigns, local authorities and Public Health colleagues, NWL will aim to target higher risk populations with specific interventions.

Working with NWL Local Education and Training Board, TCST and Cancer Research UK, a professional's cancer learning needs analysis tool will be evaluated. The results will help shape the educational and training needs of NWL front line clinical staff.

**Reducing variation**

There is considerable variation in the management of cancer in NWL. For example, the table below illustrates the level of variation in NWL with regards to the treatment of lung cancer (those in red are below the audit recommendations):

| NWL Trust | % of early stage non small cell lung cancer resected | Lung cancer active treatment rates |
|---|---|---|
| Hillingdon | 46.2% | 46.6% |
| Ealing | 33.3% | 55.2% |
| West Middlesex | 50% | 50% |
| Chelsea and Westminster | 60% | 61.4% |
| Royal Brompton | 75% | 86.4% |
| North West London Hospitals | 76.2% | 54.7% |
| Imperial | 61.3% | 72.9% |

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| | | |
|---|---|---|
| National | 52% | 61% |

*Source: The National Lung Cancer Audit 2013 report (2012 patient cohort)*

In order to reduce this variation, commissioners will use provider contracts to improve hospital performance, such as increasing resection rates for lung cancer, and follow best practice on the treatment of lung cancer and bowel cancer in order to reduce variation in outcomes.

NWL will seek to implement the best practice commissioning pathways and clinically agreed protocols, and for providers to demonstrate compliance with NICE Improving Outcomes (IOG) and the requirements of the National Cancer Peer Review programme. NWL will adopt Royal College recommendations on waiting and reporting times for diagnostic tests.

NWL will also ensure that the impact on cancer services is considered when any key strategic changes are planned.

Reducing inequalities

Nationally, the 2011 publication '*Improving Outcomes: A Strategy for Cancer*'[26] states that older people do not always receive the same standard of cancer care as younger people. NWL commissioners, through the integrated cancer system, will look to understand and reduce this variation across their population. NWL commissioners would expect Multi-Disciplinary Team (MDT's) to consider all aspects of an individual when planning treatment decisions (for example, overall health, co-morbidities, quality of life and not just chronological age), demonstrated through audit and the national peer review process.

Improving access to services

In addition to localising and implementing the Cancer Commissioning Strategy for London, NWL will also seek to use contracts to improve access to some cancer services; alongside the rest of London, specifically:

- **Breast Cancer***:* we will adopt the 23 hour pathway as the standard approach for surgery, unless there is clinical reason to justify exception, and ensure that access to reconstructive surgery be provided in a timely manner. This has been seen to have a positive effect on patient experience.
- **Colorectal Cancer***:* we will ensure that the rates of laparoscopic surgery are performed at levels of at least the national average, and that where teams are below average, action plans are provided to commissioners to achieve this. In addition commissioners will monitor length of stay to ensure that trusts are following enhanced recovery programmes where appropriate.
- **Cancer of the Unknown Primary and Acute Oncology Services***:* Commissioners will use contracts to ensure that all trusts with an A&E department have Acute Oncology and Cancer of the Unknown Primary Services that are in line with NICE guidance and peer review. Faster treatment for these patients with significant needs and shorter lengths of hospital stay can be demonstrated. For those who have implemented these services, commissioners would look for a reduction in length of stay for both those newly diagnosed and those with an emergency admission of cancer.

**Living with and beyond cancer**

The numbers of people living with **cancer as a long term condition** is increasing, and is expected to double by 2020. Therefore, we will improve support and care coordination for the NW Londoners living with and beyond cancer.

Commissioners will expand the roll-out of an integrated Recovery Package for all patients at the end of active treatment, which includes a full holistic assessment of their needs, a care

[26] *Improving Outcomes: A Strategy for Cancer;* Department of Health, 2011 (http://www.epaac.eu/from_heidi_wiki/UK_Annual_Report_2011.pdf)

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plan, and an education and information event to help people to manage their condition and promote healthier lifestyles, in line with the National Cancer Survivorship initiative (NCSI).

The Whole Systems Integrated Care programme care may be one approach to improving care for people living with and beyond cancer, as people living with cancer are one of the key patient cohort for the Whole Systems Integrated Care programme.

**End of life care**

Commissioners will commission a new proven system that co-ordinates care for people at the end of their life and supports them to die in their chosen place (see chapter 7, 'Transforming end of life care' section) for further details on the NWL End of Life Care plan).

**Improving the cancer patient experience**

We will significantly improve the **patient experience** of all patients living with cancer in London.

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# 11. Programme summary, including enablers, investment costs and timelines

*The ambition of the North West London strategic plan is enormous – no other health economy has managed to achieve this level of agreement on the scale of the changes. NWL now faces the equal challenge of implementation.*

### Introduction

The ambition of the North West London strategic plan, including the *Shaping a healthier future* programme, Whole Systems and each CCG's Out of Hospital strategies, is enormous. No other health economy has managed to achieve this level of agreement on the scale of the changes and to deliver this scale of change with their acute providers. A huge amount of work has been carried out to get to the point where commissioners were able to make the necessary decisions on the future of providers in NWL and for this decision to be robust so that it successfully withstood the inevitable legal challenges. Now it has done so, it faces the equal challenge of implementation. This involves creating the design of five major hospitals and nine local hospitals across the area in line with the quality and service intentions of the CCGs. At the same time, the out of hospital services and whole systems integrated care work needs to be delivered to ensure that patients receive high quality care and only go to hospital when they need to.

A number of enabling workstreams have been developed to ensure successful implementation of the transformation programmes, and the realisation of planned benefits, including improved performance against the outcome ambitions.

### Programme Enablers

A number of key enablers are required for the effective implementation of the NWL Strategic Plan, and workstreams have been developed to support each of these:

1. Informatics
2. Workforce
3. Communications
4. Engagement, co-design, travel and equalities
5. Clinical
6. Finance

In addition, there are a number of key dependencies and critical success factors:

7. 'Out of Hospital' strategies and reduction in acute demand
8. Benefits realisation

These have been considered in the sections below:

#### 1. Informatics

The financial and quality challenges facing the NHS, including NWL, require significant improvements in the way that both clinical and financial information is collected, accessed and shared. In addition, patients are expecting more from their healthcare providers in terms of the way they are engaged, often arising from comparison of technologies in other industries.

As part of our collaborative NWL approach, NWL has developed a shared informatics strategy across all organisations, to set out the principles and direction for Informatics in NWL. This strategy articulates a clear vision for informatics focussed on the outcomes required from Informatics by patients, care professionals, commissioners and other professionals:

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

- ***Better care for service users** through systems and information that empower them to access services, inform their care and choices*
- ***Better informed and supported professionals** having accurate and timely information available to make better decisions, and technology to support ways of working that deliver higher quality care more efficiently*
- ***Better outcomes** through optimising use of systems and technology; providing access to information to allow commissioners to make more effective procurement and commissioning decisions*
- ***Professional design, delivery and governance** throughout the Informatics estate."*

A set of design principles for Informatics in North West London have been agreed – see figure below. A number of recommendations arising from these principles have been agreed across three categories:

- Develop a number of projects and programmes to improve the quality and efficiency of patient care: e.g. push for a common Patient Identity.
- Invest in informatics solutions that will improve commissioning outcomes: e.g. push to complete a North West London Business Intelligence (BI) solution that meets the needs of users.
- Put in place appropriate informatics governance and leadership: e.g. formalise a collaboration-wide Informatics Lead role.

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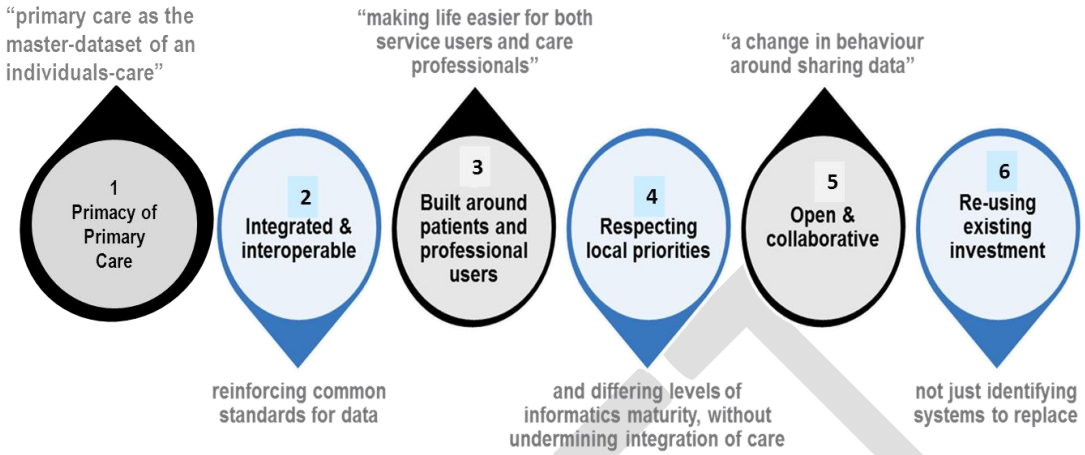
**Design principles for Informatics in North West London**




Specific Informatics plans to address national priorities over the next five years include:

- All people with a long-term condition will have a personalised care plan that is accessible, available electronically and linked to their GP health record.
- There will be greater use of telehealth and telecare to support people with long-term conditions to manage their own health and care.
- We will make best use of the *care.data* set and any other available national data sets to support our commissioning processes.
- Patients will be able to access their own health information electronically.
- Data from 100% of GP practices in NWL will be linked to hospital data over the course of 2015 - 2018, and will be encouraged earlier through improvement interventions such as integrated care.
- The NHS number will be universally adopted as the primary identifier by all of our providers.
- GP practices will promote and offer to all patients the ability to book appointments, order repeat prescriptions and access their medical notes online. GP practices will upload information about medicines, allergies and adverse reactions onto the Summary Care Record.

**2. Workforce**

Our vision for care in North West London is delivered by a flexible workforce with the right values and skills caring to patients in the setting most appropriate for patients. To support this we want to ensure that workforce planning, training and education support the existing and future workforce and drive sustainable innovation. We also want to liberate the talents and skills of all the workforce so that every patient gets the right care in the right place at the right time[27].

We have therefore established a cross-cutting Workforce Workstream managed jointly between *Shaping a healthier future* and Health Education North West London (HENWL).

All of the work done will need to be underpinned by robust workforce planning and modelling across all teams and settings of

[27] 'Liberating the Talents – Helping Primary Care Trusts and nurses to deliver the *NHS Plan'*, Department of Health, 2002 (http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076250.pdf)

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care with recruitment and retention strategies which will ensure that NWL is able to retain its existing highly skilled workforce while continuing to develop it to meet future health and care needs.

Workforce aspects of Whole System Integration

Our model of whole system integrated care will have significant implications for the whole workforce in North West London across health and social care. It will require:

- **Clinical leadership across professions** to ensure the sustainability and effectiveness of care delivery teams. This leadership needs to be visible across all organisations and professions.
- **Development of new roles and enhancement of existing roles,** with community nursing providing a greater range of care in the community and hybrid health and social care workers.
- **Multi-disciplinary care delivery teams** with staff agnostic of organisation with common aligned goals and objectives. This will facilitate a shared understanding across all professionals and organisations to ensure that everyone has the attributes required to enable integrated care and multi-professional collaboration more effective.
- **Facility and organisation independent working**, supported by flexible career paths for both clinical and non-clinical staff to ensure mutual understanding across the multi-professional team and opportunities for staff to move between settings.
- **Service users empowered** to make their own decisions and manage their own care through co-developed care plans owned by the service users.
- **Service users embedded** through co-developing and improving services with lay partners and using patient educators where possible.

A large cultural change programme is planned for the WSIC early adopters to then be rolled out to the wider workforce across NWL. Alongside this, work is underway to understand the implications of the Whole Systems changes for different cohorts of the workforce. Multi-professional education will facilitate the development of mutual understanding across the sector and coordinated working across professions.

Workforce aspects of Primary Care Transformation

GP practices working together more in networks will have a profound impact on the Primary Care team. The changes will bring huge opportunities for the staff to work differently and should identify opportunities for career and skills development. In particular these might include:

- **Practices working collaboratively with other practices** to reduce workloads and share skills enabling enhanced services and greater access out of core hours.
- **Staff developing trust across practices** to offer extended hours and be prepared to share information regarding their patients and adopt new referral patterns.
- **Staff working differently across practice boundaries**, adopting new ways of working and new behaviours to ensure that the benefits of collaboration translate into higher and more consistent standards for care.
- **Clinical staff enhancing their skills** and knowledge to support patients with complex needs. These skills should be deliberately developed in alignment with population needs and offer the opportunity for staff to develop or enhance their scope of practice, with economies of scale enabling more specialist skills in primary care.
- **Non-clinical roles becoming broader** as network managers become integral to the consistent delivery of care across networks, providing more opportunities for career development.

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We are currently providing support for our emerging networks and working to model the impact of providing seven-day access to primary care, including impacts on staff numbers. This work will report jointly to our primary care partnership board and the WSIC integration board.

We are also working to increase the provision of education and training in primary care to ensure that we are training the future primary care workforce for North West London.

Workforce aspects of Acute Reconfiguration

The transformation of acute services across North West London will also have wide reaching implications on the acute workforce including:

- A cultural shift, with staff moving to 7 day service delivery with a deeper understanding of the whole patient pathway and more trust in the provision of community care.
- Staff will spend part or all of their time delivering care in the community as care moves to settings most appropriate and convenient for the patient.
- Clinical standards driving the need for more staff across the system in some areas and, in others, requiring new ways of working and collaboration across NWL's providers.

The Workstream is working with the ten trust HR Directors across the sector to develop a set of transition principles which will form the basis for transition plans. Alongside this, the Workstream is creating a best practice approach for NWL to managing staff transition.

Trusts are managing the transition of their staff through projects for service transitions. The Workstream is providing direct support to them to ensure that their plans meet statutory requirements and are coordinated across the patch, working with HENWL to ensure that affected staff have the development support through transition to keep their much needed skills in North West London. HENWL is coordinating the education establishment's response to each service closure.

Investing in the current and future workforce in NWL to support service transformation

HE NWL has an annual budget of £265 million (2013-14 figures), and the majority of funding is invested in future workforce. The 2013/14 expenditure on developing the existing workforce was £12 million, which will be maintained for 2014/15.

Workforce development funds are split across a range of service priorities with Primary Care receiving a specific allocation which will increase year on year. All spend will align to the SaHF vision for care and develop the workforce to deliver the CCGs' out of hospital strategies.

Specific priority areas identified for 2014/15 include:

- Primary Care transformation
- Supporting the implementation of out-of-hospital strategies across NWL
- Emergency medicine and urgent care
- Band 1-4 staff development including apprenticeships

North West London has been piloting innovative models of providing education based around certain conditions and along patient pathways over the last 12 months to enable multi-disciplinary learning across the sector.

Alongside this, we will be developing Community Learning Networks which will provide the education infrastructure in primary and community care to enable integrated learning to support the cross disciplinary, multi-professional team.

Workforce workstream: structure and governance

The workforce workstream is working across six broad areas:

- Acute Reconfiguration implementation
- Acute Reconfiguration planning
- Achieving Clinical Standards

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- Primary Care Workforce Transformation
- Integrated Care Workforce Transformation
- Implementing Community Learning Networks

The Joint Workforce Steering Group provides oversight and strategic direction to all workforce related work across the programmes of work.

Workforce is embedded in each programme and work packages will develop as individual programmes of work mature.

This structure enables strategic coherence and oversight while ensuring that there are links made between programmes while maintaining sufficient local detail in each programme.

**3. 'Out of Hospital' strategies and reduction in acute demand**

A key enabler of the successful realisation of the benefits of the SaHF acute reconfiguration, including improved quality and a financially sustainable health system will be the effective implementation of the NWL 'Out of Hospital' strategies, which will deliver the reduction in overall demand for acute services.

**4. Communications**

The scale and complexity of the changes being planned and delivered in North West London necessitate a strategic and structured approach to communications. Through this workstream we ensure greater understanding of the key stakeholder groups and how messages should be shared with these groups. In this way the aim of the workstream is to ensure the right people are aligned to service transformation.

A comprehensive plan has been delivered which includes key messaging across the main sites across North West London as well as timescales for activity. For example, the Central Middlesex and Hammersmith Hospital project plan includes a detailed public information campaign to inform local residents about the key changes to the Accident and Emergency departments prior to transition.

**5. Engagement, co-design, travel and equalities**

Ensuring services are designed 'with users' and not just 'for users', and that travel and equalities considerations and statutory obligations are met are vital to ensuring new services will be fit for purpose. This enabler workstream supports that activity, from the co-design work on Whole Systems to the Travel Advisory Group that advises on the travel implications of the acute reconfiguration. This workstream also works closely with the Communications team to support the behavioural changes required for new systems and services to be successfully adopted.

**6. Clinical**

The Clinical workstream leads the development of clinical solutions underpinning service transformation, manages clinical risk, monitors changes to clinical quality and safety and is responsible for overseeing the clinical subgroups.

The Clinical workstream is aligned with and collaborates with the CWHHE and BHH Quality strategies and governance structures.

**7. Finance**

The enabling workstream works to ensure coherence between the planning assumptions of commissioners and providers and the overarching financial strategy in North West London. To this end the workstream seeks assurance that transformation solutions are financially viable from both an individual and system wide perspective within the overarching framework of the financial strategies.

**8. Benefits realisation**

This enabling workstream tracks and monitors delivery of the benefits of delivering S*haping a healthier future* and the wider transformation programme. The DMBC

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described twenty benefits, including better outcomes for patients and carers, reduced avoidable mortality, and improved patient experience. These have now been mapped to the NHS Outcome Ambitions. We need to ensure that the changes being designed and implemented over the coming five years actively contribute to the delivery of these benefits and improved outcomes.

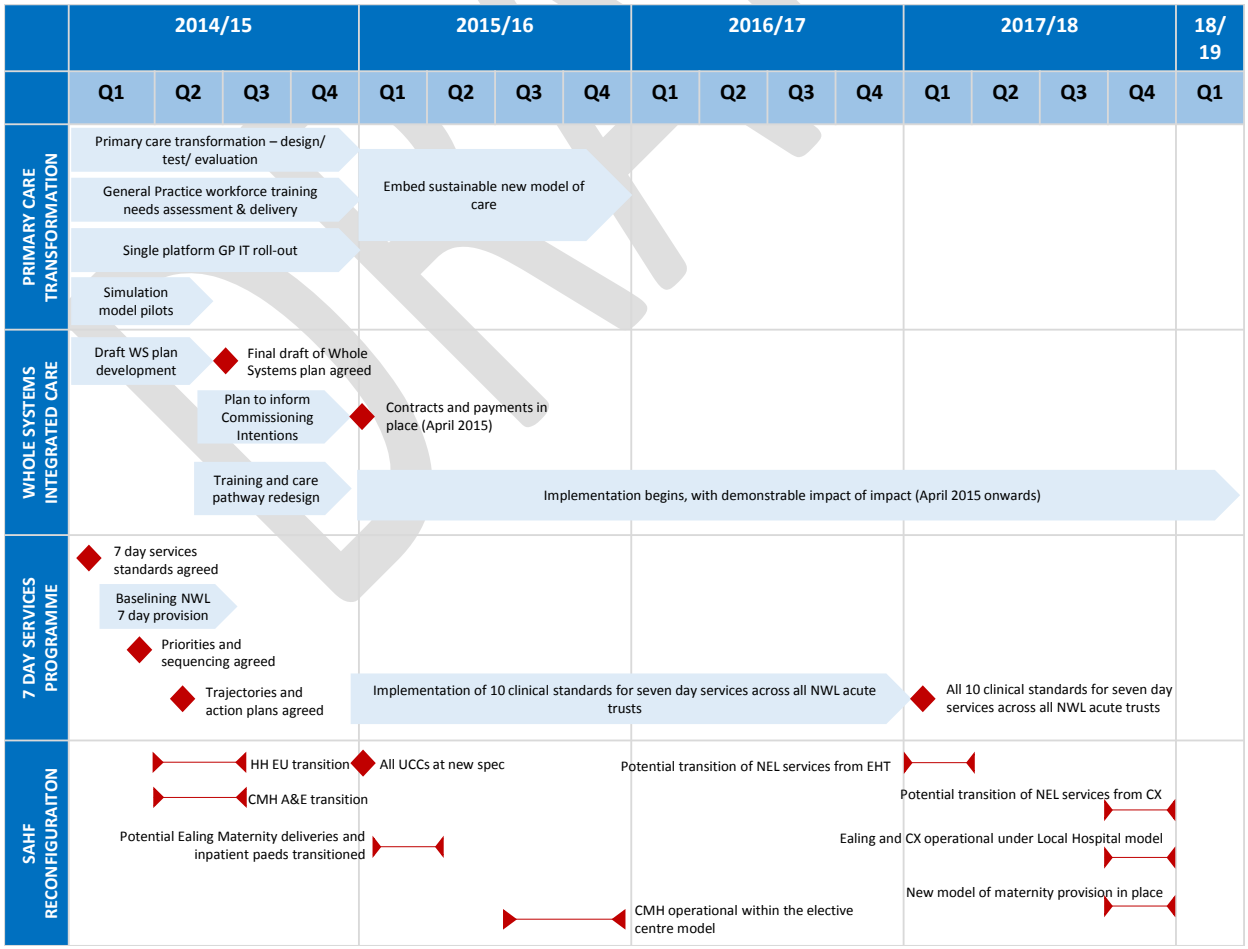
Within this workstream we also track and monitor programme progress using 'in flight indicators', such as activity shifts between acute and community settings, changes to the quality of services, and total bed numbers. This enables us to ascertain our progress in implementing the transformation programmes and the degree to which we can be confident we will deliver the required benefits.

## Programme Implementation Timeline

The high-level programme implementation timeline illustrates the timescales by which each of the programme's key milestones will be achieved, including:

- Sustainable network-based GP model in place by in 2015/16.
- Roll-out of Whole System approaches to commissioning and delivering services from April 2015.
- Consistently high standards of clinical care achieved across all days of week by 2017/18.
- The full transition to the new configuration of acute services complete by the end of 2017/18.

Programme implementation timeline

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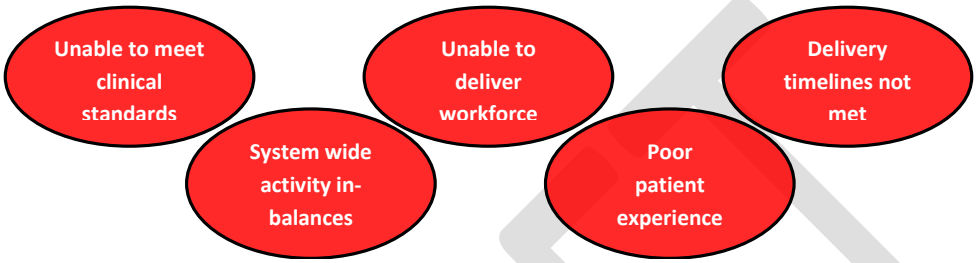
## Programme – Barriers to Success

A large number of risks to the *Shaping a healthier future* acute reconfiguration programme have been previously identified and developed into a consolidated programme risk register. These risks have been identified from a number of sources, including a series of clinically led Risk Identification workshops.

To provide strategic level oversight and a better sense of the complex interdependencies within the programme strategic level risks have been developed. This was done through a risk mapping exercise, which has led to **5 strategic areas of risk**:




When considered together, these five areas lead to only two risk outcomes. These outcomes form the corner stone of the programme's risk management activities and are what the programme should be designed to avoid. These risks have been captured in the two risk outcomes below, along with the associated mitigation plans. These risks have now been finalised by the Clinical Board and are included in all Organisational Risk Frameworks.

**Risk outcome #1:** through unsustainable demand, uncontrolled delays to the delivery timelines and an inability to deliver the required clinical workforce *Shaping a healthier future* delivers precipitate, poorly planned change, which adversely impacts quality and safety.

***Mitigating Actions***

A programme implementation governance structure has been established to ensure that there is involvement from all major stakeholders and will monitor programme progress:

- *Clinical Board* **-** brings together all of NWL's medical leaders to ensure transition is being safely planned and managed and will coordinate collective action to address any issues as required. This group will be responsible for leading clinical implementation planning, in particular advising on safe sequencing of change and readiness for change (incorporating the programme four step decision making process). Further scenario testing and readiness exercises are to be carried out.
- *Uncontrolled delays* **-** dedicated resources have been put in place across all organisations to support the delivery of the programme. These are centrally supported by the programme zones and cross cutting workstreams, which includes the involvement of all major external stakeholders. The SaHF Implementation Programme Board will continue to review the overarching programme progress.
- *Monitoring* - Clinical Board and Programme board continue to review the programme tracker which monitors key metrics on activity, quality and shape change.
- *Travel Advisory Group:* one of the concerns raised through the SaHF consultation process was transport, and how people would travel to and from new health care destinations. The Travel Advisory Group is working to address these concerns by developing mechanisms to assist patients,

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carers and relatives to undertake changed patient journeys as a result of reconfiguration. This includes carrying out patient travel surveys to understand the journeys that are currently made, and using the results of these to work with Transport for London (TfL) to look at bus routes and accessibility at tube stations. The delivery of the Out of hospital strategies will also mean that more services are delivered closer to people's homes, and therefore there will be fewer journeys made to major acute hospitals to receive health services.

- *Communications*: there is a risk that patients and the public are not sufficiently aware of the changes taking place, and how they are expected to use services differently. SaHF has developed an extensive Communications strategy to ensure that stakeholder groups are well-understood, and that messages, language and communication media are targeted accordingly, including clear and concise language. Specifically, on the Central Middlesex and Hammersmith Hospital Communications and Engagement Workstream, Lay Members have been helping to advise on putting forward ideas for additional channels as well as ensuring that the messaging is clear and concise.

**Risk outcome #2**: through an inability to meet the clinical standards, deliver the requisite workforce, deliver behavioural change, sustain expected patient experience and an unsustainable demand on the system *Shaping a healthier future* does not deliver the planned benefits to improve quality and safety of health and care across NWL.

***Mitigating Actions***

A programme implementation governance structure has been established to ensure that there is involvement from all major stakeholders and will monitor programme progress:

- *Clinical Standards* – clinical standards were approved and all providers are now creating plans which support the delivery of these standards – this will remain under review by the Implementation Clinical Board.
- *Clinical Workforce* – a steering group for the development of a NW London wide workforce has been implemented, working with HE NWL. A baseline of all acute, community and primary care workers has been defined. A joint workshop is being held to bring together all stakeholders to develop a common view on creating the workforce.
- *Unsustainable demand* – All provider CIP and commissioner QIPP plans have been designed in support of the activity shift and system wide shape change. A finance and activity modelling group consisting of all commissioner and provider Finance Directors has been established to ensure a common view for the creation of all business cases. A programme wide tracker to review activity, quality and shape change is reviewed by the programme quarterly.
- *Benefits framework* –the Decision-Making Business Case (DMBC) included a benefits framework to ensure that the programme was designed to deliver the specified benefits and this will continue to be reviewed.

The five strategic risks and two risk outcomes provide an effective mechanism for coordinated risk management across both providers and commissioners. But it's also vital that we have clarity on the risks that sit beneath this level and manage their mitigation. This is done through a robust risk management process at the project level, with those risks that cannot be managed at this level flowing up to the programme level, which in turn feed the strategic level risks to provide a rich and comprehensive picture of the risks and mitigations.

As an illustration, key programme level risks that we are currently managing include:

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- *Unable to maintain quality and safety through transition* – the Clinical Board and associated groups are carefully monitoring quality metrics as we proceed through the transformation to ensure that quality is maintained and in time improved.
- *Not all capital required can be secured* – capital process is being coordinated through the NTDA and DH and work is underway with providers to ensure financial viability of individual business cases and the wider system.
- *Out of hospital strategies do not deliver required reductions in activity in the acute setting*– substantial work underway within CCGs and the wider transformation programmes to deliver improvements in OOH capacity, and benefits already being delivered.
- *Unable to achieve recruitment and retention of workforce in sending and receiving sites* – strong communications and engagement essential, coordinated working with Health Education North West London and various workforce groups working to ensure the workforce of the future is developed.
- *Reduced support of key external stakeholders* – continuing and ongoing engagement with key stakeholders within and out with the health service.

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

*Our five year plan will deliver two key outcomes (1) improved health outcomes and patient experience, as set in our outcome ambitions; and (2) a financially sustainable health system for future generations.*

### Introduction

The NHS is collectively moving towards a more outcomes-based approach to commissioning services, and this is reflected in NWL's developing approach to measurement against our objectives.

NWL has developed a benefits framework that builds on our Case for Change by describing the benefits that are expected to be achieved as a result of implementing the recommendations. The benefits include improvements to patient outcomes and patient experience, as well as improved experiences for staff through advanced patient care, improved ways of working and opportunities to enhance skills.

NWL's five year strategic plan will deliver two key outcomes: (1) improved health outcomes and patient experience; and (2) a financially sustainable health system.

### Outcome Ambitions

As part of the strategic planning process in NWL, a benefits framework was developed to support design and evaluation of the changes. The benefits were developed in line with the clinical standards that underpin the plans for clinical change. The benefits framework was developed by clinicians and tested with patient representatives, including Programme Medical Directors, the SaHF Clinical Board, and CCG Chairs.

Operational benefits in the framework have been informed by Finance and Business Planning group and its sub-groups, Programme Medical Directors, and Out of Hospital Working Group.

The benefits framework has now been mapped where appropriate to the NHS Outcome Ambitions.

**NHS Outcome Ambitions – attainment targets and supporting transformation programmes**

Improving outcomes and securing high quality care is the primary purpose of the NHS in England.

The NHS Outcomes Framework was developed in December 2010, following public consultation, and has been updated every year to ensure that the most appropriate measures are included.

There are five domains in the NHS Outcome Framework:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Seven outcome ambitions have then been developed, each of which maps to one of the domains, as per the figure below:

7 Outcome ambitions mapped to the NHS Outcome Framework domains

*7 Outcome ambitions covers all the NHS Outcome Framework domains:*

| NHS Outcome Framework 5 Domains | 7 Outcome ambitions |
|---|---|
| *Domain 1:* Preventing people from dying prematurely | 1: Securing additional years of life for the people of England with treatable mental and physical health conditions |
| *Domain 2:* Enhancing quality of life for people with long-term conditions | 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions |
| | 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. |
| *Domain 3:* Helping people to recover from episodes of ill health or following injury | 4: Increasing the proportion of older people living independently at home following discharge from hospital. |
| *Domain 4:* Ensuring that people have a positive experience of care | 5: Increasing the number of people having a positive experience of hospital care |
| | 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community |
| *Domain 5:* Treating and caring for people in a safe environment and protecting them from avoidable harm | 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care |

Outcome measures have then in turn been identified for the ambitions, as per the figure below:

The 7 Outcome Ambitions and the baseline measures

| The 7 ambitions | Do I have to submit a 5-year 'quantifiable' ambition figure? | What is the baseline measure to set the quantifiable ambition against? |
|---|---|---|
| **1. Securing additional years of life for your local population with treatable conditions.** | ✓ | Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people) |
| **2. Improving the health related quality of life of people with one or more long-term conditions** | ✓ | Health-related quality of life for people with long-term conditions |
| **3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital** | ✓ | Quality Premium Composite Indicator |
| **4. Increasing the proportion of older people living independently at home following discharge from hospital** | *No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health & Wellbeing Board level.* | |
| **5. Increasing the number of people having a positive experience of hospital care** | ✓ | Patient experience of hospital care |
| **6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community** | ✓ | Patient experience of GP services and GP Out of Hours services |
| **7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care** | *Baseline data not yet available at CCG level to set quantifiable level of ambition against. However 'case note review' data will be available to measure progress on local plans in the next few years.* | |

Each CCG has set an attainment target for these measures, to be achieved by 2018/19, in collaboration with partners, including Health and Wellbeing Boards. The aggregated targets for NWL have been set out in the table below, along with the key contributing transformation programmes and other plans.

Summary of NWL Outcome Ambition targets and contributing plans

| Ambition | Outcome Measures | Baseline | 18/19 target | % change | Key programmes and plans |
|---|---|---|---|---|---|
| **1** | Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (adults and children) | 16,174 | 13,741 | 15.04% | • Health promotion, early diagnosis and early intervention, including integrated approach to screening and symptomatic services<br>• London-wide programmes, including the Cancer Commissioning strategy<br>• Achieving equivalence and parity of esteem for physical and mental health Screening: integrated approach to screening and symptomatic services<br>• Achieving the SaHF, London Quality and 7 Day Services clinical standards |
| **2** | Health related quality of life for people with long term conditions | 594 | 616 | 3.7% | • Whole System Integrated Care<br>• Primary Care Transformation<br>• Transforming Mental Health services |
| **3** | Composite measure on emergency admissions | 17,700 | 15,724 | 11.16% | • Whole System Integrated Care<br>• Out of Hospital strategies |
| **5** | 'Poor' patient experience of inpatient care | 1,307 | 1,213 | 7.2% | • Achieving the SaHF clinical standards, including seven day services<br>• Quality, Safety and Patient Experience plans |
| **6** | 'Poor' patient experience of primary care | 69 | 59 | 14.2% | • Whole Systems Integrated Care<br>• Out of Hospital strategies, including Primary Care Transformation |

*[Please note that outcome ambitions are being reviewed and these attainment targets may be updated further]*

Note that there are currently no baseline measures for outcome ambition 4, '*Increasing the proportion of people living independently at home following discharge from hospital'* or for outcome ambition 7, '*Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care'*. However, the former will be supported through Whole Systems Integrated Care and Primary Care Transformation, while the latter will be supported through the Quality, Safety and Patient Experience plans, including achievement of agreed clinical standards for NWL acute trusts.

**Addressing Health Inequalities**

The NHS must place special emphasis on reducing health inequalities. We need to ensure that the most vulnerable in our society get better care and better services, often through integration, in order to accelerate improvement in their health outcomes.

These issues are very pertinent to NWL, which, for example, has a higher proportion of families having children live in poverty than the national average, with higher than

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average rate of low birth weight babies and higher levels of obesity, and which serves a diverse population.

Each CCG, in collaboration with local partners through the Health and Wellbeing Board, has identified the groups of people in the area that have a worse outcomes and experience of care, and have developed Health and Wellbeing Strategies to close the gap (see Appendix D for the specific priorities identified by each Health and Wellbeing Board.

In 2013/14, NWL CCGs focused on proactively capturing insight and feedback from BME and other equality groups – for example:

- Central London CCG: commissioned insight work through the BME Health Forum to capture experience and access to A&E by BME communities.
- Hounslow CCG: commissioned Diabetes UK to engage with BME communities on Diabetes.

The feedback received through this work will be used to shape and influence service development, e.g. local Diabetes Service Redesign work.

Equality Delivery System

The Equality Delivery System (EDS) is a toolkit that has been developed to support NHS organisations to drive up equality performance and embed it into mainstream business. The NWL CCGs are committed to embedding equality and inclusion in everything that we do, and specifically in how we:

- Commission and make accessible services for all the residents of our diverse community.
- Recruit and support the development of our staff.
- Proactively inform, consult, engage and involve all our diverse communities.

Each CCG has agreed its Equality Objectives for 2013 – 2016. These were identified through a series of local processes that involved local people, CCG staff, the CCG Governing Body and other stakeholders. This included reviewing the needs of each population through the Public Health Equalities Profiles and the Joint Strategic Needs Assessments (JSNAs). Equality Objectives were set across in relation to the following national goals:

- National EDS Goal 1: 'Better Health Outcomes for All'
- National EDS Goal 2: Improved Patient Experience and Access
- National EDS Goal 3: Empowered, Engaged and Well Supported Staff
- National EDS Goal 4: Inclusive Leadership At All Levels

### A financially sustainable health system

The future pressures on the health service identified in a *Call to Action* include*:*

- Demand for health services:
  - Ageing society
  - Rise of long-term conditions
  - Increasing expectations
- Supply of health services:
  - Increasing costs of providing care
  - Limited productivity gains
  - Constrained public resources

The assumptions made by NWL CCGs are consistent with the challenges identified in a *Call to Action*. NWL plans are to improve outcomes whilst maintaining financial stability.

To fulfil its constitution, the NHS must continue to provide a comprehensive, excellent service, available to all. But these trends in funding and demand will create a sizeable funding gap. NWL has projected that without any change, the funding gap for commissioners could grow to £365m. Hospitals in NWL will also face significant financial challenges, even if they become as efficient as they can be. Achieving and then maintaining a higher level of productivity

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across care settings will mean making radical changes to the way care is delivered.

*Shaping a healthier future*, the Out of Hospital strategies and the other transformation programmes have been developed in order to address the challenges set out in our Case for Change and to realise our vision for healthcare in NWL, while delivering a sustainable NHS for future generations.

The CCG projections are to ensure a sustainable position is attained, which is consistent with NHS England Business Rules (i.e. a 1% surplus) and includes contingency (at 0.5%) to respond to risks.

The NWL CCGs' financial plans include the outcome ambitions. Non-recurrent implementation costs are assumed to be funded through the NWL financial strategy agreement to pool CCG / NHSE non-recurrent headroom (2.5% in 2014/15).

The plan on a page elements are reflected in the activity and financial projects covered in operational and financial templates, as these templates reflect the anticipated shift in activity from acute to out of hospital settings that will be achieved through implementation of the major NWL transformational programmes, including WSIC, and individual CCG Out of Hospital strategies and other QIPP initiatives. Financial sustainability in NWL will be achieved by providing more integrated community-based services and less inpatient acute care, as described in the key transformation programme section.

All organisations aim to have clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks.

There is a clear link between service plans, financial and activity plans. Please see Appendix G for further detail on the relationship between the financial and activity modelling underpinning the *Shaping a healthier future* programme and Out of Hospital strategies, the CCG's two year operational plans (including QIPP), and the Better Care Fund plans.

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# 13.How we work: Embedding partnerships at every level

*A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, service users, families and carers, building on the co-design approach designed through Whole Systems. We will also continue to work collaboratively across the eight CCGs of NWL, and in partnership with NHS England, local authorities and community groups.*

### Introduction

A fundamental element of our strategic plan is to effectively empower citizens and engage with patients, building on the co-design approach designed through Whole Systems. We will also continue to work collaboratively across the eight CCGs of NWL.

### Citizen Empowerment and Patient Engagement

A fundamental element of our NWL Plan is to ensure that we effectively empower citizens and engage with patients, harnessing technology where practical to do so. Patient engagement is a core element of the overall commissioning cycle, and is integrated into each stage. Strengthening our collaborative service development and commissioning approaches with patients will support us to achieve the principle of **personalised care**, which in turn will improve patient experience. See chapter 2 (Patient Experience section) for further details on how NWL CCGs will improve patient experience in acute, community and primary care settings.

There are four aspects to our approach, which is based on the guidance set out in '*Transforming Participation in Health and Care*'[28]:

1. **Patient self-management and self-care**: we have significant local evidence through our patient journey feedback that patients want to be in control of their condition and treatments and this project will support them to do so. Each NWL CCG will ensure that patients and carers are supported to plan manage and make decisions about their care and treatment through the services they commission. This will be achieved through:
    - Existing Expert Patient Programmes and patient user groups.

[28] 'Transforming Participation in Health and Care', NHS England, September 2013: http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- The roll-out of Personal Health Budgets from April 2014 (building on learning from existing users to ensure they are deployed as effectively as possible).
- The roll-out of care plans, as part of Whole Systems Integrated Care.
- Online access to self-management advice, support and service signposting (implemented as part of Primary Care Transformation).
- Self-management initiatives (where appropriate) to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in an out of a hospital setting, where appropriate, including peer mentoring and local champions. These will expand the role of the third sector in supporting patients and carers through peer education, peer support, therapies, advocacy, volunteer co-ordination and befriending services etc.

2. **Public participation in the commissioning process:** each NWL CCG will ensure the effective participation of the public in the commissioning process, so that services reflect the needs of local people.

   Each CCG has a patient and public engagement strategy to involve local representative groups in decision-making and that identifies the best way to engage with hard to reach groups. Our over-arching communications approach is to engage with patients and the public through a range of existing conduits, including community networks, user-led / self-help groups, voluntary sector forums, partnership boards, Patient Public Groups (PPGs), and local community stakeholders.

   NWL has a genuine desire to meaningfully co-design services with patients and the public, and we will continue to strengthen and develop our approach as we implement our plans. This will build on the work of the 'Embedding Partnerships' lay partners supporting our Whole Systems Integrated Care programme. Part of that work included developing a co-production touchstone (see chapter 7 for further details about our approach to co-design). There is a commitment to working co-productively in NWL, which means:

   - **Commitment to agreed ways of working** – everyone is valued as equal partners, we will capitalise on lived experience as well as professional learning.
   - **Supporting development and learning.**
   - **Fostering a supportive environment** – developing collective resilience and acknowledging that mistakes will be made along the journey.
   - **Working towards shared goals** – promoting local voice and enabling people to be involved in the delivery of their care and support.

   Each NWL CCG is able to demonstrate the impact of patient involvement on commissioning priorities and on our discussions with providers.

   NWL is also exploring Promoting an Asset based approach to working with patients, service users, carers and the wider community in some CCGs. Early stages of this approach will include:

   - To identify and map community and citizen assets in selected localities with relation to independence, health and wellbeing.
   - To identify gaps and strengths in community and citizen assets.
   - To mobilise community assets effectively and sustainably to promote health and wellbeing and reduce health inequalities.
   - To identify citizen and community level insights about where social

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capital can be strengthened or optimised.

- To design and deliver substantial, innovative interventions and actions which are co-produced with patients, service users and carers.

3. **Access to data and information about health and services:** NWL, working with national partners, will ensure that the population is well served by access to transparent and accessible data and advice about health and services. This will include a clear avenue for accessing up-to-date local clinical and operational service information for patients, GPs and other providers. This will include:
   - NHS Choices and the creation of a digital 'front door', which will help transform the way patients, their families and carers access information about NHS services and will provide self-management materials and information to further empower them to manage their own condition.
   - Up-to-date and accessible Directories of Service available across the health system.
   - Clinicians and other health staff able to provide accurate information about health and services to patients and carers at the point of care, as required.

   While it is recognised that not everyone has equal access to on-line information, and that therefore a wide range of other communication channels must also be used, it is hoped that over the next five years many more people will also become confident internet users.

4. **Delivering better care through the digital revolution - harnessing technology:** we will harness information technology to deliver better care and to make services more convenient for patients. While further detail about our Informatics strategy is available in chapter 11 (Programme Enablers: Informatics), aspects that will support citizen and patient empowerment include:
   - Greater use of telehealth and telecare to support people with long-term conditions to manage their own health and care.
   - Patients will be able to access their own health information electronically.
   - GP practices will promote and offer to all patients the ability to book appointments, order repeat prescriptions and access their medical notes online.

### Partnership working

There are a number of other partners across the health and care system, and it is critical that commissioners, both CCGs and NHS England, work effectively within these partnerships, including with local authorities and community groups, including through the Health & Wellbeing Boards. It will not be possible to achieve our outcome ambitions, including improving life expectancy and quality of life, without addressing the wider determinants of health, and this will require a pan-NWL approach across all major transformation programmes. This will require a concerted programme of change with our statutory and community partners to reduce demand on the NHS by enabling residents to manage their own health, support one another, and improve their health and wellbeing in the community.

### Governance Overview

Robust governance processes are in place to ensure that future plans are developed in collaboration with key stakeholders, including the local community (as per our Whole Systems approach to co-design and embedding partnerships).

The CCG Collaboration Board, a CCG-led governance structure, monitors and oversees delivery of the entire NWL strategic plan, from the acute reconfiguration to the delivery of supporting out of hospital strategies, including Whole Systems Integrated Care.

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See the following page for an overview of the programme governance structure in NWL.

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

- *Shaping a healthier future* programme: SaHF Implementation Programme Board
- Enhancing integrated care: WSIC Programme Board
- Primary care transformation: Primary Care Partnership Board
- Mental health transformation: Mental Health Programme Board

Each of these key joint programme boards include lay partners/lay people, whose role includes ensuring that all service developments remain focused on benefiting patients, and that services are wrapped around the individual patient or carer.

While there is robust governance process in place to oversee implementation of the NWL 5 Year Strategic Plan, responsibility for delivery ultimately lies with CCG Governing Bodies and Health & Wellbeing Boards. Each of these programme Boards therefore report to the CCG Collaboration.

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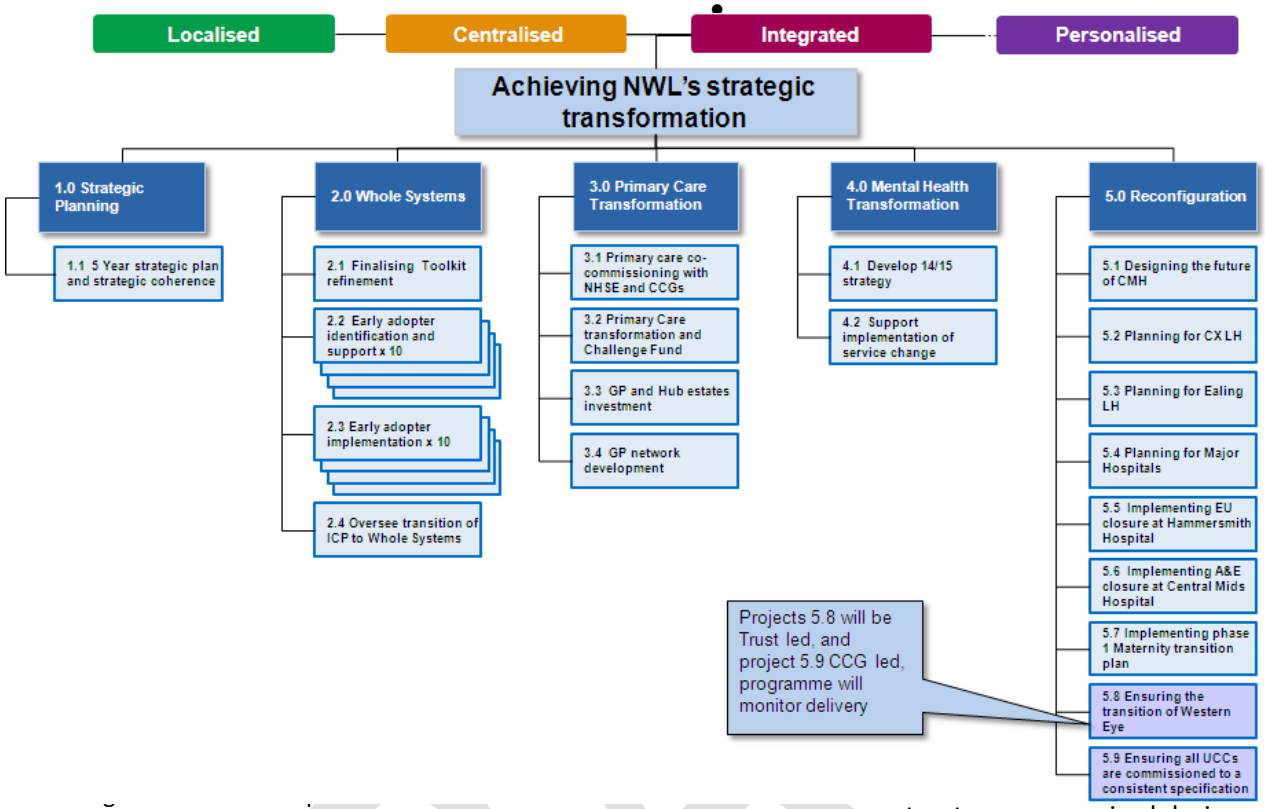
Programme governance structure*




programmes, and does not represent the full governance structure across the 8 CCGs or all of the other projects and programmes underway, e.g. CCG QIPP plans, etc.

CCG Collaboration Board

The Board will address issues across the eight North West London CCGs. The eight CCGs in NWL have agreed a Memorandum of Understanding (MOU) setting out how they will work together in a collective way to successfully implement the 'Shaping a Healthier Future' strategy whilst recognising each CCG's individual sovereignty and the need for decision making to be made at a local level.

The main tasks of the Board include:

- Take responsibility for leading the *Shaping a healthier future* Reconfiguration Programme Implementation, including receiving regular reports from the *Shaping a healthier future* Implementation Board governance structures as required during the implementation process.
- Oversee Out of Hospital (OOH) Strategy Implementation, working collaboratively where it is agreed by members to be appropriate in relation to major OOH transformation programmes and evaluation of benefits.
- Take responsibility for ensuring delivery of major transformation programmes established across the CCGs including decisions regarding programme design, resource allocation (including recommendations regarding shared procurements), overseeing progress and benefits realisation.
- Financial risk management across NW London CCGs and other commissioners, in particular the NHS Commissioning Board.
- Collaborative approach to research and education.

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# Appendices

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

## Information sources used to develop our plan

As part of the original strategic planning process, NWL clinicians developed a Case for Change, with involvement from providers, CCGs and representatives of patient groups and the public. The strategic plans for NWL have evolved further based on the initial patient and public consultation that focused on the future of acute services in NWL, the thorough engagement that has taken place with regards to whole system working and the delivery of integrated and out of hospital care, collaborative working across commissioners and providers, and based on a wide range of qualitative and quantitative data, including financial projections, current performance indicators, and local and national benchmarks.

As part of refreshing NWL's strategic plan in line with *Everyone Counts* planning guidance, the following sources of data, intelligence and local analysis were also explored:

- London Data Packs, including the North West London pack which suggests that NWL that three particular challenges to address: (1) improving support for early years (e.g. low immunisation rates and high levels of child obesity); (2) Enhancing support for LTCs (reducing the usage rate of acute services by patients with LTCs); and (3) meeting the needs of the frail elderly population.
- JSNAs: each borough has a JSNA that sets out the health needs of its population, and which supports the commissioning of health, well-being and social care services within the locality, including the local priorities set out in the Health & Wellbeing strategies and reflected in the pan-NWL transformation programmes.
- Atlas tools, including 'CCG Outcomes', 'Levels of Ambition Atlas', and 'Operational Planning Atlas'.
- Commissioning for Value insight packs.
- The 'Any town' toolkit (see Appendix C for current status across the NWL CCGS with regards to the High Impact and Early Adopter interventions described in 'Any town'): this has helped to assure and develop the CCG QIPP plans and other initiatives.

All of these inputs have supported NWL CCGs and NHS England partners in developing the vision, key transformation programmes, and other plans that are set out in our five year plan, including the Health and Wellbeing strategies. There has been a genuine change in recent years in the way that NWL commissioners work with lay partners and other stakeholders, as we increasingly focus on citizen empowerment and patient engagement, and this change is reflected in the language used to articulate this shared five year plan.

## What do the NWL Case for Change, including our current and targeted performance against the NHS Outcome ambitions, and the 'Call to Action', mean for both health services and for local people?

The messages within a 'Call to Action' resonate closely with NWL's ambitious plans to transform and improve our hospital services and bring care closer to patients.

On 2 July 2012, NWL launched a public consultation on the plans for reconfiguration of services. We consulted on a set of proposed clinical standards, clinical service delivery models and options for location of services. The consultation period ran for 14 weeks and ended on 8 October 2012. The feedback from consultation showed a clear mandate for change and broad support for the preferred consultation option. There was also challenge and criticism. We responded to this feedback, carrying out significant additional work on the analysis, in particular the clinical recommendations, options evaluation (including finance), travel, equalities and implementation planning. The

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outcome of the public consultation is eight settings of care in NWL to deliver the SaHF clinical vision and standards.

The clinical case for change and the acute reconfiguration consultation feedback provide a valuable resource to call upon, as they seek to have an honest and realistic debate about how the NHS can be shaped to meet future demand and tackle funding gap through 'honest and realistic' debate.

Other key themes that have been identified through to 'call to action' engagement events in NWL include:

- Care centred around patient – enabled by IT and shared records (see chapter 7 for Whole Systems and chapter 11 for Informatics).
- People really value access to healthcare professionals who speak their language.
- Flexibility of services (after-hours appointments, phone appointments, GP home visits) (see chapter 6 for Primary Care Transformation).
- Importance of better communication and data sharing, keeping care in the home or community and the role of signposting and care navigation (see chapter 13 for Citizen Empowerment and Patient Engagement).
- Participants expressed a strong desire to be included in the co-design of integrated care, moving beyond traditional forms of engagement and consultation to being involved at every stage of the process from ideas to implementation (see chapter 7 for Whole Systems and chapter 13 for Citizen Empowerment and Patient Engagement).

The key themes that emerged in NWL were consistent with those emerging across London, i.e.:

- Information, communication and education
- Focus on prevention and management of care
- Improving access, partnership working and integration of services

Key feedback from this level of public engagement (our NWL 'call to action' programme) has been fundamental to agreeing the programme of acute service changes in NWL, and to developing our major supporting workstreams, including Integrated Care.

In response to the compelling Case for Change and the public engagement related to the acute reconfiguration and the 'Call to Action', the NHS in NWL must:

- Support its residents to lead healthy lives and offer safe, high quality care to all
- Increase proactive care with more people being screened for preventable diseases and early detection of abnormalities, and with more people immunised against preventable diseases
- Empower patients to make informed choices about their care and help ensure they do not go into hospital unnecessarily
- Provide more specialist hospitals on fewer sites to treat patients with the most complex illnesses, with round-the-clock professional expertise on call
- Integrate the services provided by those delivering care and support – GPs, community services, hospitals, local councils and social care
- Make it easier for more patients to be treated in their community and focus future investment more in these services
- Get the best value from all NHS spending

### How community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions

Public and patient engagement is a core principle of NWL's planning processes, and has underpinned development of our key improvement interventions, both at a CCG and NWL-wide level. The stakeholder engagement associated with key NWL transformation interventions is described in further detail below.

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

**Health & Wellbeing strategies**

- Significant public consultation has taken place in each Borough to develop the Health & Wellbeing Strategies.

**Whole Systems**

- Through patient and service user workshops, interviews and surveys across North West London, we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.
- Integrated care is what people who use services want, what professionals aspire to deliver, and what commissioners want to pay for:
    - *"I know who is the main person in charge of my care. I have one first point of contact. They understand both me and my condition."*
    - *"The professionals involved with me talk to each other. I can see that they work as a team."*
    - *"There are no big gaps between seeing the doctor, going for tests and getting the results."*
    - *"I am as involved in decision making as I wish to be."*
- One of the core working groups within NWL's programme to implement a modern model of integrated care (see Improvement Intervention #3 – Enhancing the integration of care), is 'Embedding Partnerships'. This working group has a mandate to ensure the person voice is at the heart of shaping Whole Systems Integrated Care through co-design and implementation.
- Both a Lay Partners Forum and a Lay Partners Advisory Group provide input, challenge and debate from the perspective of patients, people and cares who user services across the whole programme.
- In addition to the central role of the patient and carer voice in the design of modern models of integrated care in NWL, the existing Integrated Care Programme (ICP) holds regular patient reference group meetings; members of the patient reference groups have been trained.

**Transforming Mental Health Services**

- In 2011, NWL worked with local Mental Health Trusts, GPs and other stakeholders on how to improve mental health care across the region.
- This work explored the potential for integrated care approach to mental health, and involved a range of stakeholders in the discussions and meetings.
- Feedback from service users on the key themes of the Mental Health strategy were then used to refine the strategy.

**Out of Hospital strategies, including Primary Care transformation**

We know that successful delivery of our Primary Care transformation project depends on active engagement with the people who use our services, their families and carers. Our eight CCGs commissioned a comprehensive review of patient priorities for primary care in North West London in 2012, including a survey of over 1000 residents, and consultations with BME groups, non-English speakers and patients with learning disabilities.

The survey confirmed that, of the top ten patient priorities, seven related to better access, including:

- Being able to easily access an emergency appointment
- Having a continuing, trusted relationship with a named health professional

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- Being able to easily get through on the phone to make an appointment or seek advice
- Having access to a variety of appointment types

We therefore already have good insight into the differentiated appointment types that patients in North West London want – urgent, continuity and convenient appointments, available via a range of channels. This is the foundation of our model for future General Practice in North West London.

***Shaping a healthier future*** **– acute reconfiguration**

- The design of the acute reconfiguration was supported by one of the largest NHS public consultations ever undertaken. *The Shaping a healthier future* acute reconfiguration ran a public consultation process which received some 17,022 responses over 14 weeks in summer of 2012, from the 2nd July to 8th October.
- Over 200 meetings were held, engaging with over 5,000 people to consult on:
    - Proposed clinical standards
    - Clinical service delivery models
    - Three potential options (referred to as A, B and C) for the location of acute hospital services
    - Out of hospital services
- NWL agreed the duration and method of the consultation with the JHOSC, and the consultation approach was endorsed by the Consultation Institute. The outcome of the public consultation is eight settings of care in NWL to deliver the SaHF clinical vision and standards.
- A Patient Public Reference Group (PPRG) continues to meet monthly to support implementation of the SaHF plans.

## Who has signed up to the strategic vision, and how have the health and wellbeing boards been involved in developing and signing off the plan

- NWL has engaged in a major strategic planning process across the 8 CCGs of Brent, Ealing, Central London, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow and West London, which has led to the development of the *Shaping a healthier future* programme, including supporting workstreams.
- The *Shaping a healthier future* strategic planning process, and the development of the major transformational programmes of work, have included acute, community, and mental health providers, along with commissioners, Local Authorities, Public Health, Health Education England, and lay members.
- The 5 Year Strategic Plan set out within this document has been developed through the following process:
    a) Initial development of core content from existing strategic and other planning documents
    b) Bi-lateral planning meetings with NHS England Direct Commissioners
    c) Review of key messages with constituent CCG Chairs and Chief Operating Officers/Managing Directors
    d) Agreement of key messages within the Strategic Planning Group
    e) Review and update of individual sections as required with respective leads within all constituent CCGs
    f) Contributions and sign-up from:
        - Patients & carers (pan-NWL stakeholder event held in June 2014)
        - Healthwatch/Patient Public Representative Groups (PPRG)

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    - CCGs
  - Providers
  - Health and Well-being Boards
  - Local Authorities (through the Strategic Planning Group)
  - NHS England Area Team
  - Health Education England (NWL)
  - Local Education and Training Board (LETB)

### How the Health and well-being boards have been involved in setting the plans for improving outcomes

- NWL CCGs are reviewing proposed Outcome Ambition attainment targets with their respective Health & Wellbeing Board.

### How two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here

- A necessary foundation of the NWL strategic vision is achievement of the CCG Out of Hospital strategies, and the associated shift in activity from acute settings to community settings.
- This activity shift is reflected in the activity and financial trajectories set out in the detailed two year operational plans. It is also consistent with the anticipated activity levels used to support SaHF acute reconfiguration business cases.

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# Appendix B – How our Five Year Plan aligns with NHS England planning guidance

The NWL transformation programmes and cross-cutting plans reflect the three facets of care identified in the NWL Area Deck, i.e.: Care close to home; Hospital Care; and Integrated care. They also reflect the six models of care outlined in *Everyone Counts*, as per the table below:

Relationship between NHS England's 'models of care' and the NWL initiatives

| | Model of Care | Alignment to NWL Transformation Programmes |
|---|---|---|
| **1.** | **Citizen participation and empowerment** | • Citizen participation and empowerment is a fundamental tenet of all NWL programmes, and our approach is described in chapter 13. |
| **2.** | **Wider primary care, provided at scale** | • Out of Hospital strategies, including Primary Care Transformation |
| **3.** | **A modern model of integrated care** | • Whole Systems transformation programme |
| **4.** | **Access to highest quality urgent and emergency care** | • Cross-cutting plans – Urgent & Emergency Care |
| **5.** | **A step-change in the productivity of elective care** | • *Shaping a healthier future* (SaHF) acute reconfiguration, as well as Planned Care pathway redesign as part of Out of Hospital strategies |
| **6.** | **Specialised services concentrated in centres of excellence** | • *Shaping a healthier future* (SaHF) acute reconfiguration |

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# Appendix C – Anytown interventions

NHS England has produced a toolkit called 'Any town', which using high level health system modelling, allows CCGs to map how interventions could improve local health services and close the financial gap. It is an additional guide to help commissioners with their five-year strategic plans, showing how a typical CCG could achieve financial balance over the strategic period up to 2018/19.

The NWL CCGs have analysed the proposed 'Anytown' interventions, and a summary of the status of each intervention in each CCG is summarised in the table below:

Anytown intervention status by CCG

| | Central | Ealing | H&F | Hounslow | West London |
|---|---|---|---|---|---|
| **Early diagnosis** | | Planned | Partially met - further plans | Not planned | Planned |
| **Cancer screening programmes** | | Planned | Partially met - further plans | Not planned | Partially met - further plans |
| **Reducing variability in primary care: *referring*** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Reducing variability in primary care: *prescribing*** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **GP tele-consultations** | Planned | Not planned | Not planned | Planned | Planned |
| **Reducing urgent care demand** | Partially met - further plans | Planned | Fully implemented | Fully implemented | Partially met - further plans |
| **Medicines optimisation** | Partially met - further plans (BAU) | Partially met - further plans | Fully implemented | Partially met - further plans | Partially met - further plans |
| **Safe and appropriate use of medicines** | Partially met - further plans (BAU) | Not planned | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Self-management: patient-carer communities** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Service user network** | Not planned | Partially met - further plans | Partially met - further plans | Planned | Partially met - further plans |
| **Telehealth/ Telecare** | Not planned | Partially – no further plans | Not planned | Not planned | Not planned |

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# Appendix C – Anytown interventions

| | Central | Ealing | H&F | Hounslow | West London |
|---|---|---|---|---|---|
| **Electronic palliative care coordination systems (EPaCCS)** | Partially met - further plans | Planned | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Case management and coordinated care** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans | Partially met - further plans |
| **Integration of health and social care for older people** | Partially met - further plans | Partially met - further plans | Partially met - further plans | Planned | Partially met - further plans |
| **Dementia pathways** | Planned | Planned | Planned | Partially met - further plans | Partially met - further plans |
| **24hr asthma services for children** | Not planned | Partially met - further plans | Partially met - further plans | Partially met – no further plans | Partially met - further plans |
| **Palliative care** | Planned | Fully implemented | Not planned | Fully implemented | Fully implemented |
| **Acute visiting services** | Not planned | Partially met - further plans | Planned | Partially met - further plans | Partially met - further plans |
| **Mental Health: Rapid Assessment Interface and Discharge (RAID)** | Planned | Partially met - further plans | Not planned | Planned | Partially met - further plans |
| **Acute stroke services** | Not planned | Fully implemented | Fully implemented | Fully implemented | Fully implemented |
| **Reducing elective caesareans** | Not planned | Not planned | Partially met - further plans | Fully implemented | Partially met - further plans |

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# Appendix D – Health and Wellbeing Strategies

A key element of the NWL plans, including of where the local focus is in each CCG in terms of health promotion, early diagnosis and early intervention, is the Health and Wellbeing Strategies. The priorities identified in each of the CCG's Health and Wellbeing Strategy are captured in the table below.

| | Brent | Central | Ealing | H&F | Harrow | Hillingdon | Hounslow | West London |
|---|---|---|---|---|---|---|---|---|
| **Alcohol/substance misuse** | ✓ | ✓ | ✓ | | | | | ✓ |
| **Cancer** | | | | | ✓ | | ✓ | |
| Supporting parents and the community to protect **children** and maximise their life chances / **Early Years** Intervention (0-5 yrs) / Best start in life / **Children** engaged in risky behaviour / Giving every | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| **Childhood immunisations** | | ✓ | | ✓ | | | ✓ | ✓ |
| **Childhood obesity** | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| Empowering **Communities** to take better care of themselves / fostering social cohesion and reducing isolation | ✓ | ✓ | | ✓ | | | | |
| **Dementia** | | ✓ | | | ✓ | ✓ | | |
| **Dental Health** (or Oral Health in Children) | ✓ | ✓ | | ✓ | | ✓ | ✓ | ✓ |
| Type 2 **Diabetes** | | | | | | ✓ | | |
| Ensuring Safe and Timely **Discharge** from Hospital | | | | | | | | ✓ |
| Tackling **domestic abuse** through | | ✓ | | | | | | |

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# Appendix D – Health & Wellbeing Strategies

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

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## Appendix D – Health and Wellbeing Strategies

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

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# Appendix E - The Key Ingredients of Integrating Care

NHS England has identified the "key ingredients" for integrating care, which also represents a useful framework for summarising the NWL case for change, and the key transformation programmes developed in response:

| **The Key Ingredients of Integrating Care (NHS England)** | |
|---|---|
| **Why** | • Poor patient experience<br>• Poor outcomes<br>• Increasing demand<br>• Unsustainable models of care<br>• Unprecedented financial challenge |
| **What** | **Greater integration of services around the person – *in NWL, this means***:<br>• See Chapter 6 (Whole Systems Integrated Care)<br>**Greater emphasis on self & home care – *in NWL, this means***:<br>• Existing Expert Patient Programmes and patient user groups.<br>• The roll-out of Personal Health Budgets from April 2014<br>• Online access to self-management advice, support and service signposting<br>• The roll-out of care plans<br>• Self-management initiatives to improve the quality of patient care by providing a number of interventions to enable patients to take greater control of their own care in an out of a hospital setting, including peer mentoring and local champions.<br>**Building community capacity to manage demand – *in NWL, this means*:**<br>• Healthy Living, Early Diagnosis and Early Intervention<br>• Out of Hospital strategies<br>**A new primary care offer - *in NWL this means***:<br>• Primary Care Transformation, so that primary care:<br>  ○ Accessible<br>  ○ Proactive<br>  ○ Coordinated<br>**Reconfiguration of acute services - *in NWL this means***:<br>• Acute services that are localised where possible, and centralised where necessary, to be achieved through the *Shaping a healthier future* acute reconfiguration. |
| **How** | **Whole health and care system leadership – *in NWL this means***: see chapter 13 (Governance)<br>**Three – five year plans signed off by Health & Wellbeing Boards**<br>**Local & city-wide coherence**<br>**Scale/focus**<br>**Commissioning alignment between LA/CCG/NHS England – *in NWL this*** |

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# Appendix E - The Key Ingredients of Integrating Care

| | |
|---|---|
| | ***means:***<br>• Collaborative commissioning between NWL CCGs and NHS England – see Chapter 7 (Primary Care Co-Commissioning).<br>**A way to move around money around the system - *in NWL this means*:**<br>• NWL's Medium Term Financial Strategy (MFTS) – see chapter 12 (A financially sustainable health system).<br>• Whole Systems Integrated Care Early Adopter pilots<br>**Shared information across agency boundaries- *in NWL this means***: see chapter 11 (Programme Enablers: Informatics).<br>**Flexible, engaged workforce and improved training - *in NWL this means***: see chapter 11 (Programme Enablers: Workforce).<br>**Transparent measurement of outcomes**<br>**A developing evidence base** |
| **Outcomes** | **Improved health and care outcomes** - ***in NWL this includes***:<br>• Patient experience<br>• Quality of life<br>• Health outcomes<br>**Financial sustainability of the health and care system** |

As the table above suggests, NWL's five year Strategic Plan will deliver the key ingredients required to provide integrated care.

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# Appendix F: Signposting to Key Lines of Enquiry

This plan was developed to response to the Key Lines of Enquiry set out by NHS England in the strategic plan templates. Signposting to each answer within the document is provided below.

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| Submission details | Which organisation(s) are completing this submission? | • NHS Brent CCG<br>• NHS Harrow CCG<br>• NHS Hillingdon CCG<br>• NHS Central London CCG<br>• NHS Ealing CCG<br>• NHS Hammersmith & Fulham CCG<br>• NHS Hounslow CCG<br>• NHS West London CCG<br>• NHS England | |
| | In case of enquiry, please provide a contact name and contact details | Thirza Sawtell<br>Director of Strategy and Transformation<br>NHS North West London Collaboration of CCGs | |

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# Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| a) System vision | What is the vision for the system in five years' time? | Our vision is "To improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community".<br><br>Four overarching principles support our vision - that health services need to be:<br><br>1. **Localised** where possible<br>2. **Centralised** where necessary; and<br>3. In all settings, care should be **integrated** across health (both physical and mental), social care and local authority providers to improve seamless patient care.<br>4. The system will look and feel from a patient's perspective that it is **personalised** - empowering and supporting individuals to live longer and live well. The system will enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs. | *The plan on a page* |

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# Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically:<br>1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care<br>2. Wider primary care, provided at scale<br>3. A modern model of integrated care<br>4. Access to the highest quality urgent and emergency care<br>5. A step-change in the productivity of elective care<br>6. Specialised services concentrated in centres of excellence (as relevant to the locality) | ***1.*** Citizen empowerment and patient engagement: see page: ***chapter 13, page 97 (Citizen empowerment and patient engagement)***<br>*2.* Wider primary care: ***chapter 5, page 26 (Primary care transformation)***<br>***3.*** Modern model of integrated care: ***chapter 6***<br>***4.*** Access to high quality urgent and emergency care: ***chapter 9***<br>***5.*** Step-change in the productivity of elective care: ***chapter 8, page 63 (Planned care pathways)***<br>6. Specialised services concentrated in centres of excellence: ***chapter 8***<br><br>***Summarised in Appendix B*** | *Details provided within the activity and financial templates which will be triangulated.*<br><br>• *Shaping a healthier future* Decision-Making Business Case (DMBC)<br><br>• Whole Systems Integrated Care Toolkit<br><br>• CCG Out of Hospital strategies ('Better Care, Closer to Home') |

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## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | How does the five year vision address the following aims:<br>a) Delivering a sustainable NHS for future generations?<br>b) Improving health outcomes in alignment with the seven ambitions<br>c) Reducing health inequalities? | [*Please add your response to the key lines of enquiry here.*<br><br>*A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?*<br><br>***Chapter 12, page 92 (Outcome ambitions)***<br><br>B) *You should explain how your five year strategic plan will improve outcomes in the seven areas identified, within the context of the needs of your local population and what quantifiable level of improvement you are aiming to achieve*]<br><br>***Chapter 12, page 95 (A financially sustainable health system)*** | [*Please reference additional supporting documentation you feel is helpful*]<br><br>• *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan? | [*Please provide details of the organisations who have signed up to this vision and the process by which sign up was obtained*]<br><br>***Appendix A*** | |
| | How does your plan for the Better Care Fund align/fit with your 5 year strategic vision? | ***Chapter 6, page 44 (North West London's Better Care Fund plans*** | Each of the NWL HWB Better Care Fund plan, submitted on 4th April |

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# Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| | What key themes arose from the Call to Action engagement programme that have been used to shape the vision? | [*Please provide details of key feedback from any call to action engagement and confirm how these have been incorporated into the strategic vision? ]*<br><br>***Chapter 2***<br>***Appendix A*** | NWL CCG Call to action activity submis |
| | Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included? | ***Chapter 2***<br>***Appendix A*** | NWL CCG Call to action activity submis |
| a) Current position | Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials? | ***Chapter 2***<br>***Appendix A*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Do the objectives and interventions identified below take into consideration the current state? | ***Chapter 2*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here? | ***Chapter 12 (A financially sustainable health system) 5.1*** | |

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# Appendix F: Signposting to Key Lines of Enquiry

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td rowspan="5">b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td><table><tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr><tr><td>1</td><td></td><td></td></tr><tr><td>2</td><td></td><td></td></tr><tr><td>3</td><td></td><td></td></tr><tr><td>4</td><td></td><td></td></tr><tr><td>5</td><td></td><td></td></tr><tr><td>6</td><td></td><td></td></tr><tr><td>7</td><td></td><td></td></tr><tr><td colspan="3">Chapter 12 (Outcome ambitions)</td></tr></table></td><td></td></tr>
<tr><td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td><td>See Appendix A</td><td>• Shaping a healthier future Decision-Making Business Case (DMBC)</td></tr>
<tr><td>What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and quantifiable ambitions?</td><td>See Appendix A</td><td>• Shaping a healthier future Decision-Making Business Case (DMBC)</td></tr>
<tr><td>How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?</td><td>See Appendix A</td><td>Health & Wellbeing Strategies</td></tr>
<tr><td>How have the Health and well-being boards been involved in setting the plans for improving outcomes?</td><td>Chapter 12</td><td></td></tr>
</table>

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## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| c) Sustainability | Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Are assumptions made by the health economy consistent with the challenges identified in a Call to Action? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |
| | Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates? | ***Chapter 12 (A financially sustainable health system)*** | • *Shaping a healthier future* Decision-Making Business Case (DMBC) |

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## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| d) Improvement interventions | Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the :<br>• Overall aims of the intervention and who is likely to be impacted by the intervention<br>• Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have<br>• Investment costs (time, money, workforce)<br>• Implementation timeline<br>• Enablers required for example medicines optimisation<br>• Barriers to success<br>• Confidence levels of implementation<br><br>The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit. | ***See chapters 4 - 10***<br><br>**Intervention One**<br>Overall description<br>[CCG to comment]<br><br>Expected Outcome<br>[CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics]<br><br>Investment costs<br>• Financial costs<br>[CCG to comment]<br><br>• Non-Financial costs<br>[CCG to comment]<br><br>***See chapter 12***<br><br>Implementation timeline<br>[CCG to comment]<br>***See chapter 11***<br><br>Enablers required<br>[CCG to comment]<br>***See chapter 11***<br><br>Barriers to success<br>[CCG to comment]<br>***See chapter 11***<br><br>Confidence levels of implementation<br>[CCG to comment]<br>***See section 4.12*** | |

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## Appendix F: Signposting to Key Lines of Enquiry

| Segment | Key Line of Enquiry | Organisation response | Supported by: |
|---|---|---|---|
| e) Governance overview | What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community? | ***See chapter 13*** | |
| f) Values and principles | Please outline how the values and principles are embedded in the planned implementation of the interventions | ***See chapter 1*** | |

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# Appendix G: Financial appendix

## 1. Introduction

1.1 The *Shaping a healthier future* Decision Making Business Case (DMBC) (February 2013) outlined the financial and activity strategic plan for North West London.

The DMBC outlined how Commissioner and Provider plans were aligned including:

- Commissioner financial model consistent with NHS London guidance/business rules
- Shift in activity and investment in Out of Hospital services
- Provider efficiency gains (including length of stay)
- Reduction of c£40m in provider cost base contributing to sustainable provider landscape

The continued alignment of NWL-wide commissioner and provider finance and activity plans is being maintained through a SaHF Implementation Model and coordination and alignment of Provider Business Cases/LTFMs with the NWL-wide model.

1.2 The full DMBC economic and financial analyses are due to be refreshed later in 2014, alongside a joint SaHF/NHSE/TDA assurance process of Trust Outline Business Cases, and incorporating the latest Out of Hospital plans.

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

As part of this process we will be assessing the impact of any changes in capital forecasts with particular reference to:

- DMBC value for money scoring
- Affordability to providers and overall sustainability
- Affordability to commissioners
- Capital availability (including access to Public Dividend Capital [PDC])
- Overall economic and financial case
- Level of transitional support required to support the reconfiguration

1.3 For the purposes of this five year strategy submission, a combination of latest information from the SaHF Implementation Model, together with the original DMBC capital estimates have been used (updated provider capital estimates have not been used as the draft Trust Outline Business Cases (OBCs) are yet to go through the assurance process). As noted above, this assurance process is due to take place in the second half of 2014, which will lead to the production of the Implementation Business Case (ImBC).

1.4 The schematic below provides an overview of how Commissioner and Provider finance and activity plans are aligned on an ongoing basis within NW London:

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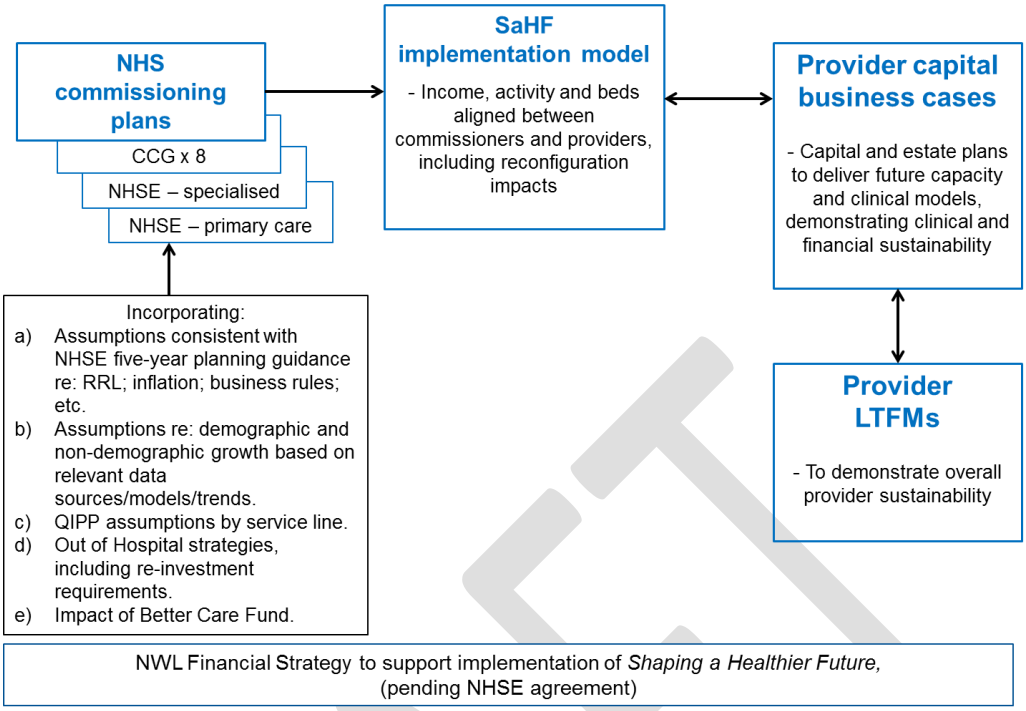


1.5 Within this context, the remainder of this section sets out:

- The financial challenge facing NW London commissioners and providers
- The strategic response
- Five-year finance and activity modelling to 18/19
- Two-year operational plans (14/15 – 15/16), including Better Care Fund
- Capital investment
- Supporting implementation – NWL Financial Strategy
- Financial risk assessment and sensitivity analysis

# 2. Financial challenge

2.1 Commissioners

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

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

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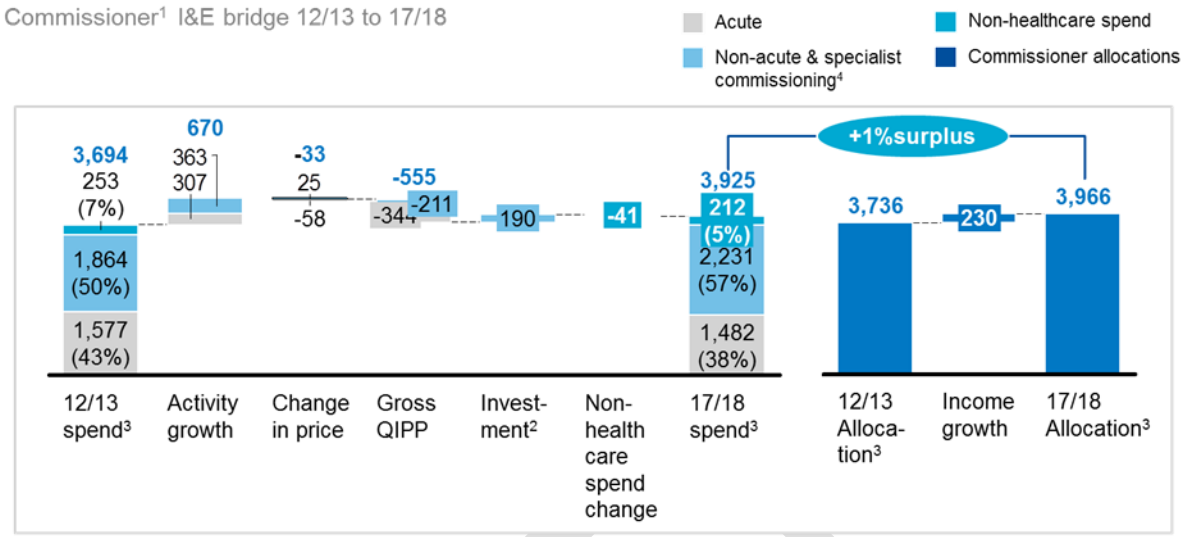


Note: Commissioner forecast assumptions and plans developed for modelling purposes based on extrapolation from existing OOH plans. High level findings agreed with CCG finance leads as representing the best available estimates at the time of the analysis

1 Commissioner model based on PCT unified allocations/expenditure. From 2013/14 the split of commissioning responsibilities and allocations between CCGs/NCB/PHE, etc., is not expected to change the strategic intention of rebalancing acute and out of hospital services, nor the QIPP impact on acute Trusts and re-investment in OOH services modelled here

2 The £190m covers reprovision of all QIPP , as well as the £0.5m recurrent spend required to fund the 10 additional paramedics for the London Ambulance Service; For modelling purposes, none of this investment is assumed within acute Trusts income

3 Surplus is carried forward but not included in the spend

4 Trusts I&E models include acute and Trust –specific proportion of specialist commissioning

Source: NWL Commissioner forecast model

2.2 The Commissioner analysis has subsequently been updated to reflect a) CCG/NHSE split of commissioning responsibilities, b) 13/14 outturn and c) the five year financial plans for 14/15 – 18/19.

The updated CCG five year financial plans for 14/15-18/19 are consistent with NHS England planning guidelines, as follows:

| **Consistency with NHSE Five-Year Planning Guidelines** | |
|---|---|
| a) RRL growth assumptions | Allocation growth as confirmed for 14/15 – 15/16, plus projections for 16/17 – 18/19 |
| b) Inflation assumptions | Reflect national tariff uplifts and NHSE guidance |
| c) Efficiency assumptions | Plans incorporate QIPP (see below) |
| d) Running costs including required reductions | The business case for CSU changes demonstrates how the reduction in running costs will be achieved |
| e) Annual in year surplus requirement of at least 1% | Yes – see bridge analysis below |
| f) Business rules – non-recurrent head room | The NWL financial strategy (see section 7 below) incorporates this. |

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

| | **2013/14 FOT** | **2013/14 Underlying** |
|---|---|---|



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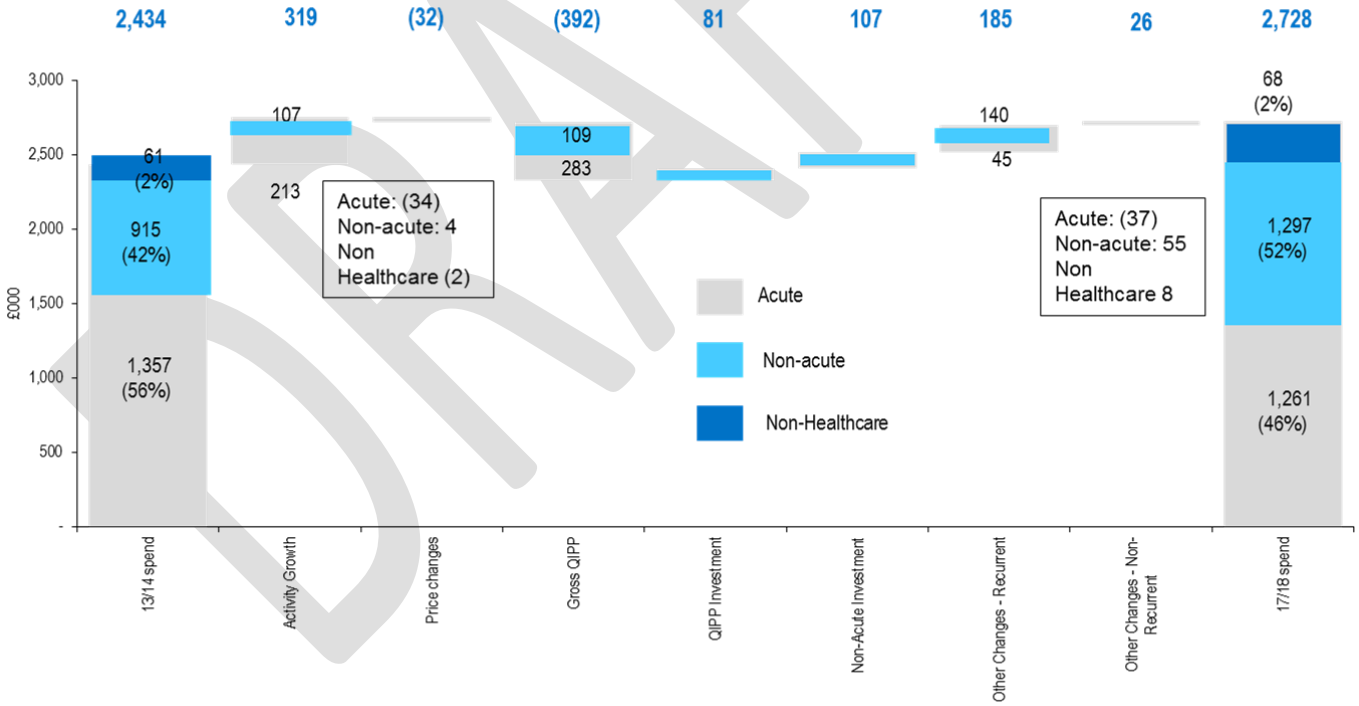
# Appendix G: Financial appendix

| | surplus/(deficit) | | surplus/(deficit) | |
|---|---|---|---|---|
| | £000s | % | £000s | % |
| Brent | 33,644 | 8.39% | 30,017 | 8.11% |
| Ealing | 6,900 | 1.67% | 9,124 | 2.20% |
| Harrow | (10,049) | (4.24%) | (13,639) | (5.92%) |
| Hillingdon | (5,007) | (1.7%) | (7,765) | (2.75%) |
| Central London | 16,938 | 4.60% | 11,990 | 4.60% |
| Hammersmith & Fulham | 12,327 | 5.08% | 15,083 | 6.22% |
| Hounslow | 1,932 | 0.68% | 552 | 0.19% |
| West London | 29,613 | 8.73% | 29,403 | 8.67% |
| **Total NWL CCGs** | **86,298** | 3.50% | **74,765** | 3.08% |

2.3 CCG Commissioner bridge – the chart below summarises the forecast movements between 13/14 and 17/18. (17/18 is presented in order to maintain consistency with DMBC timelines and modelling – this modelling will be extended to 18/19 for the ImBC analysis).

**CCG Commissioner Bridge – April 2014**




Notes:

- The bridge information is drawn directly from the eight NHSE plans submitted on 4th April (Hounslow and H&F provided an additional updated submitted 1st May)
- From the NHSE submissions Non-Acute includes Mental Health Services, Community Services, Continuing Care, Primary Care Services and Other Programme Services
- The Non-Healthcare is Running Costs and Contingency

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- QIPP investment links directly to QIPP investment on the NHSE submission
- Non-Acute Investment links to Investment on the NHSE submission
- Other Changes Recurrent links to Other FYE Impact and Other Recurrent Cost Pressures in the NHSE Submission

2.4 The total CCG QIPP and growth is analysed between acute and non-acute, and the gross acute QIPP and growth in 2014/15 to 2017/18 by NWL CCG and provider. The NWL gross acute QIPP of £251m and growth of £154m is expected to impact on Trusts as follows:

| £'000 | Brent CCG | Harrow CCG | Hillingdon CCG | Ealing CCG | Central London CCG | West London CCG | H&F CCG | Hounslow CCG | Total | | Growth |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Central Middlesex | -8,606 | -3,151 | -125 | -1,030 | 0 | -8 | 0 | 0 | -12,920 | | 8,179 |
| Charing Cross | -1,547 | -378 | -194 | -2,922 | -1,877 | -4,036 | -6,336 | -1,792 | -19,082 | | 16,069 |
| Chelsea & Westminster | 0 | -296 | 0 | 0 | -6,660 | -13,911 | -3,736 | 0 | -24,603 | | 16,206 |
| Ealing | 0 | -268 | 0 | -23,159 | 0 | -4 | 0 | 0 | -23,431 | | 14,874 |
| Hammersmith | -2,731 | -1,160 | -339 | -4,162 | -1,942 | -4,571 | -4,229 | -1,251 | -20,385 | | 16,631 |
| Hillingdon | 0 | -1,399 | -45,026 | -636 | 0 | -6 | 0 | 0 | -47,067 | | 18,375 |
| Northwick Park & St. Mark's | -14,511 | -27,265 | -839 | -2,805 | 0 | -12 | 0 | 0 | -45,431 | | 26,052 |
| St. Mary's | -6,669 | -871 | -269 | -1,631 | -10,796 | -12,365 | -1,538 | -591 | -34,730 | | 21,080 |
| West Middlesex | 0 | -13 | 0 | 0 | 0 | -2 | 0 | -23,118 | -23,133 | | 16,581 |
| Total | -34,064 | -34,802 | -46,792 | -36,345 | -21,274 | -34,916 | -15,838 | -26,752 | -250,784 | | 154,046 |
| Growth | 23,195 | 15,676 | 19,328 | 30,758 | 11,192 | 15,865 | 15,854 | 22,178 | 154,046 | | |

Note: the above represents the elements of CCG QIPP and growth applied to NWL providers (the balance is non-NWL providers).

2.5 NHS England commissioning comprises two main elements:

a) Specialised commissioning

Specialised commissioning is commissioned on a provider basis, as opposed to population based. The 13/14 outturn for NWL providers is set out in the table below:



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### Specialised commisisonig 13/14 outturn: NWL providers

In terms of future year projections, NHSE have advised to assume growth of 5% and QIPP of 3%. These projections are incorporated in the total acute provider projections (see below). However it should be noted that these projections are subject to change (as a result of affordability, revision to specialised commissioning scope etc.).

| Mental Health | Budget | Outturn | (underspend)/overspend |
|---|---|---|---|
| C & NW LONDON NHSFT | 39,813,484 | 40,296,120 | 482,636 |
| W LONDON MH NHST | 123,849,134 | 123,722,134 | -127,000 |
| **Sub-total Mental Health** | **163,662,618** | **164,018,254** | **355,636** |
| **North West** | | | |
| CHEL WESTMS HOSP NHS FT | 102,815,486 | 107,434,306 | 4,618,820 |
| EALING HOSP NHS TRUST | 9,727,150 | 9,290,620 | -436,530 |
| IMP COLLEGE HC NFT | 267,773,713 | 285,411,651 | 17,637,938 |
| NW LONDON HOSP NHST | 60,295,337 | 60,287,274 | -8,063 |
| ROY BROMP HARE NHSFT | 202,552,047 | 211,248,397 | 8,696,350 |
| THE HILLINGDON HOSP NHS FT | 12,583,425 | 12,909,608 | 326,183 |
| WEST MIDDLESEX UNIV NHS TRUST | 7,177,730 | 7,576,880 | 399,149 |
| **Sub-total North West** | **662,924,888** | **694,158,736** | **31,233,847** |
| **#N/A** | | | |
| LONDON AMBULANCE NHST | 588,155 | 588,155 | 0 |
| **TOTAL** | **827,175,661** | **858,765,145** | **31,589,483** |

b) Primary care

The 14/15 budget for primary care in NW London totals £413.3m, as per the table below:

| **GP services** | £m | £m |
|---|---|---|
| Brent | 38.0 | |
| Ealing | 42.1 | |
| Hammersmith & Fulham | 22.6 | |
| Harrow | 26.5 | |
| Hillingdon | 30.8 | |
| Hounslow | 34.6 | |
| Kensington & Chelsea | 27.7 | |
| West | 33.9 | **256.3** |
| **Dental** | | **84.7** |
| **Ophthalmology** | | **18.9** |
| **Pharmacy** | | **53.4** |
| **TOTAL** | | **413.3** |

NWL CCGs are currently exploring NHSE options for potential co-commissioning of some of the above services.

2.6 The combined CCG and NHSE QIPP/growth for 14/15 – 17/18 by Commissioner and Provider is summarised in the table below.

# Appendix G: Financial appendix

Applying QIPP and Growth for NHSE and non NWL CCGs (this is based on DMBC proportions however individual Trusts will make their own assumptions in OBCs based on local discussions with relevant CCGs) to the totals for NWL CCGs, the table below shows that total QIPP applied to Trusts is £356m with growth of £284m:

| £'000 | CCG Total | NHS England | Non-NWL CCG / Other | Total | | Growth |
|---|---|---|---|---|---|---|
| Central Middlesex | -12,920 | -500 | -1,528 | -14,948 | | 9,851 |
| Charing Cross | -19,082 | -9,046 | -4,208 | -32,336 | | 33,837 |
| Chelsea & Westminster | -24,603 | -13,585 | -13,185 | -51,373 | | 46,217 |
| Ealing | -23,431 | -1,187 | -47 | -24,665 | | 17,192 |
| Hammersmith | -20,385 | -16,680 | -3,098 | -40,163 | | 47,108 |
| Hillingdon | -47,067 | -1,147 | -2,116 | -50,330 | | 21,641 |
| Northwick Park & St. Mark's | -45,431 | -8,645 | -7,310 | -61,386 | | 45,779 |
| St. Mary's | -34,730 | -9,255 | -5,820 | -49,805 | | 39,867 |
| West Middlesex | -23,133 | -1,142 | -7,147 | -31,422 | | 22,342 |
| Total | -250,784 | -61,187 | -44,459 | -356,430 | | 283,833 |
| Growth | 154,046 | 103,670 | 26,116 | 283,832 | | |

The total 14/15 to 17/18 QIPP and Growth by Provider and POD (all Commissioners) is shown in the table below and summarises the £356m QIPP and £284m Growth by provider and POD:

| £'000 | Elective | Non-Elective | Outpatients | A&E | Maternity | Critical Care | Other | Total | | Growth |
|---|---|---|---|---|---|---|---|---|---|---|
| Central Middlesex | -1,681 | -4,968 | -5,360 | -253 | 0 | 0 | -2,010 | -14,271 | | 9,851 |
| Charing Cross | -4,153 | -14,893 | -10,960 | -904 | 0 | -395 | -5,627 | -36,931 | | 33,837 |
| Chelsea & Westminster | -2,430 | -16,489 | -18,028 | -793 | -142 | -692 | -12,799 | -51,373 | | 46,217 |
| Ealing | -87 | -6,503 | -15,350 | -3 | -229 | 0 | -2,492 | -24,665 | | 17,192 |
| Hammersmith | -8,819 | -14,055 | -8,653 | -463 | -239 | -1,521 | -7,805 | -41,555 | | 47,108 |
| Hillingdon | -5,270 | -18,535 | -13,655 | -3,602 | -232 | -32 | -9,005 | -50,330 | | 21,641 |
| Northwick Park & St. Mark's | -3,562 | -24,200 | -16,478 | -2,908 | 0 | 0 | -14,916 | -62,063 | | 45,779 |
| St. Mary's | -1,420 | -16,220 | -14,000 | -1,708 | -98 | -1,346 | -9,027 | -43,819 | | 39,867 |
| West Middlesex | -829 | -26,445 | -2,167 | -823 | -228 | 0 | -930 | -31,422 | | 22,342 |
| Total | -28,249 | -142,307 | -104,653 | -11,456 | -1,169 | -3,986 | -64,610 | -356,429 | | 283,833 |
| Growth | 62,146 | 60,966 | 45,824 | 10,685 | 13,232 | 15,331 | 75,647 | 283,832 | | |

**a) Providers**

The 13/14 outturn of the acute providers is shown in the table below. Both reported surplus/deficit and normalised (excluding non-recurrent items) are shown.

| | Surplus/(deficit) (£000s) | |
|---|---|---|
| | Reported | Normalised |
| **Imperial** | 15,128 | 20,502 |
| **ChelWest** | 7,409 | 1,464 |
| **West Middlesex** | (5,376) | (5,970) |
| **Ealing** | 220 | (8,804) |
| **NWLH** | (23,334) | (32,537) |
| **Hillingdon** | (744) | 194 |
| **TOTAL** | (6,697) | (25,151) |

[Add information from TDA re: Trust plans for 14/15 – 18/19 – however, not available until 20 June]

# 3. Strategic response

4.1 The DMBC financial and activity modelling provided a comprehensive analysis of the affordability and value for money of SaHF, building upon that in the Pre-Consultation Business Case (PCBC). The key features included:

a) **Confirmation of the preferred option**, based on NPV analyses, the value for money assessment of the options and the sensitivity analysis supporting this conclusion.

b) **Support for further consideration of alternative developments at the Local Hospitals**. (Noting the nature and amount of services should be explored further to test and demonstrate affordability and on-going viability).

c) **Support strategic outline case proposals for capital investment in out-of-hospital** estate to support the reconfiguration including:

- **i.** Capital investment in hubs
- **ii.** Capital investment in GP premises

As part of DMBC development the Finance and Business Planning (F&BP) group was tasked with overseeing the evaluation of the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The group was tasked with advising on the value for money of the options consulted upon both relative to each other, and compared to the 'do nothing' (i.e. current configuration) situation.

The analysis indicated that:

- Commissioner forecasts over the five years involve gross QIPP of £550m with reinvestment in out of hospital services of £190m.
- The acute trust I&E forecast in the 'do nothing' was that most sites would move into deficit with no overall net surplus. In the downside scenario there would be an overall deficit of £89m with all bar one acute site in deficit.

The value for money evaluation criteria used to assess the options were:

- Capital costs
- Transition costs
- Site viability
- Total trust surplus/deficit
- Net present value.

The preferred option required net capital investment of £206m to implement the major hospital model, resulting in a positive I&E position of £42m for the acute sector and has a positive net present value. For all options, the capital investment in out of hospital estates required to deliver the required changes was assessed at £6m-112m for hubs and up to £74m for GP premises.

4.2 The DMBC model suggested remaining provider sites would be viable with the exception of CMH.

The DMBC identified a £42m net improvement in provider positions as a result of the reconfiguration changes, as shown in the table below:

**Net surplus/(deficit) at site level in 17/18**

| Site | Do nothing | | | Option A | | |
|---|---|---|---|---|---|---|
| | I | C | S/D | I | C | S/D |
| St Mary's | 326 | 320 | 6 | 427 | 415 | 12 |
| Hammersmith | 327 | 325 | 2 | 361 | 353 | 7 |
| Charing Cross | 245 | 231 | 14 | 17 | 16 | 1 |
| Chelsea & Westminster | 332 | 323 | 8 | 417 | 390 | 27 |
| West Middlesex | 122 | 130 | -8 | 180 | 178 | 2 |
| Ealing | 110 | 111 | -1 | 15 | 15 | 0 |
| Central Middlesex | 65 | 76 | -10 | 31 | 41 | -11 |
| Northwick Park & St. Mark's | 247 | 255 | -8 | 294 | 293 | 1 |
| Hillingdon[1] | 135 | 140 | -4 | 156 | 155 | 1 |
| NWL Total[2] | 1,910 | 1,910 | 0 | 1,897 | 1,856 | 42 |



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4.3 Capital investment summary

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

| DMBC | |
|---|---|
| | Net capital (£m) |
| Acute (net)[1] | 230 |
| Hubs | 6-112 |
| Primary Care | 32-74 |
| **Total** | **268-416** |

[1]Based on minimum scope of local hospitals

4.4 Out of Hospital Strategies

The DMBC included Out of Hospital strategies for all 8 PCTs, and these were triangulated with acute activity projections, as summarised in the table below:

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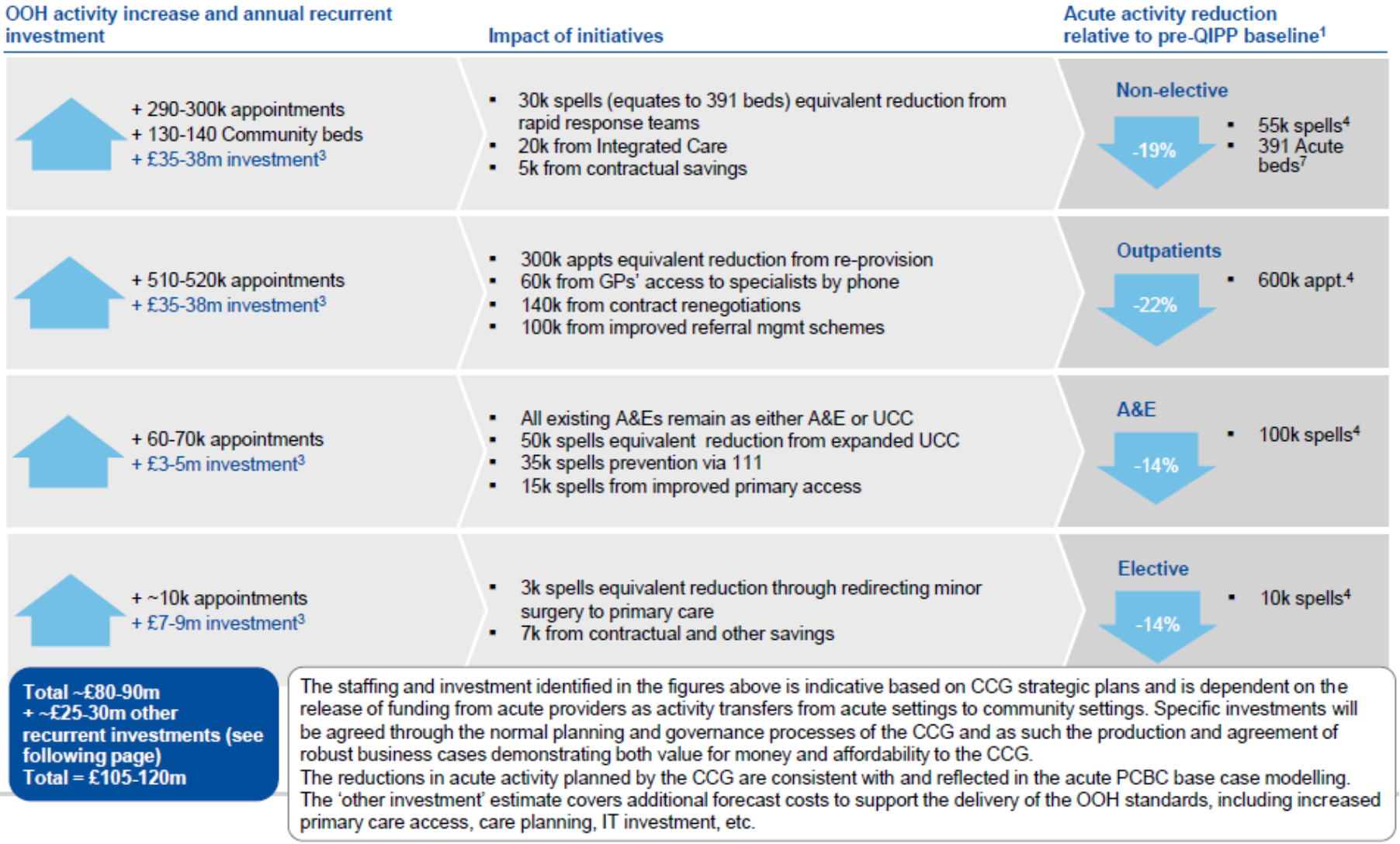
# Appendix G: Financial appendix



4.5 Central Middlesex Hospital (CMH)

Further to the DMBC analysis, which identified that CMH remained unviable, a dedicated programme was established to review options for the future of CMH.

This resulted in the agreement of a Strategic Outline Case (SOC); the key features of which are as follows:

a) Background

- The hospital site currently operates at an £11m deficit each year (forecast to rise to £15.3M) and is a major contributor to the overall deficit for North West London Hospitals NHS Trust.
- One of the decisions made as part of Shaping a Healthier Future was "that Central Middlesex Hospital should be developed in line with the local and elective hospital models of care including an Urgent Care Centre operating 24 hours a day, 7 days a week".
- The Brent out of hospital strategy, which was also agreed as part of Shaping a Healthier Future, set out a range of primary and community care services that will also be provided at Central Middlesex Hospital, as it becomes one of the local primary care hubs.
- However, under these agreed plans for Shaping a Healthier Future, Central Middlesex Hospital remains an underutilised site and will produce a financial deficit indefinitely if steps are not taken to resolve this.
- Extensive engagement was undertaken as part of the Shaping a Healthier Future consultation and feedback showed that stakeholders expressed opposition to any closure of the site. Further engagement has been undertaken during the development of this Strategic Outline Case.

b) Options development and evaluation

- It was agreed that Shaping a Healthier Future plans would be the starting point for the work –the baseline – as this is the service specification that has been consulted on.
- Options for the future of the Central Middlesex Hospital site were developed and evaluated.
- Sensitivity analysis was used to test the options before a final recommendation was made. A programme of workshops and interviews supported this work.

Two options were proposed:

- Option 1 – Optimise services at Central Middlesex Hospital
- Option 2 – Remove all services and dispose of the site

Further detailed work was done to develop proposals for Option 1 and then evaluate these using a set of hurdle criteria and the Shaping a Healthier Future evaluation criteria (clinical quality, access, value for money, deliverability, research and education). This evaluation was done in two phases, first by an Independent Clinical Panel and then a review of the impact on access. Value for money analysis was not undertaken at this stage.

Four proposals were adopted for Option 1:

A. Hub plus for Brent
B. Orthopaedic elective centre
C. Re-house mental health services from Park Royal Centre for Mental Health
D. Relocate regional genetics service from Northwick Park Hospital

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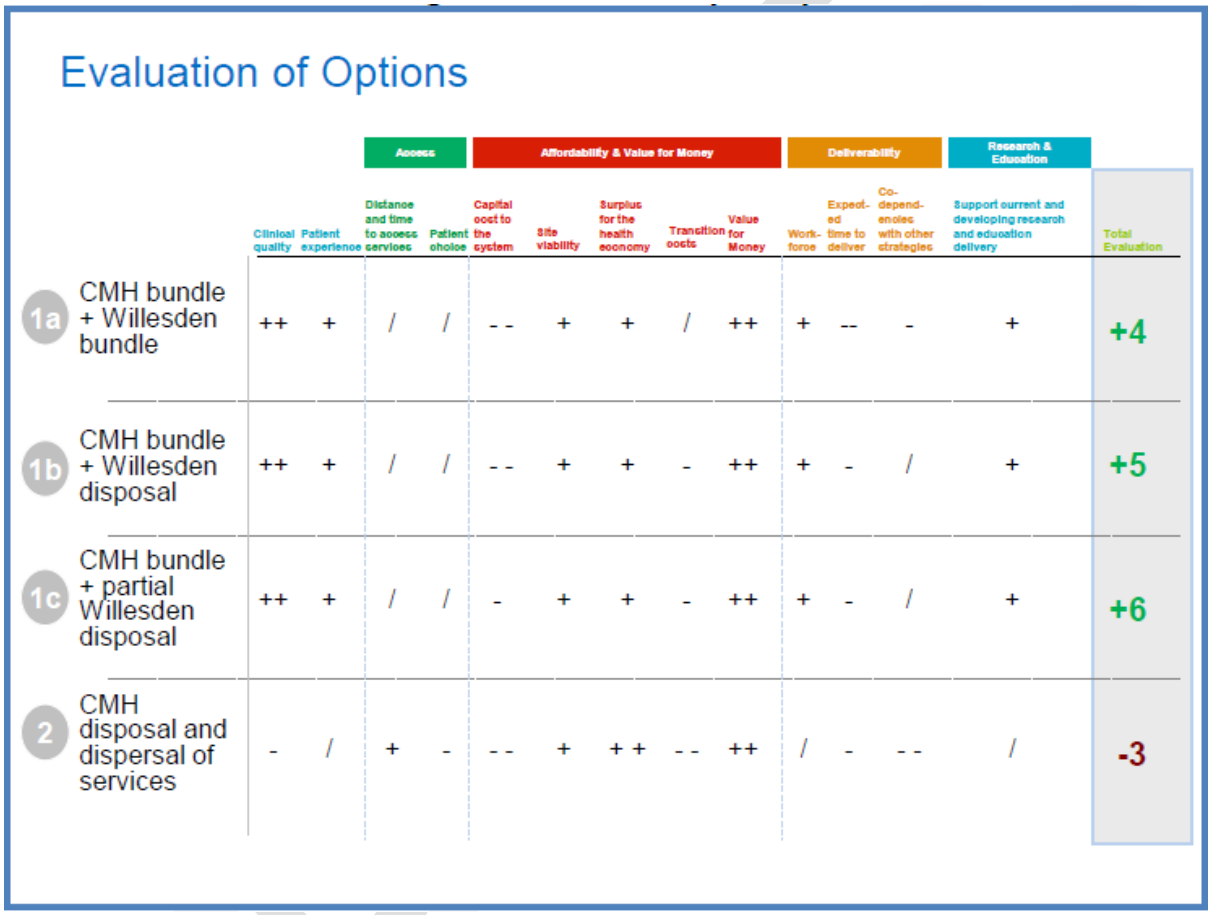
# Appendix G: Financial appendix

Proposals to relocate specialist rehabilitation services from Northwick Park Hospital and to move some or all of St Mark's Hospital were rejected mainly because of their co-dependencies with service on the Northwick Park Hospital site.
Proposal A (Hub plus for Brent) has an impact on the Willesden Centre for Health and Care as it proposes moving 41 rehabilitation beds from Willesden Centre for Health and Care to Central Middlesex Hospital. This resulted in three sub-options for Option 1:

1A. Back-fill Willesden Centre for Health and Care
1B. Close Willesden Centre for Health and Care
1C. Partially close Willesden Centre for Health and Care




The four options (1A, 1B, 1C and 2) were evaluated using the *Shaping a healthier future* evaluation criteria including a value for money analysis, as follows:

The evaluation of the options show that Option 1c optimise services at Central Middlesex Hospital and partially dispose of Willesden Centre for Health & Care is the preferred option as it improves clinical quality, patient experience, site viability, health economy surplus, workforce and supporting R&D compared to the Shaping a Healthier Future proposal. It compares better to the other options for Willesden Centre for Health and Care. The financial analysis for option 1a, assumes that the space at Willesden is fully utilised by moving services from elsewhere and releasing costs in other sites.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However, following work on options to fill this space, it appears to be highly unlikely that the space could be filled and costs released, this is reflected in the deliverability evaluation for Option 1a. Additional capital investment is required under all options at Central Middlesex Hospital, the Willesden Centre for Health & Care and at other sites depending on the option under consideration.

Option 2, to remove all services from Central Middlesex Hospital and dispose of the site, was evaluated as being worse than, or the same as, Option 1 on all criteria except access (because some people currently go to Central Middlesex for elective care even though it is not their nearest hospital) and health economy surplus (because Central Middlesex is a relatively expensive building). Option 2 was evaluated as being significantly worse than Option 1 for clinical quality (it would prevent the development of an elective centre) and co-dependencies with other strategies (because it directly contradicts what was agreed in Shaping a Healthier Future and confirmed by the Secretary of State).

c) Conclusion

The final recommendation therefore was to optimise services at Central Middlesex Hospital so that Central Middlesex Hospital will provide:

- Urgent care, via an urgent care centre
- 167,000 Outpatient appointments, with access to specialists
- Orthopaedics elective centre for North West London with activity moving from Northwick Park Hospital, Ealing Hospital and Imperial Hospitals NHS Trust, supported by a Level 2 ITU
- Other elective care (which is currently provided by North West London Hospitals NHS Trust and Ealing Hospital NHS Trust at other sites).
- Simple diagnostics (X-ray and ultrasound)
- GP and nurse appointments
- High risk primary care patients
- Extra hours including out of hours
- Community therapies
- 24/7 psychiatric liaison service
- 41 rehabilitation beds (moved from Willesden Centre for Health & Care)
- Mental health services including a mother and baby unit, an acute assessment service, treatment wards
- Central pharmacy service for Central North West London NHS Foundation Trust (and servicing the Central Middlesex Hospital site).
- Regional genetics services for North West London and surrounding counties

This will leave Central Middlesex Hospital with an on-going deficit of c. £3.3m and vacant space of 1,033m2 (less than 5% of available space). This is based on the assumption that all of the costs are met by the occupiers of the site, which has yet to be agreed.
It was noted that Willesden Centre for Health & Care would be likely to provide services including GP practices, child & adolescent mental health services (CAMHS) and the static breast-screening unit consolidated onto the Willesden Centre for Health & Care site. This would not use all the space at Willesden Centre for Health & Care and would require estimated capital investment of £0.6m for refurbishment, together with the cost associated with the partial disposal of the PFI building.

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The site at Park Royal Centre for Mental Health will be closed. Central and North West London NHS Foundation Trust (who own the site) were working through options for relocating the Low Secure Unit currently at Park Royal Centre for Mental Health.

A number of scenarios were modelled to test the sensitivity of the options to changes in key assumptions:

1. 20% reduction in net capital costs for each option
2. 50% reduction in the value achieved by backfilling Willesden Health & Care Centre under Option 1a
3. Central support amounting to £3.5m added to cover the excess PFI costs at Central Middlesex Hospital
4. Other users of Central Middlesex Hospital pay only their current costs for occupation of the site
5. The refurbishment of Central Middlesex Hospital is funded by NHS capital

Under all these scenarios Option 1c remained the best option except for Scenario 4 where Option 2 was viewed to be the best overall option. This was because in Scenario 4, the deficit at Central Middlesex Hospital was £12.1m under Option 1c compared to £1.7m for Option 2.

d) Next steps

An approvals process had been put in place to support the sign-off of the Strategic Outline Case. The implementation of the Strategic Outline Case anticipated the development of an Outline Business Case Business by the end of June 2014, a Full Business Case by the end of 2014, with the planned movement of services starting during 2015. Changes will be progressed subject to any necessary or appropriate consultation. Central North West London NHS Foundation Trust will need to develop its own business case for the movement of services from the Park Royal Centre for Mental Health.

There will be continuing public engagement and engagement with partner organisations such as the local authority and the Health Overview and Scrutiny Committee (HOSC).

## 4. Finance and Activity Modelling

4.1 The DMBC underpinning financial and activity modelling was overseen and agreed by a working group comprising the Finance Directors of all provider and commissioner organisations in North West London. This group was known as the Finance and Business Planning (F&BP) group.

The DMBC analysis was structured to provide a financial and economic analysis of alternative reconfiguration options against a base case. In order to maintain a macro financial overview and to support the alignment of Commissioner / Provider planning parameters during implementation, an Implementation Model has been developed.

4.2 Following the approval of the JCPCT to proceed, a Finance and Activity Modelling (FAM) group was established, with membership largely common to the F&BP group, tasked with taking the work forward and ensuring the overall alignment of Trust Outline Business Cases (OBCs) with the overall Implementation Model.



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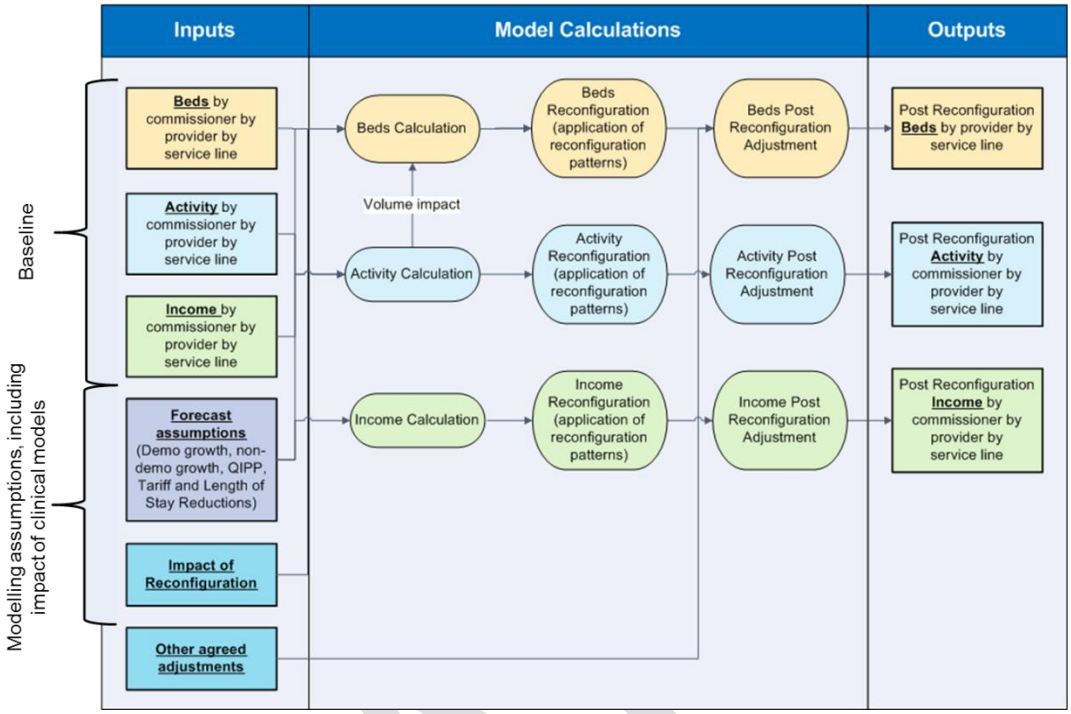
The Implementation model is also being used to ensure alignment with other strategic plans e.g. FT applications, merger Business Cases etc.

4.3 The functionality of SaHF implementation Finance and Activity Model is summarised below:

| What the model does | What the model does NOT do |
|---|---|
| • **Replicate core DMBC modelling** - activity, income and bed forecast by site and by service line, under current configuration and planned reconfiguration. Includes flows of acute activity to Local Hospitals<br>• **Produce outputs by commissioner and provider** (DMBC outputs only by provider)<br>• **Take inputs of latest commissioner and provider data in future years**; subsequent years then re-forecasted from that new starting point<br>• **Model phased implementation plans** to produce year by year forecasts (not yet utilised)<br>• **Incorporates results of detailed travel time modelling** redone at level of each commissioner and site (DMBC analysis at site level)<br>• **Allow users to adjust assumptions at the most granular level** (e.g. demand growth, price change, QIPP, ALOS, patient flows) and model dynamically refreshes outputs<br>• **Calculates tracking indicators** on latest commissioner and provider data to compare performance versus original plan | • **Model trust expenditure, estate changes or capital investments** – these will rest with the trust business cases<br>• **Model comprehensive commissioner I&E** (including allocations, and non-Acute spend) – this will rest with commissioners' strategic plans<br>• **Model at more detail than the >7,000 lines** representing every combination of service lines (35 lines), commissioners (12 commissioners), and sites (17 sites) - however, the definition of these lines can be altered if base data and assumptions are also refreshed. In particular, the model is not at specialty or HRG level – more detailed side analyses can be done outside of the model, and then applied to the service line figures output by the model<br>• **Include integrated travel time model** – however, the model will be populated with the results of travel time analysis, and users can refine assumptions on patient flows at the most granular level<br>• **Forecast beyond 5 years** – current forecast period is the 5 years from 12/13 to 17/18 |

The schematic below shows the structure and configuration of the model:




4.4 Running the Model for 2017/18 Income, Activity and Beds

Based on a) 2013/14 forecast outturn data, b) the refreshed commissioner growth / QIPP forecasts and c) other key planning assumptions (below), the Implementation Model has been updated over the period December 2013 – June 2014 to calculate updated forecasts of Trust Income, Activity and Beds.

The other key assumptions (that are largely unchanged from the DMBC) are:

- Length of stay (at 15% over 3 years) and headroom (5%)
- Reconfiguration impact – some changes to transition tables to ensure a consistent approach the DMBC
- All QIPP re-provision assumed to be in non-acute settings

4.5 The key outputs are as follows:

a) Activity

- Activity for 2017/18 is planned overall to increase for critical care, elective and maternity, and to reduce for A&E, non-elective and outpatients.
- The table below summarises the changes to activity at a POD level between 2013/14 (based on month 6 forecasts) and 2017/18. The table includes the movements between sites as a result of the planned reconfigurations:



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# Appendix G: Financial appendix

| | A&E | | Critical Care | | Elective | | Maternity births | | Non Elective | | Outpatient | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 | FOT 2013/14 | Model 2017/18 |
| Central Middlesex | 15,075 | 1,714 | 1,695 | 0 | 15,534 | 20,224 | 0 | 0 | 7,481 | 0 | 119,906 | 78,570 |
| Charing Cross | 36,031 | 7,726 | 9,718 | 0 | 45,120 | 120 | 0 | 0 | 19,833 | 55 | 214,280 | 170,346 |
| Chelsea & Westminster | 42,130 | 57,090 | 4,166 | 6,518 | 43,876 | 53,478 | 5,307 | 6,000 | 20,789 | 27,518 | 521,767 | 484,843 |
| Ealing | 40,593 | 14,890 | 3,116 | 0 | 12,687 | 0 | 2,454 | 0 | 21,264 | 0 | 134,977 | 102,343 |
| Hammersmith | 22,918 | 21,200 | 17,082 | 24,604 | 325,169 | 354,839 | 4,915 | 6,000 | 13,328 | 14,476 | 149,009 | 135,200 |
| Hillingdon | 87,494 | 54,735 | 4,028 | 5,205 | 16,456 | 20,311 | 4,033 | 6,000 | 23,724 | 22,165 | 295,174 | 232,250 |
| Northwick Park & St. Mark's | 86,645 | 79,307 | 6,716 | 10,141 | 34,924 | 40,855 | 4,901 | 6,000 | 42,092 | 46,439 | 326,462 | 265,059 |
| St. Mary's | 118,542 | 110,865 | 13,183 | 18,515 | 30,356 | 72,350 | 3,600 | 3,000 | 17,932 | 19,035 | 277,307 | 230,668 |
| West Middlesex | 55,174 | 68,575 | 2,978 | 5,722 | 13,918 | 22,686 | 4,998 | 6,000 | 21,374 | 31,331 | 170,414 | 153,780 |
| Grand Total | 504,602 | 416,103 | 62,682 | 70,704 | 538,040 | 584,863 | 30,208 | 33,000 | 187,817 | 161,019 | 2,209,296 | 1,853,060 |
| % Change | | -18% | | 13% | | 9% | | 9% | | -14% | | -16% |

The table below compares the percentage activity changes between the DMBC (13/14 to 17/18) and the refresh (14/15 to 17/18):

| % MOVEMENT | A&E | | Critical Care | | Elective | | Maternity | | Non Elective | | Outpatient | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement | DMBC % movement | Revised % movement |
| Central Middlesex | -86% | -89% | -100% | -100% | 110% | 30% | -100% | -100% | -100% | -100% | -57% | -34% |
| Charing Cross | -77% | -79% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -47% | -21% |
| Chelsea & Westminster | 42% | 36% | 45% | 56% | 20% | 22% | 16% | 13% | 4% | 32% | -19% | -7% |
| Ealing | -64% | -63% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -100% | -40% | -24% |
| Hammersmith | -2% | -7% | 1% | 44% | 5% | 9% | 20% | 22% | 6% | 9% | -9% | -9% |
| Hillingdon | -10% | -37% | 86% | 29% | 32% | 23% | 95% | 49% | -26% | -7% | -39% | -21% |
| Northwick Park & St. Mark's | -24% | -8% | 42% | 51% | 8% | 17% | 26% | 22% | -5% | 10% | -55% | -19% |
| St. Mary's | 0% | -6% | 19% | 40% | 89% | 138% | 16% | -17% | 17% | 6% | -17% | -17% |
| West Middlesex | -9% | 24% | 68% | 92% | 69% | 63% | 42% | 20% | 17% | 47% | -19% | -10% |
| Grand Total | -16% | -18% | 7% | 13% | 5% | 9% | 16% | 9% | -13% | -14% | -31% | -16% |

b) Beds

Beds Bridge DMBC v Refresh (13/14-17/18)

The DMBC projected a reduction in acute beds (from 3908 to 3160) predominantly as a result of net QIPP impacts plus length of stay reductions. In March, the projections were updated to reflect updated baseline information, plus revised activity projections. This showed a similar scale of change (see table below).

The movements between 3,990 in 2013/14 and 3,271 in 2017/18 are analysed below in respect of the breakdown between volume changes, average length of stay (reduction of 15%) and headroom (increase of 5%). These assumptions mirror the DMBC.

The table also shows the movements between sites as part of the reconfiguration:

| | Opening Beds | Volume Change | Reduction in average LOS | Headroom | Closing Beds | Reconfigur-ation | Closing Beds after Reconfig |
|---|---|---|---|---|---|---|---|
| St. Mary's | 435 | -38 | -59 | 15 | 353 | 151 | 504 |
| Hammersmith | 413 | -5 | -61 | 15 | 362 | 35 | 398 |
| Charing Cross | 484 | -26 | -71 | 19 | 406 | -394 | 12 |
| Chelsea & Westminster | 525 | -37 | -73 | 17 | 431 | 185 | 617 |
| West Middlesex | 468 | -43 | -64 | 15 | 377 | 185 | 562 |
| Ealing | 348 | -13 | -50 | 13 | 297 | -297 | 0 |
| Central Middlesex | 180 | -18 | -24 | 0 | 138 | -112 | 26 |
| Northwick Park & St. Mark's | 707 | -63 | -97 | 24 | 572 | 157 | 729 |
| Hillingdon | 430 | -52 | -57 | 14 | 335 | 58 | 393 |
| Acute Site/s - OTHER | 0 | 0 | 0 | 0 | 0 | 32 | 32 |
| **Total** | 3,990 | -294 | -557 | 132 | 3,271 | 0 | 3,271 |

Bed Bridge Comparison – DMBC v Refresh

The bed bridge from the DMBC to the refreshed model is compared below. This shows that Length of Stay and Headroom are broadly similar with the major movements driven by changes to activity volume:

| | DMBC | Revised | Variance |
|---|---|---|---|
| Opening Beds | 3,908 | 3,990 | 82 |
| Volume Change | -333 | -294 | 39 |
| Reduction in average LOS | -538 | -557 | -19 |
| Headroom | 124 | 132 | 8 |
| Closing Beds | 3,160 | 3,271 | 111 |
| Reconfiguration | 0 | 0 | 0 |
| Closing Bed after Reconfig | 3,160 | 3,271 | 111 |
| Net Reduction | (748) | (719) | 29 |

Of the total increase of 148 closing beds, 82 is due to a higher start point and 66 due to a lower net forecast reduction, the latter largely due to a reduction in the volume change.

The bed projections in March, and in particular the new build beds, have been used to inform Trust OBCs.



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As part of the forthcoming OBC assurance process, and ImBC analysis, the bed projections will be reviewed against bottom-up Trust estimates.

# 5. 2-year operational plans 14/15 – 15/16, including Better Care Fund

5.1. CCGs and Trusts in NW London have submitted operating plans to NHSE/TDA/Monitor as appropriate. All 14/15 contracts between NW London bodies are agreed [DN – check]

5.2. A key element of 14/15 operating plans is the Better Care Fund. CCG Out of Hospital plans align with Better Care Fund plans as follows:

| Out of Hospital strategies | Better Care Fund plans |
|---|---|
| • Early access to primary care<br>• Rapid response to prevent avoidable admissions<br>• Integrated care to proactively manage complex patients<br>• Planned care pathways<br>• Appropriate time in hospital | • Reduced emergency admissions<br>• Reduced permanent admissions of older people to residential and nursing care homes<br>• Increased proportion of older people at home 91 days after discharge from hospital into reablement / rehabilitation services<br>• Reduced delayed transfers of care<br>• Improved patient & service user experience |

- Delivery of BCF plans is an enabler to the delivery of our Out of Hospital strategies – i.e. they will support the shift of care from acute to community settings, and provider impacts are fully incorporated in CGG QIPP plans set out in section 2

Outcomes and Metrics

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

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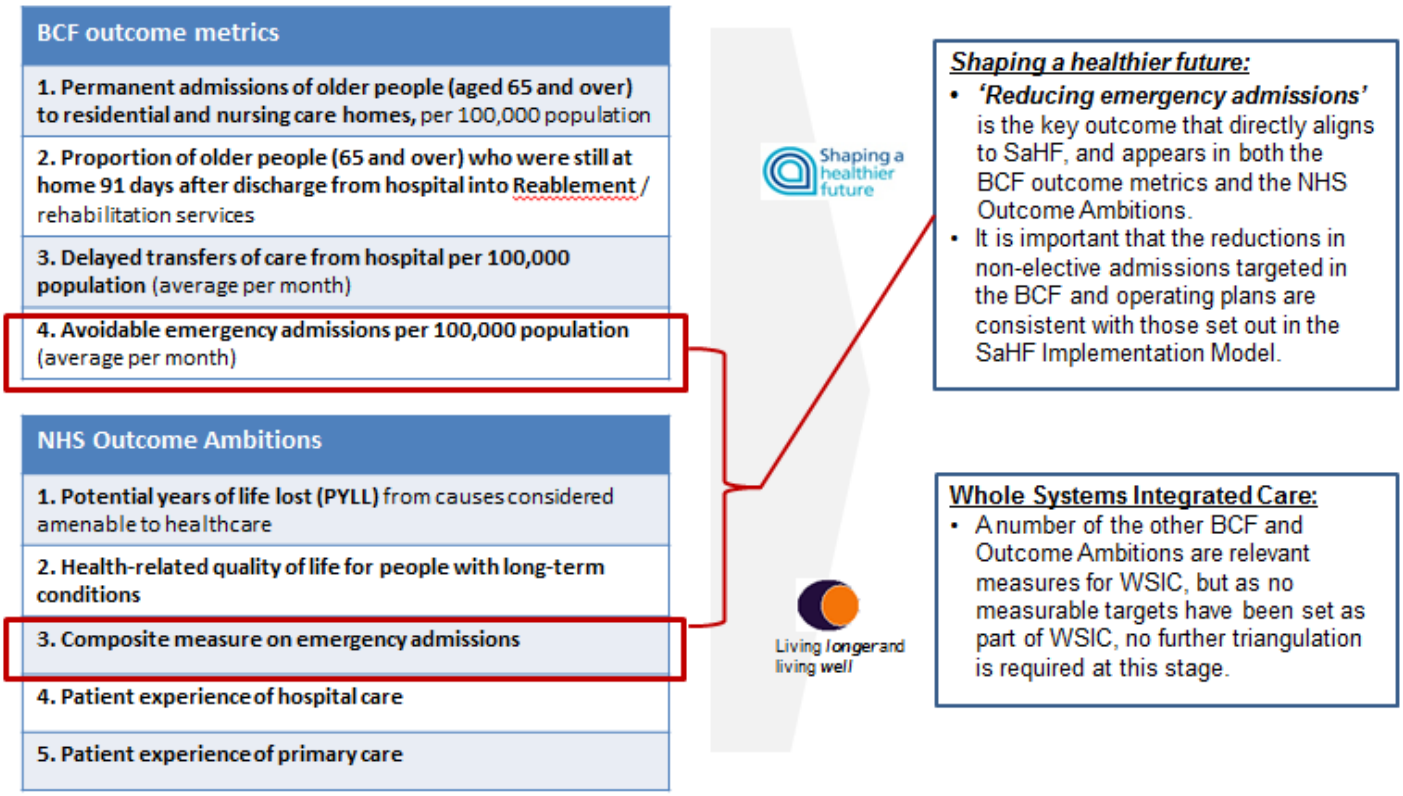
## Alignment of BCF to the NWL vision and key interventions




The Better Care Fund allocations within North West London total £40m for 2014/15, with a further £90m in 2015/16 (the latter contribution from core CCG funding), making a minimum revenue allocation of £130m.

The tri-borough BCF contributions are significantly higher than the mandated minimum allocations, mainly due to the fact that the full section 75 arrangements have been reflected.

The Acute provider impact of the BCF is incorporated in the CCG QIPP plans outlined in section 2.4.

| Organisation | Spending on BCF schemes in 14/15 /£000s | Minimum contribution (15/16) /£000s | Actual contribution (15/16) /£000s |
|---|---|---|---|
| London Borough of Ealing | £ 6,481 | £ 2,114 | £ 2,114 |
| Ealing CCG | £ 13,349 | £ 22,283 | £ 22,730 |
| **BCF Total Ealing** | **£ 19,830** | **£ 24,397** | **£ 24,844** |
| Westminster City Council | £ 28,766 | £ 1,379 | £ 26,252 |
| Royal Borough of Kensington and Chelsea | £ 22,946 | £ 874 | £ 22,004 |
| London Borough of Hammersmith and Fulham | 49,720 | £ 1,052 | £ 47,781 |
| Central London CCG | £ 26,171 | £ 13,553 | £ 42,788 |
| West London CCG | £ 15,911 | £ 17,830 | £ 39,746 |
| Hammersmith and Fulham CCG | £ 12,630 | £ 13,148 | £ 31,923 |



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| | | | |
|---|---|---|---|
| **BCF Total Triborough** | **£ 156,144** | **£ 47,836** | **£ 210,495** |
| London Borough of Hounslow | £ 833 | £ 1,610 | £ 1,610 |
| Hounslow CCG | £ 3,747 | £ 15,288 | £ 15,288 |
| **BCF Total Hounslow** | **£ 4,580** | **£ 16,898** | **£ 16,898** |
| Harrow Council | £ 3,560 | £ 1,190 | £ 1,190 |
| Harrow CCG | £ 885 | £ 13,183 | £ 13,183 |
| **BCF Total Harrow** | **£ 4,445** | **£ 14,373** | **£ 14,373** |
| Brent Local Authority | £ 6,156 | £ 6,156 | £ 6,156 |
| Brent Local Authority Disability Facilities Grant | | £ 1,852 | £ 1,852 |
| Brent Local Authority Social Care Capital Grant | | £ 748 | £ 748 |
| Brent CCG | | £ 13,676 | £ 13,700 |
| **BCF Total Brent** | **£ 6,156** | **£ 22,432** | **£ 22,456** |
| London Borough of Hillingdon | £ 4,772 | £ 2,349 | £ 2,349 |
| Hillingdon CCG | | £ 15,642 | £ 15,642 |
| **BCF Total Hillingdon** | **£ 4,772** | **£ 17,991** | **£ 17,991** |
| **BCF Total NW London** | **£ 195,927** | **£ 143,927** | **£ 307,057** |

*NB. Totals may not add due to rounding*

| | | | |
|---|---|---|---|
| Minimum revenue allocations | £ 40,697 | £ 130,759 | |

As a result of the NHSE/local government assurance process, further work is required on many local plans, particularly around the metrics and finance data, and on the extent of provider engagement in the planning process. In light of this, Ministers confirmed that no BCF plans would be formally signed off in April and that further time should be taken for CCGs and Councils, working with Health and Wellbeing Boards (HWBs), to refine their plans during June.

NSHE stated that in addition to resolving issues with the completeness and robustness of data submitted, there are a number of areas on which further information is required from CCGs and HWBs in order to ensure a rigorous assurance process ahead of any plans being recommended for sign-off. CCGs and HWBs have been asked to provide a more detailed breakdown of planned investments and savings, clarification on the impact of the BCF on the total emergency admissions, and agreement on the consequential impact on the acute sector.

NWL London will be reviewing NHSE guidance and submitting updated data templates in line with the NHSE timetable for 27 June 2014.

## 6. Capital Investment

a) DMBC summary

As described earlier in section 3, the net capital investments in the DMBC were £230m Acute, £6-112m Out of Hospital hubs and £32-74m Primary Care (totalling (£268-416m).

b) Latest position

Acute

Trusts are in the process of producing OBCs and these are due to go through the assurance process described in section 1.1 over the coming months.

Out of Hospital Hubs

**Estimated capital value of NWL hub cases in development (as at 11/06/14)**

| CCG | Description | Stage | Estimated Capital Value £ | Commentary |
|---|---|---|---|---|
| Brent | Wembley | OBC in development | 500 | |
| Brent | Willesden | PID not yet started | 1,908 | |
| Brent | CMH Hub Plus | OBC in development | TBC | |
| Central | Fitzrovia | OBC submitted | 424 | SDLT, equipment, project costs (all incl VAT) and lease exit costs |
| Central | Church St | OBC in development | 6,900 | |
| Central | St Mary's | OBC in development | TBC | |
| Ealing | Acton Health Centre | OBC in development | 7,738 | |
| Ealing | Ealing Hospital Hub | OBC in development | TBC | |
| Harrow | NE Locality Belmont/Kenmore | OBC in development | 11,500 | |
| Hillingdon | Uxbridge and West Drayton Locality | PID in development | 5,000 | The site has changed so this cost is currently very unclear |
| Hounslow | Heston | OBC submitted | 1,449 | Equipment, project costs and temporary accomodation, all incl VAT |
| West | St Charles | OBC in development | 5,800 | This was the estimate in the previous St Charles OBC and is now being reworked due to changes in the phased approach being taken at OBC |
| West | South Locality | OBC in development | 7,000 | As yet unkown, this is a holding figure from the PID |

| | |
|---|---|
| **Total** | **48,219** |

Notes:

1. Values stated are the total of estimated development and associated costs (equipment, project costs etc) for the preferred option, in the case of developed OBCs and options appraisals, or PID values.
2. Estimated construction costs for new build and refurbishment are included where it is anticipated that an NHS body or bodies will fund the scheme (e.g. DoH, NHS PS, NHSE, CCG) and excluded for schemes expected to be LIFT developments (e.g. Heston) or s106 (e.g. Fitzrovia).
3. Costs exclude VAT, other than as indicated in "Commentary".

NB. summary activity table to follow

Primary care

The latest position for primary care capital investment proposes implementing the suggested changes to GP estate across NWL requires approximately £49-73m is required. This comprises £21-34m for refurbishment and £28-39m for re-housing.
The key assumptions in this are:

- No capital receipts are assumed.
- Refurbishment is assumed to require £1,800/m2.



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- New build is £2,600/m2 plus land cost. Land cost is estimated based on a plot size three times the GIA (ratio derived from existing estate). Land costs vary by CCG.
- Co-location / re-housing in hub is captured in hub capital.
- Co-location / re-housing in existing sites assumed to have a refurbishment requirement.

c) Process for assuring affordability of recurrent costs

All capital investment will be rigorously assessed for affordability as part of the Business Case process. As well as all individual schemes being assessed as stand-alone Business Cases, the overarching SaHF DMBC economic and financial analysis will be updated as part of the Implementation Business Case.

## 7. NWL Financial Strategy

7.1. The NWL-wide financial strategy encompasses all eight NWL CCGs, plus NHS England and incorporates contributions from all organisations.

- The strategy comprises three component parts, however these are all integral and related parts of the overall strategy and as such the strategy is viewed as one pooled fund (under section 13V of the *NHS Act 2006)*, which provides that NHS England and one or more CCGs may establish and maintain a pooled fund, defined as: "*(a) a fund which is made up of contributions by the bodies which established it; and (b) out of which payments may be made, with the agreement of those bodies, towards expenditure incurred in the discharge of any of their commissioning functions".*

- The strategy enables all NWL CCGs to set a plan for 2014/15 in accordance with its statutory financial duty to ensure that its expenditure does not exceed the amount allocated.

- The strategy is consistent with the NHS England guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', which specifically anticipates that CCGs will work together to ensure strategies align. It also recognises that CCGs working together enables the pooling of resources.

- All aspects of the NWL financial strategy are subject to NHS England agreement as part of their review and sign-off of 14/15 Operating Plans for all CCGs, and as part of this, ensuring adherence to statutory and other requirements on CCGs. This is awaited.

- Subject to agreement, the mechanism to support the pooling of resources across CCGs can be undertaken by NHS England under section 223G(4) of the NHS Act 2006, whereby NHS England can make a new allotment, increasing or decreasing an allotment previously made.

7.2. It was agreed by the NWL Collaboration Board that all aspects of the financial strategy should be explicit enablers of the implementation of the NWL 5 year strategy (i.e. *Shaping a healthier future*).

The following specific objectives were therefore proposed for the strategy:

- all CCGs need to be in a position to be able to implement their Out-of-Hospital strategies in a consistent manner and timeframe.
- SaHF programme management needs to be adequately resourced.

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- significant investment in primary care (networks, estates etc.) is required to underpin OOH strategies across NWL.
- transition support for acute providers needs to be explicitly tied to SaHF implementation.
- the investment in NWL-wide S&T programmes (Whole Systems, 7 Day Working, Mental Health Transformation etc.) needed to support SaHF implementation

7.3. The business rationale for a NWL-wide financial strategy are:

- SaHF is a NWL-wide programme and the probability of successful implementation would be significantly enhanced by a NWL-wide financial strategy.
- Individual CCGs are in radically different financial positions with surpluses/deficits which are predominantly the result of inherited PCT positions, and surpluses/deficits correlate with under/over funding positions.
- If the wide disparity in CCG financial positions is not addressed through a NWL-wide financial strategy, SaHF implementation as a whole could be compromised.
- A NWL-wide financial strategy provides resilience to all CCGs in the light of potential future funding changes, and also in facing provider issues together.

7.4. The NWL Financial Strategy comprises three parts of an integrated whole:

- Part A - Pooling of CCG and NHS England non-recurrent headroom to support non-recurrent SaHF costs.
- Part B - Utilising CCG carry forward surpluses to enable Out-of-Hospital implementation across NWL
- Part C - Creation of SaHF Out-of-Hospital recurrent investment fund to support investment in Out-of-Hospital services.

7.5. <u>Part A</u>

- NHSE planning guidance for 2014/15 includes a requirement that:

"Commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. Recognising the need to accelerate efficiencies in 2014/15 both to prepare for the challenges of 15/16 and to create funding for service change, we have increased the level of non-recurrent expenditure in 14/15 to 2.5%."

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

| | **£m** |
|---|---|
| **Brent** | 9.4 |
| **Ealing** | 10.6 |
| **Central** | 6.2 |
| **Hammersmith & Fulham** | 6.1 |
| **West** | 8.4 |
| **NHS England** | 16.3 |
| **Total** | **57.0** |



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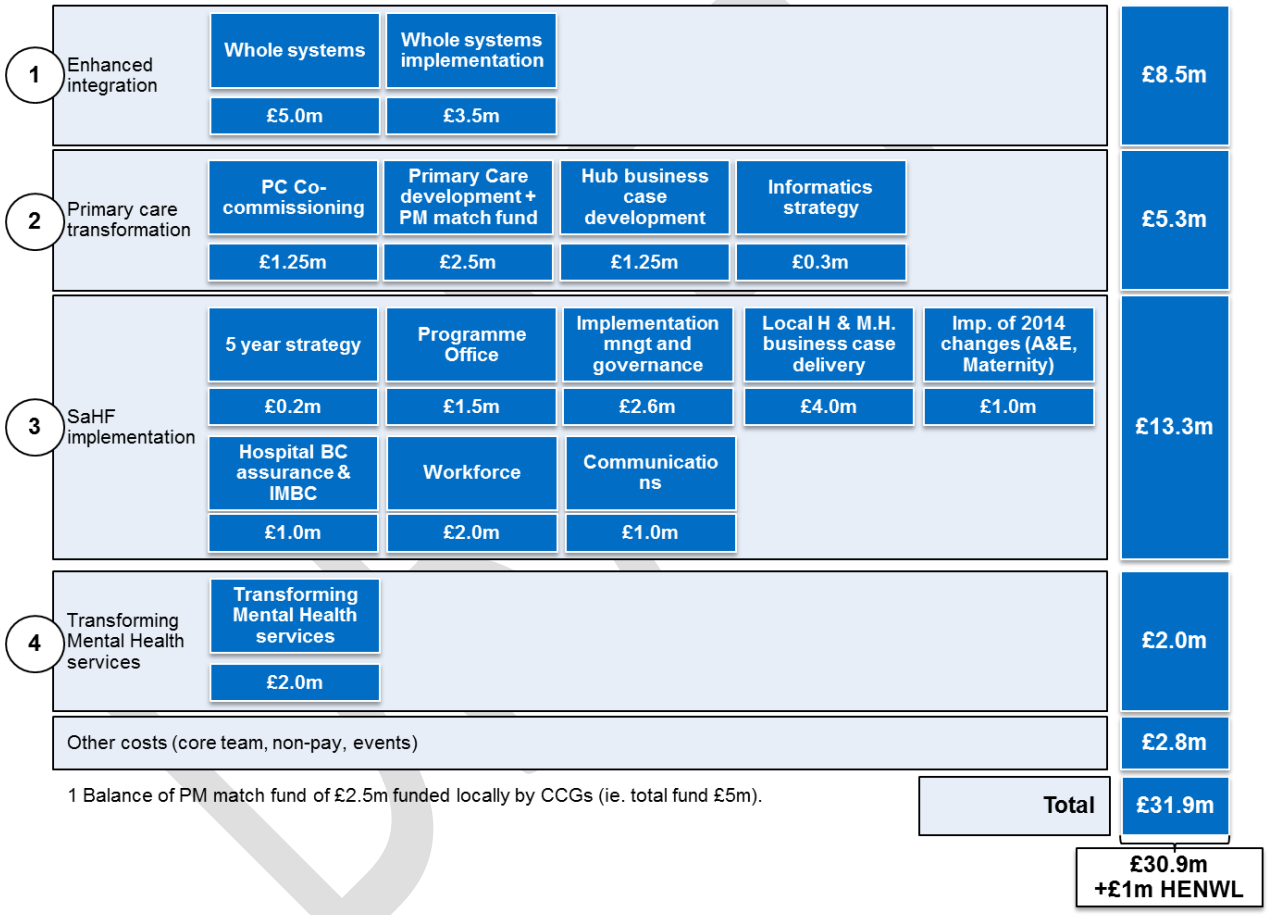
Note: Harrow, Hillingdon and Harrow 2.5% retained to support local financial position.

Part A of the fund is being used to support:

- SaHF programme and implementation costs
- Enhanced integration programme (e.g. Whole Systems)
- Other NWL-wide Strategy & Transformation programmes, including PM challenge fund and mental health transformation
- Acute provider transition, as per the criteria agreed by the SaHF Programme Board

For 2014/15, Part A funding was allocated to the Strategy & Transformation budget as follows:



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For 2014/15, Part A funding was allocated to Providers (for transition costs) as follows:

| | 2014/15 Service Change | Fixed Costs | Transaction Related | Total |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Chelsea & Westminster | 0 | 0 | 0 | 0 |
| Ealing | (a) 1,950 | 0 | 0 | 1,950 |
| Hillingdon | 0 | (c) 3,900 | 0 | 3,900 |
| Imperial | (b) 600 | 0 | 0 | 600 |
| North West London Hospitals | (b) 600 | (d) 11,000 | (e) 2,850 | 14,450 |
| West Mids | (a) 2,900 | (c) 1,800 | (f) 1,500 | 6,200 |
| | | | | |
| **Total** | 6,050 | 16,700 | 4,350 | **27,100** |

**Notes**
(a) Maternity related
(b) A & E related
(c) Fixed cost support in advance of service change
(d) CMH
(e) NWLH/Ealing Merger
(f) ChelWest transaction

7.6. Part B

- The NHSE expectation/requirement is for CCGs to operate with a 1% surplus. In 13/14, four CCGs in NWL had a much larger surplus; two had deficits.
- NHSE planning guidance states that:

"Surpluses and deficits accumulated at 31/03/14 and subsequent years will be carried forward in the following financial years".

- In addition, the planning guidance set out the process to draw-down, or spend, previous years' surpluses, which requires agreement by NHSE.
- In respect of Harrow and Hillingdon, the impact of carried forward 13/14 (and projected 14/15) deficits, would be both to render impossible the implementation of SaHF Out-of-Hospital strategies, and also to impact adversely on outcomes. Furthermore, the deficits are correlated with underfunding indicated by the National Capitation Formula.

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- It is therefore proposed that 40% of the carry forward surpluses in the 4 CCGs with large surpluses be pooled, under Part B, to be used to ensure that SaHF OOH strategies are implementable across all 8 CCGs:

| | Total (£m) | % | £m |
|---|---|---|---|
| **Brent** | 29.2 | 40 | 11.7 |
| **Central** | 16.9 | 40 | 6.8 |
| **H&F** | 12.3 | 40 | 4.9 |
| **West** | 29.6 | 40 | 11.8 |
| **Total** | **88.0** | **40** | **35.2** |

- Note: In addition to the above, further contributions to the pool of £5m (£2m from Brent CCG and £3m for CWHHE, split to be agreed) have been identified.
- As noted above, the draw-down and utilisation of carry forward surpluses requires the agreement of NHSE, and this plan reflects NWL CCGs' request to NHSE in this respect.

7.7. Part C

- In order to support the implementation of CCG Out-of-Hospital strategies in a consistent manner and timeframe, Part C of the fund is to focus on SaHF Out of Hospital (OOH) recurrent (revenue) investment. (Note – whilst the investment is predominantly recurrent in nature, NHSE have advised that in-year resource adjustments are required to be non-recurrent).
- Out of Hospital strategies also require capital investment, which is covered in section 6 above.
- Part C contributions to the fund have been calculated as follows:

a) A 1% contribution by all CCGs (£23.6m)
b) A further £23.6m contribution from the five CCGs with 13/14 underlying recurrent surpluses, in proportion to 13/14 forecast exit run rates
c) A contribution (TBC) from NHSE in respect of primary care growth (1)

Note (1) – London has received primary care growth of 1.6% in 14/15. The NWL growth, if utilised as part of the above, will enable NHSE (L) to discharge their responsibility "to account to local stakeholders for how the patterns of deprivation reflected in their allocation have been reflected in their allocation choices."

This would create an investment pool of £47.2m (excl. NHSE), which is proposed to be utilised to deliver SaHF OOH objectives (as set out in the SaHF Decision Making Business Case):

- The Out of Hospital strategies aim to meet people's changing needs by developing:
- Better care, closer to home
- A greater range of well-resourced services in primary and community settings, designed around the needs of individuals

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| | Sources (£m) | Application (2) (£m) | Net (£m) |
|---|---|---|---|
| Brent | 12.1 | 5.9 | (6.2) |
| Harrow | 2.2 | 6.5 | 4.3 |
| Hillingdon | 2.8 | 8.1 | 5.3 |
| Ealing | 5.2 | 7.5 | 2.3 |
| Hounslow | 2.7 | 8.1 | 5.4 |
| Central | 5.4 | 3.2 | (2.2) |
| H&F | 6.1 | 3.6 | (2.5) |
| West | 10.6 | 4.2 | (6.4) |
| **Total (excl. NHSE)** | **47.2** | **47.2** | **-** |
| NHSE (1) | TBC | - | |
| **Total** | **TBC** | **-** | |

NB. Totals may not add due to rounding

Note (2) – Applications across CCGs calculated as follows:

a) Return 1% to the three CCGs not in recurrent balance (£7.7m)
b) The remaining £39.5m in proportion to capitation target

7.8. Affordability and future proofing

The principles governing the 5 year strategy have been agreed by CCGs to be:

- Contributions to the financial strategy each year should be determined based on affordability, with the CCGs in the strongest financial position contributing the most. When assessing the financial position of a CCG both the underlying surplus/deficit of the CCG and its distance from target should be considered.
- All CCGs have equal right to draw from, and responsibility to contribute to, the financial strategy, should financial positions of individual CCGs change.
- In acknowledgement that NWL as a whole is £136m above the capitation funding level, all CCGs commit to ensuring that funds are invested in a way that represents value for money and reduces recurrent costs over time while maintaining high quality services.
- All CCGs commit to spending the financial strategy funding to achieve the aims for which the budget is set.

In the current financial scenario, Brent, Central, West and Hammersmith & Fulham CCGs will be significant net contributors in 14/15. In future years, if the allocation model is implemented in full, then other CCGs may well be in this position, and all 8 CCGs need to agree this strategy in acknowledgement of this.

7.9. Governance arrangements

- In line with existing governance arrangements, each CCG as a separate statutory organisation, as well as NHS England, will need to approve the NWL-wide financial strategy (based on a recommendation from the NWL Collaboration Board).
- The NWL Collaboration Board does not have financial decision-making authority other than that delegated to it by the existing CCG Governing Bodies. Given the complexity of managing and implementing a multi-year financial strategy across 8 statutory organisations, consideration needs to be given whether these existing mechanisms are sufficient and a formal collaborative finance committee to oversee the strategy has been agreed.
- For pan-NWL budgets created from the fund, day-to-day budget management will be delegated to the Director of Strategy and Transformation across the 8 CCGs, with monthly reports as now to the Collaboration Board.
- It is proposed that Central London CCG continues to act as the host for shared costs and procurement of external resources, where appropriate.
- As in 13/14, where resources are allocated from the Strategy to CCGs, each CCG would be accountable for budget management and ensuring that the objectives underpinning the allocation are delivered.
- All transitional funding allocations to providers will be subject to the review process agreed by the SaHF Programme Board; and will be agreed with the SaHF Programme Board and the Collaboration Board.

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## 8. Financial Risk Assessment and sensitivity analysis

8.1 The DMBC included a comprehensive sensitivity analysis – the key conclusions were as follows:

| Sensitivity tests | Description | High level effect |
|---|---|---|
| a) **Demand growth I:** 1%pt pa higher than plan, trust income allowed to grow | ▪ Demand is higher than expect leading to increased activity (+1%pt per year)<br>▪ Trusts are reimbursed for this additional activity | ▪ Higher income, activity and costs (scaled with increase in activity)<br>▪ More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets |
| b) **Demand growth II:** 1%pt pa higher than plan, trust income fixed as per baseline | ▪ Same as (a) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | ▪ Same as (a) except income does not increase leading to a worse financial position for the Trusts |
| c) **QIPP plans I:** 60% of plans achieved, trust receive income | ▪ QIPP initiatives do not deliver the planned level of reduction in acute activity (only 60% achieved)<br>▪ Trusts are reimbursed for this additional activity | ▪ Same as (a) except the new activity is focused on services targeted by QIPP initiatives (mainly non-elective and outpatients) |
| d) **QIPP plans II:** 60% of plans achieved, trust income is capped | ▪ Same as (d) except Trusts are not reimbursed for additional activity through contractual arrangements or block contracts | ▪ Same as (c) except income does not increase leading to a worse financial position for the Trusts |
| e) **QIPP plans III:** 110% of QIPP achieved (Trusts recover costs) | ▪ QIPP initiatives deliver 10% more reduction than planned in acute activity (110% achieved), with the associated reduction in income and in activity<br>▪ Trusts adapt by reducing variable and semi-variable costs accordingly | ▪ Lower income, activity and costs (scaled with decrease in activity)<br>▪ Less beds needed, leading to lower capital spend and ongoing costs to replace and operate the assets |
| f) **Tariff efficiency I:** Monitor guidance on tariff efficiency, and 90% productivity savings | ▪ 5% tariff efficiency (i.e. difference between cost inflation and tariff deflator) instead of 4% for 12/13 and 13/14 (modelled by varying cost inflation); 14/15 onwards remains 4.2%<br>▪ Trusts achieve only 90% planned productivity savings in 12/13-17/18 | ▪ Increased cost inflation, and less cost saving from productivity, leading to a worse financial position |

| Sensitivity tests | Description | High level effect |
|---|---|---|
| g) **Tariff efficiency II:** Monitor downside on tariff efficiency | ▪ 5.5% tariff efficiency in 12/13 and 14/15<br>▪ 5% efficiency in 15/16 onwards | ▪ Increased costs inflation leading to a worse financial position |
| h) **LOS reduction I:** 10% reduction achieved (instead of 15%) | ▪ Trusts achieve only 10% reduction in average length of stay, compared to 15% assumed in the main analysis | ▪ More beds needed, leading to higher capital spend and ongoing costs to replace and operate the assets |
| i) **LOS reduction II:** no ALOS reduction on maternity, paediatrics nor critical care | ▪ Trusts keep average length of stay for maternity and critical care constant, and achieve15% reduction for other categories | ▪ 15% more beds needed in maternity and critical care, leading to higher capital spend and ongoing costs to replace and operate the assets |
| j) **Transition costs:** 20% higher than plan | ▪ Higher revenue impact from recon-figuration (e.g. due to more expensive or extended transition period) | ▪ Increased one-off transition costs |
| k) **Consolidation savings:** 50% of the consolidation savings achieved | ▪ Only 50% of the modelled savings in pay costs due to consolidating services are achieved (i.e. 2.5% of pay costs when consolidated on Hammersmith site; 5% for all other sites) | ▪ Less cost saving delivered when consolidating services |
| l) **Higher new build cost:** 30% higher than plan | ▪ Higher capital costs to add new capacity | ▪ Increased capital requirements and ongoing costs to operate and replace assets |
| m) **Lower net land receipts:** 30% lower than plan | ▪ Lower net disposal value for unused land (e.g. due to restrictions or difficulties selling land, or higher exit and demolition costs) | ▪ Increase in net capital requirements |
| n) **Higher cost of capital:** NPV discount rate of 4.5% instead of 3.5% | ▪ Decease the relative value of long term benefits compared to short term costs when evaluating NPV to reflect the cost of up front capital, and the risk of future returns | ▪ Reduces NPV, particularly for medium-to-long term benefits and costs |

## Appendix G: Financial appendix

| Sensitivity tests | Description | High level effect |
|---|---|---|
| o) **Time to deliver reconfiguration** | ▪ Acute reconfiguration changes take 2 years longer to implement (than originally planned; e.g., delays due to planning or delivering required QIPP or LOS reductions) | ▪ Extends the time for which current trading deficits need to be covered, and delays the benefit of reconfiguration – reduces the NPV of options |
| p) **Lower outpatient activity:** Local Hospitals retain 40% rather than 85% of outpatient activity | ▪ Less outpatient activity retained at Local Hospitals (40% compared to base assumption of 85%) reducing income and variable/semi-variable costs, but with the same fixed costs | ▪ Reduces the contribution margin for Local Hospitals, potentially impacting site viability |
| q) **Period for NPV assessment** | ▪ Period for NPV assessment increases from 20 years (no terminal value) to 60 years (no terminal value) | ▪ Increases the NPV of options |
| r) **Theatre efficiency** | ▪ Theaters assumed to run 50 hours per week instead of 40 hours | ▪ Less new theatres needed, leading to lower capital spend and ongoing costs to replace and operate the assets |
| s) **Lower new build cost:** 30% lower than plan | ▪ Lower capital costs to add new capacity | ▪ Decreased capital requirements and ongoing costs to operate and replace assets |
| t) **Reduced fixed cost savings at Local Hospitals:** Only 75% of net savings delivered | ▪ Reduced net savings in fixed costs at local hospitals to 75% of modelled savings | ▪ Increases cost at Local Hospitals (potentially impacting viability) and reduces cost saving benefit in NPV |
| u) **Imperial College I:** NHS contributes 100% of capital; no net revenue impact | ▪ Increases NHS capital contribution; no change to on-going revenue cost assuming these costs are already incurred for the existing services | ▪ Increases capital cost and reduces VfM NPV. No change to expanded NPV as total capital already included |
| v) **Imperial College II:** NHS contributes 100% of capital; full revenue impact added to ongoing costs (est. 11.5% of capital) | ▪ Increases NHS capital contribution; on-going revenue costs increased by 11.5% of capital costs | ▪ Increases capital and revenue costs, and decreases total VfM and expanded NPV |

The sensitivity analysis supported the conclusion that Option A was the leading option in financial terms. It had the highest expanded NPV values under all 22 sensitivity tests and was also the highest in terms of VfM scores under all tests (joint first with Options B or C in three of them).

However, as highlighted pre-consultation, it was noted the Programme needs to mitigate against the risk of a number of downside sensitivities happening simultaneously if the overall financial benefits are to be realised. Pre-consultation, a negative NPV over 20 years occurred if the top four sensitivities occurred at the same time. Since this, the analysis above suggested that the top two sensitivities would have this impact. Similarly whilst Option A delivers and improved I&E position over 'do-nothing', a combination of the two worst sensitivity impacts would reduce this by approximately 50%.

The highest risk sensitivities are listed below. It was noted in the DMBC that these risks need to be very carefully managed in order for any reconfiguration to be successful and for improvements in acute sector finances to be delivered. Some of these adversely affect the 'do nothing' and all reconfiguration options, whereas others reduce the benefits of all options with respect to 'do nothing' and potentially differentially impact the options relative to each other:

**Sensitivities that affect the 'do nothing' and all reconfiguration options:**

- In the review, -two of the key risks highlighted in the pre-consultation analysis remained significant risks: These both involve higher activity than planned, but where Trusts are not reimbursed for the additional activity
    - Sensitivity B: 1% higher demand, but Trusts not reimbursed
    - Sensitivity D: Only 60% of QIPP delivered, but Trusts not reimbursed
- Two other sensitivities on tariff efficiencies (F and G) were not explicitly tested pre-consultation, but were shown to be high risk through the pre-consultation downside scenario. These demonstrated that higher tariff efficiency (through higher experience cost inflation) or under-delivery of CIP is a significant risk for providers

**Sensitivities that reduce benefits of all options relative to 'do nothing' and potentially differentiate options:**

- Sensitivity T: Reducing fixed costs (defined as establishment, premises & fixed plant, depreciation and PDC) at local hospitals was highlighted as a key sensitivity in the pre-consultation analysis. Failure to reduce these costs (e.g. by retaining more buildings than the estate plans indicate is required) would result in unviable sites and under-delivery of the cost saving analysis through the number of sites in deficit and the reduced NPV, respectively)
- Sensitivities on bed capacity and capital build costs did not have a large impact in the PCBC analysis, but in DMBC analysis emerged as significant risks. These all involved increases to the capital expenditure for adding new capacity, and now have larger impact because of the revisited higher capital costs per bed and because the analysis now accounts for step changes when adding capacity that were identified through the more detailed estates work. It was noted that these sensitivity analyses model the case where all of the additional capacity is built at the Major Hospital sites; the additional capacity could be mitigated through the better use of spare beds at Central Middlesex, or out of hospital capacity.
    - Sensitivity H: Only 10% ALOS reduction achieved

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  - Sensitivity I: No ALOS reduction in maternity, paediatrics and critical care (new sensitivity analysis)
  - Sensitivity L: New build capital costs 30% higher than modelled
- Sensitivity K (50% of the consolidation savings through merging into larger clinical teams) has a larger impact on the Value for Money assessment than in the pre-consultation analysis because Option A is now closer to the scoring thresholds, particularly on total I&E and Site Viability.

8.2 The NWL strategic planning workshop on 6 May 2014, (comprising NHSE, CCGs, providers and local authorities), reviewed key financial risks (and mitigations) and the following is based on the outcome of the workshop.

| Risk area | Risk | Mitigation | L x C (post-mitigation) |
|---|---|---|---|
| A. Financial positions | 1. Commissioner funding - NWL CCGs are collectively £136m above fair shares target, with wide variation across CCGs | a) Using NHSE guidelines re future allocation<br>b) NWL financial strategy shares risk across commissioners | |
| | 2. Inherited commissioner financial positions vary across CCGs | a) NWL financial strategy shares risk across commissioners | |
| | 3. Local authority financial pressures impact on health | a) Joint work through BCF | |
| | 4. BCF leads to financial instability in CCGs/acute providers | a) Agreement of BCF by local health community | |
| | 5. NHSE position regarding specialist services | a) NHSE to share recovery plan with CCGs | |
| B. Out of Hospital plans | 6. Shaping a healthier future hospital capacity plans dependent on achievement of Out of Hospital e.g. reducing unavoidable admissions | a) Alignment of Business Case assumptions<br>b) Tracking Out of Hospital schemes | |
| | 7. Shaping a healthier future Out of Hospital plans require capital and revenue investment to increase capacity of Out of Hospital services | a) Joint work with NHSE on Business Case development for Out of Hospital Hubs | |



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| | | | |
|---|---|---|---|
| C. Capital | 8. Realigning acute sector capacity also requires significant capital investment (over and above DMBC estimates) | a) Outline business case process in train to determine whether this capital investment is affordable, both to individual organisations and collectively (Implementation Business Case) | |
| | 9. Under-utilisation of new Out of Hospital capacity | | |
| D. Other | 10. Significant challenges in securing and maintaining a viable provider landscape, including performance targets (A&E, 18 weeks, etc.) | a) Alignment of SaHF Implementation Business Case with Trust LTFMs | |
| | 11. Transition process – tension between securing service change and supporting current service configuration | a) Targeted application of pooled non-recurrent funds as part of NW London Financial Strategy | |
| | 12. Specialist commissioning planning not integrated with CCGs | | |

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**Appendix I – Update Note: Strategic Estate Development (prepared by Hillingdon Council in conjunction with Hillingdon Clinical Commissioning Group)**

# UPDATE: STRATEGIC ESTATE DEVELOPMENT

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Ian Goodman, Chair, Hillingdon CCG<br>Councillor Philip Corthorne |
| **Organisation** | Hillingdon Clinical Commissioning Group<br>London Borough of Hillingdon |
| **Report author** | Simon Harwood, Strategic Estates Consultant, Hillingdon CCG<br>Nicola Wyatt, S106 Monitoring & Implementation Officer, Residents Services Directorate, London Borough of Hillingdon |
| **Papers with report** | Appendix 1: Section 106 Healthcare Facilities Contributions (Dec 2018) |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This paper updates the Board on the CCG strategic estate initiatives and the proposed spend of S106 health facilities contributions in the Borough. |
| **Contribution to plans and strategies** | Joint Health and Wellbeing Strategy, Out of Hospital Strategy, Strategic Service Delivery Plan. |
| **Financial Cost** | To be identified as part of the business case for each individual project. |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCGs strategic estates plans.**

## 3. HILLINGDON ESTATE STRATEGY - OVERVIEW

Below is an outline of the Hillingdon vision of how the key priorities outlined within the Five Year Forward view and the STP guidance will be addressed:

Health and Wellbeing

- Working collaboratively across health, social care and public health we will improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long Term Conditions (including both physical and mental health LTCs) and

emergent categories of LTCs such as pain, frailty and social isolation.
- Our coordinated programme of work will bring together our existing plans for the BCF and our Health and Wellbeing Strategy (HWBS) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.

Care and Quality

- We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services.
- We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices.
- We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.

Finance and Efficiency

- It is simply not viable to continue trying to respond to increasing demand for services, particularly at the expense of preventative action. We are committed to finding financial savings and ways to achieve better outcomes for individuals and their families through the better integration of services and by reducing demand through an increased focus on prevention and patient activation.

Key Drivers and Challenges

- To meet an estimated increase in demand and complexity of care delivered in the community for out of hospital care across the area of 30%-35%.
- Enable a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes.
- A need to improve utilisation of the existing estate and effectively target strategic investment in new estate in locations appropriate for a Hub health care delivery model.
- Forecast population and demographic growth in Hillingdon suggests an increasingly diverse population.

<u>Key points emerging from the Strategic Estates Plan</u>

- The need to progress the aims of the Out of Hospital strategy. Focussing investment in locations which support the implementation of the strategy at Uxbridge/West Drayton, North Hillingdon and Hayes & Harlington
- The need to secure long term premises solution for the Shakespeare Medical Centre and Yeading Court Surgery.
- The need to address poor primary care infrastructure by making sure GP practices are in the right location and in fit for purpose accommodation.
- To build primary care estate capacity in Hayes Town to respond to the growth derived from the Housing Zone.
- To secure a replacement site for Yiewsley Health Centre and build additional capacity to respond to local residential development.
- The need to improve access to health care for people living in the Heathrow Villages.
- Consideration of any potential impact from the Southall Gas Works site development on Hillingdon practices.

- To develop a plan for the future of the Northwood and Pinner Community Hospital that respects the heritage of the site and realises the potential of its location.
- Consider any opportunity created by the future plans of Brunel University.
- Support The Hillingdon Hospital NHS Foundation Trust with its master planning for both sites.

Current status of strategic estate priorities

The table below summarises the projects and the current status:

| Project | Status | Indicative Timeline |
|---|---|---|
| Create an Out of Hospital Hub in North Hillingdon | Two concurrent work streams have begun marking the commencement of the delivery phase of this project for a combined redevelopment of the Northwood & Pinner Community Hospital and Northwood Health Centre sites:<br>1. GP Selection: The formal CCG approval route for the selection of practices to move into the new hub has been agreed. Local practices have been briefed ahead of formal expressions of interest being invited in February 2019.<br>2. Scheme Design: NHSPS has replaced the project team and met with planners and heritage officers to revisit the scheme design.<br><br>These two work streams will allow the selected GPs to engage on detailed design over the summer to feed into the OBC drafted in the autumn. | GP selection process complete: June 2019<br><br>Target date for outline business case: November 2019<br><br>Projected hub opening date: December 2021 |
| Create an Out of Hospital Hub in Uxbridge and West Drayton | The same two work streams have been initiated for the redevelopment of the Uxbridge Health Centre.<br><br>Local GPs have been engaged ahead of the formal expressions of interest process.<br><br>An informal meeting with planners has been arranged for late February to help the QTS project team finalise the scheme design.<br><br>The project timing is then as per the Hillingdon North hub (above). | GP selection process complete: June 2019<br><br>Target date for outline business case: November 2019<br><br>Projected hub opening date: December 2021 |
| Building capacity for Hayes and Harlington | Heads of Terms have been substantially agreed for the new health facility in The Old Vinyl Factory (TOVF) development, with a target date of March 2019 for this to be concluded.<br><br>Using Council housing projections, the CCG has | S106 agreed for TOVF<br><br>Heads of Terms to be completed March 2019 |

| Project | Status | Indicative Timeline |
|---|---|---|
| | established a further requirement of circa 600-1,000 $m^2$ of health care space in Hayes to accommodate the new population. A new health centre is still being considered as part of the community infrastructure provision on the former Nestle Factory Canteen building. Building surveys are currently being carried out to determine the future size and configuration. | |
| New premises for Shakespeare Medical Centre and Yeading Court Surgery | Following a detailed design exercise, a refined set of Heads of Terms have been agreed between the two practices and Council for the relocation of the practices to new premises on the redeveloped former Woodside Day Centre site. The CCG will be approving a refreshed Outline Business Case in early March 2019 to enable the practices to complete Agreements for Lease without further delay. | Agreements for lease signed by the two practices in March 2019<br><br>Target date for project completion: 2021 |
| Yiewsley Health Centre | Lease terms have finally been agreed between the practices and NHS Property Services. The funding deadline has been extended enabling the project to commence. The contract price is being reviewed ahead of contract signature.<br><br>The project will convert vacant space at the site into additional clinical accommodation, creating additional capacity for primary care provision at the site. In addition, a proposal to spend some health s106 funding on improving the entrance, reception and waiting area has been agreed by Cabinet.<br><br>A long-term solution for the site is still being explored with the support of CNWL and the Council's planning team. | Extension secured for grant funding<br><br>Lease terms agreed<br><br>Target date for project commencement: March 2019 |
| Heathrow Villages provision | A site has been secured in Harmondsworth for a potential new health facility. The CCG is preparing a feasibility study for an assessment of affordability. | Feasibility study complete by end of March 2019 |
| Improving Access to Primary Care | The CCG continues to review the quality and capacity of primary care premises across the Borough. A primary care strategy has been developed and was approved by the CCG in November 2017.<br><br>Thirteen GP practices have received NHS funding to invest in improving practice premises. The total amount of investment made totals £2.7 million and will benefit more than 70,000 patients.<br><br>The CCG completed the preliminary approval process for 2019/20 Improvement Grant funding in | **Kincora Surgery** - Works almost complete to create an additional 4 consulting rooms with scheme on plan to complete by end of March 2019<br><br>**St Martin's Medical Centre** - Works to complete the extension of the premises are nearing |

| Project | Status | Indicative Timeline |
|---|---|---|
| | July.<br><br>NHS England is now expected to inform practices if their schemes have support in principle in March. The delay has been due to NHSE London waiting for National to agree the budgets.<br><br>There are 11 Hillingdon schemes awaiting approval with a total works value of £1.6m. If these schemes are approved, they will result in improved infection control and DDA compliant premises and provide for an additional seven consulting rooms across the Borough.<br><br>Infection control works at Mountwood Surgery has received early approval to complete works by end of March and the practice has already completed and had their due diligence approved. | completion. S106 funding has been received to support the practice's 34% financial contribution of the £750,000 scheme<br><br>**Acrefield Surgery** - Due diligence completed and approved by NHSE with works having started and due to complete by end of March 2019<br><br>**Wood Lane Medical Centre** - Infection control improvements to premises now to be completed by March 2019. Delays due to lowest bidder contractor being unable to start works as early as expected |

**FINANCIAL IMPLICATIONS**

The NWL Strategic Outline Case Part 1 (SoC1) to deliver the Shaping a Healthier Future and Strategic Transformation Plan has been assured by NHS England but capital bids are now to be submitted under an STP wide Wave 4 funding bid to invest in facilities for GP Practices, Hubs and acute hospitals in NWL.

In Hillingdon, this includes:

- additional investment in a number of GP practice premises to improve access, clinical capacity and quality.
- the capital investment required to deliver the North Hillingdon and Uxbridge & West Drayton hubs.
- the expansion and refurbishment of key areas at Hillingdon Hospital.

Hillingdon Council, in consultation with the NHS in Hillingdon, has been collecting s106 contributions for health from residential developers where the size and scale of the housing scheme has been identified as having an impact on the delivery of local health services. Funding has been secured by the Council for investment in health premises and services in the Borough in order to help meet increased demand for health services as a result of new development. This additional non-recurrent funding has been used to build capacity within the primary care estate and, subject to the Council's formal s106 allocation process; it is proposed that any further contributions received are used to help to offset the cost of the hubs.

The CCG will identify the financial implications of all estate investment as part of the business case development process for each project.

## S106 HEALTH CONTRIBUTIONS HELD BY THE COUNCIL

Appendix 1, attached to this report, details all of the s106 health facilities contributions held by the Council as at 31 December 2018. The Council has not received any further contribution since the last report to the Board in December. As at 31 December 2018, the Council holds a total of £1,240,470.62 towards the provision of health care facilities in the Borough.

The CCG has "earmarked" the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. A request to allocate individual contributions towards further schemes will be submitted as each scheme is brought forward.

To note is one contribution held at case reference H/34/282F (£15k) which has a spend deadline of February 2019. Hillingdon CCG has requested that these funds are allocated towards an existing scheme to provide additional clinical space at St Martin's Medical Centre, Ruislip. A Cabinet Member report to request the formal allocation and release of the funds towards the scheme was submitted to the Leader of the Council and the Cabinet Member for Finance, Property and Business Services in December, and received Cabinet Member approval (Cabinet Member Decision 20/12/2018). The funds have now been transferred to HCCG to be used towards the agreed scheme in line with the current Service Level Agreement.

## HILLINGDON COUNCIL FINANCIAL IMPLICATIONS

As at 31 December 2018, there is £2,908,567 of Social Services, Housing and Health s106 contributions available, of which £1,668,096 has been identified as contributions towards affordable housing. The remaining £1,240,471 is available to be utilised towards the provision of facilities for health and £562,891 of these contributions have no time limits attached to them.

Officers, in conjunction with the CCG and NHSPS, continue to work actively towards allocating all outstanding health contributions to eligible schemes. To date, funds totalling £1,074,840 are provisionally earmarked towards proposed health hub schemes as detailed below:

| **Proposed Health Hub Scheme** | **Amount** |
|---|---|
| North Hub | 140,484 |
| Uxbridge / West Drayton Hub | 520,593 |
| Yiewsley Health Centre Refurbishment | 1,691 |
| New Yiewsley Health Centre | 408,170 |
| Pine Medical Centre | 3,902 |
| **Total Earmarked** | **1,074,840** |
| **To be determined** | **165,631** |
| **Total** | **1,240,471** |

The remaining balance of £165,631, comprising four separate contributions, is yet to be earmarked to any schemes, although it is anticipated that they will be expedited by their respective deadlines. The contributions are £35,621 (ref H/30/276G), £39,689 (ref H/69/404F), £81,329 (ref H/70/40M) and £8,992 (H/73/420E) respectively.

The s106 contribution held at H/34/282F for £15,031 has a time limit to spend by February

2019, which has been earmarked to the North Hub Health Scheme. Hillingdon CCG has requested that this contribution is allocated towards St Martin's Medical Centre in order to ensure that the funds are used towards an eligible scheme before the spend deadline. This contribution has now been transferred to Hillingdon CCG in early February 2019.

## HILLINGDON COUNCIL LEGAL IMPLICATIONS

Monies paid to the Council pursuant to a Section 106 agreement can only be used for the purpose specified in the particular agreement. The Council's procedures require the release of Section 106 monies to be approved by the Leader and Cabinet Member for Finance, Property and Business Services. All reports submitted under this procedure include legal advice to ensure that the release of funds is authorised by the Section 106 agreement.

**Appendix J – Email from Mike Paterson confirming that no Council property is available for the Health Facility**

**Subject:** Re: Yiewsley Swimming Pool Site - Health Care Facility
**Date:** Thursday, 25 June 2020 at 14:14:38 British Summer Time
**From:** Michael Paterson
**To:** Richard
**Attachments:** image001.png, image002.jpg, image003.jpg

Richard

I can confirm that none of the Council sites are available for disposal. All property that the Council is marketing for sale or to let appears on the Council's website - see link for details

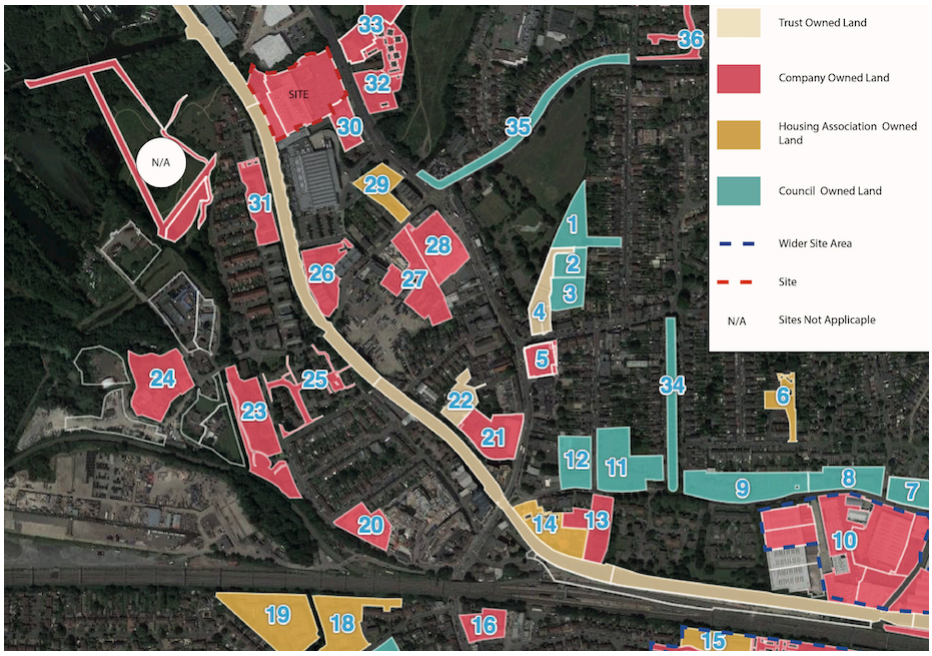
https://archive.hillingdon.gov.uk/propertysales

Regards
Mike
Mike Paterson
Head of Property & Estates
Residents Services
2W/04 Civic Centre
London Borough of Hillingdon

Tel : 01895 250925
Fax : 01895 250941
Email : mpaterson@hillingdon.gov.uk

On Wed, 24 Jun 2020 at 10:08, Richard <richardconroy@progressplanning.co.uk> wrote:

> Hi Mike,
>
> Further to my email last week, please see below a plan showing on sites in Yiewsley. It shows Hillingdon Council land in green. Would you mind just confirming that none of this land is available to purchase at the moment? If any are, please let me know as I am sure I will be interested.






Kind regards,

Richard

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**From:** Richard <richardconroy@progressplanning.co.uk>
**Date:** Wednesday, 17 June 2020 at 13:10
**To:** "mpaterson@hillingdon.gov.uk" <mpaterson@hillingdon.gov.uk>
**Cc:** James Rodger <jrodger2@hillingdon.gov.uk>
**Subject:** Yiewsley Swimming Pool Site - Health Care Facility

Hi Mike,

Thanks for the call earlier, as discussed, I am doing an exercise to support our proposal (Health Hub and 235 residential units) at the B&M site in Yiewsley to demonstrate that there are no alternative sites for the health facility in the area. You mentioned that the Council attempted to deliver a health facility on the Yiewsley Swimming Pool site over an approximate 3 year period but ultimately you couldn't get it to work as it was unviable for the CCG. Put simply they had no money, not even to kit the building out. We are delivering a health hub on very favourable terms to the CCG and they wouldn't be able to expand their health facilities without this development.

As discussed, I would welcome if you could confirm that this site is no longer available as the Council has other aspirations for it and that it was unviable anyway. If you can provide some more detail on how it was unviable that would be helpful too as the CCG's lack of monetary resources is a key element of why no other site in Yiewley would be viable either and to hear it from you would give James who is cc'd in much more comfort on the financial constraints preventing expansion of health facilities in this part of the borough.

Kind regards,

Richard Conroy BSc MSc (TP)

PROGRESS PLANNING

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