Introduction

Vision for Healthcare across North West London

CCG Objectives and priorities for 2016-17

Demonstrating progress against plan

QIPP and Finance

CCG Objectives and Strategic Risks

Version history

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<th>Version</th>
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<tr>
<td>V0.1</td>
<td>CCG GB Seminar 23 Sep 2015</td>
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<td>Amended sections: Patient empowerment and self-management; incorporation of elements from JSNA and HWBS; Cancer services; Mental Health; London wide commissioning intentions; QIPP information</td>
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This document provides an overview of our plans to commission high quality health care to improve health outcomes for Ealing registered patients for 2016/17 and beyond. It outlines the commissioning intentions for NHS Ealing Clinical Commissioning Group (CCG) for 2015/16 and builds on the commissioning plans implemented in 2015/16.

Our priorities in 2016/17 reflect the 2015/16 implementation of the CCG’s longer term strategic vision and the medium term financial strategy, and set out the areas where the CCG wishes to contract differently, improve quality or transform service delivery. The priorities outlined in this document set out the priority contracting intentions for our provider organisations, which will inform contract negotiations.

This business plan have been developed through a series of workshops with leads across the CCG and has been formulated within the framework set by the following strategies and documents

1. The Five Year Forward View: The ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like; http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
3. Ealing Draft Health and Wellbeing Strategy 2016-21
4. Ealing CCG Operating Plan 2015-16, including Potential Years of Life Lost approach
8. Ealing CCG’s agreed vision and strategic objectives, including delivery of integrated out of hospital care
9. Commissioning For Value Packs :In depth analysis of 13 conditions; http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value
The population of Ealing has risen from 286,400 in 1994 to 342,500 in 2013 according to the latest Office of National Statistics (ONS) mid-year estimates.

Ealing has a higher proportion of both males and females aged 0-9 and 25-44, but a lower proportion of persons aged 50 and above as compared to the England average.

According to the 2013 mid-year population estimates, Ealing is the third largest London borough in terms of population, after Croydon (372,800) and Barnet (369,100). At 63 persons per hectare Ealing is also the third most densely populated borough in Outer London (after Brent and Waltham Forest).

There are 407,541 people registered with 79 GP practices in Ealing. Out of this, 49% (200,317) are aged 15-44. 52% of all registrations are male and 48% female. Average number of registered persons per GP practice in NHS Ealing CCG is 5,159 (7,041 average in England in 2013).

According to the Greater London Authority (GLA) population projections, the White ethnic group population is expected to have a small drop in numbers between 2010 and 2025 (from 167,000 to 163,900), but then rise again to 2010 levels by 2040. For all other ethnicities the projections indicate a steady rise in numbers over the 30 years’ period: Asian/Asian British by 41%, Black/Black British by 49% and Chinese by 38%.

The White British population remains the largest group in Ealing schools, but continues to fall in numbers – despite an increase of over 1,000 in the overall school population. There are 281 less White British pupils in Ealing schools than there were in 2013. The Eastern European, Asian and Arab populations continue to grow steadily. There are now 4,597 Eastern European pupils (an increase of 387 in the last year), 3,500 Asian pupils (nearly half of whom are Tamil speakers) (an increase of 183), and 1,788 Arab pupils (an increase of 186) in Ealing schools.

Ealing’s crude general fertility rate (GFR) (71.9/1,000 females) is significantly higher than the England average (63.7/1,000 females). The only wards with significantly lower fertility rates than England are Ealing Broadway, Ealing Common and Hanger Hill which have significantly lower fertility rates.

Southall Green (76.9) and Northolt West End (77.4) have significantly lower male life expectancies at birth as compared to the England average (78.8).

South Acton (80.4) and Norwood Green (81.1) have significantly lower female life expectancies at birth as compared to the national average (82.7).

The majority (73%) of homeless people in England reside in London. Ealing’s homeless rate (8.6/1,000) is significantly lower than the London average (11.9/1,000) but more than three times the England average (2.4/1,000).

Lower Super Output Areas (LSOAs) within Norwood Green and Elthorne wards are among the 10% most health deprived in the country.
Public Health Outcomes Framework
The Public Health Outcomes Framework sets out outcomes and indicators to help us understand how public health is improved and protected in Ealing compared to the rest of England. There are two overarching outcomes relating to life expectancy and inequalities in life expectancy and further indicators clustered into four ‘domains’ of:

1) wider determinants of health
2) health improvement (lifestyles and choices)
3) health protection and
4) healthcare public health and premature mortality and finally, preventable ill health.

Ealing does better on breast feeding, school readiness, hospital admissions due to childhood accident/injury, NHS health checks and premature cancer mortality.

Below is a selection from the framework of areas of challenge for Ealing:

- Ealing’s female healthy life expectancy at birth (60.1) is significantly lower than the national (64.1) or London average (63.6). There has been a slight decline since 2009/11.
- Ealing’s premature mortality rate (under 75) is significantly higher than the national average (353/100,000 versus 350/100,000 in 2010/12) and has risen since 2009/11.
- At 3.6%, Ealing’s low birth weight is similar to London average (3.2%), but higher than England average (2.8%).
- MMR and flu vaccine for two doses (5 years old) at a rate of 82.5% of population is lower than the national average (87.7%) and has declined since 2011/12. However, the borough’s rate is higher than the London average (80.8%).
- The excess weight prevalence rates among Ealing children aged 10-11 years (37.9%) is higher than the national average (33.3%), but on London level (37.4%). This has risen since 2011/12.
- At 1,392, chlamydia detection rates among young people in Ealing are lower than the national set targets of 2,300 or more. For London, the achieved figure was 2,179 and in England, 2016. Overall Ealing’s rate has risen since the previous year, although among males the rate has slightly declined.
- Ealing’s utilization of outdoor space (10.2%) is significantly lower than the national average (15.3%), although similar to London’s figure (10.5%). However this is a substantial improvement from 6.6% in 2011/12.
- The incidence of TB in Ealing (69.1 per 100,000) is higher than for both London average (41.4 per 100,000) and the national average (15.1 per 100,000) and has risen since 2009/11.

At 67.6%, breast cancer screening rates in Ealing are lower than those for London (68.6%) and national average (76.3%) and have declined since 2012. The figures for cervical cancer screening are similar: in 2012/13 Ealing rates were 64.6%, compared to London (68.6%) and England (73%).

Emergency hospital admission rates due to falls among older people in Ealing are higher than the national and London average and have risen since 2011/12.

Social Determinants of Health
The Marmot Review available at: http://www.instituteofhealthequity.org/ showed that if the conditions in which people are born, grow, live, work, and age are favourable, and distributed more equitably, people would have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. Health professionals can tackle the social determinants of health by helping to create the conditions in which their patients can have control over their lives.

The policy objectives for the social determinants of health are:

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
C. Create fair employment and good work for all
D. Ensure a healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill-health prevention

NHS organisations, and therefore their staff, have considerable influence through their sizeable purchasing power, both as employers and contractors of staff and as commissioners of services. The health sector often accounts for 15–20% of a local community’s employment and income. This gives CCGs significant power to affect the health and wellbeing of their local population. CCGs also have a legal duty to consider how procurement might improve the economic, social and environmental wellbeing of their area. Employment should be designed to be particularly beneficial for those from lower socio-economic groups, as this will reduce inequalities. In addition to providing a good quality place of work, this can be achieved by ensuring that there is security and flexibility of employment and retirement age, and that jobs are suitable for lone parents, carers and people with mental and physical health problems.

Ealing CCG is working with Public Health colleagues to consider ways to ensure that it commissions services to reduce health inequalities and encourages provider organisations to do this through contracts, payment, incentives, service transformation and pathway design.
Vision for healthcare across North West London
North West London (NWL) is changing. We are undertaking a historic transformation of the healthcare system that will dramatically improve care for over two million people. We are on the cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals. All eight of NWL’s Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement this change. Our vision is to deliver care which is:

1. **Personalised** – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is **unique**.
2. **Localised** – Localising services where possible, allowing for a wider variety of services closer to home. This ensures care is **convenient**.
3. **Integrated** – Delivering care that considers all the aspects of a person’s health and is coordinated across all the services involved. This ensures care is **efficient**.
4. **Centralised** – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is **better**.

Our vision is centred on the needs of the NWL population, developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.

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**Vision for Healthcare in North West London**

We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan-NWL level:

- Acute Reconfiguration;
- Primary Care Transformation;
- Whole Systems Integrated Care;
- Mental Health Transformation

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15 and 2015/16. We intend to build on these further during 2016/17.

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This vision is supported by **3 principles**:

1. People and their families 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
Delivery of our vision will mean that care across North West London will be unique, convenient, efficient and better.

Care across NWL will be ... 

Service user benefits will be ... 'I' statements

- "I know how to lead a healthy lifestyle and can manage my own care" 
- "I feel in control over my care because decisions are taken with me and consider my lifestyle and individual choices"
- "My care is now more convenient because the services closer to my home are more accessible"
- "I'm not treated 'in parts', but as a whole person in a coordinated way"
- "I have a positive experience in a great hospital environment which helps me feel confident in the quality of care provided to me"
- "I am kept in hospital no longer than I need to be, and am able to receive effective care sooner rather than later"

This will mean ...

- More information, advice and support available online and over the phone. The public are able to easily find out whether they need care, and if so, where to get it, as well as knowing how to get support for existing conditions.
- People can use technology to understand their own health and wellbeing at home. People who need to monitor their conditions will be able to do so through convenient methods to ensure it minimally impacts their lifestyles.
- Promoting self care and providing education and training to the Ealing population, including for patients and their carers.
- People, not the provider, are at the centre of the design of their own care and of the services available within their community. This is true for the most vulnerable groups in society, too – reducing inequality in health outcomes.
- Wellbeing is seen in its widest sense - it is not only about seeing a doctor and getting medical support – people are able to explore other routes, such as through community support and alternative treatment, where appropriate. Treatment is appropriate for not only the condition, but also for the person.
- Personalising a person’s care through new interventions.
- Consultations are more accessible and flexible through the use of telephone, email and video consultations available for all local services, allowing for people to have better access to medical advice.
- People are able to access their GP at more suitable times for them through the availability of appointments seven days a week. There is more availability of GP services offered in other community settings, too.
- Greater accessibility of GP services, allowing the GP to be at the centre of managing a patient's care.
- Prevention and self-care support is consistently available across NWL communities, care settings, ensuring people can take care of their mental and physical health.
- All services that can be provided within the community are, such as minor surgeries, simple tests and outpatient appointments, within buildings that are modern and fit-for-purpose.
- Expanding the variety of services offered within the community and Primary Care settings.
- Development of the workforce and estates to manage the shift in settings of care from acute.
- Mental and physical care are given equal importance in all care settings, ensuring that the person’s health care and wellbeing are considered in a more holistic way, resulting in the best outcomes for the person. This is true for children as much as for any other population segment.
- Care isn’t just limited to hospitals and GP surgeries; services provided within the community are considered to help prevent illness and support wellbeing.
- Focus on mental health needs to achieve parity of esteem between mental and physical health needs.
- Enabling technologies to support service integration.
- Redesigning pathways of care, ensuring services are integrated.
- Integration of health providers, maximising patient benefits.
- All those involved in a person’s care work in collaboration with them and/or their carer, and each other. People aren’t left on their own to coordinate the care they receive and can’t see the parts between different services.
- Care is delivered through structured planning with the patients and their carer, and single-point coordination. Staff are trained to deliver integrated working.
- People are treated in modern facilities with the latest technology available, dealt by compassionate staff across all hospital sites, giving them confidence in their care.
- People are directed to centres for specialist care, whether that's within hospitals or in out-of-hospital settings, relevant to their condition, considering the patient's choice at all times.
- Delivering centralised services to provide greater access to specialist treatment and availability of consultant-led care.
- People are treated at the right time, by the right person, in the right care setting, appropriate for the person and their condition, regardless of the day of the week.
- Higher quality care is available through increased consultant coverage, delivering more personalised care.
- Increasing the seven day services offered in acute settings.
- Focussing on improving the patient experience within acute settings.

This allows us to achieve patient-centred care in all our care settings, across NW London, ensuring reduced inequality of care outcomes and delivery of services that are bespoke to the needs of the local population.
Ealing plans to deliver the vision by 2019 through the following:

### Service user benefits will be…

**‘I’ statements**

- **Personalised**
  - "I know how to lead a healthy lifestyle and can manage my own care”
  - "I feel in control over my care because decisions are taken with me and consider my lifestyle and individual choices”

- **Localised**
  - "My care is now more convenient because the services closer to my home are more accessible”

- **Integrated**
  - "I’m not treated ‘in parts’, but as a whole person in a coordinated way”
  - "Whoever I see, knows me and my preferences, and I no longer have to repeat my details each time”

- **Centralised**
  - "I have a positive experience in a great hospital environment which helps me feel confident in the quality of care provided to me”
  - "I am kept in hospital no longer than I need to be, and am able to receive effective care sooner rather than later”

### Ealing CCG will deliver the vision through …

**Focus on prevention and early support through proactive services and public education:**
- New Models of Care within Primary care that focus on a proactive and preventative approach, including non-medical services, teleimplemented
- Commission a service model that covers health, social care, housing, education/employment, based on findings from Joint LAL/HiS needs assessment
- Care Plans for patients allowing better patient integration in care design

**Greater accessibility to services through convenient methods:**
- Consistent signposting on GP website, providing key information on local settings of care for people to refer to
- Interoperability through the integrated IT system (split by provider), allowing access to patient records and information
- Optimising the diagnostic process across NW London’s health economy, ensuring the principle of one patient, one diagnostic record across NW London

**Delivering patient-centred care:**
- All services to be co-designed with service users, e.g. Lay Partners Forum
- Ensuring patient-centred care is delivered and patient experience is improving through measuring against agreed set of outcomes across all eight Early Adopters of Whole Systems Integrated Care
- Commissioning care to ensure that care plans are done in partnership with patients and carers, encouraging more ownership of the care plans

**Making use of a variety of services to deliver care:**
- Pharmacy to make greater contributions to care, by providing further advice and support
- Appropriate funding from pooled budget to fund implementation of relevant programmes/services to develop, resource and deliver integrated Health and Social Care
- Provision of carers’ information, advice and support

**Redesign of community and Primary Care pathways:**
- Co-commissioning implemented through working with NHS-E to support GPs to deliver local primary care that is accessible, co-ordinated, and pro-active
- New Model of Care providing improved outcomes for patients while ensuring sustainability of the general practice
- Embedding the new Cardiology Community service, and expanding the variety of services offered within the community and Primary Care settings

**Better accessibility to GP appointments and services:**
- Greater flexibility to schedule GP appointments – e.g. through advanced booking
- Networks to offer the availability to a GP appointment between 8am Monday-Friday and for 6 hours on Saturday-Sunday
- Ensuring services for people experiencing mental health crises are at all times as accessible responsive and high quality as other urgent and emergency services

**Greater variety of services being delivered closer to home:**
- Consistent, high quality interventions available within the community for people with communmental health needs
- 24/7/005 services available for mental health crisis within the community
- Tracking out of hospital delivery, gaining commissioners greater visibility of real time progress of patients in settings of care from hospitals
- Enhancing the capacity and capability of primary care services to provide more care Out of Hospital
- Supporting the Care Closer to Home

**Focus on mental health needs to achieve parity of esteem between mental and physical health needs:**
- New Models of Care agreed for implementation across primary, community and acute settings that are based on clear outcomes for people dealing with serious and long term mental health issues
- Single NW London Transformation Plan in response to the NHS-E Future in Mind – describing areas of work and investment for the next five years to improve children and adolescent mental health and wellbeing
- 24/7 psychiatric liaison services available at all A&E and Urgent Care Centres
- Crisis Care ‘Constantly’ signed to ensure people in a mental health crisis are directed to the appropriate setting of care

**Integration of all services across the health economy:**
- Data warehouse to be established to enhance data and intelligence sharing between care settings and for performance management, leading to better outcomes for the patients
- New IHI Sentinel to be fully operational, leading to reductions in readmissions and A&E attendances. The service will include direct referrals from LAS, GP CCGs, NHS 111, GPs and other health and social care professionals, as well as District Nursing to link in through Community/Services Transformation
- Integrated 111 service with out of hours and Urgent Care Centres
- New team-based ways of working that support integration and continuity established
- Reduction in out of area placements and more effective movement of patients through the pathway

**Investment into NW London areas:**
- Implementation Business Case to be developed which will provide access to a significant quantum of capital investment, enabling the creation of purpose built health facilities
- Individual hospital business cases to be developed, existing relocations which meet patient needs and the creation of capacity to facilitate non-elective service transitions from Ealing and Charing Cross, enabling those communities to receive better care

**Developing the local hospitals within NW London:**
- Moving services from Ealing and Charing Cross hospitals to other sites in North West London to give patients greater access to specialist clinical opinion and attain better outcomes for the patients
- New estates at Ealing, Charing Cross and Central Middlesex/Hospital to provide care closer to home for patients who need access to localised, local hospital services

**Care delivered that is day-dependent:**
- 24/7 support for all Urgent Care Centres at hospital sites, working to a common enhanced specification
- Manage first to follow up ratio in line with other provider rates, therefore reducing the number of follow up outpatient appointment and or procedures
- Enhance maternity services across NW London
  - Transition of maternity services from Ealing Hospital
  - Offering patients access to maternity services in a close to home setting. New service is being commissioned in Ealing for women with serious perinatal mental health problems
  - Enhance paediatric services across NW London
  - Better outcomes for children through greater access to consultant-led care on fewer sites
  - Rapid access clinics which enables GPs to access consultant opinion and care for children at short notice

While we work in a collaboration across NW London, it is crucial that the overarching NW London vision is tailored to the local population of Ealing. Each borough have their own requirements and priorities, driven by the needs of their local residents. This is how Ealing plan to achieve the vision.
CCG Objectives and priorities for 2016-17
**CCG Vision**

*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."*

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Our vision is underpinned by following key work streams of

1. Patient empowerment and self-management
2. Primary Care Transformation
3. Whole Systems Integrated Care
4. Mental Health Transformation
5. Service reconfiguration underpinned by Shaping a Healthier Future

We started the implementation of this vision in 2013/14, and have been putting many of the fundamental building blocks in place during 2014/15 and 2015/16. We intend to build on these further during 2016/17 as described on the next pages in this section.
## CCG Objectives

1. Enabling people to take more control of their health and wellbeing
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6. Delivering our statutory and organisational duties

## Area

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| Service Reconfiguration underpinned by SaHF

### Planned Care

1. Dermatology: Continuation of 15/16 scheme
2. Ophthalmology
3. Respiratory Services
4. Cross Border issues
5. Learning Disabilities
6. Community Gynaecology
7. Older Person Pathway: Frailty, Falls, Fractures
8. Wheelchair Service Clinical Assessment, Maintenance/Repair and rehab engineering
9. Acute Conditions
10. Connecting Care 4 Children

### Community Services

1. Community Services Transformation
2. Cardiology: Embedding the new Cardiology service
3. Respiratory Services
4. Cross Border issues
5. Learning Disabilities
6. Community Gynaecology
7. Older Person Pathway - Frailty, Falls, Fractures
8. Wheelchair Service Clinical Assessment, Maintenance/Repair and rehab engineering
9. Acute Conditions
10. Connecting Care 4 Children

### Mental Health

1. Adult Mental Health Service Transformation - evaluate implementation of 2015/16 developments: Urgent Care Business Case; Eating Recovery House; Primary Mental Health Care Team: Cognitive Impairment and Dementia Services (CIDS)
2. Adult Mental Health Services – working with other CCGs and local authority and police colleagues to review the potential impact of investing in a Street Triage service
3. Adult Mental Health Service Transformation – implement new rehabilitation service (Glyn Mott)
4. Adult Mental Health Service Transformation – implement extended Talking Therapies provision (including IAPT)
5. Adult Mental Health Services for people with learning disabilities or autism who also have a mental health problems
6. Adult Mental Health Services – working with the Trust and other colleagues in NW London pilot of Liaison and Diversion Scheme for people with MH, LED or substance misuse problems in the criminal justice system
7. CAMHS community eating disorder service
8. CAMHS Out of Hours expansion
9. Community Perinatal Service
10. Transformation of children’s mental health: Better LD/CAMHS pathways/services; Improved transition from children’s to adult services; Improved early intervention services with training and development for the wider children’s workforce; Maximisation of impact of IAPT; Pathway re-design across tiers

### Integration and / or WSIC

1. Accountable Care Partnerships (ACPs)
2. Ealing Integrated Model of Care

### Patient empowerment and self-management

1. Care Place
2. self Care Programmes
3. Prevention
4. Carers’ Commissioning
5. Patient Participation
6. T

### Primary Care

1. 7 Day Working
2. Eating Community Transport
3. Education & workforce development
4. Estates
5. Out of Hospital Services

### Other

1. Diagnostic Cloud
2. Interoperability
3. Quality of CHC and Residential Care
4. Safeguarding - Adults
5. Safeguarding - Children

### Enabling people to take more control of their health and wellbeing

- Patient empowerment and self-management
- Primary Care
- Other

### Securing quality healthcare services for people in Ealing

- Planned Care
- Community Services
- Mental Health
- Integration and / or WSIC

### Enhancing organisation’s culture – developing people, processes and systems to deliver high quality commissioning

- Service Reconfiguration underpinned by SaHF
- Planned Care
- Community Services
- Mental Health
- Integration and / or WSIC

### Establishing a collaborative and proactive culture with partners and the people of Ealing

- Planned Care
- Community Services
- Mental Health
- Integration and / or WSIC

### Planning, delivering and evaluating effective strategies & actions that reduce inequalities & improve health outcomes

- Planned Care
- Community Services
- Mental Health
- Integration and / or WSIC

### Delivering our statutory and organisational duties

- Planned Care
- Community Services
- Mental Health
- Integration and / or WSIC

## CCG Objectives

1. Enabling people to take more control of their health and wellbeing
2. Securing quality healthcare services for people in Ealing
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5. Planning, delivering and evaluating effective strategies & actions that reduce inequalities & improve health outcomes
6. Delivering our statutory and organisational duties
1. Patient empowerment and Self-management

Since the start, Ealing CCG has been working in partnership with patients, carers, the wider public and the voluntary and community organisations. Our aim was and continues to be to commission services which are high quality, safe and responsive to the needs of our local community and also offering a positive experience.

We are fully committed to continuing our conversations with all our key stakeholders i.e. our patients, carers and partner organisations, through existing and new channels as we carry on in our journey to transform health and social care in Ealing.

Ealing CCG’s original vision for engagement and participation is set out in its Patient & Public Engagement Strategy. Through experience and learning it has evolved and will be reflected in the refreshed strategy document later this year. This document sits alongside our Commissioning for Compassionate Care: Patient & Carer Experience Strategy 2014 -2017 for the collaborative of five CCGs (CWHHE) and our Equality Objectives.

Our vision includes our commitment to:
• Promote participation and engagement with patients, carers, public and communities through a relationship based on trust, transparency and shared decision making.
• Ensure meaningful engagement and participation from service users and patients throughout each stage of the commissioning cycle so that their experiences and views influence change and make a positive impact.
• Treat our lay partners and patient and public representatives as equal partners and engage them in an open process of commissioning and procurement with accessible information and appropriate support.
• Ensure that those involved understand how they are able to contribute and influence and how they are influencing our approach and decision making.
• Ensure that service change options and financial implications are clearly communicated and community views are sought, acknowledged, valued and responded to in the decision making process.
• Address health inequalities and make improvements using feedback from a variety of sources and stakeholders including partners in the voluntary and statutory sectors, individuals, groups of specific patient populations, GP members and the wider public.
• Optimise the use of existing forums, boards, committees and relationships with community groups through partner agencies to hear the voices of hard to reach sectors.
• Encourage patients to be leaders for change and help them consider and debate new ways of delivering high quality services offering better patient experience.
• Achieve a streamlined process for co-creation and co-design.

Our approach to patient and public engagement will continue to be:
• Collaborative: bringing together clinicians, staff, patients, service users and the community together as equal partners
• Evidence-based: engaging the public to co-design evidence based and locally appropriate solutions to promote services which integrate health and social care
• Asset-based: developing the capacity of patients, service users and the community to engage effectively in identifying needs, feeding into plans and service designs, procuring, evaluating and monitoring
• Cyclical and iterative: engaging to build and refine sustainable models for local delivery that reflect the needs and aspirations of local people and frontline staff
Ealing CCG has made an on-going commitment to capturing public feedback and patient experiences. This information is gathered through a number of conduits, including public events, stakeholder meetings, the local community networks, local voluntary sector forums, partnership boards, a range of patient and carer-led groups, Healthwatch, complaints, Patient Participation Groups at local GP practices, and via patient representatives.

There are a number of engagement interactions each quarter. These are collated into a three monthly report, drawing out the key themes and patterns. This report is scrutinised by both Ealing CCG’s Patient and Public Engagement Committee and the Quality and Safety Committee, before it goes to the CCG’s Governing Board to inform its commissioning, decision-making and planning.

Many of the key issues identified through the engagement work described above have directly informed our commissioning intentions 2016/17. Community transport, interpreting services and support for carers have been frequently raised through our PPE work. Consequently, these themes are all clearly referenced as areas for action in our commissioning intentions.

The CCG’s top twenty community stakeholders have been identified and there is regular communication with them to cascade messages and invite responses. Our approach to consultation, engagement and communication will be to use existing community networks, voluntary sector forums, self-help groups, patient forums, Healthwatch and partnership boards in the borough.

Healthwatch, in particular, is key to our patient and public engagement work stream as it enables us to identify patient and carer representatives to participate in our service re-design and commissioning projects. There have been good examples of Healthwatch volunteers helping to share service specifications and participating on steering groups and in procurement exercises. We aim to continue this joint work with Healthwatch and ensure that Healthwatch and local residents are involved in our contract negotiations with providers as well as service redesigns.

Information gathered through engagement and consultation events will be collated and outlined in quarterly reports which will be scrutinised by the Patient and Public Engagement Committee and the Quality and Safety Committee, before being presented to the CCG’s Governing Board. Information gathered will feed into the relevant business plan and support decision-making and planning. The annual report to NHSE will outline how patient and public voice has contributed to and shaped services for the residents of Ealing.
Ealing CCG is working with London Borough of Ealing colleagues to develop the Health and Wellbeing Strategy (HWBS) 2016-21, which will be taken for approval to Health and Wellbeing Board in November 2015 and will be in place by March 2016. The overarching purpose of HWBS is to improve the health and wellbeing of the local community and reduce inequalities. HWBS specifically addresses the potential for integrating health and social care services, plus the opportunities for closer working with commissioner of other health-related services, such as housing, transport, the economy and the environment.

Ealing HWBB in July 2015 approved a draft strategic framework to inform the development of the Strategy. The framework has been based around the key issues for Ealing emerging from the JSNA. As well as the four key themes relating to the different stages of life set out in the framework, HWBS has two cross-cutting themes: behavioural change, and integration.

The aim would be to encourage everyone to gain more control of their health. The focus would be on prevention and early intervention in relation to a range of factors, recognising that reducing health inequalities requires action across all the wider determinants of health and multiple agencies. Behavioural change will also assist in reducing demand for health and social care services in future, helping to address the mismatch between needs and resources – estimated to be around £30 billion in the NHS alone by 2021/22, based on current demand patterns and likely available funding.

Integration is proposed as the second cross-cutting theme. A significant work programme is already underway looking at the integration of health and social care services. This is an important new model for delivering care, which places the individual and their needs at the centre, and makes sure the whole system’s resources are directed at those needs. The aim would be to provide holistic, or person-centred, care rather than disease-specific or organisation-specific silo’d care. Taking a person-centred approach also has the potential to reduce duplication, and improve the efficiency and effectiveness of services, and could align well with demand management approaches.

HWBS would explore opportunities to expand this type of approach to other cohorts, particularly where there is added value in collaboration across services and potential to achieve better outcomes for individuals. Priority groups that would benefit from an integrated service approach are likely to include children aged 0-5; people with long-term conditions; frail elderly people; people with dementia; people with alcohol and sexual health problems in areas that currently engage poorly with health and social care services.

Further work is currently being undertaken to conduct analysis of the key issues from the JSNA and reviewing current trends and benchmarking with our statistical neighbours to identify areas where we are significantly worse than others or where outcomes are significantly worse.
The CCG has worked with Public Health colleagues to explore the key areas to focus on to enable CCG to deliver its strategic objectives in relation to Prevention.

This work has been informed by the JSNA, NICE guidance and the burden of disease attributable to risk factors. Figure 1 shows the top 5 risk factors attributable to the burden of disease in the UK are:

a) Tobacco  
b) High blood pressure  
c) High BMI  
d) Physical inactivity  
e) Alcohol use

There is strong evidence to suggest that by focusing on: tobacco, diet, physical activity and alcohol use, a person can reduce the risk of developing a disease later in life such as cancer or heart failure. Leading a healthier lifestyle can add up to 14 years onto life and increase the quality of life. There is good evidence to support the focus on these four lifestyle behaviours.

Annual costs to the NHS of cigarette smoking, alcohol-related conditions, physical inactivity and poor diet have been estimated to be £13.3bn. The WHO estimates that if these ‘big four’ behavioural risk factors were eliminated, up to ‘80% of heart diseases, stroke and type 2 diabetes and over a third of cancers could be prevented’

The Global Burden of Disease Study 2010 showed the major causes of years lived with disability (YLDs) in 2010 were mental and behavioural disorders (including substance abuse; 21.5%, and musculoskeletal disorders, 30.5%.

1. Patient empowerment and Self-management

Prevention – key areas of focus

Source:
Tobacco
Over the last 35 years, smoking prevalence in England has halved: fewer than one in five adults smoke today. But smoking still kills. Millions of smokers in England face the risks of smoking-related illness and premature death, hundreds of young people start smoking every day, and smoking remains the principal cause of health inequalities.

Although the prevalence of smoking in England and Ealing has declined dramatically, prevalence remains stubbornly high in lower socio-economic groups and disadvantaged groups including people with mental health problems, people with long-term conditions and people within the criminal justice system. In 2013, smoking prevalence in the Routine and Manual group was 28.6 per cent compared to 12.9 per cent in the Professional and Managerial group. Tackling these inequalities is the core challenge for tobacco control in the years ahead and recent strategies for cancer have called for adult smoking prevalence to be no more than 5% in all socio-economic groups.

The CCG will work with Public Health colleagues and provider organisations to:

- Increase stop smoking referrals from Ealing GP practices and supporting adoption of referral system into SystmOne
- Incorporate smoking cessation referral protocols and smokefree policies in provider contracts to ensure that patients are offered very brief advice and referral as part of their routine treatment and care in hospital
- Encourage mandatory electronic recording of smoking status for all patients by their providers (Part of London Clinical Senate’s programme, ‘CO4’).
- Make ‘Very Brief Advice’ (VBA) a mandatory training for all provider staff to enable them to confidently raise the issue of smoking and make a referral in 30 seconds
- Ensure maternity Services implement an ‘Opt out’ referral scheme for pregnant smokers and Carbon Monoxide (CO) screening at booking
- Ensure relevant care pathways include: identification of people who smoke, provision of advice on likely smoking-related complications, advice to stop smoking and proactive referral to stop smoking services.

High BMI, Diet, Physical activity and Alcohol
Healthy eating is a vital part of a healthy lifestyle and poor nutrition can contribute to CHD, diabetes and some cancers. One in three deaths for cancer and CHD are attributable to poor diet. Only 30% of adults, 10% of boys and 7% of girls aged 11-18 years meet the 5 a day recommendation (PHE, 2014 National Diet and Nutrition Survey). Up to 79% of children who are obese in their teens are likely to remain obese adults (NICE Guideline on managing overweight and obesity). Reducing salt to 6gm a day could contribute to 17% reduction in high blood pressure in the UK (BHF, 2014). Many contributory factors lead to obesity such as over eating, inactivity, poor knowledge of healthy foods, poor habits and inappropriate portion sizes.

The top reason people give for not taking exercise is lack of time. Over 1 in 4 women and 1 in 5 men do less than 30 minutes of activity per week. 38.8% of Ealing adults participate in 30 minutes of activity each week.

Alcohol related liver disease costs the NHS £1 billion per year. 80% of adults drink alcohol and alcohol misuse is associated with stroke, cancer, liver disease, accidental injury and suicide.

An estimated 4 in 10 cases of cancer could be prevented, largely through modifying aspects of our lifestyles which we have the ability to change. The main risk factors include tobacco, weight, diet, alcohol consumption, UV exposure and lack of sufficient physical activity.

The CCG is already taking action in this area; specific examples include rolling out Making Every Contact Count (MECC) as part of the Better Care Fund (BCF) model and Coaching for Life in primary care. In addition, the CCG is also committed to implementing the London Healthy Workplace Charter as work plays a key role in keeping people in good physical and mental health.
Making Every Contact Count (MECC)

There is more that can be done in relation to Making Every Contact Count. Making Every Contact Count encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.

MECC is widely used to support health professionals and non-health professionals alike to develop their individual role and contribution to providing “health chats” as part of everyday contacts with the public.

The ambition is to make health everyone’s business. There are e-learning modules that support learning and development in behaviour change. It may cover the lifestyle issues of smoking, alcohol, sexual health, mental health and wellbeing, healthy weight, physical activity and healthy eating.

The target audience includes:

- The health and social care workforce across a wide range of settings and anyone working with the public
- Administrative and support staff in health care across a range of settings such as primary care, acute and tertiary care
- Administrative and support staff in other public sector settings such as local authorities and the voluntary sector
- MECC is for anyone who has regular interaction with the public but can also be applied to family and friends.

The CCG aims to build the delivery of MECC into its day to day business and encourage providers to do this through contracts, payment, incentives, service transformation and pathway design.

London Healthy Workplace Charter

On average, Londoners spend 37% of their waking hours at work. Work can play a key role in keeping Londoners in good physical and mental health but currently the potential benefits are not being realised. Instead, London employers lose 6.63 million working days each year due to stress, anxiety or depression.

The London healthy workplace charter is an assessment framework that provides a series of standards for workplaces to meet under key headings. These are: corporate support, health and safety, attendance management, physical activity, smoking cessation, substance use and mental health and well-being.

The Healthy Workplace Charter provides a mechanism to support and recognise employers in London and Ealing investing in health and well-being through a framework.

The Charter supports delivery of pan and local London public health priorities. For example, supporting public health outcomes around physical activity, healthy eating, smoking cessation and reduced sickness absence. We also know that investing in health at work makes business sense, improving productivity and employee engagement.

The CCG has committed to promoting the London Healthy Workplace Charter locally, effectively managing and supporting employers to achieve the Charter standards (corporate support for well-being, health and safety, attendance management, alcohol misuse, healthy eating, physical activity, obesity, mental health and smoking cessation).

Potential Years of Life Lost (PYLL) work

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. Some of these deaths could have been avoided had effective healthcare been provided. ECCG has committed to reducing PYLL that are amenable to healthcare by 3.2% per year over the course of the 5 year strategy.

CCG is identified four main areas within this work: Cardiovascular, Cancer, Respiratory & Public Health. The CCG is going to work with Voluntary and Community Sector (VCS) organisations to target these clinical areas.
Embedding principles of personalisation to support the enhanced delivery of integrated care and support

Ahead of the 2016/17 planning round, the Healthy London Partnership’s Personalisation and Participation Programme encouraged CCGs across London to signal their intentions to re-negotiate their existing contracts with community and mental health providers.

The CCG has a number of existing initiatives that support the movement towards offering people more choice and control. By building on progress being made on health and care integration, the prioritisation of care and support planning and Personal Health Budgets (PHBs) within the 2016/17 planning round will further help the development of more personalised models of care. This will move us away from standardised care pathways and the ‘one size fits all’ model.

The CCG is acting on Personalisation and Participation Programme’s 2016-17 commissioning intentions pack which includes guidance on:

- Increasing the take-up, range and profile of PHBs
- Encouraging a commitment from community and mental health providers to work with commissioners to proactively resolve issues around existing block contracts.
- Recommending the extension of existing CQUINs or agreeing a new local incentive scheme for integrated personalised care and support planning and/ or PHBs.

Increasing the take-up, range and profile of Personal Health Budgets in London

Personal Health Budgets (PHBs) have proven to be an important catalyst for placing people at the centre of decisions and enabling them to take more control, working alongside health and care professionals. An independent evaluation of national pilots identified PHBs help people feel in control of their condition; remain independent; improve quality of life; and are cost-effective. Evidence suggests people want to be more actively engaged as partners, but services frequently underestimate their willingness. The potential impact of harnessing this contribution could have huge economic value and lead to better outcomes. Approaches that personalise support to people’s level of ‘activation’, that build skills and confidence and use peer-support have shown a positive impact.

A commitment for community and mental health providers to work with commissioners to proactively resolve issues around existing block contracts

Block contracts present barriers to offering people choice and control. CCG commissioners need provider’s time and input to proactively resolve these issues and in particular agree ways funding from existing contractual arrangements can help PHBs to be taken up by a wider cohort of people.

Commissioners across London understand provider’s concerns about the potential wider availability of PHBs could have in destabilising the local market. This is why commissioners are encouraged to work with community and mental health providers to explore:

- Negotiating a local risk-share agreement releasing aspects of block contracts.
- Extending an existing CQUIN or developing a new scheme which will incentivise providers to free up a percentage of its block contract to be prioritised for the wider uptake of PHBs and enable the supported transition to a more diverse local supplier marketplace.

Extend an existing CQUIN or agree a new local incentive scheme for integrated personalised care and support planning and/ or PHBs

There is a strong argument that an increased commissioner focus on personalised care and support planning and PHBs in the forthcoming planning round can support the delivery of integrated care. The Healthy London Partnership’s Personalisation and Participation Programme summarises below why this should be prioritised by CCGs and promotes evidence and good practice principles that can support local areas to make it happen.

The programme encourages local CCGs to enter into a dialogue with their local community and mental health providers about incorporating a commitment to personalised care and support planning and/ or PHBs into existing CQUIN schemes that support the delivery of integrated care and support. In order to complement existing local planning, including the Better Care Fund ‘refresh’, CCGs that do not already have CQUIN schemes in place for integration are also encouraged to work with their local providers to agree incentive schemes to be established for 2016/17. This could feature any aspect of personalisation including personalised care and support planning, PHBs, proactively engaging with a specific population groups or integrated health and care assessments.
## 1. Patient empowerment and Self-management

### 2016-17 Priorities

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<tbody>
<tr>
<td>Empowering patients</td>
<td>8.1</td>
<td>Care Place</td>
<td>Launch of new Care Place platform in partnership with Local Authority in 15/16 but in 16/17 embedding, refining and increasing usage</td>
<td>Localised Personalised</td>
<td>Embedding, refining and increasing usage</td>
<td></td>
<td>Launch of Care Place website; a tool for self care, providing a directory of services available in Ealing to deal with Mental health and other physical health needs</td>
</tr>
<tr>
<td>Empowering patients</td>
<td>8.2</td>
<td>Self Care Programmes</td>
<td>Develop Self Care Strategy. Provide training and support for healthcare professionals in Joint Care Team. Provide motivational training for patients and carers and in other languages for hard to reach communities. Support voluntary sector</td>
<td>Localised Personalised</td>
<td>Evaluate Self Care Strategy and provision of support for delivery. Embed Self-care principles in Homeward and Models of Care as these are fully implemented. Consider how self-care fits in any service transformation programme. Additional capacity commissioned for Diabetes Patient Education sessions. Cardiac rehabilitation service onstream.</td>
<td></td>
<td>• Commission primary care to ensure that care plans are done in partnership with patients and carers, encouraging more ownership of the care plans</td>
</tr>
<tr>
<td>Empowering patients</td>
<td>8.3</td>
<td>Prevention</td>
<td>The CCG has worked with Public Health colleagues to explore the key areas to focus on to enable CCG to deliver its strategic objectives in relation to Prevention. This work has been informed by the JSNA, NICE guidance and the burden of disease attributable to risk factors. Figure 1 shows the top 5 risk factors attributable to the burden of disease in the UK are: Tobacco High blood pressure High BMI Physical inactivity Alcohol use</td>
<td>Localised Personalised</td>
<td>Making Every Contact Count (MECC) The CCG aims to build the delivery of MECC into its day to day business and encourage providers to do this through contracts, payment, incentives, service transformation and pathway design. The CCG has committed to promoting the London Healthy Workplace Charter locally, effectively managing and supporting employers to achieve the Charter standards (corporate support for well-being, health and safety, attendance management, alcohol misuse, healthy eating, physical activity, obesity, mental health and smoking cessation). CCG is progressing detection work for hypertension through the PYLL work</td>
<td></td>
<td>MECC and Healthy workplace charter to be made a local commitment</td>
</tr>
<tr>
<td>Empowering patients</td>
<td>8.4</td>
<td>Carers’ Commissioning</td>
<td>Provision of carers’ information, advice and support</td>
<td>Integrated Personalised</td>
<td>Recommission carers’ services jointly with the Council</td>
<td>Voluntary sector providers</td>
<td>All providers need to consider the needs of carers in care planning and delivery</td>
</tr>
<tr>
<td>Empowering patients</td>
<td>8.5</td>
<td>Patient Participation</td>
<td>Increased number of people/users involved in various commissioning programmes at different stages</td>
<td>Localised Personalised</td>
<td>Further developing and implementing of network PPGs Work with Healthwatch to increase level of patient engagement. Include patients in contract meetings, procurements and service redesign programmes. Provide training to support lay participation. Proactively engage with partnership boards in local authority</td>
<td></td>
<td>• Patient empowerment system in each network/federation though Patient Participation Groups, Care Planning • Lay partners will be involved in contract meetings with providers</td>
</tr>
<tr>
<td>Empowering patients</td>
<td>8.6</td>
<td>IT</td>
<td>Enable patient access to a suite of online services as well as their own records within a robust and secure environment including summary care record, online access to appointments and online access to prescribing</td>
<td>Localised Personalised</td>
<td>• Particular focus on how to consent to patients and increasing usage of IT tools • Sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community</td>
<td></td>
<td>To be completed</td>
</tr>
</tbody>
</table>
2. Primary Care Transformation

“Placing Primary Care at the heart of whole system working, and improving access to GP services”

Primary Care, and in particular General Practice, is at the centre of the NWL vision. However, the model of general practice that has served Londoners well in the past is now under unprecedented strain. There are significant challenges that must be addressed, including increasing demand and projected shortages in workforce. Patients’ needs are changing and the systems that are currently in place need to evolve to ensure that they are still fit for purpose in light of this change.

The implementation of Shaping a Healthier Future (SaHF) will deliver a vision where patients can benefit from:

- Improved health outcomes, equity of access, reduced inequalities and better patient experience;
- Services that are joined up, coordinated and easy to use;
- More services available, closer to homes;
- High quality out-of-hospital care;
- More local patient and public involvement in developing services, with a greater focus on prevention, staying healthy and patient empowerment.

This will then enable us to provide accessible, coordinated and proactive care, as set out in the London-wide Strategic Commissioning Framework.

As we move through this year, our priority areas in 16/17 are as follows:

- Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across NWL and ensuring that this is a fundamental part of an integrated care offer for patients;
- Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts);
- Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs);
- Progressing with the primary care estates strategy that takes into account the development of out of hospital hubs across NWL. Currently, 19 sites are in the pipeline. Once delivered these will provide significant additional space to deliver primary and integrated care.

To ensure the vision is successfully realised and these benefits become tangible and sustainable, the model of Primary Care needs to be transformed so that it can become the strong and sustainable for Whole Systems Integrated Care (WSIC).
### 2. Primary Care Transformation

#### 2016-17 Priorities

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<tr>
<td>Primary Care</td>
<td>9.1 7 Day Working</td>
<td>Improved access to primary care</td>
<td>Centralised</td>
<td>Review primary care access in Ealing to support 7 day working across GP networks. This will include a review of the OOHS extended hours service and the NHSE extended hours DES. Link GPs to the discharge pathway at weekends when patients are discharged.</td>
<td>All Providers</td>
<td>Improved access to primary care, pathology pick ups at weekends, access to diagnostics at the weekend where required, pharmacy access, social care support where required for patients at the weekend.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>9.2 Ealing Community Transport</td>
<td>Patients who require assistance to be able to travel to and from GP Practices, are supported to do so – improving access, reducing number of GP home visits, and reducing number of Practice DNAs</td>
<td>Localised</td>
<td>Develop and implement plans for a sustainable community transport service, building on the successful pilot</td>
<td>All Providers</td>
<td>Improved access to primary care, reduced number of GP home visits, and reduced number of Practice DNAs</td>
</tr>
<tr>
<td>Primary Care</td>
<td>9.3 Education &amp; workforce development</td>
<td>A coherent and strategic plan to support and develop the primary care workforce in Ealing</td>
<td>Localised</td>
<td>Implement the primary care workforce and education strategy, working closely with the CEPN and HENWL. Particular focus on nursing and Health Care Assistants. Identify new roles for primary care and the training for the extended primary care teams</td>
<td>All Providers</td>
<td>A coherent and strategic plan to support and develop the primary care workforce in Ealing, which will support delivery of the CCG’s wider primary care transformation agenda. Community Services and other providers to work with local GPs to deliver some of the core training and education such as diabetes, wound care or dementia etc.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>9.4 Estates</td>
<td>A coherent and strategic plan to manage and develop the primary care estate across Ealing</td>
<td>Localised</td>
<td>Implement the primary care estates strategy working closely with the property services, NHSE, and LA</td>
<td>All Providers</td>
<td>A coherent and strategic plan to manage and develop the primary care estate in Ealing, which will support delivery of the CCG’s wider primary care transformation agenda, working closely with LA, and NHSE in particular</td>
</tr>
<tr>
<td>Primary Care</td>
<td>9.5 Out of Hospital Services</td>
<td>• Supporting the Care Closer to home principle • Supporting the ambitions of integrated delivery where providers work together • Enhancing the capacity and capability of primary care services to provide more care Out of Hospital</td>
<td>Localised Personalised Centralised</td>
<td>Review OOHS performance and conduct a review of services in partnership across CWHHE. This will include reviewing and amending the service specifications. Develop new services that align to the OOH Services such as Dementia or Paediatric Phlebotomy</td>
<td>All Acute Providers GP Federation</td>
<td>Amendment of service specifications will impact upon capacity and capability of primary care, and activity shift from other providers. Certain service lines will be impacted – e.g phlebotomy provision in acute trusts, diabetes community service will be required to work closely with primary care to deliver the shift in activity. WILHMT, PCMHWs will be required to work with the practices to manage complex common mental health concerns and Shifting Setting of Care as per the specification.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>9.6 Primary Care Transformation</td>
<td>Delivering the primary care model of care offer in partnership with NHSE Developing Federation to become a strong entity that has a credible standing and voice in the future Accountable Care Partnership</td>
<td>Localised</td>
<td>Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across NWL and ensuring that this is a fundamental part of an integrated care offer for patients; Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts); Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs);</td>
<td>GP Federation</td>
<td></td>
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3. Whole Systems Integrated Care

“Coordinating care across commissioning bodies and provider, centred around the patient”

Across NWL we are approaching year three of a five year journey towards delivering the Whole Systems Integrated Care (WSIC) vision. The characteristics of WSIC (outcome-based models of care, accountable care partnerships, capitated payments and system-wide risk and reward sharing) have been reinforced through national policy as articulated by the “Five Year Forward View”.

Full implementation of WSIC will require a multi-year transition towards:

- Jointly commissioned population level outcomes that span health and wellbeing;
- Accountable care partnerships (ACPs) delivering co-produced models of care and managing the clinical and financial risk for their registered populations;

During 16/17 early adopters will continue to:

- Roll out, review and refine new models of care that reflect the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities:
- Embed new ways of working, culture and behaviours to underpin the system changes required;
- Develop new governance arrangements
- Embed co-production throughout ways of working;
- Share learning and best practice across and beyond NWL.

To support transition during 16/17 commissioners will:

- Engage formally with the development of ACP boards;
- Work collaboratively with providers to set a clear roadmap for transition to 18/19;
- Shape an approach to system assurance that ensures WSIC provides the best quality and best value care for the population of NWL;
- support providers who wish to explore alternative contracting approaches that enable providers to jointly reallocate existing workforce to the new models of care within an agreed funding envelope;
- Produce shadow population-level capitated budgets.
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<tr>
<td>Integration and / or WSIC</td>
<td>7.1</td>
<td>Accountable Care Partnerships (ACPs)</td>
<td>ACPs delivering co-produced model of care and managing the clinical and financial risk for their registered populations</td>
<td>Localised</td>
<td>• Support and engage with shadow ACP boards as they develop. • Shape an approach to assurance that ensures WSIC provides the best quality and best value care for the population of NWL. • Embed new ways of working, culture and behaviours to underpin system changes required • Introduce a ring-fenced element of real risk share where appropriate</td>
<td>All Providers</td>
<td>Providers / partners will need to organise themselves into ACPs with the appropriate governance structure and system wide risk and reward share to be eligible to deliver NWL Whole Systems Integrated Care</td>
</tr>
<tr>
<td>Integration and / or WSIC</td>
<td>7.2</td>
<td>Ealing Integrated Model of Care</td>
<td>Integrated Model of Care implemented across Ealing that reflects the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities • Working across primary, community and acute settings and based on clear outcomes for people aged 75 and above with one or more long term conditions • Reduction in unplanned admissions to acute facilities or residential care • Patients and service users able to remain as independent as possible in their own home supported by appropriate services within the community</td>
<td>Integrated</td>
<td>• Continue to evaluate, review and refine the Ealing Integrated Model of Care and report against outcomes achieved. • If successful recommend Model be rolled out to other cohorts of patients • Align thinking and development with Leader Provider / ACP as it develops • Embed new ways of working, culture and behaviours to underpin system changes required • Monitor Integrated Model of Care against a shadow population-level capitated budget once available • Continue to embed co-production throughout ways of working • Share learning and best practice across and beyond NWL. • Develop Model of care for further population segments • Develop the commissioning landscape to deliver outcomes /values based commissioning</td>
<td>All Providers</td>
<td>• Provider / Partners will be expected to fully engage with the NWL Whole Systems Integrated Care programme • Providers will need to assign members of the Joint Care Team and work through how this Model becomes business as usual • Voluntary sector will need to form consortia to respond to the procurement for Care Navigators from October 15, and be in a position to recruit and manage 7 Care Navigators aligned to the wider Model of Care and Joint Care Teams • Community services, acute consultants, WLMHT, social workers to continue to engage in primary care multi-disciplinary group meetings and practice based MDT meetings • Community services and WLMHT to fully align to Networks of GPs and form Joint Care Teams in partnership with care coordinators, social workers and primary care teams.</td>
</tr>
<tr>
<td>Integration and / or WSIC</td>
<td>7.3</td>
<td>Better Care Fund</td>
<td>Appropriate funding from pooled budget aligned to relevant programmes / schemes to develop, resource and deliver Integrated Health and Social Care</td>
<td>Integrated</td>
<td>• Further refine the programmes of work to align the health and social care budgets to a more integrated way of working • Continue to report against activity via an approach to assurance that ensures WSIC provides the best quality and best value care for the population of NWL.</td>
<td>Providers to continue to sign post patients to support services such as commissioned voluntary sector services</td>
<td></td>
</tr>
<tr>
<td>Integration and / or WSIC</td>
<td>7.4</td>
<td>IT</td>
<td>• Shared IT platform using community module of SystmOne to share records for patients on Integrated Model of Care • Data sharing agreement signed by all providers to deliver capitated budget</td>
<td>Integrated</td>
<td>• Implementation of community module across all joint care teams • Whole Systems information sharing agreement signed by all parties and data feeding into data warehouse</td>
<td>Providers to continue to sign post patients to support services such as commissioned voluntary sector services</td>
<td></td>
</tr>
</tbody>
</table>
4. Mental Health Transformation

“Improving mental and physical health through integrated services”

NWL is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value. This strategy is being signed off this year.

Across the system we have agreed to ensure that there is:

• Support for people who have experienced mental health problems to live well in the community;
• Promotion of recovery, resilience and deliver excellent health and social care outcomes including employment, housing and education;
• Development of new high quality services in the community, focusing on community based support rather than inpatient care so that people can stay closer to home;
• Services that provide urgent help and care which are available 24 hours a day 7 days a week for people who experience or are close to experiencing crisis.

As part of our commissioning intentions we would want providers to be proactively involved in transformation work and in implementing the outputs of transformation work. Specifically in 2016/17 we want to focus on:

• Implementation of new urgent care pathways and compliance with national target waiting times;
• Implementation of Future in Mind, the national strategy for children and young people to respond to local needs;
• Work with local specialist Mental Health and Learning Disabilities providers to implement local pathways to enable people to be cared for within NWL;
• Work collaboratively to implement the emerging outputs of the Like Minded strategy.

Following the publication of the Like Minded Case for Change in August, the four priority work streams agreed by the multi agency NWL Mental Health & Wellbeing Transformation Board to progress initially are:

1. Children & Young People: NWL’s Transformation Plan in response to ‘Future in Mind’
2. Serious & Long Term Mental Health Needs
3. Common Mental Health Needs
4. Wellbeing & Prevention: workplace wellbeing & parenting interventions to prevent conduct disorder
1. Ensure parity between mental health and physical health by:
   • Improving the physical healthcare of people with mental health problems
   • Improving the mental health care of people with long term conditions
   • Develop services that are integrated and wrap around the person no matter what their physical, mental or social care needs are.

2. Effective support and pathways of care for people with mental health needs at times of crisis in accordance with national, local crisis care concordat plans and London mental health commissioning standards and recommendations

3. Ensure people with mental health problems have access to appropriate evidence-based NHS assessment and treatment services that support recovery, in line with the access and waiting time standards (e.g. IAPT and EIP)

4. Strengthening the provision of mental health care in the community, including ensuring appropriate access to and offering a wide range of services for people with mental health problems.

5. Support the delivery of training to enable the up-skilling of the primary care workforce to support patients in the community.

6. Effective support and pathways of care for perinatal mental health concerns and conditions

7. Effective support and pathways of care for Children and Young People with mental health concerns and conditions

8. Support and improve the mental wellbeing of Londoners through the provision of an online digital mental wellbeing services committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value. This strategy is being signed off this year.

Across the system we have agreed to ensure that there is:

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• Work collaboratively to implement the emerging outputs of the Like Minded strategy.

How we will measure success:
1. Evaluate patient experience/satisfaction
2. Measuring against performance:
   • Improving access to psychological therapies - 75% of people referred will be treated within 6 weeks of referral, 95% will be treated within 18 weeks of referral, 50% of people completing treatment move onto recovery
   • Early intervention in psychosis - over 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral

3. Improved mortality rates
4. Development of new access standards in perinatal and liaison psychiatry
## Mental Health Transformation

### 2016-17 Priorities

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</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>6.1</td>
<td>Adult Mental Health Service Transformation - evaluate implementation of 2015/16 developments: Urgent Care Business Case, Ealing Recovery House, Primary Mental Health Care Team, Cognitive Impairment and Dementia Services (CIDS), This is Transformational - linked to Crisis Concordat</td>
<td>Reconfiguration of the pathways relating to: Psychosis, Complex depression, anxiety and trauma, Personality disorder, Rehabilitation, Urgent care and access, Linked to Primary Care Out of Hospital developments for mental health</td>
<td>Personalised, integrated, localised</td>
<td>Evaluate the effectiveness of transformation changes implemented during 2015/16 and how they impact on the configuration of services and the cost of services</td>
<td>WLMHT</td>
<td>Specifications for these services to be included in the 2016/17 Contract</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.2</td>
<td>Adult Mental Health Service Transformation – implement new rehabilitation service (Glynn &amp; Mott)</td>
<td>Reduction in out of area placements and more effective movement of patients through the pathways.</td>
<td>Personalised, integrated, localised</td>
<td>Ensuring services for people experiencing mental health crisis are at all times as accessible responsive and high quality as other urgent and emergency services</td>
<td>WLMHT</td>
<td>Specification for this service to be included in the 2016/17 Contract</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.3</td>
<td>Adult Mental Health Service Transformation – implement extended Talking Therapies provision (including IAPT)</td>
<td>Increased talking therapies offer for Ealing residents to support those with complex common mental health conditions and stable serious mental illness</td>
<td>Personalised, integrated, localised</td>
<td>Consider outcome of talking therapies review undertaken in 2015/16 and commission services to meet identified gaps.</td>
<td>Voluntary sector and WLMHT</td>
<td>Implementation of new service proposals</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.4</td>
<td>Adult Mental Health Services for people with learning disabilities or autism who also have a mental health problems</td>
<td>Improved services for this cohort of residents, contributing to keeping them supported in the community</td>
<td>Personalised, integrated, localised</td>
<td>Develop more effective provision between providers and increase local offer for this cohort</td>
<td>WLMHT and LNWHT and independent sector</td>
<td>All providers need to work together to develop appropriate responses to these complex needs.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.5</td>
<td>Adult Mental Health Services – working with the Trust and other colleagues in NW London pilot of Liaison and Diversion Scheme for people with MH, LD or SM needs and diverts them from the criminal justice system, providing a more appropriate response to their needs</td>
<td>Evaluating whether the service effectively reaches this cohort of people with MH, LD or SM needs and diverts them from the criminal justice system, providing a more appropriate response to their needs</td>
<td>Personalised, integrated, localised</td>
<td>Evaluate the pilot and work with colleagues to consider whether this approach should be continued following the pilot.</td>
<td>WLMHT, CNWL, independent sector, Police, Probation</td>
<td>The transformation of services and the implementation of the mental health tariff should result in a more effective use of bed-based services enabling the Trust to achieve financial balance.</td>
</tr>
</tbody>
</table>
## Mental Health Transformation
### 2016-17 Priorities

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| Mental Health | 6.6 | CAMHS community eating disorder service CCG is funded from 2015/6 to set up this service as are all other CCGs. The service must be provided on basis of total population of least half a million. Ealing CCG will work with Hammersmith and Fulham and Hounslow CCGs to commission this service from WLMHT. | Children with eating disorders will be supported to live at home; Tier four admissions should be reduced; children should receive specialist input at an earlier stage thus preventing escalation of problems. | Personalised, integrated, localised | • In 2015/16 and 2016/7 we will commission an eating disorder service from WLMHT working with two other CCGs.  
• Impact of service will be monitored.  
• Although much of the set up should be in 2015/6 full implementation will be 2016/7. | WLMHT | • Commission with Hounslow and Hammersmith and Fulham CCGs an eating disorder service for children  
• WLMHT to provide service  
• Contract to be amended  
• Tender waiver to be applied for |
| Mental Health | 6.7 | CAMHS Out of Hours expansion This is being commissioned in 2015/6 with Hammersmith and Fulham and Hounslow CCGs. It is being commissioned for a pilot period. WLMHT is provider. | Streamlined pathways across tiers This may be expanded under local transformation plan to include home treatment and crisis intervention. | Personalised, integrated, localised | Include crisis intervention and home treatment service in CAMHS out of hours provision. | WLMHT with some impact on CNWL | • Evaluate effect of extended out of hours service for CAMHS and subject to evaluation to expand model to include crisis intervention and home treatment  
• Embed outcome focussed framework comprehensively within CAMHS |
| Mental Health | 6.8 | Community Perinatal Service New service is being commissioned in Ealing for women with serious perinatal mental health problems. Work is in conjunction with Hounslow and Hounslow CCGs. | Service to be commissioned in 2015/16 but to be operational from end of the year Service model is to be evaluated over the next 18 months | Personalised, integrated, localised | Full implementation of new service  
• Evaluation of model | WLMHT | • Offering patients access to maternity services in a close to home setting  
• Provision of new service in Ealing and expanded service in other two CCG areas  
• WLMHT to provide service |
The CCG is also considering key recommendations from the Ealing Dementia JSNA chapters are set out below:

- To increase the number of care homes in the borough able to look after people with challenging behaviour and complex needs
- To develop alternative models of respite care other than bedded respite care for people with dementia, such as domiciliary care
- To improve post diagnostic support for people with dementia and their carers including better, more accessible and timely information, crisis response and support, support for carers
- To continue to improve towards improving diagnosis rates, pathways and recording of data for people with dementia
- To locally raise public and professional awareness on the signs and symptoms of dementia and the links to vascular risk factors
- To raise awareness and access to dementia services amongst
  - People with learning disabilities
  - BME groups
- To continue to work towards making Ealing a dementia friendly community
- To ensure that public facing staff especially those in the local authority and NHS receive appropriate dementia awareness training.
- To locally work to destigmatize and promote positive attitudes towards as part of any national campaigns

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<tr>
<td>Mental Health</td>
<td>6.9</td>
<td>Transformation of children’s mental health</td>
<td>• More streamlined services&lt;br&gt;• Children supported as needed across all children’s services</td>
<td>Personalised, integrated, localised</td>
<td>• Commission new services&lt;br&gt;• Design and deliver workforce development and training&lt;br&gt;• Improve pathways&lt;br&gt;• Improve accessibility of services</td>
<td>WLMHT</td>
<td>• Jointly commission training and public education programmes with the Local Authority&lt;br&gt;• Subject to further exploration of benefits and cost, o commission home treatment and crisis intervention&lt;br&gt;• Work with WLMHT schools, LA and voluntary sector on pathway re-design</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6.10</td>
<td>Adult Mental Health Services – working with other CCGs and local authority and police colleagues to review the potential impact of investing in a Street Triage service&lt;br&gt;This is a Sector priority – linked to Crisis Concordat</td>
<td>Reduction in use of s136 assessments and effective response to client needs,</td>
<td>Personalised, integrated, localised</td>
<td>Evaluate the benchmarking work and decide whether to commission Street Triage in North West London.</td>
<td>WLMHT, CNWL, Police, other providers</td>
<td>All providers need to be involved in considering whether this approach is likely to be appropriate and cost effective in North West London</td>
</tr>
</tbody>
</table>
In NWL, we have recognised the changes in population demographics and lifestyles, and, as such, are changing the way we organise our hospitals and community health services. By making these changes, we can ensure that the highest standards of care are met; that our hospitals have the specialist doctors and facilities in place to deal with your specialist needs round-the-clock, and out-of-hospital services are on hand to treat your everyday health needs as quickly and conveniently as possible, either closer to or within your own home.

Acute Reconfiguration aim to deliver:
- 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 concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:
- Deliver a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in NWL
- The delivery of the transition of paediatric services from Ealing Hospital by June 30, as agreed by Ealing CCG Governing Body (on behalf of all other Governing Bodies in NWL) earlier this year
- Planning for the transition of other services from Ealing and Charing Cross Hospitals as we continue to transform these sites to their future state

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### Area # Programme of Work Expected Outcomes Alignment to Vision What we will do in 2016/17? Providers impacted Implications on Providers

<table>
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<tr>
<th>Service Reconfiguration underpinned by SaHF</th>
<th>Programme of Work</th>
<th>Expected Outcomes</th>
<th>Alignment to Vision</th>
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</thead>
<tbody>
<tr>
<td>1.1 Paediatrics Transition</td>
<td>Complete Paediatric transition</td>
<td>Localised</td>
<td>Complete transition of Paediatric Services from Ealing Hospital as per SAHF plans by June 2016 Implement recommendations from the review of Paediatrics Rapid Access Clinic at EHT</td>
<td>Ealing Hospital Decommission Paediatric Services from Ealing Hospital as per SAHF plans by June 2016 Implement recommendations from the review of Paediatrics Rapid Access Clinic at EHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Reconfiguration underpinned by SaHF</td>
<td>Ealing Local Hospital</td>
<td>Ensure plans are operationalised to enable Ealing Local Hospital to become Centre of Excellence</td>
<td>Localised</td>
<td>Continue to develop plans for developing Ealing Hospital as a Local Hospital and enable it to become Centre of Excellence. Develop robust transition plan</td>
<td>Ealing Hospital</td>
<td></td>
</tr>
<tr>
<td>Service Reconfiguration underpinned by SaHF</td>
<td>Delivery Architecture</td>
<td>NWL CCGs are working on design of a transformational ‘System Operating Model’ (&quot;SOM&quot;) for the delivery of priority programmes across the North West London (&quot;NWL&quot;) healthcare system. The SOM will be designed in order to ensure that a number of outcomes can be achieved for patients and organisations</td>
<td>Centralised</td>
<td>Development of a pan-NWL bank and addressing agency spend Creating a top class orthopaedics service, as an early adopter of ‘Getting it right first time’. SOM will design an architecture which can enable the delivery of consistent clinical pathways and standardised operating procedures to reduce clinical variability Improving the way that end-of-life care is delivered across the sector and where it is delivered</td>
<td>All providers</td>
<td>The design of the SOM, in line with the requirements set out above, which is acceptable to stakeholders and can be approved by Trust Boards and CCG Governing Bodies The establishment and mobilisation of each of the SOM bodies, which must include core project infrastructure such as terms of reference and agreed membership An undertaking from all NWL organisations that they are progressing the local implementation of priority schemes for 16/17</td>
</tr>
<tr>
<td>Service Reconfiguration underpinned by SaHF</td>
<td>7 Day Working</td>
<td>To adhere to the National 7 Day Clinical Standards</td>
<td>Centralised</td>
<td>Development of the workforce to ensure staff are competent and compassionate across all settings of care</td>
<td>All</td>
<td>7 day services: Integrated 7 day multi professional discharges and improved post discharge care. Improved discharging: Proactive multi-agency/multi professional management of complex discharges in timely manner</td>
</tr>
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</table>
Maternity services
London Maternity Strategic Clinical Network - Generic Maternity Services Specification

The NWL CCGs communicated the London Maternity Strategic Clinical Network - Generic Maternity Services Specification to all provider organisations.

This Generic Maternity Services specification sets out a generic maternity services specification for London. It draws on national documents, published evidence and locally available data and information. This collaborative document has been produced with input from local CCG commissioners of maternity services from across London as well as service providers, healthcare professionals and service users.

It recommends an approach to local commissioning based on best practice and evidence to support maternity services to reduce unwarranted variation and improve quality outcomes across London.

Locally defined outcomes
Linked to the Outcomes Framework, the programme of work for the Maternity Strategic Clinical Network is focused on three main priorities:

- Reduction in mortality and morbidity of pregnant women
- Reduction in stillbirth rates in London
- Improvement in women’s and families experience of maternity care

As such, the following local outcomes have been identified: to:

- Deliver safe and effective care to mother, child and family.
- Continuously improve outcomes for mothers and babies by reducing the risk of morbidity and mortality, stillbirth, low birth weight and infant mortality.
- Deliver care that is compliant with national reviews, standards and evidence based practice.
- Deliver care that is responsive to local need.
- Deliver care that engages women as partners in shaping the maternity service so that it best reflects their needs and priorities, leading to improved access and choice.
- To increase the number of ‘eligible’ (defined as healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications) women accessing midwifery led settings and increase the number of women accessing continuity of midwife care.
- Promote and increase the numbers of ‘normal’ births (defined as without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery).
- Work with public health teams in local authorities to improve public health outcomes such as early access to maternity services, breastfeeding initiation, healthy eating, and reducing smoking in pregnancy and pregnancy planning for women with pre-existing conditions.
- Ensure that all women and their babies have timely access to appropriate level maternal, fetal and neonatal medicine services, provided within a network.
- Embed safeguarding across the pathway in line with local safeguarding procedures.
- This would include responsibilities for Female Genital Mutilation (DH safeguarding women and girls FGM)
- Ensure access to translation, interpreting and advocacy services based on an assessment of need.
- Bring equity between physical and mental health.
- Maintain strong communication links to relevant health professionals and the woman’s GP throughout the pregnancy and following birth.
- Encourage an open and transparent environment where staff are able to raise concerns and challenges and create an environment of learning from incidents and user feedback.
- Develop a framework around training to support staff and address poor performance or poor attendance and ensure a training analysis is conducted for all key staff groups. Use lessons gained from clinical incidents to aid and inform training sessions.
- Reduce where possible, London's maternal death rate; including commitment to continuous learning and support for the London-wide review process for severe maternal morbidity and maternal deaths.

Service specification: key points
Maternity services commissioned should be safe, woman-centred, evidence based and of high quality, delivered at the right time, in the right place and by a planned, educated and trained workforce. This will be undertaken by ensuring that:

- The transition from pregnancy to parenting and family life is supported through high quality services that are woman and family centred.
- Women and their families are able to access a full range of pre-conception advice, antenatal, intrapartum and postnatal care, taking account of individual choice and clinical need.
- Women and their families are given evidence based information and advice about all stages of their pregnancy.
- Continuity of care is delivered across the maternity pathway.
- Maternity care provision is flexible, appropriate and accessible to women, placing a significant emphasis upon the need to engage women from disadvantaged and marginalised groups, those from high risk environments and other families with complex social needs.
- Service providers work in partnership to deliver community based multi-professional care across organisational and geographical boundaries to deliver seamless services.
- Service providers should have failsafe systems in place which operate across organisational boundaries to identify women / babies at risk of not receiving timely screening.
- Providers and commissioners work in partnership with women and their families, predominantly through Maternity Services Liaison Committees (MSLC) to design, develop, improve and deliver services which meet local need.
## Service Change 2016-17 Priorities: Planned Care Services

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<tr>
<td>Planned Care</td>
<td>2.1</td>
<td>Dermatology</td>
<td>Continuation of 15/16 Scheme</td>
<td>Centralised</td>
<td>• Manage first to follow up ratio’s in line with other provider rates, therefore reducing the number of follow up outpatient appointment and or procedures • Work with providers across the system to improve Dermatology pathways for patients</td>
<td>LNWHT ICHT</td>
<td>• Provider to adopt more efficient methods for treating patients. Manage the first to follow up ratios • Closer working relationships with other CCG commissioned services across dermatology pathways</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2.2</td>
<td>Ophthalmology</td>
<td>Creating more efficient pathways and use of resources</td>
<td>Centralised</td>
<td>Commission a new way of delivering community ophthalmology services, ensuring that those patients who need to be seen at a HES are seen within a timely fashion, whilst those suitable for community management are treated in such a setting</td>
<td>Moorfields ICHT (Western Eye)</td>
<td>• Negotiate community provision with existing Hospital Eye Services (HES) at a local tariff thus negating the need for unnecessary formal procurement • Close working relationships with providers and commissioners across ophthalmic pathways.</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2.3</td>
<td>Latent TB management</td>
<td>Expansion of latent TB screening subject to funding from TB control board</td>
<td>Centralised</td>
<td>• Identification of patients with Latent TB • Increase in outpatients activity</td>
<td>LNW- Ealing site</td>
<td>Increase in Outpatient Activity managing latent TB cases</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2.4</td>
<td>Gastroentrology Radio Pathways</td>
<td>Review of specific pathways in conjunction with Brent CCG</td>
<td>Localised</td>
<td>A shift of stable patients with fatty liver disease and monitoring of patients on DMARS to primary care. Review of pathway for endoscopy</td>
<td>LNWHT</td>
<td>Reduction in Outpatient activity and reduction in endoscopies</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2.5</td>
<td>Musculoskeletal services</td>
<td>Bring onstream the Community Pain service and community based Rheumatology service Improve efficacy and outcomes for patients with elective surgery</td>
<td>Localised</td>
<td>Bring onstream the Community Pain service and community based Rheumatology service. Creating a top class orthopaedics service, as an early adopter of ‘Getting it right first time’. SOM will design an architecture which can enable the delivery of consistent clinical pathways and standardised operating procedures to reduce clinical variability. Develop integrated community service with MSK, Pain and Rheumatology</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>2.6</td>
<td>Cancer Services</td>
<td>Cancer services commissioned in line with a number of national and regional cancer priorities and quality standards</td>
<td>Integrated Localised</td>
<td>Outputs from Cancer Commissioning Board will inform this content</td>
<td>All Providers</td>
<td>A number of services will be commissioned to support the earlier diagnosis of cancer in line with the Pan London Early Detection pathways</td>
</tr>
</tbody>
</table>
Cancer Services

2016-17 intentions

Cancer is one of the four priority areas for improvement identified by NHS England (London) to transform the health, wellbeing and lives of Londoners.

The Five-year Cancer Commissioning Strategy for London1, was launched in February 2014. The strategy was developed collaboratively by NHS England with significant input from cancer clinicians, representatives from the Integrated Cancer Systems (London Cancer and London Cancer Alliance) linking into the clinical pathway groups, CCG clinical commissioners as well as commissioners from Public Health England and NHS England.

These commissioning intentions will support the delivery of cancer waiting times across London and have a strong focus on diagnostics. They include the changes to services required to meet the new NICE suspected cancer guideline (2015). This will enable GPs to have direct access to a greater range of diagnostic tests to support them to identify which patients need to be referred under the two week standard. An immediate first step is for providers to work with their commissioners and the TCST at a system level to set out plans for how they will secure the diagnostic capacity, including the workforce required to deliver cancer waiting times standards, the new NICE referral urgent cancer guidance and the GP direct access pathways. Plans will also need to take into account of RTT and increases in uptake in the bowel screening service. In line with National expectations these plans should implement NICE guidance by mid-2016.

All services will also be commissioned against timed tumour level pathways. The approach taken for 2016/17 is to refine and build on last year’s commissioning intentions as they will not all have been fully delivered by April 2016 and only to add limited additional areas. The Commissioning Intentions for 2016/17 are outlined below.

Earlier detection of cancer and increasing access to diagnostics

GP direct access to a wider range of diagnostics in line with NICE Suspected Cancer Guidelines: Recognition and Referral (2015), including:
- Chest x-ray (same day chest x-ray for high suspicion of cancer)
- Non-obstetric ultrasound
- Gastroscopy
- MRI for specific patient cohort to improve early detection of brain cancer
- CT scan of abdomen to improve early detection of pancreatic cancer

Additionally
- GP straight to test access to flexible sigmoidoscopy/colonoscopy via a diagnostic triage service that will assign the most appropriate diagnostic test.
- In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently

- In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent care centres and inpatient chest x-rays (CxR) and implementation of National Patient Safety Alert 16/2007
- JAG accreditation for endoscopy services and implementation of lower GI surveillance guidelines
- Endobronchial US (EBUS) services are commissioned to an agreed service specification and tariff.

Reducing variation in secondary care

- Cancer waits – timed pathways in every tumour site, adoption of the ICS inter-provider policy with referral to treating trust by day 42 at the latest (some pathways earlier) and median wait for first appointment (where cancer suspected) within 7 days.
- All services will participate in national cancer peer review or other assurance programme defined by commissioners. All cancer MDT’s are quorate for 95% of meetings and individual core members attend 66% of meetings (in order to support improved MDT decision making)
- Lung cancer – including requirement to follow a best practice timed pathway, a thoracic surgeon present at all MDTs, CT prior to first OPA, CT scan prior to bronchoscopy and Clinical nurse specialist present at diagnosis
- Breast cancer - including requirement to follow a best practice timed pathway, that an individual surgeon has a caseload of 50 per annum, each service provides a one stop triple assessment service, the service is delivered through the 23-hour stay model, that patients have access to immediate reconstruction and that 70% of new patients are followed up through a stratified pathway of supported self-management
- Prostate cancer - including to follow a best practice timed pathway, requirement that an MRI is performed pre-TRUS Bx for a given cohort, 40% of new patients are followed up through a stratified pathway of supported self-management, use of multi parametric MRI (to be adopted in year dependent on outcome of current trial)
- Colorectal cancer - including requirement that to follow a best practice timed pathway, all surgeons are completing the required minimum numbers of 20 cases with curative intent per annum, each MDT completes a minimum of 60 cases with curative intent per annum, enhanced recovery programme embedded, all suitable patients to be offered laparoscopic surgery and resection rates to match the England average and the age of referral for low risk, but not no risk of cancer lowered to 45, Barium Enema not to be used as diagnostic test for suspected cancer, people who need emergency treatment should be treated by an emergency team
- Providers to agree and implement service consolidation plans
- Services will be commissioned to provide pathways for the management of treatment related fertility issues (NICE Guidance 2013)
- Services will be commissioned for the management of those with a family history of moderate risk breast cancer to a Pan London specification (NICE Guidance 2013)
- Services for the provision of Metastatic spinal cord compression will be commissioned in line with NICE QS56 (Feb 2014).
- CNS and AHPs in cancer MDTs will attend advanced communications training and Level 2 psychological assessment skills training, and will have access to on-going psychological support supervision.
- Services required to follow NICE guidance on smoking cessation
Living with and beyond cancer - recovery package (NCSI)
• All cancer services commissioned to deliver the recovery package (holistic needs assessments and care plans, treatment summaries; health and well-being events) within a specified time-frame
• Services will have pathways in place to manage some of the consequences of anti-cancer treatment specifically: the management of GI late effects, lymphedema, psychological and physical sexual related problems, psychological support (reference CI 15) and managing hormonal symptoms

Additional Commissioning Intention that’s the CCG is considering include:
• Stratified follow-up in the community of stable or low risk prostate cancer patients

Access To Psychological Support For Cancer Patients
In order to continue progression towards achieving the aims of the London cancer strategy, the cancer commissioning intentions for 2016-17 includes a focus on improving the management of psychological support for cancer patients. Acute Trusts are required to build psychological assessment capacity into their MDTs and have access to on-going psychological support supervision. Commissioners have the intention to commission mental health providers to provide pathways for the management of psychological support for cancer patients.

This commissioning intention for mental health providers in 2016/17 states:
IAPT services will be commissioned to provide pathways for the management of psychological support for cancer patients.

These commissioning intentions were signed off by the Pan London Cancer Commissioning Board (CCB) on 29 September 2015

Local Improvement Scheme (LIS)
The CCG through its LIS 2015-16; has tried to improve access to cancer screening services (Bowel screening). This is an important part of the CCG’s plans to improve clinical outcomes and reduce inequalities. This is reflected in the CCG’s 2015/16 Outcome Domains and Measures around ‘securing additional years of life’ for the local population. The CCG intends to continue this in 2016-17.

The CCG is also considering actions for the following findings from Ealing JSNA Cancer Chapter:

Prevention
• Include prevention and raising awareness of key lifestyle, red flag symptoms and screening/case finding opportunities, in all cancer pathways, especially in relation to breast and prostate.
• Support local targeting of national ‘Be Clear on Cancer (BCOC)’ or other cancer awareness campaigns with primary care and council and voluntary sector, especially for breast (in BME, older, deprived women), bowel (men, deprived areas & BME) and prostate cancer symptoms.

Screening
• Breast cancer screening coverage remains an area of poor outcome, persisting since JSNA 2012 and warrants an action plan informed by further analysis into underlying issues (lead NHS England).
• Target BME women in deprived areas for cervical and breast screening awareness.

Treatment
• Breast cancer treatment remains an area of poor outcome, persisting since JSNA 2012 and requires an action plan informed by further analysis into underlying issues (lead Ealing CCG/Cancer Network).
• Referral to Treatment within 62 days pathway is a key priority to ensure current cancer pathways are operating consistently (CCG/providers)
• Review impact of NICE Suspected Referrals Guidance on diagnostic capacity, especially endoscopy, and plan impact on cancer pathways before implementing. (Cancer network)
• High rates of premature prostate cancer mortality warrant further review, to apply lessons from good practice elsewhere. (lead CCG/Cancer network)
• End of Life warrants a separate JSNA chapter (JSNA steering group)
1. Community, Primary and Acute care contracts - Provide a joined up, equitable U&EC system

1.1. Access for all and to the same integrated clinical pathways
- All U&EC facilities are able to receive adults and children and young people.
- All U&EC facilities are able to receive patients that self-present (“walk-in”) or arrive by ambulance services.
- Regardless of the initial service accessed, patients are able to access the same integrated clinical pathways across the health and social care system. This is achieved through the enablement of all registered health and social care professionals within the U&EC system, following telephone consultation or clinical review of a patient, to make direct referrals and/or direct appointments across settings.
- Patients referred or booked into another U&EC facility and whose immediate U&EC need was not met by the referring facility should not present at the new service as a new patient (e.g. Patients referred from a UCC to EC for diagnostics).

1.2. Integrated clinical governance
- All facilities are part of the regional U&EC network they are situated within.
- Nested integrated clinical governance arrangements, under strong clinical leadership and with clear lines of accountability to commissioners, are in place joining all facilities within a SRG (e.g. a UCC provider and EC provider within a SRG having integrated clinical governance). They will feed into the U&EC network for whole system accountability. This integrated governance will assure provider clinical quality and safety across facilities and ensure issues are identified and improvements made.

2. Community and Primary care contracts - Offer consistent UCC services in the community and co-located with EDs

2.1. Meet the London Quality Standards for urgent care centres

2.2. Consistent opening hours and staffing
- Consistent service provision within both co-located and standalone centres.
- All UCCs to be open for a minimum of 16 hours per day.
- Each site a UCC is located on must provide urgent care from 08:00 to midnight (if the UCC is co-located with an EC then the EC may provide urgent care for part of this time period but the UCC should still be open for at least 16 hours).
- Consistent staffing and service provision throughout days and weeks. During the hours that they are open, UCCs are staffed by multidisciplinary teams, including: at least one registered medical practitioner (either a registered GP or doctor with appropriate competencies (reflected below) for primary and emergency care), and at least one other registered healthcare practitioner.

2.3. Co-location
- Co-located UCCs and ECs have a single front door to access U&EC, with one reception team under the same governance.
- Co-located UCCs and ECs have a single point of initial clinical assessment.

2.4. Access to diagnostics
- Access to the following diagnostics for adults and children and young people during hours the UCC is open, with real time access to images and results:
  - Plain film x-ray: immediate on-site access with formal report within 24 hours of examination
  - Blood testing: immediate access with formal results received within one hour of the sample being taken

3. Acute care contracts - Ensure high quality Emergency and Acute care

3.1. Meet the London Quality Standards acute emergency care

3.2. EDs
- EDs are under the continuous supervision and accountability of one or more consultants in Emergency Medicine.
- A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine is present in the ED 24 hours a day, seven days a week.
- A consultant in emergency medicine is scheduled to deliver clinical care in the ED for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant is on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.
- EDs adhere to the clinical co-dependency framework to ensure all services are available.

3.3. Acute care
- Increased consultant presence across seven days a week.
- Consultants on-take are free of all other clinical duties to focus on emergency admissions.
- All emergency admissions are seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.
- Consultant involvement for patients considered ‘high risk’ is within one hour 24/7.
- A clear multi-disciplinary assessment that includes input from nursing, physiotherapy, occupational therapy, pharmacy, and acute pain management (where appropriate) is in place within 24 hours of admission.
- All patients are seen and reviewed by a consultant during twice daily ward rounds.
- 24 hour timely access to key diagnostic imaging and reporting.

3.4. Inter-hospital transfers
- Senior clinician involvement, from both transferring and receiving organisations, in all transfer requests with consultant involvement for critically ill patients.
- Responsibility for the patient remains with referring organisation until the patient reaches the destination.
- All transfers – initial and repatriation – are accepted and transferred within agreed timeframes.
- Escalation process for when agreed timeframes are not adhered to.
- Sending organisation ensures patient is accompanied by an appropriate escort.
- The patient’s privacy and dignity is maintained.
4. Mental health care – Ensure equity for Mental Health crisis care

4.1. Community care contract
- A mental health crisis helpline available 24 hours a day with links to out of hour’s alternatives and other services including NHS 111.
- Access to all information needed to make decisions regarding crisis management including self-referral.
- Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, 7 days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 4 hours of call.
- Services adopt a holistic approach to the management of people presenting in crisis. This includes consideration of possible socioeconomic factors such as housing, relationships, employment and benefits.

4.2. Primary care contract
- Training to be provided for GPs, practice nurses and other community staff regarding mental health crisis assessment and management.
- Ensure out of hours services know referral routes for those in mental health crisis.
- Arrangements should be put in place to ensure that crisis plans are accessible to GPOOHs and NHS 111 teams.

4.3. Acute care contract (incorporated into the Emergency Centre facilities specifications)
- Emergency departments to have a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis and resources are in place to ensure those experiencing a crisis can be continuously observed.
- All emergency departments to have access to on-site liaison psychiatry services 24 hours a day, 7 days a week.
- All emergency departments’ frontline staff should be trained in the assessment and management of mental health crisis.
- Systems should be in place to ensure that people who regularly present to emergency departments in crisis are identified and their care plans appropriately reviewed.
- Arrangements should be put in place to ensure that crisis plans are accessible to emergency departments and ambulance staff.
- Emergency departments should have immediate access to psychotropic medications routinely used in the management of mental crises.
- Mental Health Act assessments undertaken in emergency departments should be completed within 4 hours of the person’s presentation to the emergency department.

4.4. Organisations commissioned to provide places of safety should have dedicated 24 hours, 7 days a week, 365 days a year telephone numbers in place. Mental Health care contract
- Arrangements to be in place to ensure that when Mental Health Act assessments are required they take place promptly and reflect the needs of the individual concerned.
- Ensure crisis and recovery houses are in place as a standard component of the acute crisis care pathway and they are offered as an alternative to admission or when home treatment is not appropriate.
- Mental health provider organisations to provide crisis and home treatment teams, which are accessible and available 24 hours a day, 7 days a week.
- Those under the care of secondary mental health services and subject to the Care Programme Approach (CPA) and people who have required crisis support in the past should have a documented crisis plan.
- Mental health providers to follow the London Mental Health Partnership Board section 136 Protocol and adhere to the pan London section 136 standards.

Organisations commissioned to provide places of safety should have dedicated 24 hours, 7 days a week, 365 days a year telephone numbers in place.

Each individual U&EC network, through appropriate governance structures, will lead on and be responsible for the designation of U&EC facilities within their region. The designation process will seek to verify the ability of services to provide the care described within the U&EC facilities specification. It will also seek to ensure that across a network the number and location of UEC facilities provides optimum coverage in regards to access, value for money, deliverability and strategic coherence.

In parallel to this a specific collaborative work programme focussed on mental health crisis care has been established to support the system to meet the mental health crisis commissioning standards. This includes:
- The development of facility specifications for Health Based Places of Safety with a similar purpose as the U&EC specifications above – to provide a more coordinated and consistent service across London. The specifications will describe the minimum standard of what a HBPoS facility should offer at both mental health Trusts and EDs.
- A consistent pathway for mental health patients who present to EDs, including the clinical and legal roles and responsibilities of all staff involved.

U&E C networks will play a role in facilitating these system changes and the designation of services where appropriate.
Commissioners and the London Ambulance Service (LAS) will be expected to continue to transform London’s ambulance services, support the principles and detail of SYFV, deliver high performance when measured against the ambulance clinical quality indicators, and provide services that reduce costs within the wider emergency and urgent care system, all within the context of a financial environment of significant fiscal constraint.

Furthermore, there is an expectation that during 2016/17 LAS will work to deliver the NHS Nine High Impact actions to improve ambulance performance with input from CCGs.

Taking into consideration the guidance in Transforming Urgent and Emergency Care Services in England (August 2015), key commissioning priorities for 2016/17 are in part a continuation from the priorities outlined in the 2015/16 commissioning intentions; and are aligned to the LAS Integrated Business Plan, with a focus on the system wide Quality, Innovation, Productivity and Prevention opportunities.

LAS implementation of a revised model of care, optimising use of resources and clinical outcomes, acknowledging and adopting the NHS Guidance 'Transforming Urgent and Emergency Care services in England (August 2015)', through:
• Appropriate levels of Hear & Treat, utilising the benefits of 111 services.
• Increased appropriate levels of ‘See & Treat’ and ‘See and Refer’ (to other non-acute services) with maximisation of the use of the Directory of Service (DoS).
• Continued and in depth consideration of the implementation of the use and development of NHS Pathways in the 999 Emergency Operations Centre environment.
• Enabling workforce transformation, with appropriate skill mix and tasking. Commissioners continue to support LAS in enhancing the Paramedic workforce and increasing skill mix.

2015/16 has seen a failure to deliver performance against the agreed performance improvement trajectory for Category A call response times. Commissioners need to see a resilient recovery of performance; consistent timely Red 1 and Red 2 performance, for potentially life-threatened patients, regardless of season, time of day or location in London. Commissioners also want to see a significant improvement in Green call response performance.

Continued focus on Demand Management and fundamentally aligning LAS resources and systems, to enable the wider system to consolidate a co-ordinated approach to Urgent & Emergency Demand Management:
• Increased and optimised use of mobile DoS systems, (as agreed with commissioners), to facilitate access to alternative care pathways
• Clear production of evidence to support appropriate alternative care provision development
• Consolidate actions and operational policies around specific demand areas - Police, Public Transport, Alcohol, and Care Home referrals
• Identify frequent callers/locations, and develop appropriate plans

Strengthening clinical outcomes for patients across all care pathways, Patient and public engagement and involvement in pathway development

The above priorities are underpinned by the CQUIN framework; proposed schemes are currently being developed by CCGs, in partnership with LAS.
During 2016-17, NWL CCGs will continue the whole systems review of all services delivering urgent and emergency care services being inclusive of NHS 111, GP OOHs, Urgent care centres, mental health services, community services, secondary care, social services (where applicable) and new models of care in federated networks for all patients registered with local GPs. Current contracts for NHS 111 services are due to expire over the next year. We aim to commission a safe, high quality integrated urgent care whole system which will align the NHS 111 service to the other urgent care services. The new service will support our vision to deliver care closer to home, provide for a single point of access and monitor the availability and provision of services for the needs of our local patients. All the parties involved in the delivery of the new system will need to ensure that they actively work with the commissioner to:

- keep the Directory of Service fully up to date
- maximise the utilisation of the summary care record and locally determined electronic health care record
- maximise the utilisation of MiDOS
- ensure full compliance of the national standards for the electronic transmission of information and interoperability

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- maximise the utilisation of MiDOS
- ensure full compliance of the national standards for the electronic transmission of information and interoperability

Regarding urgent care centres changes occurring during 2016-17, we would particularly draw your attention to potential contractual changes for UCCs in Hillingdon (due to expire 30/09/2016), Hounslow (due to expire 31/01/2017) and Harrow (due to expire 31/03/2017). The Ealing UCC contract will be going out to tender during the current contract year with a view to a new service commencing in April 2016. An extension to the urgent care centre contract at Chelsea & Westminster is currently in discussion, which is likely to run until October 2016. The CCGs are currently considering their approach to the model and provision of these services as part of the wider integrated urgent care project including NHS 111 and GP Out of Hours services.

e) undertake participation in full clinical "end to end" patient journey experience reviews
f) participate in patient experience feedback of the whole patient journey
g) work with the commissioner to develop outcomes based measures
Healthy London Partnership (HLP) Children and Young People (CYP) Programme

London Wide Commissioning intentions

HLP CYP Outputs for commissioning intentions 2016 - 2017

The HLP CYP programme has published two important sets of standards this year designed to drive improvements in outcomes for CYP. We are writing to you as joint SROs to highlight these standards and ask that they be considered for inclusion in local CCG commissioning intentions for 2016 – 2017.

Acute in-patient care for CYP

The first set of standards collates a number of existing standards for acute in-patient care from diverse sources such as Royal Colleges, NICE and the Department of Health. Over 800 individual standards were identified which have been collated into one document to be used as an overarching commissioning resource for acute in-patient care for CYP. As an overarching framework for this document, two recommendations were made within the standards. We are recommending that these are cited in commissioning intentions as a practical way of commencing implementation of the standards. This will be supported by a planned programme of peer review of 2016 – 2017 supported by the CYP programme team within HLP. The two recommendations we are making are that the first steps to delivering the acute inpatient standards will be the following:

1. Appointment (if not already in place) of a board level lead responsible for the quality and safety of CYP services within all acute trusts.
2. As described in the standards, trusts should have agreed operational policies for the following elements of their CYP service which are shared with their commissioning CCG. Any gaps in services against the acute standards should be highlighted and discussed with the local CCG
   - Paediatric service
   - Management of the acutely unwell child including transfers
   - Surgery and anaesthesia for CYP
   - Radiology and pathology services for CYP
   - Safeguarding

CYP with asthma

A group of asthma expert clinicians has developed the London CYP asthma standards which aim to address variances in care by setting out clear and transparent standards for commissioning for and providing better outcomes for CYP across London. We are making the following recommendation in relation to the asthma standards Healthy London Partnership – Transforming London’s health and care together 4th Floor Southside, 105 Victoria Street, London SW1E 6QT

“Commissioners and providers will collaborate to develop integrated ways of working across health and social care to deliver the London asthma standards (2015) which include the use of a recognised management plan and regular reviews”.

London’s Ambition For Asthma care

Each organisation (primary and community care, acute care, pharmacy, schools) will have a clear named lead who will be responsible and accountable for asthma (which includes children) and the delivery of the following:

Proactive care

Every child with asthma should:
- Have access to a named set of professionals working in a network who will ensure that they receive holistic integrated care which must include their physical, mental and social health needs.
- Be supported to manage their own asthma with the help of their family including access to advice and support so they are able to lead lives free from symptoms.
- Grow up in an environment that has clean air that is smoke free.
- Have access to an environment that is rich with opportunities to exercise.

Accessible care

Every child with asthma should:
- Have their diagnosis and severity of wheeze established in a timely fashion.
- Have prompt access to their inhaler device and other medicines and asthma care advice from trained named professionals or asthma champions in school.
- Have access to immediate medical care, advice and medicines in an emergency.
- Have access to high quality, evidence based care from primary, secondary and tertiary healthcare professionals within a timely manner, 24 hours a day, seven days a week.

Co-ordinated care

Every child with asthma should:
- Be enabled to manage their own asthma by having access to a personalised, interactive, evidenced based asthma management plan linked to their medical record which they understand.
- Have a regular structured review by trained healthcare professionals at least yearly or every three months, depending on control, and within two working days after an exacerbation.
- Have access to a commissioned package of care which includes educational packages, self-management tools and access to peer support.
- Be able to expect all professionals involved in their care to share clinical information in real time to ensure seamless care.
- Have access to a structured, formalised transition processes from child to adult care to ensure children don’t fall between the gaps.

Full details are outlined at the following links:

## Children’s Services

### 5.1 Atopic Conditions

**Expected Outcomes:**
- An effective solution to managing allergies, eczema and asthma in the community
- Reduced A&E attendances related to Asthma and allergies.

**Alignment to Vision:**
Localised

**What we will do in 2016/17:**
- Ensure that Ealing has an effective nurse led atopic conditions service, modelled on the existing Itchy Sneezy Wheezy model of care. Thus patients will receive a timely, holistic, one stop shop for allergies, eczema and asthma within a community setting.

**Providers impacted:**
- LNWHT
- ICHT

**Implications on Providers:**
- Upon the outcome from the Itchy Sneezy Wheezy CQUIN currently in place at LNWHT the CCG will look to formally commissioning an effective solution to managing allergic, eczema and asthma in a community setting.

### 5.2 Connecting Care 4 Children

**Expected Outcomes:**
- Short term outcomes are expected to be improved GP expertise, patient care and improve system synergy
- Long term outcomes we expect to see a change in GP referral patterns, and hence a reduction in outpatient appointments

**Alignment to Vision:**
Localised

**What we will do in 2016/17:**
- Trial the Connecting Care 4 Children model for a period of 12 months with the Southall and Acton Networks.

**Providers impacted:**
- LNWHT
- ICHT

**Implications on Providers:**
- Providers adjusting their model of delivery to enable the CC4C model of care for Southall and Acton GP Networks.
- Imperial supporting the Acton GP Network
- LNWHT Supporting the Southall Network

### 5.3 Review of Community Paediatric Services

**Expected Outcomes:**
- Commission a resilient community service for Ealing Patients
- Reduce the risk of non delivery

**Alignment to Vision:**
Localised

**What we will do in 2016/17:**
- Review community based paediatric pathways and services. This is in lieu of the changes to Ealing Hospital inpatients and the risks prevalent within the community paediatric nursing in delivering a whole service due to difficulties in establishment services.

**Providers impacted:**
- LNWHT

**Implications on Providers:**
- Providers supporting the review of community services.
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</table>
| Community Services | 4.1 | Community Services Transformation | • Redesign and recommissioning of community services aligned with integrated model of care and as an extension of Primary Care  
• Joint care teams established across the borough aligned to primary care networks | Localised | Recommissioning of the agreed service | LNWHT, WLMHT, Local Authority | • Redesign and recommissioning of community services aligned with integrated model of care and as an extension of Primary Care  
• Joint care teams established across the borough aligned to primary care networks |
| Community Services | 4.2 | Cardiology Embedding the new Cardiology service | • Expanding the variety of services offered within the community and Primary Care settings | Centralised, Localised | Embedding and monitor performance of community service  
• Streamlining patient pathways between community and secondary care services | ICHT, LNWHT | Cardiology: Decommissioning of the elements of outpatients services and non-electives completed in 2015  
• New service provider and clinical pathways in place in Nov 2015/16 following the service redesign and procurement  
• Reduction in Outpatient activity |
| Community Services | 4.3 | Respiratory Services | Review of current services and options for delivery of pulmonary rehab and oxygen assessment services | Localised, Personalised, Centralised | Review of current arrangements | Possible changes to service provision; linked to Community service transformation |
| Community Services | 4.4 | Cross Border issues | Patients who reside in 1 CCG but are registered with a practice in a different CCG are able to access all services (e.g. community) equally | Personalised, localised | Work in partnership with neighbouring CCGs to develop resolutions for cross border issues | All Providers | All providers need to be aware of their responsibilities to see patients across CCG/LA borders. |
| Community Services | 4.5 | Learning Disabilities | To provide for the increasing number of people with complex needs requiring care to prevent admission to hospital or to enable discharge | Personalised | • Invest in the Community Team For People with Learning Disabilities (CTPLD)  
• For those with learning disabilities and their families, following on from the Winterbourne View Concordat, implement recommendations from the national guidance from the recently established Joint Improvement Programme and NHS England National Expert and Advisory Group | LNWHT | Providers will be expected to work with and implement the changes required under the Winterbourne |
| Community Services | 4.6 | Community Gynaecology | Pilot a community gynaecology service | Localised | Negotiate a community gynaecology service with a local tariff | LNWHT | Transfer of service from secondary to a community setting with tariff change |
| Community Services | 4.7 | Older Person Pathway - Frailty, Falls, Fractures | Combines frailty, falls and fracture services, which will reduce admissions of the elderly and reduced LOS | Service redesign to OPRAC, outpatients and falls service to address gaps highlighted in review undertaken in 15/16 | All Providers – especially LNWHT | Re-commission OPRAC, linked to Frailty Pathways/Falls and community services transformation |
| Community Services | 4.8 | Wheelchair Service Clinical Assessment, Maintenance/Repair and rehab engineering | Procure wheelchair service in collaboration with 6 other local CCGs – commencement due Summer 16/17 | Personalised, localised, integrated | Completion of procurement of new service. Followed by Mobilisation, implementation, and embedding new service | LNWHT Community Services NRS KCH (Rehab Engineering) | Decommissioning of Wheelchair Assessment Service |
We wish to further develop the established Information Technology integration programme delivered to date via IT CQUINS to achieve one of three levels of systems development either through a) single common IT systems, b) integrated IT systems that allow standardised message transfer, or c) greater utilisation of the summary care record. The objective is to build on existing programmes of work from previous years and incorporate technical delivery and clinical utilisation within core contractual frameworks.

In line with the NW London Whole Systems Integrated Care programme and the establishment of an integrated data warehouse to support the objectives, the CCG will seek to formalise the information flows from trusts to further this work and develop an operational solution that will benefit patient care across organisational boundaries. This will be reliant on trusts implementing systems and processes for populating the data warehouse at higher frequency rates than at present and effectively utilising the outputs of this common solution and/or making more effective use of local or regional initiatives such as the Care Information Exchange. This will mean extension of existing contractual information schedules and information delivery mechanisms.

Other objectives include alignment of individual Trust development plans with regional (NW London wide) Information Technology and Management programmes across all trusts and local authorities in order to deliver the objectives of the National Information Board and London wide healthcare informatics development programmes. This would be achieved by developing a combined digital roadmap during the remainder of 2015-16.

From 2016/17 there will be on-going governance and strategic coordination framework and the expectation that the trust will be a formal active stakeholder within that governance framework with senior executive representation to co-ordinate the development of the digital maturity of trusts within NW London through monitoring and implementation of national digital maturity frameworks as issued by NHS England.

The specific nationally defined objectives that the CCG will be commissioning will be in line with those of the National Information Board and the plans outlined by HSCIC around information exchange standards for transfer of care, namely:

- Applying the HSCIC maturity model such as that of the NHS e-referrals service and the Summary Care Record to establish improved utilisation of national strategic IT systems
- Maintaining the target of removing the use of fax and paper clinical correspondence from October 2015
- Removing the reliance on emailing clinical correspondence by end of quarter 3 2016/17 and establishing standardised discharge information structures across different settings of care
- During 2016/17 working towards delivery by October 2018 of standardised coding of diagnosis and procedures using SNOMED CT.
- Using dm+d coding for medications in line with changes within primary care coding such that by June 2017 all information exchange on medications will be dm+d compliant.
- Establishing resources and mechanisms for improving data quality and coding at least within shared clinical information and medical records used across different settings of care.

### Information Management and Technology

#### Other

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<tbody>
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<td>Other 10.1</td>
<td>Diagnostic Cloud</td>
<td>Optimising the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London</td>
<td>Integrated Localised</td>
<td>Diagnostic cloud to be optimised to ensure that unnecessary duplication of diagnostics are avoided, and ensure provider contracts reflect this</td>
<td>All Providers</td>
<td>Providers need to ensure that all clinicians are accessing the diagnostic cloud and not repeating tests already actioned elsewhere.</td>
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<td>Other 10.2</td>
<td>Interoperability</td>
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<td>Centralised</td>
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<td>To be completed</td>
<td>To be completed</td>
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<td>Other 10.3</td>
<td>Quality of CHC and Residential Care</td>
<td>PLACEHOLDER</td>
<td>Personalised</td>
<td>To be completed</td>
<td>To be completed</td>
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<td>Other 10.5</td>
<td>Safeguarding - Children</td>
<td>To be completed</td>
<td>Integrated</td>
<td>To be completed</td>
<td>All Providers</td>
<td>To be completed</td>
</tr>
<tr>
<td>Other 10.6</td>
<td>Community Equipment Services</td>
<td>Reprocurement of current service</td>
<td>Effective and integrated equipment services</td>
<td>Personalised Integrated</td>
<td>Commence reprocurement of equipment services jointly with the other NW London CCGs and Local Authorities</td>
<td>Equipment providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area</th>
<th>Programme of Work</th>
<th>Expected Outcomes</th>
<th>Alignment to Vision</th>
<th>What we will do in 2016/17</th>
<th>Providers impacted</th>
<th>Implications on Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other 10.1</td>
<td>Diagnostic Cloud</td>
<td>Optimising the diagnostic cloud across the NW London health economy, ensuring the principle of one patient, one diagnostic record across NW London</td>
<td>Integrated Localised</td>
<td>Diagnostic cloud to be optimised to ensure that unnecessary duplication of diagnostics are avoided, and ensure provider contracts reflect this</td>
<td>All Providers</td>
<td>Providers need to ensure that all clinicians are accessing the diagnostic cloud and not repeating tests already actioned elsewhere.</td>
</tr>
<tr>
<td>Other 10.2</td>
<td>Interoperability</td>
<td>To be completed</td>
<td>Centralised</td>
<td>To be completed</td>
<td>To be completed</td>
<td>To be completed</td>
</tr>
<tr>
<td>Other 10.3</td>
<td>Quality of CHC and Residential Care</td>
<td>PLACEHOLDER</td>
<td>Personalised</td>
<td>To be completed</td>
<td>To be completed</td>
<td>To be completed</td>
</tr>
<tr>
<td>Other 10.4</td>
<td>Safeguarding - Adults</td>
<td>To be completed</td>
<td>Integrated</td>
<td>To be completed</td>
<td>All Providers</td>
<td>To be completed</td>
</tr>
<tr>
<td>Other 10.5</td>
<td>Safeguarding - Children</td>
<td>To be completed</td>
<td>Integrated</td>
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<td>All Providers</td>
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<td>Equipment providers</td>
</tr>
</tbody>
</table>
Quality and Safety Standards

Quality, which encompasses patient safety, health outcomes and patient experience, and Safeguarding will and must remain central to all aspects of the contract in the coming year. All services commissioned by NWL CCGs must comply with the current legislation, multi-agency and NHS assurance systems covering safeguarding children and adults. Core to contract monitoring, will be to the requirement to ensure that providers, through a culture of learning, have robust and aligned mechanisms to report, monitor and improve quality of services. This will be achieved by a number of approaches including clinical visits and monthly Clinical Quality Group meetings.

Aligned to CQG reporting, the Quality schedule will ensure consistency across NWL commissioned providers. We expect to see a strong focus from providers on Sepsis and antimicrobial stewardship which we will be supporting providers to implement, the national rollout of Friends and Family Test across all services and mortality (including specialty level mortality rates), in conjunction with the TDA.

Providers will be required to comply with the current London multiagency policy and procedures to safeguard adults from abuse and with the requirements of the Mental Capacity Act (including the Deprivation of Liberty Safeguards).

It is expected that Services be compliant with the Care Act 2014 following implementation in April 2015. They will also be required to implement the Prevent agenda that requires all healthcare organisations to work in partnership to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation. We also expect to work closely with our providers to implement key areas of strategic change and development as per Shaping a Healthy Future; Better Care Fund and Five Year Forward View initiatives.

We are keen through the contracting round to work with providers to streamline the quality schedule so that it focuses on the key quality and safety issues, reducing the burden of reporting as far as is appropriate to do so.

CQUIN

We expect to reflect both National and London guidance on CQUINs in our contract, utilising where possible local flexibilities, as we have done in previous years, to secure a mutually acceptable but challenging agreement around CQUIN that reflects National, London and local clinical commissioning priorities and which supports achievement of our NWLCCG strategic objectives. In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2016-17 contract, as well as identify new priorities for CQUIN development for 2016-17. We see CQUINs as a way in which we can start to incentivise movement towards new models of care and integrated working. Commissioners will be developing their proposed local CQUIN priorities and plans for discussion with providers at an early stage of the contract negotiations and we welcome proposals from providers which are aligned to achievement of our strategic objectives and CCG priorities as part of this process.

Safeguarding

All services commissioned by the CWHHE CCGs must comply with current legislation, statutory guidance and NHS assurance system requirements covering safeguarding children and adults. Of particular note are developments in relation to Female Genital Mutilation (FGM) work, where the CCG is committed to developing co-ordinated pathways for FGM. The CCG will require unscheduled care providers to be able engage with and utilise in practice Child Protection – Information System (CP-IS).


In respect of safeguarding adults, the CCG monitors its commissioned services to ensure they are compliant with the latest London Safeguarding Adults Policy and Procedures, Care Act (2014), Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards 2007).

All commissioned services (both for adults and children) are monitored for their compliance to the Prevent Duty (2015).

Services must provide quarterly reports completed in a framework agreed with the designated nurses and adult leads and be prepared to report on their compliance with any additional statutory frameworks and emerging areas of safeguarding published during the period of the contract.

Quarterly reports must include training data, supervision provision, activity utilising partnership working, as well as a summary of learning from local and national case reviews or reports. The quality schedule is cross referenced to these points.

A safeguarding annual report must be submitted annually to the CCG by August 1st. Referrals to the Local Authority - Designated Officer (LA- DO) in relation to allegations against staff who may pose a risk to children or vulnerable adults must be reported to the Designated Nurse and Commissioner within one working day.
Commissioning Intentions for Homeless Services 2016/17

The Health Services for Homeless People Programme has been set up to improve health services and access to those services for the homeless population in London. Aligned to the recommendation set out in the London Health Commission’s Better Health for London report, the Programme advocates a multi-agency, pan-London lead commissioner model to support delivery of pan-London principles at a local level and to help address a number of key health issues relating to London’s homeless population. There are a number of workstreams instrumental to achieving the project’s outcomes and the following relate directly to provider services and our intentions for 2016/17:

- Review of current commissioning arrangements for homeless health services within individual CCGs and/or sub-regions. This will be carried out utilising efficacy, equity and efficiency criteria.

- Identifying good practice and innovation. This will relate to both specialist/mainstream and clinical/non-clinical provision. The process will involve discussions with relevant stakeholders, eg: CCG commissioners, clinical leads, representatives from the GLA – who commission pan-London services for rough sleepers and boroughs where integrated health and social care arrangements have led to innovative pilots.

- Liaison with Care Quality Commission to enforce GP registration for homeless populations; issue guidance on registration to patients and GP practices; develop a communications plan for CCGs.
CCG Business As Usual (BAU) commitments

As well as the transformation programme summarised in this plan, the CCG will also continue to deliver its statutory obligations through the following programmes:

- Financial and Operating Performance
- Contract management
- Provider engagement
- CCG management
- Organisational development
- Collaborative working
- Public and patient engagement
- Primary care engagement
- IT infrastructure
- Governance
- Quality monitoring
- NHS Constitution Delivery. We plan to deliver all of the standards, including RTT, Cancer, Diagnostics, IAPT, and urgent care
- NHS England reporting and assurance
Demonstrating progress against plan
Demonstrating Progress against Plan

For each project there will be one or two measurable outcomes. These could include: actual improvements to patient outcomes, or number of milestones achieved against target. A scorecard will be produced for alternate Governing body meeting (i.e. three times per year). Narrative updates will be provided for each Governing Body, perhaps focusing on key achievements and key changes.

All schemes are subject to development through Ealing CCG forums which include the CCG Executive Management & Innovation Committee, CCG Finance & Performance Committee and/or CWHHE Investment Committee. The PMO and Governance for monitoring progress can be seen below.
The CCG holds a monthly Delivery Assurance Group (DAG) meeting which includes deep dives into all CCG projects, programmes and schemes. The DAG group challenges and provides rigor to underlying assumptions, as well as providing feedback to project leads to develop robust plans and assurances for delivery, and understand performance against plan. CCG Clinical Leads are also engaged in this process.

- During project set up at the beginning of the year, Project managers fill in a standardised excel-based project workbook for the PMO. The workbook includes information on project milestones and general risks, as well as contact points with the formal governance framework. An example is attached.
- Project Managers update these books on a regular basis the first week of the month. Progress is matched against SUS data to identify activity impacts of the different transformation compared to expected benefit realisation timeframes. We are working on improving quality of these project books – an example of recent feedback provided is attached.
- A PMO performance report is produced detailing performance of all schemes and their financial and activity impacts, as well as initially identify secondary system indicators highlighting outcomes.
- Assurance. The PMO report is reviewed at progressively more senior levels, building up to the ultimate assurance provided to NHS England on a quarterly basis.

Illustrative: Project Plan template

Illustrative: Highlight Report template

Illustrative: Slippage template
QIPP and Finance
Ealing CCG’s last Medium Term Financial Strategy (MTFS) 5 year planning model (2014/15 – 2018/19) was based on M9 2013/14 and was approved by the Governing Body in March 2015. Broadly, it included investment amount of c.£7m a year subject to delivery of QIPP of £12m a year. The CCG is now working with CWHHE colleagues to revise the MTFS model based on in-year performance using M6 2015-16 numbers. The initial work suggests a target of Gross £12m QIPP for 2016-17; however further work needs to be done to agree the target QIPP and investment figures for 2016-17 and beyond.
Risks
### Organisational Objectives and Strategic Risks
#### Board Assurance Framework

The CCG has identified the top strategic risks facing us as an organisation. These have been pulled together into the Board Assurance Framework (BAF) 2015-16. The BAF identifies key risks to the delivery of the CCG’s strategic objectives and sets out the controls that have been put in place to manage those risks and the assurances that have been received that demonstrate whether the controls are having the desired impact. It includes an action plan to further reduce the risks and an assessment of current performance. Risks ratings are reviewed throughout the year by the allocated leads.

The CCG will review these in coming months and agree which strategic risks will need to be incorporated in our 2016-17 BAF.

<table>
<thead>
<tr>
<th>CCG Objective</th>
<th>Description of Risk Identified</th>
<th>Initial Score</th>
<th>Current Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1:</strong> Enabling people to take more control of their health and wellbeing</td>
<td>1 – If we do not successfully empower patients and change behaviours, activity will continue to grow and the system will become unsustainable.</td>
<td>16</td>
<td>16</td>
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<td></td>
<td>2 – Safeguarding children: Risk that we cannot always comply with the Children Act and the NHSE assurance framework, due to complexities of multi-agency working, especially in the case of looked after children placed out of borough, as well as the way tier 4 child and adolescent mental health services (CAMHS) are commissioned, leading to a child being seriously harmed.</td>
<td>15</td>
<td>15</td>
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<tr>
<td></td>
<td>3 – Safeguarding adults: Risk that we do not sustain compliance with the Care Act and the NHSE assurance framework across all the services that we commission, leading to an adult being seriously harmed.</td>
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<tr>
<td></td>
<td>4 – Chelsea and Westminster: Risk that during the acquisition of West Middlesex Hospital, standards are not maintained leading to less optimal care. Particular focus on unified policies, procedures and training across the Trust including safeguarding arrangements.</td>
<td>16</td>
<td>16</td>
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<td></td>
<td>5 – Imperial: Risk that the Trust does not deliver quality and performance requirements and strategic change to the require timescales, particularly in relation to:</td>
<td></td>
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<tr>
<td></td>
<td>• Accident &amp; Emergency performance</td>
<td></td>
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<td></td>
<td>• Non-elective pathway changes</td>
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<tr>
<td></td>
<td>• Referral to Treatment performance</td>
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<td></td>
<td>• Outpatients</td>
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<td>6 – Ealing Hospital: Risk that the Hospital does not deliver quality and performance requirements to the require timescales, particularly in relation to:</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>• Cancer</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Staffing levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trust finances</td>
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<tr>
<td></td>
<td>7 – West Middlesex: Risk that during the acquisition by Chelsea and Westminster, standards are not maintained leading to less optimal care. Particular focus on unified policies, procedures and training across the Trust including safeguarding arrangements, temporary leadership and financial position.</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>8 – Central London Community Healthcare: Risk that the organisation is not delivering strategic change and operational performance with a focus on safe services during the procurements of care home services.</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>9 – West London Mental Health Trust: Risk that the organisation is not well positioned to deliver strategic change and operational performance.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>10 – Central &amp; North West London Trust: Risk that the Trust does not deliver quality and performance requirements and strategic change to the required timescales, particularly in relation to:</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>• Staffing levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Financial position</td>
<td></td>
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<tr>
<td></td>
<td>• Service transformation and capacity to deliver change</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Bed capacity – Care Quality Commission Report</td>
<td></td>
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<tr>
<td></td>
<td>11 – LCW and Care UK (111): Risk that the service does not support overall plans to improve urgent and emergency care services leading to difficulties in delivering the A&amp;E access targets.</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>12 – London Ambulance Service: Risk that the workforce is not in place to deliver the high quality, value for money service required, leading to delays in attending patients and risk of serious patient harm.</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>13 – Hounslow and Richmond Community Healthcare: Risk that the organisation is not well positioned to deliver strategic change and operational performance.</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>14 – Care homes: Risk that quality and financial challenges in care homes leads to patient harm and/or safeguarding concerns, as well as to pressure on Accident &amp; Emergency and non-elective activity.</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>15 – Federations: Risk that Primary care is unable to deliver increased activity due to organisational and workforce issues (includes implications of the PMS review and establishing GP federations).</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>
## Organisational Objectives and Strategic Risks

### Board Assurance Framework

<table>
<thead>
<tr>
<th>CCG Objective</th>
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</tr>
</thead>
</table>
| **Objective 3:** Enhancing the organisation's culture – developing people, processes and systems to help deliver high quality commissioning | 16 – **Primary care co-commissioning:** Risk that the structures and behaviours established to jointly commission primary care with NHS England:  
- do not enable us to commission the change required to deliver our strategy  
- adversely affect relationships with member practices  
- create significant conflicts of interest  
- there is not the finance or capacity to deliver  
Leading to challenges in delivering the change to services in our plans. | 16            | 16            |
| 17 – **Organisational and Leadership Development:** Risk that we cannot attract and retain excellent staff to deliver the CCG’s plans.                                                                                                                      | 12            | 12            |
| **Objective 4:** Establishing a collaborative and proactive culture with partners and the people we commission services for | 18 – If we do not engage member practices, the LMC and other partners in the change programmes, we will not be able to realise the intended quality improvements. | 16            | 16            |
| 19 – **Risk that working arrangements with colleagues in local authorities (through such structures as the Health and Wellbeing Board and the Better Care Fund) are unclear, leading to lower likelihood of achieving improved outcomes.** | 12            | 12            |
| **Objective 5:** Planning, developing and delivering strategies and actions that reduce inequalities and improve health outcomes | 20 – **Conflicts of interest:** Not managing conflicts of interest adequately leaves us open to challenge and reputational damage.                                                                                      | 15            | 15            |
| 21 – **Strategic change (workforce):** Risk that we do not have the required resources in place across the system to deliver strategic change including:  
- workforce to deliver new models of care  
-  
- training and development for future workforce  
- organisational development programmes that challenge the status quo, communicate the change needed, shape the culture and values needed and empower staff  
- finances to fund transitional change  
- IT systems that make good use of technology | 16            | 16            |
| 22 – **Strategic change (organisations):** Risk that provider organisations are not able to support implementation of the strategic changes to acute services . | 16            | 12            |
| 23 – **Strategic change (reputation):** Risk that if an adverse event happens that might not be related to strategic change, then there could be a perceived or real attribution of a link leading to negative impact on our reputation and subsequent risk to delivery. | 9             | 9             |
| **Objective 6:** Empowering staff to deliver our statutory and organisational duties | 24 – **Information governance:** Risk that lack of awareness of how to apply information governance rules leads to a breach or lack of flexibility to support delivery of new models of care | 12            | 12            |
| 25 – **Finance:** Risk that we do not achieve our financial duties in 2015/16, as well as ensuring the longer term financial stability and security of the system, whilst remaining within the management spend budget | 15            | 15            |