Health and Wellbeing Board

AGENDA

DATE: **Thursday 8 September 2016**

TIME: **1.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre**

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Sachin Shah**

Board Members:

Councillor Simon Brown	**Harrow Council**
Dr Amol Kelshiker (VC)	**Chair, Harrow Clinical Commissioning Group**
Dr Genevieve Small	**Harrow Clinical Commissioning Group**
Dr Shaheen Jinah	**Harrow Clinical Commissioning Group**
Councillor Varsha Parmar	**Harrow Council**
Councillor Janet Mote	**Harrow Council**
Councillor Mrs Christine Robson	**Harrow Council**
Vacancy	**Harrow Healthwatch**

Reserve Members:

Councillor Ms Pamela Fitzpatrick	Harrow Council
Councillor Antonio Weiss	Harrow Council
Councillor Anne Whitehead	Harrow Council
Councillor Susan Hall	Harrow Council

Non Voting Members:

Chris Spencer, Corporate Director, People, Harrow Council
Bernie Flaherty, Director Adult Social Services, Harrow Council
Andrew Howe, Director of Public Health, Harrow Council
Rob Larkman, Accountable Officer, Harrow Commissioning Group
Jo Ohlson, NW London NHS England
Simon Ovens, Borough Commander, Harrow Police
Carol Foyle, Representative of the Voluntary and Community Sector
Javina Sehgal, Chief Operating Officer, Harrow Clinical Commissioning Group

Contact: Miriam Wearing, Senior Democratic Services Officer
Tel: 020 8424 1542 E-mail: miriam.wearing@harrow.gov.uk

Harrow COUNCIL LONDON

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. CHANGE IN MEMBERSHIP

To note the appointment of Dr Shaheen Jinah as a Clinical Commissioning Group (CCG) representative in place of Dr Kaushik Karia.

3. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Board;
(b) all other Members present.

4. MINUTES (Pages 5 - 14)

That the minutes of the meeting held on 30 June 2016 be taken as read and signed as a correct record.

5. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Board Procedure Rule 14.

Questions will be asked in the order notice of them was received and there be a time limit of 15 minutes.

[The deadline for receipt of public questions is 3.00 pm, Monday 5 September 2016. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

6. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

7. DEPUTATIONS

To receive deputations (if any) under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

8. INFORMATION REPORT - OUTCOME OF THE CARE QUALITY COMMISSION INSPECTION OF THE LONDON NORTH WEST HEALTHCARE NHS TRUST (Pages 15 - 46)

Report of the Director of Strategy and Deputy Chief Executive Officer, London North West Healthcare NHS Trust (NWHT).

9. HARROW LOCAL SAFEGUARDING ADULTS BOARD (LSAB) ANNUAL REPORT 2015/16 (Pages 47 - 112)

Report of the Director of Adult Social Services.

10. HARROW CLINICAL COMMISSIONING GROUP (CCG) PATIENT APP (Pages 113 - 118)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group.

11. UPDATE ON SUSTAINABILITY AND TRANSFORMATION PLAN (Pages 119 - 192)

Joint report of the Corporate Director of People, Harrow Council and Chief Operating Officer, Harrow Clinical Commissioning Group

12. ANY OTHER BUSINESS

Which the Chair has decided is urgent and cannot otherwise be dealt with.

AGENDA - PART II - NIL

*** DATA PROTECTION ACT NOTICE**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

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HEALTH AND WELLBEING BOARD

MINUTES

30 JUNE 2016

Chair:	*	Councillor Sachin Shah	
Board Members:	*	Councillor Simon Brown	Harrow Council
	*	Councillor Janet Mote	
	*	Councillor Varsha Parmar	Harrow Council
	*	Councillor Mrs Christine Robson	Harrow Council
	*	Dr Amol Kelshiker (VC)	Chair of Harrow CCG
	*	Arvind Sharma	Harrow Healthwatch
	*	Dr Genevieve Small	Clinical Commissioning Group

Non Voting Members:	*	Varsha Dodhia	Deputy Representative of the Voluntary and Community Sector	Voluntary and Community Sector
	*	Bernie Flaherty	Director of Adult Social Services	Harrow Council
	*	Andrew Howe	Director of Public Health	Harrow Council
	†	Rob Larkman	Accountable Officer	Harrow Clinical Commissioning Group
		Jo Ohlson	Head of Assurance	NW London NHS England
	*	Chief Superintendent Simon Ovens	Borough Commander, Harrow Police	Metropolitan Police
	*	Javina Sehgal	Chief Operating Officer	Harrow Clinical Commissioning Group
	†	Chris Spencer	Corporate Director, People	Harrow Council

In attendance:	Sarah Crouch	Public Health Consultant	Harrow Council
	Jon Manzoni	Head of Strategic Commissioning	Harrow Council
	Joanne Murfitt	Director of Public Health Commissioning and Health in the Justice System and Military Health	NHS England
	Susan Whiting	Assistant Chief Operating Officer	Harrow Clinical Commissioning Group

* Denotes Member present
† Denotes apologies received

142. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

143. Amendment to Terms of Reference

It was noted that the number of Members of the Council nominated by the Leader of the Council had been increased from 4 to 5. This decision had been taken in accordance with the procedure for minor matters as the next meeting of the Council was not until 22 September 2016.

In response to a question, the Chair stated that the increase in numbers enabled him to take a place on the Board as Leader of the Council and to enable the continued attendance of an opposition Member. The Vice-Chair expressed concern at the change in membership as it would have an impact on the voting balance between Council and other nominations, although it was noted that a vote had not yet been taken on a decision of the Board.

RESOLVED: That the change in membership be noted.

144. Appointment of Vice-Chair

RESOLVED: It was noted that Amol Kelshiker was appointed as Vice-Chair of the Board for the 2016/17 municipal year in his capacity as Chair of the Harrow Clinical Commissioning Group.

145. Declarations of Interest

RESOLVED: To note that the following interests were declared:

Agenda Item 10 – Information Report – Walk In Centres
Dr Genevieve Small declared a non-pecuniary interest in that she was a GP at the Ridgeway Surgery, one of the successful providers. She would remain in the room whilst the matter was considered and voted upon.

Dr Amol Kelshiker declared a non-pecuniary interest in that he was a GP at the Pinn Medical Centre which had a Walk In Centre. He would remain in the room whilst the matter was considered and voted upon.

Councillor Janet Mote declared a non-pecuniary interest in that she was a patient at the Pinn Medical Centre. She would remain in the room whilst the matter was considered and voted upon.

Agenda Item 16 – Harrow and Brent Systems Resilience Group (SRG)
Councillor Janet Mote declared a non-pecuniary interest in that her daughter was a nurse at Northwick Park Hospital. She would remain in the room whilst the matter was considered and voted upon.

146. Minutes

RESOLVED: That the minutes of the meeting held on 11 May 2016, be taken as read and signed as a correct record.

147. Public Questions, Petitions and Deputations

RESOLVED: To note that no public questions, petitions or deputations were received at this meeting.

RESOLVED ITEMS

148. INFORMATION REPORT - NHS England's Annual Update on the Delivery of National Immunisation and Screening Programmes in Harrow

The Board received an update on the progress in the delivery of national immunisation and screening programmes. It updated members on performance and actions undertaken by NHS England where performance had not met national targets.

The representative of NHS England drew particular attention to the following:

- the need to encourage early access to ante natal bookings to ensure sufficient time to screen pregnant women and explain the results. Other challenges included improvement in the processing of laboratory request forms, a focus on the reduction in the proportion of babies having to have a repeat bloodspot sample taken, and timely referral for women who had screened positive for hepatitis B;

- the promotion of the shingles vaccination was welcomed;

- there had not been a serious flu outbreak recently which could be due to the preventative immunisation of children as they were 'super spreaders' or because there had not been a serious outbreak recently;

- with regard to cancer screening, NHSE were concerned at the reduction in the uptake of cervical screening especially amongst younger women. With regard to bowel cancer screening, the proposal for one test instead of three from 2018 was hoped to increase take up;

- data for diabetic eye screening programmes had not been available since the procurement exercise to reconfigure the seventeen programmes to five. There was a backlog of patients which was being addressed;

- a pilot of e-red books, which included phone reminders regarding vaccination appointments, would commence in December 2016.

The Board expressed concern at the lack of the BCG vaccination and that, although a small amount had become available, there were no plans for a catch up programme. It was noted that priority was given to high risk families and the areas of highest incidence. The NHS England representative reported that providers had found it challenging to be proactive in communicating the situation to the public. It was noted that latent TB testing continued and was being promoted.

In response to questions, the Board was informed that:

- NHSE did not purchase vaccine, this was the responsibility of Public Health England. As the manufacture of vaccine was a complicated process with stringent requirements, the number of interested companies was low. Public Health England was trying to source additional suppliers;

- the NHSE representative undertook to contact the police representative with regard to the request for consideration to be given to the immunisation of key workers within the borough for flu;

- details would be sought on the 'baby in the box' system in use by Imperial Hospital Trust based on an initiative from Finland;

- additional funding had been offered to LNW to promote whooping cough vaccine for pregnant women and assistance of the CCG in this was sought. Harrow had achieved a 49.5% uptake compared to 52% across London and 61.4% in England. The offer of assistance by the community and voluntary sector was welcomed.

RESOLVED: That the report be noted.

149. INFORMATION REPORT - Walk-in Centres

The Board received a report which set out the summary position and progress for the procurement and commissioning progress for Walk In Centres across the borough.

Members were informed that, as a result of the open procurement process, the Pinn Medical Centre and the Ridgeway Surgery had been selected as the preferred providers for implementation in August 2016. Proposals to implement and deliver a third Walk In Centre in the east of the borough had not met the core criteria of the service specification so a preferred provider had not been selected. The CCG had instigated a further procurement and it was anticipated that the new service would commence in November 2016.

Members of the Board expressed the hope that the Walk In Centres would alleviate pressure on A&E.

In response to questions from the Board, it was noted that:

- with regard to provision for the south east of the borough, a proportion of funding would be made available for the facility at Edgware community centre;

- an extension of hours was under consideration and would be reported to the Board. Within the limited resource envelope for integrated urgent care, clinical assessment and triage proposals were at design stage.

RESOLVED: That the report be noted.

150. INFORMATION REPORT - Future in Mind Update

A CCG Clinical Lead updated the Board on the work that had been undertaken subsequent to the approval of the transformation plan in October 2015. It was noted that particular focus had been placed on tier 2 CAMHS children, those with behavioural, emotional and lower level mental health issues, who had not previously been part of the commissioning service. Particular attention was drawn to the new eating disorder service which aimed at a swift response, within 24 to 48 hours if required.

In response to questions it was noted that .the Brandon Centre was the chosen provider for the mainstream schools pilot, in accordance with which a lot would be based within the school environment. The aim was to have a cross Harrow approach. There had been a good response from schools and a meeting was being held that morning with two secondary heads.

The Healthwatch representative expressed appreciation at the partnership work that was taking place and was interested to know if a correlation between the pilot and achievement and progress became evident. The CCG Clinical representative responded that it had been proven that early intervention made a significant impact.

RESOLVED: That the report be noted.

151. INFORMATION REPORT - Better Care Fund Update

The Board received a report which set out the progress on the Better Care Fund for Quarter 4, 2015/16.

It was reported that the BCF 2016/17 was moving forward to the delivery and assurance stage. The final 2016/17 Plan was more data driven and it was the joint Council and CCG intention to ensure a greater level of analysis in future progress reports.

The submission of these regular quarterly progress reports would enable the Board to hold BCF 2016/17 delivery to account.

RESOLVED: That the report be noted.

152. Harrow Physical Activity and Sports Strategy 2016-20

A report was received which set out the strategic priorities to increase levels of physical activity and sport in Harrow with particular focus on those groups more prone to physical inactivity and the associated ill health. It was noted that the action plan identified some of the indicators which would be used to measure success and that further work was planned.

It was noted that Sport England had set out in its new strategy a plan to invest over £250m in tackling inactivity. It was therefore imperative that the borough collaborate to be in the best position possible to attract new funding.

The Board supported the proposal that arrangements be made for representatives to complete a walk of a mile immediately prior to the meeting.

In response to questions from the Board, it was noted that:

- further stakeholder engagement would be carried out on 18 July and beyond with the communications campaign launching in September 2016. Local data from across Harrow had been used for the benchmarks that illustrated the report;

- the first walk for patients led by a local GP had taken place;

- good progress had been reported on the introduction of the 'golden mile' in schools;

- a competition had been held in Civic 1 of the Civic Centre for the most stairs climbed, the winner achieving 396 floors.

A CCG clinical lead expressed disappointment that there was no recognition of the work of the CCG or primary care in the strategy, particularly with regard to physiotherapy and respiratory rehabilitation for lung disease. The officer stated that the work on the strategy to date had focused on achieving

involvement throughout the Council in the strategy and that it was now in a good position to include representation from the CCG, such as with regard to diabetes and obesity. Details of the consultation event on 18 July 2016 would be circulated.

The Healthwatch representative considered that the strategy was a positive development in the number of partners wishing to work together.

RESOLVED: That

(1) the report be endorsed;

(2) members of the Board increase their personal levels of physical activity and act as champions in work and home setting;

(3) further stakeholder engagement including the campaign launch later in the year be supported;

(4) consideration be given to other strategic opportunities to encourage residents to be more active, making physical activity an integral part of policy, planning and commissioning across departments and cross sectors.

153. INFORMATION REPORT - Update on the Health and Wellbeing Action Plan

The Board received a report which set out the progress made on Health and Wellbeing Strategy actions as of 31 May 2016.

An officer drew particular attention to the following:

- the pilot of integrated employment/mental health support was at risk due to Brexit as it was in part funded by European social fund;
- with regard to workplace health, there was a considerable interest from local organisations in the programme;
- the Health Impact assessment framework had been well received on two pilot Harrow regeneration schemes and had helped highlight demands from primary care services;
- with regard to involvement from the local community, the vacancy for a representative of the voluntary and community sector on the Board had now been filled and a number of initiatives with the police were taking place.

RESOLVED: That the report be noted.

154. Update on Sustainability and Transformation Plan

The Board considered an update on the previous work presented at its meeting on 11 May 2016. The report focused on local work in two main areas: stakeholder engagement and the emerging local themes for the nine NWL priorities of work. It was noted that the final North West London checkpoint submission to NHS England would be presented to the next meeting of the Board.

It was reported that presentations had been given to the Harrow Voluntary and Community Services Forum and Healthwatch, the focus being to raise awareness of the STP and the local Harrow process. The Harrow chapter of the Plan detailed the plan of how to get ready, the delivery going forward and how the process would be held to account.

RESOLVED: That

(1) the report be noted and the actions taken to progress the Harrow contribution to the North West London Sustainability and Transformation Plan be endorsed;

(2) a development session on the Sustainability and Transformation Plan be held.

155. Harrow and Brent Systems Resilience Group (SRG)

The Board received a report on an overview of the Brent and Harrow System Resilience Group (SRG), with particular focus on Harrow.

Particular attention was drawn to the following:

- as a result of it being recognised by all parties that that the structure was not the most effective, there were now two sub – groups, Elective Sub-Group and Non Elective Sub-Group:

- the first run of the self-assessment had found that the SRG was currently rated as 'Plans in Place'. It was anticipated that assessment of each change would move up in the ratings once leads had been identified to give comprehensive updates against the assessment data and once further documents and evidence were interrogated.

In response to questions from the Board it was noted that:

- robust analysis regarding the closure of the Ealing Hospital paediatric ward concluded that there was no anticipation that children would not be able to attend Accident and Emergency or urgent care assessment. The indication was that Hillingdon and Northwick Park Hospitals could accommodate extra patients and this would be monitored. A meeting was due to be held with the acute trust that day. Some work was taking place with Harrow CCG regarding community provision to ensure the most appropriate services in the community;

- the previous confusion of outpatients attending Ealing Hospital from other boroughs who then required follow up referrals or more complex care had been resolved. Any experience of further difficulty or other local intelligence would be followed up;

- with regard to social care, Harrow Council provided the most senior representative that was available depending on capacity. SRG was not a passive group but was powerful with senior representation;

- once the community systems were in place then a reduction in hospital beds could be made on an evidence base;

- consideration was being given to a patient empowerment app.

RESOLVED: That the report be noted.

(Note: The meeting, having commenced at 12.30 pm, closed at 2.40 pm).

(Signed) COUNCILLOR SACHIN SHAH
Chair

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	8th September 2016
Subject:	**INFORMATION REPORT –** Outcome of the Care Quality Commission Inspection of London North West Healthcare NHS Trust
Responsible Officer:	Simon Crawford Director of Strategy and Deputy CEO, London North West Healthcare NHS Trust
Exempt:	No
Wards affected:	All
Enclosures:	Presentation

Section 1 – Summary

FOR INFORMATION

The report outlines the actions by the Trust following the Care Quality Commission in October 2015 and the Quality Summit held on 13th July 2016.

The Board is requested to note this report.

Section 2 – Report

Following the inspection to London North West Healthcare NHS Trust by the Care Quality Commission (CQC) in October 2015 and the Quality Summit held on 13th July 2016, a report was issued which is available on the CQC or Trust websites http://www.cqc.org.uk/provider/R1K / http://lnwhintranet/working-life/care-quality-commission-inspection-report-2015/

In response to the report, action plans have been devised to improve in the areas highlighted within the report. The Trust has considered the findings of the report and developed internally a list of plans to address the issues raised. The action plans have been separated into the following areas with oversight by lead Executive Directors and Board Committees.

- Estates and IT
- Safety and Quality
- Clinical Pathways
- Workforce
- Patient Experience
- Risk

As part of the final report of the CQC review process, a Quality Summit was held with key stakeholders and partners on 13th July 2016 to discuss the report and attached is the presentation delivered by the Trust Chief Executive at the Quality Summit that will be discussed at the Health and Wellbeing Board.

Section 3 – Further Information

Trust lead Executive Directors and Board Committees will have regular oversight of the action plans which will be periodically reviewed at the Trust Board. The Trust will provide an update to partners as requested, however public minutes of the Board and papers will be available on the Trust's website.

Section 4 – Financial Implications

This report is a focus on the CQC Report findings.

Section 5 - Equalities implications

Not applicable

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Not applicable

Section 7 - Contact Details and Background Papers

Contact: Simon Crawford, Director of Strategy and Deputy CEO
Simon.crawford1@nhs.net

Background Papers: Care Quality Commission Inspection of London North West Healthcare NHS Trust

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Our Quality Improvement Plan following the CQC report

Welcome to LNWHT

Thanks to the CQC……

“ Free quality advice”

The Trust

The Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust merged on 1 October 2014 to form London North West lealthcare NHS Trust.

We are now an integrated organisation that delivers acute and community care for the boroughs of Brent, Ealing and Harrow and a range of specialist care nationally.

The Trust

- We serve a population of 850,000
- We employ over 9,500 staff
- We have 1,240 inpatient beds
- We see on average 980 patients in the Emergency Department every day
- 2,000 patients attend outpatient clinics daily
- We provide 50 adult and 25 children's community services across six boroughs
- Key player in Shaping a Healthier Future programme
- We delivered our 2015/16 plan with a deficit of £83.3m

Summary from CQC visit in October 2015

- Overall Trust rating - Requires Improvement

- Good ratings for:
  - care of patients
  - a number of community services

- Received a warning notice in December 2015 for three key issues:
  - Elective High Dependency Unit (eHDU)
  - Surgical incident reporting (Datix)
  - Radiology staffing out-of-hours

Summary from CQC visit in October 2015

- Two areas rated inadequate:
  - Medical Care effective (including older people's care) Northwick Park
  - Surgery (Safer Domain) – Northwick Park (reporting of incidents)

- Regulatory Notice
  - Duty of Candour – lack of moderate evidence for feedback to patients

- 85 Must Do's - we will improve month on month

Examples of good practice

Good overall for caring – all areas

Good overall End of Life for community

A newly opened Emergency Department

Community good overall in three areas, effective, caring and responsive

Examples of good practice

Recognition of dedicated staff

Research projects – including stroke

Refurbished Jack's Place

The availability and input of dedicated Psychotherapist at Willesden

Responding to concerns - Well Led

London North West Healthcare NHS
NHS Trust

- ✓ Integration of Community Services across all divisions
- ✓ Governance structures embedded
- ✓ Address Fit and Proper persons test
- ✓ Regular Staff Forums led by CEO including:

  Strategy, Vision and Values, Quality Accounts
  Acuity and Dependency, CQC
- ✓ Safely closed Ealing Paediatrics in-patient services as part of the reconfiguration of service and staff across North West London

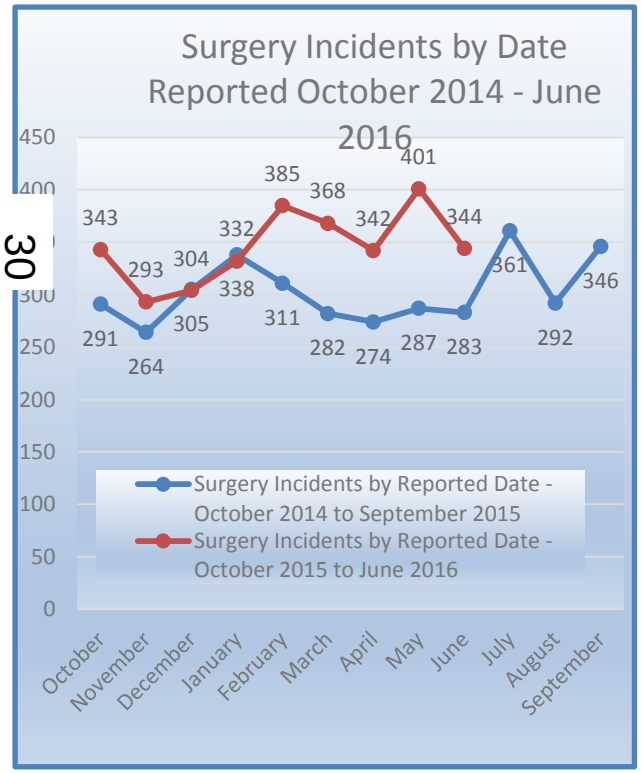
Elective HDU

- ✓ eHDU returned back to a Surgical Intensive Recovery Unit (SIRU) model
- ✓ Standing Operating Procedure in place and ongoing audit
- Critical care review and ICNARC data highlight the need for increased capacity in the Intensive Care Unit (ICU) and High Dependency Unit (HDU)
- ✓ Business case currently under discussion with Commissioners for new surgical ICU/HDU in place by 2017

Surgery (Safe Domain)

- ✓ New Divisional Structure – two Divisions now:
  - Surgery
  - St. Mark's
- ✓ Improved surgical pathways from the Emergency Department (ED) to surgical intervention
- ✓ Safer Surgery Checklist – audit and review
- ✓ Strengthen Governance arrangements in relation to incident reporting
- ✓ Renewed emphasis on serious incident management and feedback

Surgery Datix reporting and feedback
(improved reporting)



- ✓ Improved reporting
- ✓ All Consultants sent a letter from Chief Medical Officer reminding them of their responsibility
- ✓ Requested all Consultants have an NHS email for routine feedback
- ✓ Reminder also placed in Team Brief for all staff
- ✓ Regular training and dissemination sessions
- ✓ Regular reporting through local and corporate Clinical Quality and risk

Medicine (effective domain)

- ✓ New Divisional Structure - two Divisions
  - Emergency and Ambulatory Care
  - Integrated Medicine

- ✓ Dementia Strategy August 2016 with a focus on
  - John's story
  - Dementia champions
  - Dementia training

- ✓ A greater focus on End of Life Care
  - Identifying champions on wards
  - Linking it with our CQUINS
  - Focus on communication – Sage and Thyme Training
  - Needing to learn from areas such as – Meadow House Hospice

Medicine (effective domain)

- ✓ Focus on frailty and Ambulatory care
- ✓ Increased emphasis on nutrition and hydration
- ✓ Established a Deteriorating Patient Group
- ✓ Improving Emergency Department Performance
- ✓ New modular ward beds open

ED Performance

- ✓ One of the most improved London Acute Trusts
- ✓ Transformation programme in place
- ✓ Reducing London Ambulance Service (LAS) breaches
- ✓ Working with external agencies
- ✓ Introduced **RED** and **GREEN** days
- ✓ Greater ownership of patient breaches by all specialties
- ✓ Focus on frailty and ambulatory care
- ✓ Tasked department with ensuring compliance with national audits

Radiology

- ✓ Reviewed staffing guidance against Royal College of Radiology
- ✓ Reviewed on-call arrangements
- ✓ On-call Consultant available for all three sites out-of-hours
- ✓ On long weekends we have on-site Consultant presence specifically to review registrar reported scans to avoid unacceptable delays in reviews (eight hours)

Radiology

- ✓ We have a Radiology Consultant on the seven day Regional North West London working group and BMA group to assure us that we deliver the recommended national working patterns and processes, due for implementation in April 2017

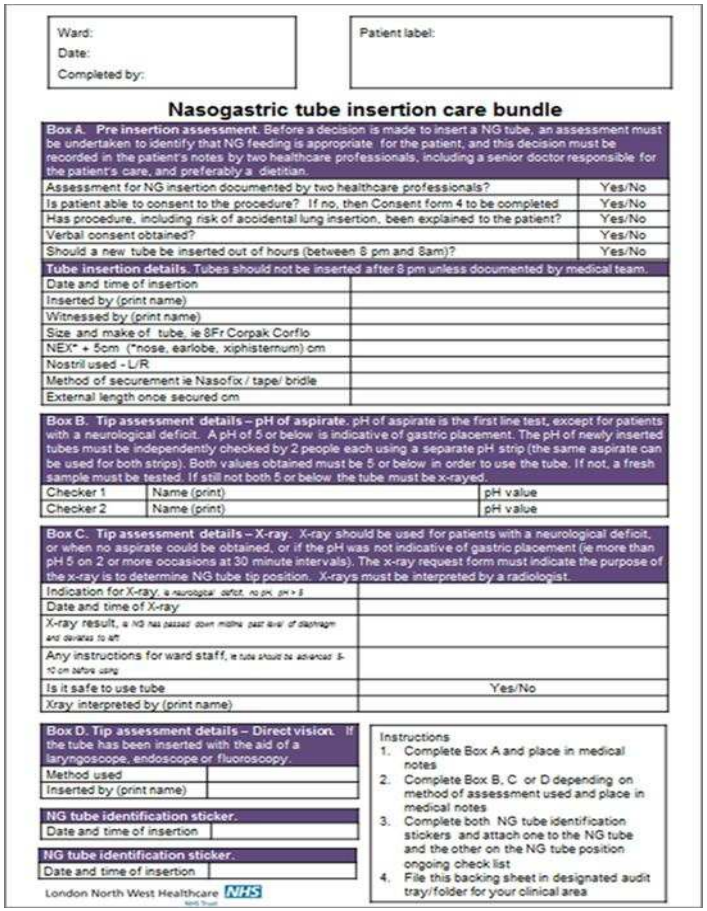
- ✓ We are reviewing job plans to provide on-site weekend cover this year

Risk and Governance

- ✓ Increased awareness of statutory requirements to inform patient of any incidents verbally or written within 10 days. (Duty of Candour)
- ✓ Recording of Duty of Candour has improved and is monitored externally
- ✓ Formalised reporting of incidents at clinical quality and risk committees at local and corporate levels
- ✓ Systematic approach to local and national audits with new lead in place
- ✓ Focus on themes and trends “learning from mistakes” and sharing across divisions and Trust
- ✓ Human factors training commenced in Surgery Division

London North West Healthcare NHS
NHS Trust

- ✓ Every month, the Trust is holding learning sessions so that staff can learn from serious incidents and never events that have occurred within the organisation
- ✓ A different theme is presented monthly on different sites and all staff are invited to attend
- ✓ National exemplar for nasogastric tubes



Ward:
Date:
Completed by:

Patient label:

Nasogastric tube insertion care bundle

Box A. Pre insertion assessment. Before a decision is made to insert a NG tube, an assessment must be undertaken to identify that NG feeding is appropriate for the patient, and this decision must be recorded in the patient's notes by two healthcare professionals, including a senior doctor responsible for the patient's care, and preferably a dietitian.

Assessment for NG insertion documented by two healthcare professionals?	Yes/No
Is patient able to consent to the procedure? If no, then Consent form 4 to be completed	Yes/No
Has procedure, including risk of accidental lung insertion, been explained to the patient?	Yes/No
Verbal consent obtained?	Yes/No
Should a new tube be inserted out of hours (between 8 pm and 8am)?	Yes/No

Tube insertion details. Tubes should not be inserted after 8 pm unless documented by medical team.

Date and time of insertion	
Inserted by (print name)	
Witnessed by (print name)	
Size and make of tube, ie 8Fr Corpak Corflo	
NEX* + 5cm (*nose, earlobe, xiphisternum) cm	
Nostril used - L/R	
Method of securement ie Nasofix / tape/ bridle	
External length once secured cm	

Box B. Tip assessment details – pH of aspirate. pH of aspirate is the first line test, except for patients with a neurological deficit. A pH of 5 or below is indicative of gastric placement. The pH of newly inserted tubes must be independently checked by 2 people each using a separate pH strip (the same aspirate can be used for both strips). Both values obtained must be 5 or below in order to use the tube. If not, a fresh sample must be tested. If still not both 5 or below the tube must be x-rayed.

Checker 1	Name (print)	pH value
Checker 2	Name (print)	pH value

Box C. Tip assessment details – X-ray. X-ray should be used for patients with a neurological deficit, or when no aspirate could be obtained, or if the pH was not indicative of gastric placement (ie more than pH 5 on 2 or more occasions at 30 minute intervals). The x-ray request form must indicate the purpose of the x-ray is to determine NG tube tip position. X-rays must be interpreted by a radiologist.

Indication for X-ray, *ie neurological deficit, no pH, pH > 5*	
Date and time of X-ray	
X-ray result, *ie NG has passed down midline, past level of diaphragm and deviates to left*	
Any instructions for ward staff, *ie tube should be advanced 5-10 cm before using*	
Is it safe to use tube	Yes/No
Xray interpreted by (print name)	

Box D. Tip assessment details – Direct vision. If the tube has been inserted with the aid of a laryngoscope, endoscope or fluoroscopy.

Method used	
Inserted by (print name)	

NG tube identification sticker.

Date and time of insertion	

NG tube identification sticker.

Date and time of insertion	

Instructions
1. Complete Box A and place in medical notes
2. Complete Box B, C or D depending on method of assessment used and place in medical notes
3. Complete both NG tube identification stickers and attach one to the NG tube and the other on the NG tube position ongoing check list
4. File this backing sheet in designated audit tray/folder for your clinical area

London North West Healthcare NHS

Patient Experience

- ✓ A range of quality metrics displayed on the ward
- ✓ “You said We Did” Boards
- ✓ Re-focused Patient Experience Group – active involvement
- ✓ Engaging with Healthwatch and patients
- ✓ Recent cancer survey results overall positive
- ✓ Quality Accounts focus on key areas
- ✓ Patient videos to Board
- ✓ FFT results in ED
- ✓ 1st Nurse in the country to get 5* across all areas for FFT (IBD)
- ✓ Safely closed Ealing Paediatrics in-patient services as part of the reconfiguration of services across North West London

Workforce Quality and Safety

- ✓ New HR and Organisational Development (OD) Director in post
- ✓ Development of People Strategy
- ✓ Review of recruitment function – reducing vacancies and time taken to recruit
- ✓ HR restructure underway with an OD function - supporting Trust wide integration
- ✓ Events - annual open day and staff well-being health days planned
- ✓ Work with Staffside

Workforce Quality and Safety

- ✓ Work on culture and values commenced
- ✓ More regular staff surveys are being introduced
- ✓ Bank and Agency cross sector workstream established

Workforce Quality and Safety

Nursing and Midwifery

- ✓ Staffing now reviewed every day via safety brief with acuity
- ✓ Midwifery ratio 1:29 and Green in recent LSA report
- ✓ One of only 12 Trusts in Carter review using CHPPD (Care Hours Per Patient Day) initial findings not an outlier
- ✓ Annual Nursing and Midwifery and Health Visitors conferences established
- ✓ Reduced Nurse agency spend by 32% - improving quality and reducing cost

Medical workforce

- ✓ Part of North West London seven day a week working group
- ✓ New workforce model being established in ED
- ✓ Working with Health Education England on developing new roles
- ✓ Number of experienced Physician Associates from USA - working in the organisation

Workforce Quality and Safety

Number of Permanent Consultants Recruited by Specialty from October 2015	
Specialty	**Count of FTE**
Anaesthetics Medical N.W.L	2
Clinical Haematology N.W.L	1
Endocrinology N.P.H	2
Orthopaedics N.P.H	1
Clinical Genetics	1
Radiology Medical N.W.L	4
Vascular Surgery N.P.H	1
.M.U Medical E.H	1
Meadow House Medical E.C.S	1
Elderly Care E.H	1
Grand Total	**15**

Compliance %		
MaST	**Oct-15**	**May-16**
Overall Vacancy %	**14.4**	**11.2**
Nurse Vacancy %	**21.5**	**14.7**
Sickness Rate %	**3.5**	**3.1**
Turnover Rate %	**17.9**	**16.1**

Estates

- ✓ Estates strategy “hand in hand” with Clinical strategy
- ✓ Health and Safety Fire compliance rolling programme
- ✓ Access to Capital – a challenge
- ✓ Work completes on new Haematology daycare centre October 2017
- ✓ Exploring land release to support further investment and development
- ✓ Shaping a Healthier Future supporting investment to deliver new models of care
- ✓ Mock Place inspections including patient representatives
- ✓ 2nd highest backlog maintenance requirement in the country

Summary

- Looking forward to working with partners to address a range of issues
- We welcome the review by the CQC
- Lots to do!
- Committed to the challenge
- This is not a quick fix

**“This is not the end,
This is not even the beginning of the end,
But it is perhaps the end of the beginning”**

Winston Churchill

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REPORT FOR: **HEALTH AND WELLBEI BOARD**

Date of Meeting:	8 September 2016
Subject:	**INFORMATION REPORT** Harrow Safeguarding Adults Board (HSAB) Annual Report 2015/2016
Responsible Officer:	Bernie Flaherty (Director, Adult Social Services – Harrow Council)
Exempt:	No
Wards affected:	All
Enclosures:	Harrow Local Safeguarding Adults Board Annual Report 2015/2016

Section 1 – Summary

This report provides the Health and Wellbeing Board with an overview of the Harrow Safeguarding Adults Board (HSAB) Annual Report for 2015/2016, which summarises safeguarding activity undertaken in that year by the Council and its key partners. It sets out the progress made against priorities, analyses the referrals received and outlines priorities for the current year (2016/17), including those areas where the support of the H&WB Board would be most appropriate. This is the first year (as required by the Care Act 2014) that the HSAB has been on a statutory footing and the NHS, Police and Council representation has to be at a relevant and senior level.

FOR INFORMATION

Section 2 – Report

2.1 The Care Act 2014

Under the Care Act 2014 the local Safeguarding Adults Board has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- the Harrow LSAB has a 3 year strategic plan for 2014 – 2017

ii. publish an annual report

- Harrow LSAB's 8th Annual Report (for 2014/2015) was presented to the Council's Scrutiny Committee in October 2015. This 9th report for 2015/2016 will go to a Scrutiny meeting on November 21st 2016
- each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent
- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- these will be carried out as required. There were none required in 2015/16

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow SAB (as at 31st March 2016) is shown in Appendix 3 and their attendance record is shown at Appendix 4

2.2 Management Information/statistics

The full set of statistical information for safeguarding adults activity is at Appendix 1 of the attached report.

Headline messages – safeguarding adults

This section outlines the Harrow position last year with commentary based on the last available set of national data and local intelligence:

- 1,690 concerns (previously called "alerts") compared to 1,227 in 2014/15, represented a growth of 38% locally. This year the growth in numbers is likely to be related to implementation of the Care Act 2014

which widened the remit for safeguarding adults and lowered the threshold for making enquiries

- 40% of Harrow concerns (680 cases) were taken forward as enquiries (previously called "referrals"), compared to 51% in 2013/14. It is difficult to be sure what percentage of concerns should meet the threshold for enquiries, although it certainly would not be 100%.

  Given another high increase in concerns it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or "root cause analysis" for pressure sores.
  As previously, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage

- repeat enquiries in Harrow increased very slightly from 18% in 2014/2015 to 19% in 2015/2016. The last known national figure was 18%, so Harrow is closely aligned with the performance in other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board wants to continue to monitor closely. The most recent independent file audit (for cases completed between March 2015 and September 2015) looked at repeat referrals and with one exception found that they were all for a new concern, which is reassuring

- completed enquiries in Harrow (100%) is significantly better than the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully against the indicative timescales to ensure that there is no "drift", however the introduction of Making Safeguarding Personal has slowed down the process because the user is in control of dates and venues for meetings etc

- in Harrow the female: male ratio at the end of 2015/2016 was 63:37 for enquiries, which is very close to the last known national position of 61:39

- numbers for older people decreased again last year from 363 in 2014/15 to 314, even so they remain the highest "at risk" group

- for adults with a physical disability the figure in Harrow last year was 40% of concerns. As indicated in last year's annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory

- mental health numbers improved significantly last year from 16% of enquiries (103 users) in 2014/15 to 31% (210 users). This is now higher than the last national figure of 24% and is very positive given the

large amount of focused work done by CNWL Mental Health NHS Trust in 2015/16

- in Harrow the number of enquiries for people with a learning disability in 2015/2016 was exactly the same (88 cases) as the previous year and at 13% is lower than the last available national figure of 19%

- it is very pleasing to note that the concerns from "BME" communities rose again last year to 51% from 45% in 2015/2016 – which is in line with the makeup of the Harrow population. The enquiries figure was 48% which is also positive, as it suggests that a proportionate number of concerns are progressed and people from "minority" communities are not being disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow remain broadly similar to 2015/16, with the highest percentage being in the service user's own home (61%) and 20% in care homes (long term and temporary placements). This is almost exactly the same figures as in 2014/15. Figures in other settings remain small e.g. 1% in an acute hospital (10 cases); 4% in mental health in-patient units (25 cases) and 4% in supported accommodation (26 cases)

- allegations of physical abuse (23%) and neglect (at 21%) remained the most common referral reasons last year. Concerns about sexual abuse rose from 42 cases in 2014/2015 to 65 last year. It is the first year for cases of self-neglect to be reported under the safeguarding adults' statistics and there were 11 concerns dealt with under the local arrangements

- financial abuse (17%) and emotional/psychological abuse (20%) are the other significant figures and both have reduced very slightly – by 3% and 2% respectively

- in Harrow, social care staff e.g. "domiciliary care workers" (22%); "other family members" (25%) and "partner" (10%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2014/2015

- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of concerns and this is the second time that year on year comparison has been possible for the HSAB to carry out. Last year the highest numbers (16%) were from social workers/care managers and mental health staff. The increase in concerns (from 55 in 2014/15 to 112 last year) raised by the latter is very positive given the significant focus on this work by managers in the Trust.

  The other sources were: primary health care staff (10% - a small decrease from the previous year); residential care staff (10% - a small increase from 2014/2015); family (8% - a small decrease on the last 2 years); secondary health care staff (a 7% decrease [40 less cases]

than in 2014/15); Police (6% - a 2% increase) and friend/neighbour (3 more cases [12 cases] than the previous year)

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2014/2015 statistics of 89 cases have increased to 105 – which is positive. The safeguarding adults team supported by the Police continue to give this area a high priority

- outcomes for the adult at risk include: increased monitoring (13%); community care assessment and services (13%); management of access to perpetrator (5%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (1%); application to Court of Protection (1%)

  All figures are broadly similar to 2014/2015 and although the percentage is the same as the previous year there were 9 cases (an increase of 5) taken to the Court of Protection which is positive.

Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the fourth year that the HSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (including those that are placed out of borough), the HSAB needs to be reassured that they are carefully applied and monitored.

There were 798 requests for authorisations last year (an increase of 414 on the previous year) of which 644 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 122 requests from hospitals compared to 16 in 2014/2015 – an increase of 13%.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2014/2015 position. In some important areas e.g. mental health referrals and concerns from BME communities, there was significant improvement. There was also a small improvement in the numbers of cases subject to Police action/prosecution.

Given that these were areas prioritised by the HSAB for 2015/16 this is a very positive outcome. Areas for focus in 2016/17 include the reduction for the 3rd year of cases being referred from secondary care and the need to ensure that self-neglect concerns are being recorded correctly - as the numbers in year 1 appear lower than the research suggests they might have been. The HSAB would also like to be reassured that the numbers of concerns received from family/friends are as high as they should be.

The action plan in this report (year three of the HSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis..

2.3 Making a difference – (progress on 2015/2016 objectives)

This section of the report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2015/2016, as set out in the annual report for 2014/2015.

Theme 1 - Prevention and Community Involvement

The LSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

The HSAB's prevention strategy 2014 – 2017 ("Promoting Dignity and Prevention of Abuse") was formally agreed at the Board meeting in March 2014. 2015/2016 was the second year of implementation which built on the work done from the previous year. Examples of work in this area include:
Care providers ran events to mark Dignity Awareness Day (1st February 2016). Some poignant quotes from older people who took part at Princess Alexandra Home included: "*dignity is about choice"; "dignity is being there for me, coming to me to have a conversation"; "dignity is simply being nice and pleasant to people - treating them the way you'd like to be treated*". Other events included: pancakes at College Hill Care home; a resident singing West End favourite songs at Grove House; a "digni tea" at Primrose House; celebrations and reminiscence at Holly Bush Nursing Home.
To mark the 10th World Elder Abuse Awareness Day (June 2015) the HSAB organised a Best Practice Forum on self-neglect which was attended by 55 staff from a range of local organisations. Up to date research was presented by Michael Preston-Shoot (Professor of Social Work at University of Bedfordshire) which focused on how best to work with people who were reluctant to accept care or support..

The Safeguarding Adults Services continues to promote distribution of "The Little Book of Big Scams" produced by the Metropolitan Police and the Home Office which is extremely popular with members of the general public.

Ensure effective communication by the HSAB with its target audiences

A formal Communications Plan for the HSAB was approved by the Board at the March 2015 business meeting. It aims to ensure that its target audiences across the whole community know about abuse and how to report it and that resources are used for publicity and awareness related events in the most time/cost efficient ways.
The HSAB's newsletter which commenced in 2013 continued throughout last year aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The editions published (July and October 2015 and January 2016) included topics such as: statistical information; Law Commission consultation on possible DoLS reforms; scams (e.g. door step crime); Dignity Action Day 2016; Home Office report on inspection of custody arrangements for vulnerable people; the new "pan London" procedures; Prevent; and training information.

Articles were also written for “News and Views” which is produced for people with a learning disability with a particular focus on keeping safe including e-safety on-line.

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Contributions continued from the Safeguarding Adults Service to the Multi-agency Risk Assessment Conference (MARAC – domestic violence focus); Multi-agency Public Protection Arrangements (MAPPA – public safety focus); Prevent (prevention of terrorism focus), and Anti-social Behaviour Group (ASBAG – anti social behaviour focus) - ensuring effective information sharing and communication where vulnerable adults are victims or perpetrators.

There is evidence that the Harrow HSAB’s work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding enquiry is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that all the users interviewed were very happy with the outcome of the enquiry and (an important change from her previous findings) had felt in control of the process. It is believed that new approaches introduced under the “Making Safeguarding Personal” project e.g. holding strategy meetings at user’s own homes have been major factors in this improvement.

Service users attended the HSAB Annual Review Day again last year (June 2015). They told the HSAB about what was important to them in keeping safe and provided challenge to Board members:
“people come to the front door and ask for our Bank information – this is scary”; “lots of people are worried about door step crime”; “my house was burgled when I was in hospital – I was scared to go back”; “carers should not tell other people what the key safe number at the front door is”; ”we would like more leaflets about keeping safe”; “taxi drivers should be told not to speak on their mobile phone when they drive us anywhere”; “tell head teachers at the end of term not to let students be rude to us”; “we don’t think that the Police know much about mental health problems”; “we would like to know which staff in mental health services know about what to do if we tell them about abuse”; “who are the CNWL champions for keeping safe?”
The HSAB Annual Report for 2014/15 was presented to the Local Account Group and discussed in detail. There was a request that more awareness raising was done in local mental health services which has been implemented by CNWL.

Outcomes for prevention work included:

More work has been done to set up a Harrow Safe Place scheme. Choices For All students and users at Creative Support are helping by visiting shops, churches and cafes near the Bus Station (as the first priority area) asking them to sign up.

At its meeting in September 2015, the HSAB formally approved a protocol for working with people who self-neglect based in large part on the research presented by Professor Preston-Shoot. The effectiveness of the new approach was reviewed at the HSAB meeting in March 2016 and was assessed as working well.
The referrals from "BME" communities increased last year to 51% which is very much in line with the local demographic makeup of the borough and suggests that the HSAB's messages are reaching a wider audience.
The very positive arrangements between the Safeguarding Adults Service and the local Fire Service continued last year with 83 referrals for free home fire safety checks.
As requested by users and the Local Account Group, more awareness raising and focus was given to safeguarding adults work by CNWL with a very significant improvement in numbers of concerns dealt with in that area.
The "champion" information was displayed at relevant units by CNWL.

Mental health concerns rose by 15% (107 more people) suggesting that (as requested by users and the Local Account Group) a greater number of staff in these services know what to do about allegations of abuse.

Theme 2 – Quality and Performance Review

The HSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the HSAB at all of its meetings in 2015/2016. See 2.2 above for detailed analysis.
A second "mystery shopping" exercise was commissioned by the HSAB which was carried out by users (supported by Mind in Harrow) in November 2015. The areas contacted were: 101 – Police non-emergency service; SPA (Single Point of Access for CNWL) and 3 GP practices. The findings were presented to the Board in December 2015 and feedback has been given to the agencies contacted in the exercise.

File Audit
Both internal and external (independent) audits of casework continued in the Council's Safeguarding Adults and DoLS Service during 2015/2016 with headline massages presented to the HSAB.

A total of 96 cases were reviewed with the key focus being on areas highlighted from performance reports e.g. checking that repeat referrals were for different concerns. The audit findings were fed back to relevant front-line staff and managers as a way of informing continuous improvement.
In May 2015, in CNWL Mental Health Trust, an audit of procedures and recording of safeguarding adults enquiries was undertaken by an external auditor. One outcome was the creation of a specific role 'Lead Safeguarding Adults Manager' (Lead SAM) to undertake reform of policies and procedures for raising a concern, verifying if a further enquiry was required and organising a Safeguarding Adults Manager to conduct this.
A further very positive outcome was a marked improvement in the number of concerns raised/reported. In Quarter 1 of 2015/16 the average was 10 a month, in Quarter 4 it was 35 a month.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The HSAB has received statistical reports at each of its meetings, including the full year position for 2014/2015 at its Annual Review Day. In addition, the new Strategic Plan for 2014 – 2017 included trend analysis looking back over the previous 3 years and all reports included comparison with the national position wherever possible.

Outcomes:
Ongoing analysis by the HSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with areas identified for future work covered in the action plan at section 4
Changes were made to the multi-agency training programme and also to the specific sessions for front-line staff. For example, a bespoke course on "pressure sore prevention and management" was delivered by a local Tissue Viability Nurse.

Theme 3 –Training and Workforce Development

The HSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

Multi-agency training remains a high priority for the HSAB. The existing programme is competency based. This ensures that all staff know about the competencies required to meet their safeguarding adults' responsibilities within the workplace.

As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Some targeted briefing sessions took place: Pubwatch landlords (with a focus on the sexual exploitation of vulnerable adults and done in partnership with the HSCB); Enhanced Practice Nurses; the Wiseworks Centre for people with mental health difficulties; MIND in Harrow users and volunteers; St Luke's Hospice and care providers (primarily about DoLS).

Funding was also received from the Department of Health which enabled the HSAB to hold its first conference. The focus was on use of the Mental Capacity Act, sessions were run by Edge Training and included input from Alex Ruck-Keene a leading barrister in the field. Evaluation was almost 100% positive from the 107 multi-agency staff that attended.

Attendees by sector (multi-agency training programme)	**2015-16**
Harrow Council Internal	187
Health	49
Statutory (other)	1
Private	373
Voluntary	85
Sub-total:	**695**

SGA Team Briefing Sessions

Age UK Harrow Volunteers		10
Deprivation of Liberty Safeguards (DoLS) Briefings		72
Housing Team		15
Members Briefings		12
Pubwatch		50
HSAB annual conference (focus on the Mental Capacity Act)		107
Pressure Area Care		29
Self-Neglect & Hoarding (learning from research)		55
Kenmore NRC		19
Marlborough Hill Day Centre / Wiseworks		9
Milmans Service User Briefings		20
MIND in Harrow Service Users & Volunteers		5
Carers Briefing		14
Enhanced Practice Nurses		19
GP Surgeries (Clinical & Non-Clinical Staff)		17
St Luke's Hospice		25
	Sub-total	**478**
Total Attending (all sessions)		**1173**

Outcomes

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions.

Last year there was a focus on ensuring that the requirements of the Care Act 2014 were addressed in both formal and briefing sessions. This included self-neglect and the other new areas of work e.g. modern slavery.

DOLS arrangements (including for health funded services and facilities) are effective

The Deprivation of Liberty Safeguards (DoLS) statistics are at section 2.2 of this report.
The statutory timescales were met in all the cases assessed last year in Harrow which in comparison to many other Councils across the country where there are significant waiting lists is excellent. This may not be sustainable in 2016/17 given withdrawal of the Government grant, pressure on Council finances and a continuing growth in referral numbers.

Outcomes:

The HSAB can be reassured that for the 789 cases where a DoLS was authorised, some of the most vulnerable people they are responsible for have been protected. It is also positive that more cases were referred from hospitals suggesting that staff in those settings are becoming clearer about their responsibilities as managing authorities.

There are also good case examples of the involvement of a Best Interest Assessor or independent section 12 doctor highlighting ways in which restrictions on individual's can be reduced e.g. picking up where sedative medication has not been reviewed and could be reduced.

Theme 4 - Policies and Procedures/Governance

Ensure production of the HSAB Annual Report and presentation to all relevant accountable bodies

The HSAB Annual Report 2014/2015 was agreed formally by the Board at its annual review day in June 2015. This report for 2015/2016 will be discussed at the same event in June 2016. Following its formal agreement by the HSAB, the report was presented to the Health and Wellbeing Board (14th October 2015), the Council's Scrutiny Committee (26th October 2015) and subsequently to all partner agencies' Executive meetings or equivalent.

Outcomes:

As in previous years, following the decision to sign off the annual report by the HSAB last June a "key messages for staff" version of the report was produced for the third time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

The general public is aware of safeguarding issues and the work of the HSAB

The safeguarding adults' website was kept up to date and has a section for easy to read information.

As stated above the Safeguarding Adults Service finds that the "little book of big scams" produced by the Metropolitan Police is popular with the general public and is therefore actively promoting it as widely as possible across Harrow.

The HSAB (jointly with the Safeguarding Children's Board) takes a "family first" approach to its work

Joint common meetings continued again last year e.g. bi-annually with the Multi-agency [children's] Safeguarding Hub (MASH) and London Ambulance Service.
Joint briefing sessions are run wherever possible e.g. with Pubwatch/pub landlords about sexual exploitation.

Outcomes:
Independent file audits continue to show growing confidence in this area of work by staff in Adult Services. These audit findings were fed back to and discussed with the Children's Safeguarding Board (HSCB) quality assurance sub-group meeting.

The HSAB has strategic oversight of local safeguarding adults work

Year two actions from the HSAB Strategic Plan 2014 – 2017 were implemented with an exception report at each Board meeting. This section of the annual report covers the work carried out and some of the outcomes achieved as a result.

Theme 5 – Partnership with the Local Safeguarding Children's Board (HSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Independent file audit last year again reviewed cases where domestic violence was a factor. The HSAB was reassured by the finding that referrals were being routinely made to MARAC and it is becoming much more common for a worker or manager from the Safeguarding Adults/DOLS Service to attend the meetings for specific cases.

Some audited cases also recognised work done with both the Looked After Children's and Children with Disability Teams.

Outcomes:
Better outcomes for young adults in specific cases where joint work was effective.

The HSAB (jointly with the HSCB) takes a "family first" approach to its work

See above. In addition, a practitioner representative from the Council's Safeguarding Adults/DoLS Service and relevant NHS staff provide information to MASH (Multi-agency Safeguarding Hub) where threshold decisions about referred children are discussed. This ensures appropriate information sharing and therefore decisions are taken in the most informed way possible.

2.4 HSAB Objectives for 2016/2017

The LSAB's objectives for 2016/2017 build on those established the previous year and address the priorities identified in its Strategic Plan for 2014 - 2017. The priorities include: specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety); commission the 3rd "mystery shopping" exercise ensuring feedback is given to providers and learning is implemented; and develop an action plan to address relevant recommendations from the inspection of vulnerable people in custody report.

Section 3 – Further Information

All relevant information is contained in the attached document.

Section 4 – Financial Implications

The revenue cost of the Safeguarding Adults Service (and related activities e.g. publicity) is outlined in the Annual Report under the "HSAB Resources" section. The increased activity during 2015/2016 resulted in additional costs incurred by the Safeguarding Adults and DoLS Service, however this was contained within the overall adult social care budget.

As highlighted last year, the other financial implication arising from this report relates to the Supreme Court judgement in the DoLS work area and the numbers are at section 2.2 above.

The Council received a financial contribution for 2015/16 from the Department of Health (DoH) of £104K in recognition of the extremely high numbers of cases, however this was removed in 2016/17 despite the rising numbers, so the Council has had to fund the remaining cost pressure. Whilst in previous years costs have been contained within the Adult social care budget, the increasing care cost pressures together with the reduced budget to deliver MTFS savings to contribute towards council budget gap are likely to influence the ability to contain these pressures moving forward.
The expectation is that the outcomes can be delivered within the annual financial envelope, however this continues to prove challenging where the pressures are demand led and of a statutory nature.

Section 5 - Equalities implications

The HSAB considers local safeguarding adults statistics at each Business Meeting and at its annual review/business planning event, with particular emphasis on ensuring that alerts (now "concerns") are being received from all sections of the community. The Strategic Plan for 2014/17 has been developed such that the HSAB will monitor the impact of abuse in all parts of Harrow's community and will focus its awareness raising sessions in areas where low/no referrals have been received in the previous period. Safeguarding adults' work is already focused on some of the most vulnerable and marginalised residents of the local community and the 2015/2016 statistics demonstrate that concerns are coming from all sections of the Harrow community.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report primarily relates to the Corporate priorities of:

- making a difference for the vulnerable
- making a difference for communities

STATUTORY OFFICER CLEARANCE

(Council and Joint Reports)

Name: Anthony Lineker Date: 15th August 2016	X	on behalf of the Chief Financial Officer
Ward Councillors notified:		**NO** - the report affects all Wards

Section 7 - Contact Details and Background Papers

Contact: Visva Sathasivam (Assistant Director, Adults) - 02087366012

Background Papers:

Harrow Safeguarding Adults Annual Report 2015/2016

Harrow COUNCIL LONDON

& our Partners,

Committed to Safeguarding Adults

Harrow Safeguarding Adults Board (HSAB)

Annual Report 2015 - 2016

Harrow COUNCIL LONDON

in partnership with:

HAD Harrow Association of Disabled People

mind For better mental health

Harrow mencap Providing opportunity : promoting change

harrow carers supporting family & friends

Royal National Orthopaedic Hospital NHS Trust

The North West London Hospitals NHS Trust

Central and North West London NHS Foundation Trust

London Ambulance Service NHS Trust

Ealing Hospital NHS Trust

Harrow Community Services NHS Trust

NHS Harrow

Harrow age UK

LFB LONDON FIRE BRIGADE

METROPOLITAN POLICE Working together for a safer London

Local Safeguarding Children Board

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"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (HSAB Vision)

Foreword

This is the 9th Annual Report published on behalf of Harrow's Safeguarding Adults Board (HSAB) and contains contributions from its member agencies. The Board coordinates local partnership arrangements to safeguard adults at risk of harm. This report details the work carried out by the HSAB last year (2015/2016) and highlights the priorities for 2016/2017.

Nationally, the Care Act 2014 has placed Local Safeguarding Adults Boards on a statutory basis in primary legislation for the first time. This meant that by 1st April 2015 the Board had to meet the requirements of the Act and I can confirm that the Harrow Board is compliant with those requirements, which include having as core partners the Local Authority, the Clinical Commissioning Group and the Police. The Board has always published an annual report, which is now a statutory requirement.

The Board has taken the opportunity provided by the Care Act 2014 to review its policies and procedures and to introduce new ones where required. The Board has also been aware of the introduction into adult safeguarding arrangements of self-neglect, modern slavery and institutional abuse, alongside sexual exploitation and hate crime.

There was a lot of excellent work done last year on the priorities that the HSAB had agreed were important and I think that once again this annual report demonstrates the difference that the Board's work has made to the lives of the most vulnerable people in the borough (see section 3) and trust you agree once you have read it.

A key priority for the HSAB in the coming year will be specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety).

As ever, everything the HSAB does is to achieve its vision – "*that Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business".*

I am delighted to present this report to you and hope you will use it to raise awareness of adult safeguarding and to identify issues that you can take forward in your own organisation.

Bernie Flaherty (Chair of the HSAB)

SECTION 1 - INTRODUCTION

1. Introduction to the annual report

This Annual Report describes the activities carried out by the partnership organisations that form the Harrow Safeguarding Adults Board (HSAB) during 2015/16 and it also looks ahead to the priorities for 2016/17.

1.1 The Harrow Safeguarding Adults Board (HSAB)

The Harrow Safeguarding Adults Board (HSAB) is chaired by Bernie Flaherty (Director – Adult Social Services, Harrow Council) and is the body that oversees how organisations across Harrow work together to safeguard or protect adults who may be at risk of significant harm, or who have been abused or harmed.

The HSAB takes its leadership role very seriously with appropriate senior management attendance from member organisations and the active involvement of the elected Councillor who is the Council's Portfolio holder for adult social care, health and well-being. The list of members (as at March 31st 2016) is at Appendix 3, with their attendance record at Appendix 4.

1.2 Acknowledgments

The Board would like to thank staff, volunteers, users and carers from all agencies who have contributed to safeguarding and dignity/respect work in Harrow over the last year.

1.3 HSAB Accountability

Under the Care Act 2014 the HSAB has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- the HSAB has a 3 year strategic plan for 2014 – 2017 which is updated each year after production of the annual report

ii. publish an annual report

- the HSAB's 8th Annual Report (for 2014/2015) was presented to the Council's Scrutiny Committee on 26th October 2015. This 9th report for 2015/2016 will go to the Health and Wellbeing Board on 8th September 2016 and a Scrutiny meeting on 21st November 2016
- consultation on the 2014/15 annual report as well as the 2015/16 draft version was done with Healthwatch in Harrow as well as the Local Account Group
- each partner organisation represented at the HSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent

- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- these will be carried out as required, but there were none that needed to be done in 2015/16

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow's HSAB (as at 31st March 2016) is shown in Appendix 3 and their attendance record is shown at Appendix 4

1.4 "London Multi-Agency Adult Safeguarding Policy and Procedures"

The final version of the London Multi-Agency Adult Safeguarding Policy and Procedures was produced in December 2015 and formally launched on 9th February 2016. An update was required to ensure that the procedures were compliant with the Care Act 2014. As required, the Harrow Safeguarding Adults Board formally adopted the procedures at its meeting on 16th March 2016 and will implement them from 1st April 2016. The main points from the new procedures are:

- the process is now 4 stages: concerns; enquiry; safeguarding plan and review; and closure;
- Section 75 agreements continue to allow for Mental Health Trusts to act on behalf of the Local Authority to undertake safeguarding adult duties;
- the Safeguarding Adults Manager (SAM) who oversees the enquiries is allocated in the Local Authority or (where Section 75 agreements are in place), the relevant Mental Health Trust;
- there are no definitive timescales, (however indicative ones similar to the previous pan London procedures are given), as the focus has become more about user led processes in line with Making Safeguarding Personal;
- there is more focus on outcomes than process;
- the initial lead actions in response to a safeguarding concern should always be taken by the Local Authority for the area where the incident occurred. The "placing Local Authority" continues to hold the overall responsibility for the individual;
- the new areas introduced under the Care Act 2014 are referenced e.g. modern slavery; and
- HSAB partners are required to ensure the widest possible dissemination amongst staff

There will be a formal review in one year's time.

SECTION 2

HSAB Work Programme in 2015/2016

2.1 Harrow HSAB business meetings – work areas covered

The HSAB met on 4 occasions in 2015/2016 – three Business Meetings and an Annual Review/Business Planning Day. The following table lists the main topics discussed by the Board at those meetings – some being standing items (e.g. quarterly statistics); some were items for a decision (e.g. the new London multi-agency procedures); some were for information/discussion (e.g. training); others were aimed at Board development (e.g. Prevent/radicalisation), and there were also specific items providing challenge to the Board (e.g. user input to the annual review/business planning day). Some items (e.g. Making Safeguarding Personal) were discussed at more than one meeting.

Prevention and Community Engagement (including user involvement)

- Prevent and radicalisation – presentation/discussion (item for Board development)
- User Engagement - feedback on progress with the Harrow Safe Place Scheme development and from the discussions with the Local Account Group about the HSAB Annual Report 2014/15 (items for challenge; information and discussion)
- Mystery Shopping exercise – year 2 (item for information and decision)
- "Safeguarding is all about us" – user input to annual review/business planning day (item for challenge)
- World Elder Abuse Awareness Day 2015 in Harrow – local arrangements agreed (item for decision)
- Harrow Safe Place Scheme (item for information)
- Budget cuts and any impact on vulnerable people – (item for challenge)
- CSE; FGM and gangs – adult social care perspective (item for information)
- User outcomes – feedback from independent file audits and interviews with users (item for information)

Training and Workforce Development

- Formal review of the Safeguarding Adults (multi-agency) training programme (item for decision)
- HSAB Training programme for 2016/2017 (item for information and decision)
- Feedback from Best Practice Forums e.g. self-neglect (item for information)
- HSAB conference 25th November 2015 (item for discussion and information)

Quality and Performance Review

- Peer Review action plan monitoring (item for decision)
- Quality assurance framework for safeguarding adults' work (standing item)
- File audits – confirmation of each Board member organisation's audit processes (item for information)
- Mystery Shopping exercise – year 2 (item for information and decision)
- Quarterly statistics – discussed and findings used by the HSAB to inform changes to the training programme and local practice (standing item at every meeting)
- Home Office Inspection of Vulnerable People in Custody (item for decision)

Policies and Procedures/Governance

- HSAB Strategic Plan 2014/17 – exception reports (standing item)
- The HSAB Annual Report 2013/2014 - discussed and formally signed off (item for decision)
- Care Act 2014 implementation (items for decision)
- HSAB membership and revised Terms of Reference (item for decision)
- Safeguarding Adults Reviews (SAR) Policy – (item for decision)
- London multi-agency policy/procedures 2016 (item for decision)
- Making Safeguarding Personal – action plan agreed (items for discussion and decision)
- Metropolitan Police information sharing agreement (item for discussion)
- Self-neglect protocol (item for decision)

Joint work with the Harrow Safeguarding Children's Board (HSCB)

- HSCB independent audit (item for information)
- HSCB Annual Report 2014/2015 (item for information)
- Transition protocol for safeguarding work (item for decision)
- Child Sexual Exploitation – HSCB feedback (item for information)
- Female Genital Mutilation (FGM) – update on local arrangements (item for information)
- Learning from serious case reviews - (item for information)

Safeguarding Adults Reviews (SARs)

There were no cases for the HSAB to commission a SAR or review in 2015/2016.

2.2 Management information (statistics)

The Board collates multi agency information on a range of adult safeguarding statistics in order to produce a management report. The report which is available at each business meeting is overseen by and discussed at the HSAB.

It attempts to identify trends in referral data and to provide accessible and useful statistics to Board members which can then be used to inform decisions e.g. identifying where awareness campaigns or training should be focussed.

The statistical information for safeguarding adults services in 2015/2016 is shown at Appendix 2.

Headline messages – safeguarding adults

This section outlines the Harrow position last year with commentary based on the last available set of national data and local intelligence:

- 1,690 concerns (previously called "alerts") compared to 1,227 in 2014/15, represented a growth of 38% locally. This year the growth in numbers is likely to be related to implementation of the Care Act 2014 which widened the remit for safeguarding adults and lowered the threshold for making enquiries

- 40% of Harrow concerns (680 cases) were taken forward as enquiries (previously called “referrals”), compared to 51% in 2013/14. It is difficult to be sure what percentage of concerns should meet the threshold for enquiries, although it certainly would not be 100%. Given another high increase in concerns it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or “root cause analysis” for pressure sores. As previously, both internal and external file audits continue to check that appropriate concerns are being taken forward to the enquiries stage
- repeat enquiries in Harrow increased very slightly from 18% in 2014/2015 to 19% in 2015/2016. The last known national figure was 18%, so Harrow is closely aligned with the performance in other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board wants to continue to monitor closely. The most recent independent file audit (for cases completed between March 2015 and September 2015) looked at repeat referrals and with one exception found that they were all for a new concern, which is reassuring
- completed enquiries in Harrow (100%) is significantly better than the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully against the indicative timescales to ensure that there is no “drift”, however the introduction of Making Safeguarding Personal has slowed down the process because the user is in control of dates and venues for meetings etc
- in Harrow the female: male ratio at the end of 2015/2016 was 63:37 for enquiries, which is very close to the last known national position of 61:39
- numbers for older people decreased again last year from 363 in 2014/15 to 314, even so they remain the highest “at risk” group
- for adults with a physical disability the figure in Harrow last year was 40% of concerns. As indicated in last year’s annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory
- mental health numbers improved significantly last year from 16% of enquiries (103 users) in 2014/15 to 31% (210 users). This is now higher than the last national figure of 24% and is very positive given the large amount of focused work done by CNWL Mental Health NHS Trust in 2015/16
- in Harrow the number of enquiries for people with a learning disability in 2015/2016 was exactly the same (88 cases) as the previous year and at 13% is lower than the last available national figure of 19%

- it is very pleasing to note that the concerns from "BME" communities rose again last year to 51% from 45% in 2015/2016 – which is in line with the makeup of the Harrow population. The enquiries figure was 48% which is also positive, as it suggests that a proportionate number of concerns are progressed and people from "minority" communities are not being disproportionately closed before that stage of the process

- statistics showing where the abuse took place in Harrow remain broadly similar to 2015/16, with the highest percentage being in the service user's own home (61%) and 20% in care homes (long term and temporary placements). This is almost exactly the same figures as in 2014/15

  Figures in other settings remain small e.g. 1% in an acute hospital (10 cases); 4% in mental health in-patient units (25 cases) and 4% in supported accommodation (26 cases)

- allegations of physical abuse (23%) and neglect (at 21%) remained the most common referral reasons last year. Concerns about sexual abuse rose from 42 cases in 2014/2015 to 65 last year. It is the first year for cases of self-neglect to be reported under the safeguarding adults' statistics and there were 11 concerns dealt with under the local arrangements

- financial abuse (17%) and emotional/psychological abuse (20%) are the other significant figures and both have reduced very slightly – by 3% and 2% respectively
- in Harrow, social care staff e.g. "domiciliary care workers" (22%); "other family members" (25%) and "partner" (10%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2014/2015
- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of concerns and this is the second time that year on year comparison has been possible for the HSAB to carry out. Last year the highest numbers (16%) were from social workers/care managers and mental health staff. The increase in concerns (from 55 in 2014/15 to 112 last year) raised by the latter is very positive given the significant focus on this work by managers in the Trust. The other sources were: primary health care staff (10% - a small decrease from the previous year); residential care staff (10% - a small increase from 2014/2015); family (8% - a small decrease on the last 2 years); secondary health care staff (a 7% decrease [40 less cases] than in 2014/15); Police (6% - a 2% increase) and friend/neighbour (3 more cases [12 cases] than the previous year)

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2014/2015 statistics of 89 cases have increased to 105 – which is positive. The safeguarding adults team supported by the Police continue to give this area a high priority
- outcomes for the adult at risk include: increased monitoring (13%); community care assessment and services (13%); management of access to perpetrator (5%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (1%); application to Court of Protection (1%)

  All figures are broadly similar to 2014/2015 and although the percentage is the same as the previous year there were 9 cases (an increase of 5) taken to the Court of Protection which is positive.

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Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the fourth year that the HSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (including those that are placed out of borough), the HSAB needs to be reassured that they are carefully applied and monitored.

There were 798 requests for authorisations last year (an increase of 414 on the previous year) of which 644 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 122 requests from hospitals compared to 16 in 2014/2015 – an increase of 13%.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2014/2015 position. In some important areas e.g. mental health referrals and concerns from BME communities, there was significant improvement. There was also a small improvement in the numbers of cases subject to Police action/prosecution. Given that these were areas prioritised by the HSAB for 2015/16 this is a very positive outcome. Areas for focus in 2016/17 include the reduction for the 3rd year of cases being referred from secondary care and the need to ensure that self-neglect concerns are being recorded correctly - as the numbers in year 1 appear lower than the research suggests they might have been. The HSAB would also like to be reassured that the numbers of concerns received from family/friends are as high as they should be.

The action plan in this report (year three of the HSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 HSAB Resources

As at 31st March 2016, the staffing of the dedicated Safeguarding Adults Service located in the Council is as follows:-

1 Service Manager (Safeguarding Adults and DoLS)

1 DoLS Co-ordinator

1 Safeguarding Adults Co-ordinator

1 Team Manager

2 wte Safeguarding Adults Senior Practitioners

7 wte qualified Social Workers

Under the formal Section 75 agreement there are also a number of trained Safeguarding Adults Managers with a dedicated Lead located in Central and North West London Mental Health NHS Foundation Trust (CNWL). The nature of the work carried out is included in CNWL's statement at Appendix 1.

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In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit and administrative support to the HSAB etc.

The costs of these services are primarily borne by the People Services Department within Harrow Council, with contributions totalling circa £20,500 p.a. from three of the four local NHS partner agencies (Harrow Clinical Commissioning Group; North West London Hospitals Trust; and the Royal National Orthopaedic Hospital Trust) and also the London Fire Service. In 2016/2017 there will be an additional contribution from the Metropolitan Police of £5,000 p.a.

Costs related to the time spent by partner agencies on HSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual organisations.

SECTION 3 – MAKING A DIFFERENCE

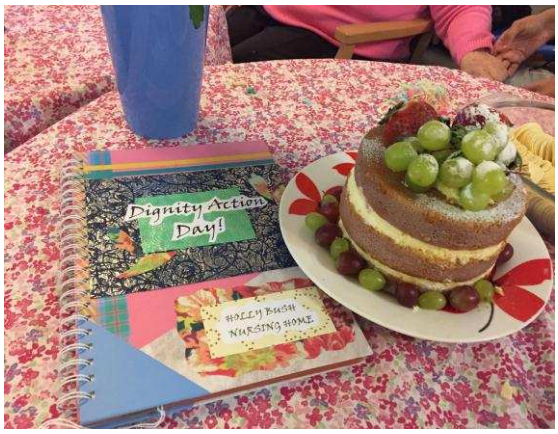
(PROGRESS ON OBJECTIVES 2015/2016)

This section of the report looks at what difference the work of the HSAB made last year by reviewing progress on the priorities agreed for 2015/2016, as set out in the annual report for 2014/2015.

Theme 1 - Prevention and Community Involvement

The HSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

The HSAB's prevention strategy 2014 – 2017 ("Promoting Dignity and Prevention of Abuse") was formally agreed at the Board meeting in March 2014. 2015/2016 was the second year of implementation which built on the work done from the previous year. Examples of work in this area include:



Care providers ran events to mark Dignity Awareness Day (1st February 2016). Some poignant quotes from older people who took part at Princess Alexandra Home included: "*dignity is about choice"; "dignity is being there for me, coming to me to have a conversation"; "dignity is simply being nice and pleasant to people - treating them the way you'd like to be treated*".
Other events included: pancakes at College Hill Care home; a resident singing West End favourite songs at Grove House; a "digni tea" at Primrose House; celebrations and reminiscence at Holly Bush Nursing Home.

To mark the 10th World Elder Abuse Awareness Day (June 2015) the HSAB organised a Best Practice Forum on self-neglect which was attended by 55 staff from a range of local organisations. Up to date research was presented by Michael Preston-Shoot (Professor of Social Work at University of Bedfordshire) which focused on how best to work with people who were reluctant to accept care or support.

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The Safeguarding Adults Services continues to promote distribution of "The Little Book of Big Scams" produced by the Metropolitan Police and the Home Office which is extremely popular with members of the general public.

Ensure effective communication by the HSAB with its target audiences

A formal Communications Plan for the HSAB was approved by the Board at the March 2015 business meeting. It aims to ensure that its target audiences across the whole community know about abuse and how to report it and that resources are used for publicity and awareness related events in the most time/cost efficient ways.

The HSAB's newsletter which commenced in 2013 continued throughout last year aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The editions published (July and October 2015 and January 2016) included topics such as: statistical information; Law Commission consultation on possible DoLS reforms; scams (e.g. door step crime); Dignity Action Day 2016; Home Office report on inspection of custody arrangements for vulnerable people; the new "pan London" procedures; Prevent; and training information.

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Articles were also written for "News and Views" which is produced for people with a learning disability with a particular focus on keeping safe including e-safety on-line.

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Contributions continued from the Safeguarding Adults Service to the Multi-agency Risk Assessment Conference (MARAC – domestic violence focus); Multi-agency Public Protection Arrangements (MAPPA – public safety focus); Prevent (prevention of terrorism focus), and Anti-social Behaviour Group (ASBAG – anti social behaviour focus) - ensuring effective information sharing and communication where vulnerable adults are victims or perpetrators.

There is evidence that the Harrow HSAB's work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding enquiry is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that all the users interviewed were very happy with the outcome of the enquiry and (an important change from her previous findings) had felt in control of the process. It is believed that new approaches introduced under the "Making Safeguarding Personal" project e.g. holding strategy meetings at user's own homes have been major factors in this improvement.

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Service users attended the HSAB Annual Review Day again last year (June 2015). They told the HSAB about what was important to them in keeping safe and provided challenge to Board members:

"people come to the front door and ask for our Bank information – this is scary"; "lots of people are worried about door step crime"; "my house was burgled when I was in hospital – I was scared to go back"; "carers should not tell other people what the key safe number at the front door is"; "we would like more leaflets about keeping safe"; "taxi drivers should be told not to speak on their mobile phone when they drive us anywhere"; "tell head teachers at the end of term not to let students be rude to us"; "we don't think that the Police know much about mental health problems"; "we would like to know which staff in mental health services know about what to do if we tell them about abuse"; "who are the CNWL champions for keeping safe?"

The HSAB Annual Report for 2014/15 was presented to the Local Account Group and discussed in detail. There was a request that more awareness raising was done in local mental health services which has been implemented by CNWL.

Outcomes for prevention work included:

More work has been done to set up a Harrow Safe Place scheme. Choices For All students and users at Creative Support are helping by visiting shops, churches and cafes near the Bus Station (as the first priority area) asking them to sign up.

At its meeting in September 2015, the HSAB formally approved a protocol for working with people who self-neglect based in large part on the research presented by Professor Preston-Shoot. The effectiveness of the new approach was reviewed at the HSAB meeting in March 2016 and was assessed as working well.

The referrals from "BME" communities increased last year to 51% which is very much in line with the local demographic makeup of the borough and suggests that the HSAB's messages are reaching a wider audience.

The very positive arrangements between the Safeguarding Adults Service and the local Fire Service continued last year with 83 referrals for free home fire safety checks.

As requested by users and the Local Account Group, more awareness raising and focus was given to safeguarding adults work by CNWL with a very significant improvement in numbers of concerns dealt with in that area.

The "champion" information was displayed at relevant units by CNWL.

Mental health concerns rose by 15% (107 more people) suggesting that (as requested by users and the Local Account Group) a greater number of staff in these services know what to do about allegations of abuse.

Theme 2 – Quality and Performance Review

The HSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the HSAB at all of its meetings in 2015/2016. See 2.2 above for detailed analysis.

A second "mystery shopping" exercise was commissioned by the HSAB which was carried out by users (supported by Mind in Harrow) in November 2015. The areas contacted were: 101 – Police non-emergency service; SPA (Single Point of Access for CNWL) and 3 GP practices. The findings were presented to the Board in December 2015 and feedback has been given to the agencies contacted in the exercise.

File Audit

Both internal and external (independent) audits of casework continued in the Council's Safeguarding Adults and DoLS Service during 2015/2016 with headline massages presented to the HSAB. A total of 96 cases were reviewed with the key focus being on areas highlighted from performance reports e.g. checking that repeat referrals were for different concerns. The audit findings were fed back to relevant front-line staff and managers as a way of informing continuous improvement.

In May 2015, in CNWL Mental Health Trust, an audit of procedures and recording of safeguarding adults enquiries was undertaken by an external auditor. One outcome was the creation of a specific role 'Lead Safeguarding Adults Manager' (Lead SAM) to undertake reform of policies and procedures for raising a concern, verifying if a further enquiry was required and organising a Safeguarding Adults Manager to conduct this.
A further very positive outcome was a marked improvement in the number of concerns raised/reported. In Quarter 1 of 2015/16 the average was 10 a month, in Quarter 4 it was 35 a month.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The HSAB has received statistical reports at each of its meetings, including the full year position for 2014/2015 at its Annual Review Day. In addition, the new Strategic Plan for 2014 – 2017 included trend analysis looking back over the previous 3 years and all reports included comparison with the national position wherever possible.

Outcomes:

Ongoing analysis by the HSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with areas identified for future work covered in the action plan at section 4

Changes were made to the multi-agency training programme and also to the specific sessions for front-line staff. For example, a bespoke course on "pressure sore prevention and management" was delivered by a local Tissue Viability Nurse.

Theme 3 –Training and Workforce Development

The HSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

Multi-agency training remains a high priority for the HSAB. The existing programme is competency based. This ensures that all staff know about the competencies required to meet their safeguarding adults' responsibilities within the workplace.

As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Some targeted briefing sessions took place: Pubwatch landlords (with a focus on the sexual exploitation of vulnerable adults and done in partnership with the HSCB); Enhanced Practice Nurses; the Wiseworks Centre for people with mental health difficulties; MIND in Harrow users and volunteers; St Luke's Hospice and care providers (primarily about DoLS).

Attendees by sector (multi-agency training programme)		**2015-16**
Harrow Council Internal		187
Health		49
Statutory (other)		1
Private		373
Voluntary		85
Sub-total:		**695**
SGA Team Briefing Sessions		
Age UK Harrow Volunteers		10
Deprivation of Liberty Safeguards (DoLS) Briefings		72
Housing Team		15
Members Briefings		12
Pubwatch		50
HSAB annual conference (focus on the Mental Capacity Act)		107
Pressure Area Care		29
Self-Neglect & Hoarding (learning from research)		55
Kenmore NRC		19
Marlborough Hill Day Centre / Wiseworks		9
Milmans Service User Briefings		20
MIND in Harrow Service Users & Volunteers		5
Carers Briefing		14
Enhanced Practice Nurses		19
GP Surgeries (Clinical & Non-Clinical Staff)		17
St Luke's Hospice		25
	Sub-total	**478**
Total Attending (all sessions)		**1173**

Funding was also received from the Department of Health which enabled the HSAB to hold its first conference. The focus was on use of the Mental Capacity Act, sessions were run by Edge Training and included input from Alex Ruck-Keene a leading barrister in the field. Evaluation was almost 100% positive from the 107 multi-agency staff that attended.

Outcomes

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions.

Last year there was a focus on ensuring that the requirements of the Care Act 2014 were addressed in both formal and briefing sessions. This included self-neglect and the other new areas of work e.g. modern slavery.

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DOLS arrangements (including for health funded services and facilities) are effective

The Deprivation of Liberty Safeguards (DoLS) statistics are at section 2.2 of this report.

The statutory timescales were met in all the cases assessed last year in Harrow which in comparison to many other Councils across the country where there are significant waiting lists is excellent. This may not be sustainable in 2016/17 given withdrawal of the Government grant, pressure on Council finances and a continuing growth in referral numbers.

Outcomes:

The HSAB can be reassured that for the 789 cases where a DoLS was authorised, some of the most vulnerable people they are responsible for have been protected. It is also positive that more cases were referred from hospitals suggesting that staff in those settings are becoming clearer about their responsibilities as managing authorities.

There are also good case examples of the involvement of a Best Interest Assessor or independent section 12 doctor highlighting ways in which restrictions on individual's can be reduced e.g. picking up where sedative medication has not been reviewed and could be reduced.

Theme 4 - Policies and Procedures/Governance

Ensure production of the HSAB Annual Report and presentation to all relevant accountable bodies

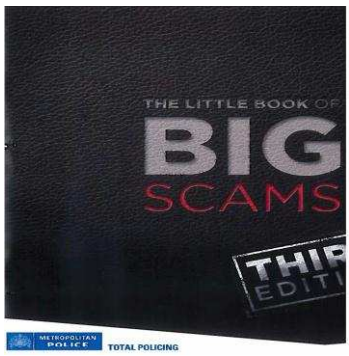
The HSAB Annual Report 2014/2015 was agreed formally by the Board at its annual review day in June 2015. This report for 2015/2016 will be discussed at the same event in June 2016. Following its formal agreement by the HSAB, the report was presented to the Health and Wellbeing Board (14th October 2015), the Council's Scrutiny Committee (26th October 2015) and subsequently to all partner agencies' Executive meetings or equivalent.

Outcomes:

As in previous years, following the decision to sign off the annual report by the HSAB last June a "key messages for staff" version of the report was produced for the third time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

The general public is aware of safeguarding issues and the work of the HSAB

The safeguarding adults' website was kept up to date and has a section for easy to read information.



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As stated above the Safeguarding Adults Service finds that the "little book of big scams" produced by the Metropolitan Police is popular with the general public and is therefore actively promoting it as widely as possible across Harrow.

The HSAB (jointly with the Safeguarding Children's Board) takes a "family first" approach to its work

Joint common meetings continued again last year e.g. bi-annually with the Multi-agency [children's] Safeguarding Hub (MASH) and London Ambulance Service.

Joint briefing sessions are run wherever possible e.g. with Pubwatch/pub landlords about sexual exploitation.

Outcomes:

Independent file audits continue to show growing confidence in this area of work by staff in Adult Services. These audit findings were fed back to and discussed with the Children's Safeguarding Board (HSCB) quality assurance sub-group meeting.

The HSAB has strategic oversight of local safeguarding adults work

Year two actions from the HSAB Strategic Plan 2014 – 2017 were implemented with an exception report at each Board meeting. This section of the annual report covers the work carried out and some of the outcomes achieved as a result.

Theme 5 – Partnership with the Local Safeguarding Children's Board (HSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Independent file audit last year again reviewed cases where domestic violence was a factor. The HSAB was reassured by the finding that referrals were being routinely made to MARAC and it is becoming much more common for a worker or manager from the Safeguarding Adults/DOLS Service to attend the meetings for specific cases.

Some audited cases also recognised work done with both the Looked After Children's and Children with Disability Teams.

Outcomes:

Better outcomes for young adults in specific cases where joint work was effective.

The HSAB (jointly with the HSCB) takes a "family first" approach to its work

See above. In addition, a practitioner representative from the Council's Safeguarding Adults/DoLS Service and relevant NHS staff provide information to MASH (Multi-agency Safeguarding Hub) where threshold decisions about referred children are discussed. This ensures appropriate information sharing and therefore decisions are taken in the most informed way possible.

Section 4: Action Plan (objectives 2016/2017)

NB. There are a range of actions for all partner agencies that will be taken forward in 2016/17 not reflected below as the HSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

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Theme 1 – Prevention and Community Engagement

Overall objective

All the agencies represented at the HSAB have agreed to take a "zero tolerance" approach to the abuse of adults at risk from harm. The vision for the Board adopted in 2011 states "Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business". As such the HSAB has agreed that prevention of abuse (in both domestic and institutional settings), publicity campaigns and information which reaches all sections of the community should be a high priority.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow Source: PR; WV; CA and ADASS	Implement the Prevention Strategy 2014 – 2017 Updates on progress presented at Board business meetings (user outcomes)	March/April 2017 Quarterly at Board Meetings
Ensure effective communication by the HSAB with its target audiences Source: ADASS and CA	Implement the HSAB Communications Policy as agreed at the March 2015 Board meeting (service delivery and effective practice)/(user outcomes)	End March 2017

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence Source: HPS and CA	Specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety) are taken forward over the 3 years of the HSAB Strategic Plan – and users report feeling safer in annual surveys and in focus group discussions (user outcomes); (leadership); (strategy)	End March 2017
There is evidence that the Harrow HSAB's work is influenced by user feedback and priorities Source: CA; MSP	Demonstrable changes in policy and practice are evident following annual evaluation of user feedback and presentation at the HSAB Review Day; Local Account Group and similar (user outcomes); (people's experiences of safeguarding)	End July 2017

Theme 2 – Training and Workforce Development

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the HSAB has signed up to a multi-agency workforce development/training strategy. In addition, the main messages drawn from the Bournemouth University/Learn To Care research (May 2010) "Towards a National Competence Framework for Safeguarding Adults" suggests that there needs to be better coordination, quality and breadth of multi-agency staff training.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act Source: BU; file audit; HPR and CA	Update the training programme implementing the results from the 2015/16 formal evaluation and recognising any learning from file audit and user interviews Run Best Practice Forums as appropriate to supplement the formal training programme in order to cover specific topics of interest (service delivery and effective practice)	End July 2016 End March 2017
DOLS arrangements (including for health funded services and facilities) are effective Source: HWB and WV	HSAB receives DoLS performance information at each Board Meeting (people's experiences of safeguarding)	Quarterly

Theme 3 – Quality and Performance Review

Overall objective

The HSAB has agreed to oversee robust performance management frameworks for monitoring the quality and effectiveness of safeguarding work across all sectors. The existing QA framework for the HSAB has user/carer challenge at its centre.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The HSAB oversees effective practice and ensures continuous improvement Source: HPR; NHS; ADASS and CA	Commission the 3rd "mystery shopping" exercise ensuring feedback is given to providers and learning is implemented Develop an action plan to address relevant recommendations from the inspection of vulnerable people in custody report (performance and resource management)	End March 2017 End October 2016
Statistical data improves understanding of local patterns enabling improved planning of responses to allegations Source: HPR; SAR; CA and AR	Ensure presentation of statistics at each HSAB Board Meeting and at the Annual Review/Business Planning Day, including comparisons with any available national data (performance and resource management)	Quarterly
The HSAB is confident that safeguarding adults work is person centred Source: HPR; MSP	HSAB receives reports on the findings of the user interviews conducted by the independent social worker at the end of the safeguarding adults process – ensuring that any learning is implemented (service delivery and effective practice)	End March 2017

Theme 4 – Policies, Procedures and Governance

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the HSAB has signed up to a multi agency partnership, oversight by each organisation's executive body to the work and the London Multi-agency Policy & Procedures that describe the framework for responding to concerns/enquiries.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Ensure production of the HSAB Annual Report Source: HPR and CA	HSAB receives the draft Annual Report within 3 months of the end of the financial year – with a focus on outcomes wherever possible (Local Safeguarding Adults Board)	End June 2016
Ensure that the HSAB Annual Report is presented to all relevant accountable bodies Source: PR; AR; CA	Presentation is made to Scrutiny Committee to include progress against the previous year's action plan and objectives for the coming year Feedback is obtained from Healthwatch in Harrow All partner agencies present the Annual Report to their Board (or equivalent) within 3 months of the agreement by the HSAB	First available Scrutiny meeting after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016) First available Board meeting (or equivalent) after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016)

	Presentation is made to Health and Wellbeing Board with particular reference to progress on agreed joint priorities and recommendations for the coming year (leadership); (Local Safeguarding Adults Board); (Strategy)	First available Health and Wellbeing Board meeting after the Annual Report is discussed and agreed at the HSAB (and no later than the end of October 2016)
The general public is aware of safeguarding issues and the work of the HSAB Source: ADASS and PR	Implement the HSAB Communications Policy as agreed by the Board at its March 2015 Board meeting The HSAB Annual Report is published in an easy to read format and posted on all partner websites (service delivery and effective practice)	End March 2017 End October 2016
The statutory HSAB is effective; Care Act compliant and has strategic oversight of local safeguarding adults work Source: ADASS; CA and HPR	The HSAB Strategic Plan is monitored at Board meetings and updated at the Annual Review/Business Planning Day (leadership)	Quarterly and end of June 2017
Ensure local arrangements are London multiagency Policy/Procedures compliant and cover the new safeguarding areas e.g. human trafficking Source: CA	The HSAB formally adopts the new London multiagency Policy/Procedures when available	As determined by relevant guidance when the new procedures are issued

Theme 5 – Partnership with the Harrow Safeguarding Children's Board (HSCB)

The HSAB and HSCB have agreed to work in collaboration to ensure sharing of information, learning and ideas such that effective and safe services are offered with a "family first" approach. This ensures that staff working in Children's Services recognise any vulnerable adults in the family and staff working with adults recognise any risks to children.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC. Source: PR and ADASS	Consider all possible areas for joint approaches e.g. in relation to safeguarding training, work with schools and sexual exploitation (working together)	End March 2017
The HSAB (jointly with the HSCB) takes a "think whole family" approach to its work Source: WV and NHS	Audit processes in both Adults and Children's Services across all HSAB partner agencies look at the whole family (working together)	End March 2017

Source Documents:

AR – Harrow Safeguarding Adults Board Annual Reports

HPR – Harrow formal Peer Review recommendations

PR – Peer Review (incorporating Association of Directors of Adult Social Services – National Framework for Good Practice Standards; Care Quality Commission (CQC) reports and the reviews of “No Secrets” and “Putting People First”)

NHS – National Health Service audit tool (local priorities)

BU - Bournemouth University/Learn To Care research “Towards A National Competence Framework For Safeguarding Adults” (May 2010) and Harrow (Safeguarding Adults Board) Training Strategy

FA - File Audit learning/recommendations

WV – Winterbourne View or Francis report findings and Government response

HWB – Health and Wellbeing Board priority

SAR – national statistics (Harrow data)

UES – Harrow (Safeguarding Adults Board) User Engagement Strategy

HPS - Harrow (Safeguarding Adults Board) Prevention Strategy 2014 - 2017

ADASS – Advice and guidance to Directors of Adult Social Services

CA – Care Act 2014

MSP – Making Safeguarding Personal

Appendix 1

Statements from key HSAB partners

The following statements have been provided by some of the key agencies represented on the HSAB. The reports cover adult safeguarding issues from each organisation's perspective and some identify key priorities for 2016/17.

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healthwatch Harrow

28th July 2016

Mr Seamus Doherty
Safeguarding Adults Co-ordinator
2nd Floor, East Wing
Harrow Council
Civic Centre
Station Road
Harrow HA1 2XF

Dear Seamus
Re: SAB Annual Report

Thank you for inviting Healthwatch Harrow to make a formal response to your annual report, which is as follows:
As the manager of the Healthwatch Harrow service, Harrow in Business and its staff, volunteers and networks, look forward to supporting the work of the Harrow Safeguarding Adults Board during 2016/17, especially by communicating key priorities and actions as outlined in the 2015/16 Annual Report, through our range of business and community engagement activities and social media channels to the local people, businesses and others. Wherever possible, we will look to support each other at key events and community engagement forums and via our regular e-bulletins and e-newsletters.
Yours sincerely
Ash Verma
Chair (HiB)

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Harrow Mencap

Harrow Mencap continues to support a zero tolerance approach to safeguarding and feels the best way to show its commitment is to actively promote the rights of people with learning disabilities and be working in partnership with other agencies and individuals to actively raise awareness.

Outcomes for prevention and community development

- through a contracted service we have provided advocacy support for 33 individuals who were subject to safeguarding alerts ensuring their voice was heard in the process of protecting them. And the safeguarding process was focussed on the outcomes they wished to achieve
- provided staying safe workshops for young people (aged 18-25) with learning disabilities. This has included keeping safe on line
- as part of our partnership with other NWL Mencaps we have delivered quality checks on services for older and disabled people and have worked with providers to improve services
- safeguarding is an integral part of all person centred support plans

Outcomes for Training and Workforce Development

- 3 members of staff have undertaken safeguarding and advocacy training
- all Care and Support staff undertake DOLS training
- all staff receive basic awareness training for Children & Adults as part of their induction and these are refreshed annually
- safeguarding is discussed at every team meeting
- safeguarding incidents are critically reviewed so staff can learn from the process

Outcomes for Quality and Performance Review

- safeguarding leads meet regularly to review incidents and the response to incidents so any barriers are identified and addressed

Outcomes for Governance

- safeguarding is on the agenda for every board meeting so the board is aware of issues and develop appropriate and responsive plans and policies
- we continue to ensure that that there is a designated trustee with responsibility for safeguarding

Priorities for 2016-17

- continue to ensure that all staff are aware of their responsibilities under the Care Act (2014)
- to hold a learning disability Forum to explore what being safe means to individuals and how to keep safe whilst having active lives
- to continue to campaign to ensure that the rights of people with learning disabilities are upheld

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Royal National Orthopaedic Hospital (RNOH)

Outcomes for Prevention and Community Engagement:

- An FGM leaflet has been developed for staff and visitors which raise awareness of FGM, the support available and our legal responsibilities.

Outcomes for Training and Workforce Development:

- Staff trained to level 2 currently at 85.86%. Staff trained to level 1 currently at 91.33%.
- The effect of this is an increased awareness amongst all levels of staff resulting in safeguarding concerns being raised by a variety of staff/departments such as administrators in the appointment booking department.
- The Trust Induction programme now contains MCA and DoLS training for all new starters.
- The mandatory training programme includes awareness of self-neglect and it's complexities in relation to patients who have mental capacity to make 'unwise' decisions. Modern slavery is now also covered in all mandatory training. Sexual exploitation is discussed in both the Adult and Children's Safeguarding training.
- RNOH has revised the Adult Safeguarding workforce. Adult Safeguarding now has a 0.8 WTE Named Nurse and a full time Learning Disability nurse.

Outcomes for Quality and Performance Review:

- Bi-monthly meetings of the Safeguarding Adult Committee are held with attendance from named professionals, operational leads from nursing, Allied Health Professional, social work and patient representative.

Outcomes for Policies and Procedures/Governance:

- HSAB Annual Report 2014/2015 was presented to the organisation's Trust Board

Outcomes for joint work with the HSCB - "think family":

- Domestic violence is now incorporated in all Adult Safeguarding training as well as Children's Safeguarding training.
- The Adult Safeguarding Named Nurse and Children's Safeguarding Named Nurse are working closely together to facilitate cross learning in light of the 'think family' initiative.

Priorities for 2016/17:

- Undertake regular audit of knowledge and skills and corresponding outcomes.
- Engage service users to provide feedback and lessons learnt.
- Complete FGM policy and leaflet.

- Review all Adult Safeguarding documentation: SG referral, MCA/BID in order to make them more user friendly and incorporate the 'making safeguarding personal' agenda.
- Complete Prevent policy.
- Implement training strategy for the soon to be finalised Intercollegiate Document for adult Safeguarding.
- Newsletter to include lessons learnt from staff and patient feedback in order to disseminate learning widely across the organisation.
- Implement Safeguarding Champions in all departments to engage and feedback to staff on a local level any new developments/recommendations and to ensure Safeguarding is at the forefront of each department's agenda.
- Implement staff supervision programme.
- Update the Trusts Adult Safeguarding webpage to make it more user friendly so as to encourage staff to utilise the resources available to them.
- Continue to raise the profile of all Adult Safeguarding issues and embed best practice across all aspects of the organisation.

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Age UK Harrow (AUKH)

Age UK Harrow is firmly committed to Safeguarding Adults and believes that all have the right to live free from abuse of any kind. Age or circumstances should not have any bearing or effect on this basic right

Outcomes for Prevention and Community Engagement

- WEAAD: 16th June 2015;

  AUKH led on this day and this year organised an all day drop in sessions in the office. This enabled people to come in and speak to the staff on a one to one basis as well as collect information. Staff and volunteers gave out information on the subject and how to report it. Although the numbers attending were not great, those who did come had no idea of elder abuse and AUKH staff were able to raise the awareness on the subject. This did not generate a huge number of people coming in but the message did get to those who had no awareness on the subject.

  On-going articles on safeguarding in the newsletter to remind members about scams.

- Outcomes have been that a number of clients have been signposted to Safeguarding and are aware of how the service operates. Some have been clients who have called on behalf of someone else etc.
- Made 2 direct safeguarding referrals.

Outcomes for Training and Workforce Development

- Staff continue to attend basic awareness course. Refresher training is also offered where appropriate.
- Volunteers are offered in house training delivered by Council staff or AUKH staff.
- Induction of new staff/volunteers/trustees – now includes presentation on safeguarding that was developed by the Council Safeguarding team.
- All support group meetings and staff meeting have Safeguarding as a standing agenda item where issues relating to this are discussed.

Due to all the above, the outcomes have been:-

- Staff and volunteers are more aware of safeguarding issues and the signs to look out for.
- Are more aware of how to report any safeguarding issues and staff knows how to deal with the issues if volunteers raise any alerts.
- Through the annual review of volunteers and clients to find out any safeguarding problems – outcome was to have Boundary training and this was accessed.

Outcomes for Quality and Performance Review

- Attained quality marks for our Advice and Advocacy service and both had safeguarding reviewed as part of the audit.
- AUKH has contributed to quality and performance review through our Chief Executive, Avani Modasia, attendance at HSAB meetings, HSAB away day in 2015.
- All staff now more aware of procedures internally on reporting safeguarding issues.

Outcomes for Policies and Procedures/Governance

The work done over the years on Safeguarding has resulted in the outcomes below:-

- Safeguarding is standing agenda item at AUKH Board meetings which includes feedback from the HSAB Board is given.
- The annual HSAB report was tabled at the board meeting.
- We have continued to implement pan London Procedures.
- Worked to ensure production of the HSAB Annual Report
- Reviewed the safeguarding policy to reflect the changes under the care act.
- Reviewed our internal the safeguarding reporting system for the organisation.

Our priorities for 2016/17 are:-

- As a result of incidents, work to introduce extensive volunteer safeguarding training with practical examples.
- Organise 11th annual World Elder Abuse Awareness Day event in partnership with the Council and other partners.
- Continue training staff and volunteers to spot risk/harm and take appropriate action,

- Raise awareness about safeguarding issues especially for vulnerable elderly and encourage more people to get help. Outcome same as above
- Continue working with Health watch in doing enter and view sessions and thus raise awareness about safeguarding.

Personal Pledges made at HSAB 2015 planning day

- Update all Safeguarding policies to include the Care Act
- Develop internal procedures on what referrals to be sent to Safeguarding Team. (Work on both the pledges has been started)

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Mind in Harrow

Mind in Harrow is firmly committed to Safeguarding Adults in partnership with Harrow Council, NHS, police and independent sector organisations with a particular focus on adults at risk owing to their mental health.

Outcomes for Prevention and Community Engagement:

- Contributed to safeguarding prevention by offering support and information through our Care Act Information & Advice Service (SWiSH), in conjunction with Harrow Council Safeguarding Team and CNWL NHS Foundation Trust, to people with mental health needs who have reported to us that they may be at risk of abuse or mistreatment.
- Increased community engagement and contributed to safeguarding prevention through the Chief Executive being a Trustee of Harrow Equalities Centre, which runs a Hate Crime project.
- Increased awareness of the need for improved coordination between the police and NHS mental health services for BMER community members who are arrested and detained and could be at risk owing to their mental health problems through our Somali Olole Isbedel project campaign.

Outcomes for Training and Workforce Development:

- Increased our staff awareness of safeguarding procedures through implementation of our policy that all our new employees are required to undertake the Harrow Council introduction to safeguarding training course.
- Increased our volunteer and mental health service user representatives' awareness of safeguarding procedures through training delivered by the Harrow Safeguarding Team/Freelance trainer three times a year.
- Increased our staff awareness of Prevent programme through attendance at Harrow Council training, resulting in one referral being made in May 2016.

Outcomes for Quality and Performance Review:

- Increased awareness of mental health safeguarding issues from a voluntary sector perspective through our Chief Executive's attendance at Harrow Multi-Agency Safeguarding Adults Board meetings 2015-16, the Harrow LSAB away day in 2015.
- Contributed to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a 'Mystery Shopping' exercise with 111 number, CNWL NHS Foundation Trust Single Point of Access (SPA) and a sample of GP practices in the autumn of 2015, which has resulted in learning reported to the Safeguarding Board.

Outcomes for Policies and Procedures/Governance:

- Improved Child Protection Policy through our annual review.
- Improved our Safeguarding Adults at Risk Policy by incorporating the new Pan-London Multi-Agency Procedures reviewed as a result of Care Act 2014 implementation.
- Improved our Board of Trustees awareness of current local safeguarding issues through our Chief Executive's presentation of the new Pan-London Multi-Agency Procedures and other safeguarding changes introduced as a result of the Care Act 2014 to a May 2016 meeting.
- Improved awareness of the need for a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, from local evidence and the Home Office inspection report for Brent and Harrow 'The welfare of vulnerable people in police custody' (March 2015).

Outcomes for joint work with the LSCB ("think family"):

- Increased our staff awareness of safeguarding procedures by our policy that all new senior staff and casework staff are required to undertake Harrow Council introduction to safeguarding children training session.
- Encouraged improved coordination between Harrow adult mental health safeguarding service lead and child protection services for situations raised with us where the alleged perpetrator is someone experiencing mental health problems.

Priorities for 2016/2017:

In addition to continuation of Mind in Harrow's actions and outcomes for 2015-16:

- Contribute to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a new 'Mystery Shopping' exercise 2016-17 and repeat the exercise for 2015-16 for improved responses.
- Contribute to a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, through the new working group to be convened from June 2016.

- Contribute to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a new 'Mystery Shopping' exercise 2016-17 and repeat the exercise for 2015-16 for improved responses.
- Contribute to a better coordinated multi-agency response to people experiencing mental health problems who are arrested and detained, including appropriate adult provision, through the new working group to be convened from June 2016

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HARROW Clinical Commissioning Group (CCG)

Outcomes for Prevention and Community Engagement

Harrow CCG is committed to engaging with the community about health services for patients. We make decisions based on the feedback we get to ensure that the services we commission and redesign are services that residents need and can access.

We hold regular events so that patients can have their say in the design and development of local services.

In 2015/16 we consulted with patients, carers, stakeholders and the wider general public on a number of issues including:

- The Harrow spinal multi-disciplinary team (MDT) triage service
- NHS 111
- Procurement of the IAPT (Improving Access to Psychological Therapies Programme) service
- Review and redesign for paediatric pathways
- Wheelchair services

We also consulted on our commissioning intentions 2016/17 by holding a large public event. 181 people attended and were given an overview of our vision and our priorities for the year ahead.

For commissioning intentions 2016/17 the CCG also facilitated discussions with:

- GPs
- Mind in Harrow
- Age UK Harrow
- Harrow Patients' Participation Network (HPPN)
- Patient participation groups (PPGs)
- Local Medical Committee
- Healthwatch Harrow
- Existing and prospective providers

This year Harrow CCG developed an agreement with the Harrow Patients' Participation Network (HPPN) which brings together patient participation groups (PPGs) from surgeries across the borough.

This agreement will ensure a successful working partnership that helps improve services. The CCG also worked closely with partner organisations (Harrow Council and Healthwatch Harrow) to ensure engagement relating to health in the borough is more joined up.

The CCG continues to use its patient newsletter (Patients First), its website and social media to connect and share healthcare messages with local people.

We have an Equality and Engagement Committee which includes representatives from Healthwatch and the voluntary sector, and is chaired by our Governing Body lay member for public and patient engagement. It meets bi-monthly and oversees the engagement work carried out by the CCG to ensure it is open and inclusive.

NHSE Deep Dive

CCG Harrow participated in the NHS England deep dive review of Safeguarding Adults as part of the assurance process for CCGs in 2015/2016

Overall, Harrow CCG was assured as good.

An action plan has been drawn up following the Designated Safeguarding Professionals meeting held on the 4th April, 2016 to address areas where there was limited assurance.

NHS England commended CCG Harrow for good quality framework for undertaking provider assurance clinical visits

Outcomes for Training and Workforce Development

Currently 97% of the Harrow CCG staff have received Safeguarding Adults training.

The new categories of abuse have been embedded into the training materials.

Prevent training is also on-going. Harrow CCG and its providers are currently above the trajectory set by NHS ENGLAND

Outcomes of Quality and Performance Review:

Harrow CCG has works closely with other CCGs to commission high quality health services and monitor the effectiveness of the providers in delivering safe care.

Harrow CCG take the lead for undertaking this for the CNWL mental health services across NWL and are associate commissioners for the London North West Hospital Trust (LNWHT) contract and Imperial College HealthCare NHS Trust.

During 2015/16 the Brent, Harrow and Hillingdon CCGs Federation Quality and Safety Team underwent significant changes since July 2015. Jan Norman joined the organisation as the Director for Quality and Safety, Sandra Corry, the Deputy Director for Quality and Safety and Nicky Brown John, the Assistant Director for Quality and Safety. Safeguarding Adults within the CCG has since been delegated to the Quality and Safety Team.

For 2016/17 quality indicators for safeguarding adults are firmly included within the core requirements for North West London and an outcomes framework is being developed in collaboration with providers who will be required to submit quarterly reports to the CCGs.

Outcomes of Policies and procedures/Governance

Updates from the Safeguarding Adults Board Meeting and from national guidelines and legislation have been shared with staff of the CCG during team meetings.

Outcomes for Joint work with Children Safeguarding:

The Designated Nurse Safeguarding Children and the Lead Nurse Safeguarding Adults have attended various work streams be work streams within the CCG. The aim is to give updates on Safeguarding and to ensure the work streams have embedded Safeguarding correctly in their processes

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Central & North West London (CNWL) NHS Foundation Trust

Outcomes for Quality and Performance Review:

- The Board had previously formed a view there was a possible under-reporting of Concerns within Trust's services.
- In May an Audit of Procedures and Recording of Safeguarding Adults Enquiries was undertaken by an External Auditor.
- One outcome was the creation of a specific role 'Lead Safeguarding Adults Manager' (Lead SAM) to undertake reform of policies and procedures for raising a Concern, verifying if Further Enquiry was required and organizing a Safeguarding Adults Manager to conduct this.
- A further Outcome was a marked improvement in the number of Concerns raised/reported. In Quarter 1 of 2015/16 the average was 10 a month, in Quarter 4 it was 35 a month.
- The HSAB Annual Report 2014/2015 was presented to CNWL's Executive Board in September 2015.
- In December 2015 the new Single Point of Access for CNWL was a participant in a Mystery Shopper exercise. Following feedback further training was undertaken with the staff of the SPA by the Lead SAM about how to responded to a Concern raised by third parties.

Outcomes for Policies and Procedures/Governance:

- In September 2015 the following email account is launched for all to make enquiries to: cnw-tr.mentalhealthsafeguardingharrow@nhs.net
- In November 2015 the Trust launched the Single Point of Access (SPA) to receive referral for people professionals hold concerns that their wellbeing is suffering due to mental health difficulties (cnw-tr.SPA@nhs.net)

- In March 2016, the Trust's Care Quality Meeting for its Harrow Service, ratified a new Operational Policy in regard to the Allocation of Safeguarding Adults Manager to conduct Enquiries
- Also in March 2016 the reconfiguration of community services for mental health was completed. The 4 teams are now all based in a single site: Bentley House

Outcomes for Training and Workforce Development:

- Training entitled "Safeguarding Adults: Developments due to the Implementation of the Care Act 2014" was provided by the Lead SAM. Staff from the following services areas attended: the Single Point of Access, Liaison Psychiatry, Home Treatment Team, Ellington, Eastlake & Ferneley Wards; and those formerly of the Community Recovery Team, Assertive Outreach Team, Personal Budget Team and Community Rehabilitation Team.
- This covered the new categories of abuse, FGM, as well as good practice in regard to when and how to raise a Concern.
- Training on when and how to raise a Concern was also provided to staff of partner agencies RETHINK Bridge Centre & Look Ahead Support.

Priorities for 2016/17:

- To engage Patients and Carers
- To engage Staff

Personal pledges made at the Annual Review/business planning day 2015:

- Photographs of each Champion for Learning Disabilities is now displayed on the Wards at Northwick Park Hospital Mental Health Centre. This has achieved a personal pledge of the Trust.

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Harrow Police

Outcomes for Prevention and Engagement

Harrow Police incorporate measures to ensure the continuation of quality outcomes and support for vulnerable members of the community, in particular:

- increasing staffing levels in MASH and incorporating updated MPS operational models around Protecting Vulnerable Persons
- ensuring early identification of vulnerable victims and increasing referrals to services through MASH where appropriate.
- early engagement from Neighbourhood Policing Teams to provide re-assurance and crime prevention advice.
- enforcing a positive action response against those committing crime against vulnerable victims

- daily review of crimes with a focus upon Domestic Abuse, Hate Crime and crime involving vulnerable victims
- joint community engagement work with Partners, including Secure streets, Action Days and ward-based Street Briefings

Outcomes for training and Workforce Development

All front-line officers receive corporate in-house training around Mental Health, Safeguarding issues and dealing with Vulnerable persons. This includes referral thresholds and Merlin minimum standards and supporting partner training to ensure wider awareness of roles, responsibilities and available services. This is an integral part of induction training for new officers and is also delivered to the existing workforce. Additional bespoke training is provided to staff in specialist roles on an on-going basis.

Outcomes for Quality and Performance Review

The internal MPS Quality Assurance framework drives minimum standards for cases involving vulnerable victims, including elderly persons and situations involving Mental Health issues. Domestic Abuse now includes cases of coercive control and Honour Based Violence and there is an increasing focus on a wider variety of investigative outcomes, including Criminal Behaviour Orders, Victimless Prosecutions and Domestic Violence Protection Notices/Orders.

Outcomes for Policies and Procedure/Governance

Harrow Police are fully engaged with the strategic partnerships for Safeguarding adults and children and is represented on the appropriate boards and executive groups. Harrow Police are fully engaged with internal and external auditing of case management and referrals. MPS structures, including around Protecting Vulnerable Persons, are currently being reviewed at an organisational level and this may include an uplift in officers deployed in this portfolio and a redesign of central delivery around the policing response to Safeguarding Adults. All changes will be communicated to strategic partners in sufficient time to ensure continuity of service delivery. Any actions arising from the LSAB annual report have been dealt with and completed.

……..

Harrow Council – Adult Services

Harrow Council's Safeguarding Adults and DoLS Service takes the lead coordinating role for safeguarding vulnerable adults at risk from harm. This role is both in relation to multi-agency strategic development of the work as well as enquiries into individual cases of abuse and instances of institutional abuse. The Service also supports the HSAB arrangements; organises a range of public awareness campaigns; oversees the multi-agency training programme and runs briefing sessions. In 2015/2016 as with the previous year, the Safeguarding Adults and DoLS Service had a work programme which supported the overall objectives and priorities in the HSAB Business Plan and progress is monitored at a regular meetings. The work of the Service and any outcomes, including the numbers of referrals handled are covered in the body of this report.

.....

Safeguarding Adults Concern & Enquiry Data - 1st April 2015 - 31st March 2016

Summary Statistics

No. of Concerns: -	**1690**	**%**
Taken forward as Enquiries: -	680	40%
Dealt with at Concern Stage: -	1010	60%
No. of Repeat Enquiries: -	132	19%
No. of Completed Enquiries: -	677	100%
Concerns Female	1041	62%
Concerns Male	642	38%
Not Stated / Recorded	7	0%
	1690	**100%**
Enquiries Female	430	63%
Enquiries Male	249	37%
Not Stated / Recorded	1	0%
	680	**100%**

Concerns

From different Ethnic Backgrounds (non white UK): -	**863**	**51%**
Female	523	61%
Male	335	39%
(ethnicity) Not Stated / Recorded	49	6%
	863	**99%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	827	863
White UK	49%	51%

Enquiries

From different Ethnic Backgrounds (non white UK): -	**323**	**48%**
Female	197	61%
Male	126	39%
(ethnicity) Not Stated / Recorded	23	7%
	323	**100%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	357	323
White UK	53%	48%

Where Abuse / Harm took Place: -

Own Home	423	61%
Care Home - Permanent	57	8%
Care Home with Nursing - Permanent	52	8%
Care Home - Temporary	11	2%
Care Home with Nursing - Temporary	11	2%
Alleged Perpetrators Home	15	2%
Mental Health Inpatient Setting	25	4%
Acute Hospital	10	1%
Community Hospital	3	0%
Other Health Setting	2	0%
Supported Accommodation	26	4%
Day Centre/Service	6	1%
Public Place	27	4%
Education/Training/Workplace Establishment	4	1%
Other	11	2%
Not Known / Not Recorded	7	1%
	690	**100%**

Many cases involve multiple locations of abuse and this is highlighted in these figures

Service User Group: -

Older People	314	46%
Learning Disability	88	13%
Physical Disability Support	269	40%
Mental Health	210	31%
Support with Memory and Cognotion	35	5%
Sensory Support	18	3%
Substance Misuse		0%
Other Adult at Risk / Social Support	50	7%
Not Stated / Recorded	10	1%
Total No. of Service Users	**680**	**146%**
No. of Multiple Service User Groups	**314**	**46%**

Some Service Users have multiple conditions e.g. older person with a physical disability and mental health issue and this is highlighted in these figures

Type of Abuse / Harm: -

Physical	201	23%
Sexual	65	7%
Emotional/Psychological	179	20%
Financial	154	17%
Neglect	190	21%
Self-Neglect	11	1%
Discriminatory	6	1%
Organisational / Institutional	24	3%
Domestice Abuse	55	6%
Modern Slavery		0%
Not Stated / Recorded		0%
Multiple Abuses	217	25%
	885	**125%**

Many cases involve multiple abuses and this is highlighted in these figures

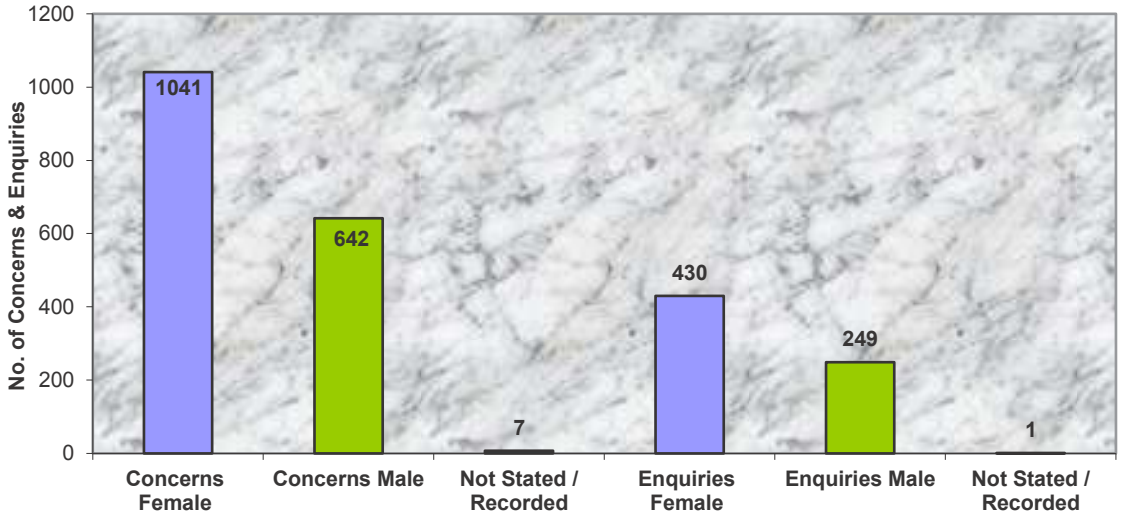
Person Alleged to have caused Abuse / Harm:-			
	Health Care Worker	39	6%
	Neighbour or Friend	33	5%
	Main Family Carer / Other Family Member	173	25%
	Other Professional	26	4%
	Other Vulnerable Adult	25	4%
	Partner	71	10%
	Social Care Staff	151	22%
	Stranger	55	8%
	Volunteer or Befriender	3	0%
	Other	104	15%
	Not Known/Stated/Recorded	0	0%
		680	**100%**

	Source of Referral		
Social Care Staff	Domiciliary Staff	23	3%
	Residential Care Staff	68	10%
	Day Care Staff	17	3%
	Social Worker/Care Manager	106	16%
	Self -Directed Care Staff	6	1%
	Other Social Care Worker	37	5%
Health Staff	Primary/Community Health Staff	70	10%
	Secondary Health Staff	59	9%
	Mental Health Staff	112	16%
	Other Health Care Worker		0%
Other Sources of Referral	Self-Referral	10	1%
	Family member	54	8%
	Friend/neighbour	12	2%
	Other Service User	3	0%
	Care Quality Commission	1	0%
	Education/Training/Workplace Establishment	5	1%
	Housing	21	3%
	Police	44	6%
	Other (anon, probation, contracts, MAPPA, MARAC, etc	32	5%
	Not Recorded	0	0%
		680	**100%**

Outcomes for Adult at Risk (completed cases) :-				
	Increased Monitoring	116	13%	**Many cases allow for multiple outcomes and this is highlighted in these figures**
	Removed from property or service	27	3%	
	Community Care Assessment & Services	122	13%	
	Civil Action		0%	
	Apllication to Court of Protection	9	1%	
	Application to change appointee-ship	2	0%	
	Referral to advocacy scheme	18	2%	
	Referral to Counselling/Training	22	2%	
	Moved to increase/Different Care	48	5%	
	Management of access to finances	13	1%	
	Guardianship/Use of Mental Health Act	8	1%	
	Review of Self Directed Support (IB)	15	2%	
	Management of access to Perpetrator	45	5%	
	Referral to MARAC	15	2%	
	Other	382	42%	
	No Further Action	11	1%	
	Not Recorded	66	7%	
		919	**100%**	

Outcomes for Person Alleged to have caused the Abuse / Harm (completed cases) :-				
	Criminal Prosecution/Formal Caution	10	1%	**Many cases allow for multiple outcomes and this is highlighted in these figures**
	Police Action	95	11%	
	Community Care Assessment	46	6%	
	Removal from Property or Service	30	4%	
	Management of Access to Adult at Risk	46	6%	
	Referred to ISA / DBS	1	0%	
	Referral to Registration Body	12	1%	
	Disciplinary Action	27	3%	
	Action By Care Quality Commission	16	2%	
	Continued Monitoring	56	7%	
	Counselling/Training/Treatment	36	4%	
	Referral to Court Mandated Treatment	1	0%	
	Referral to MAPPA	2	0%	
	Action under Mental Health Act	8	1%	
	Action by Contract Compliance	27	3%	
	Exoneration	84	10%	
	No Further Action	37	4%	
	Not Known	232	28%	
	Not Recorded	66	8%	
		832	**100%**	

Safeguarding Adults Concern & Enquiry Data - 1st April 2015 - 31st March 2016
Male / Female Ratio

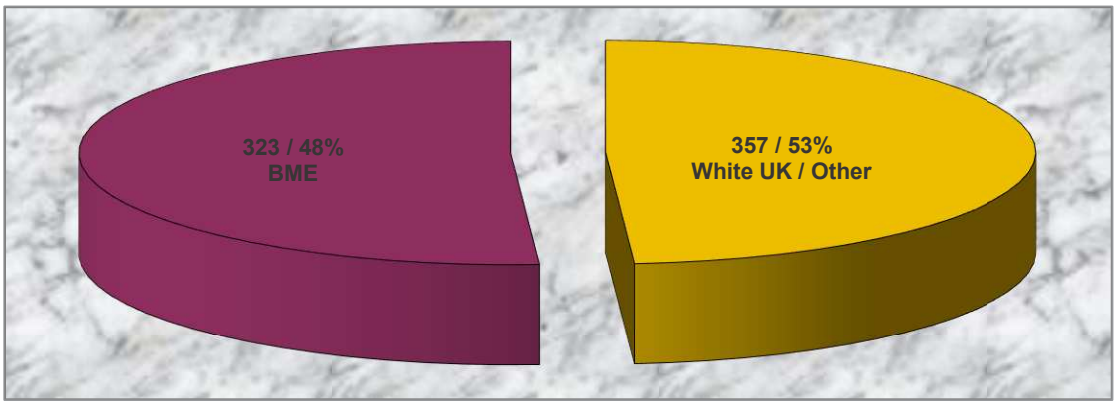


Total No. of Concerns - 1690
Proceeding to Enquiry - 680

Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Male / Female Ratio
(from different ethnic backgrounds)

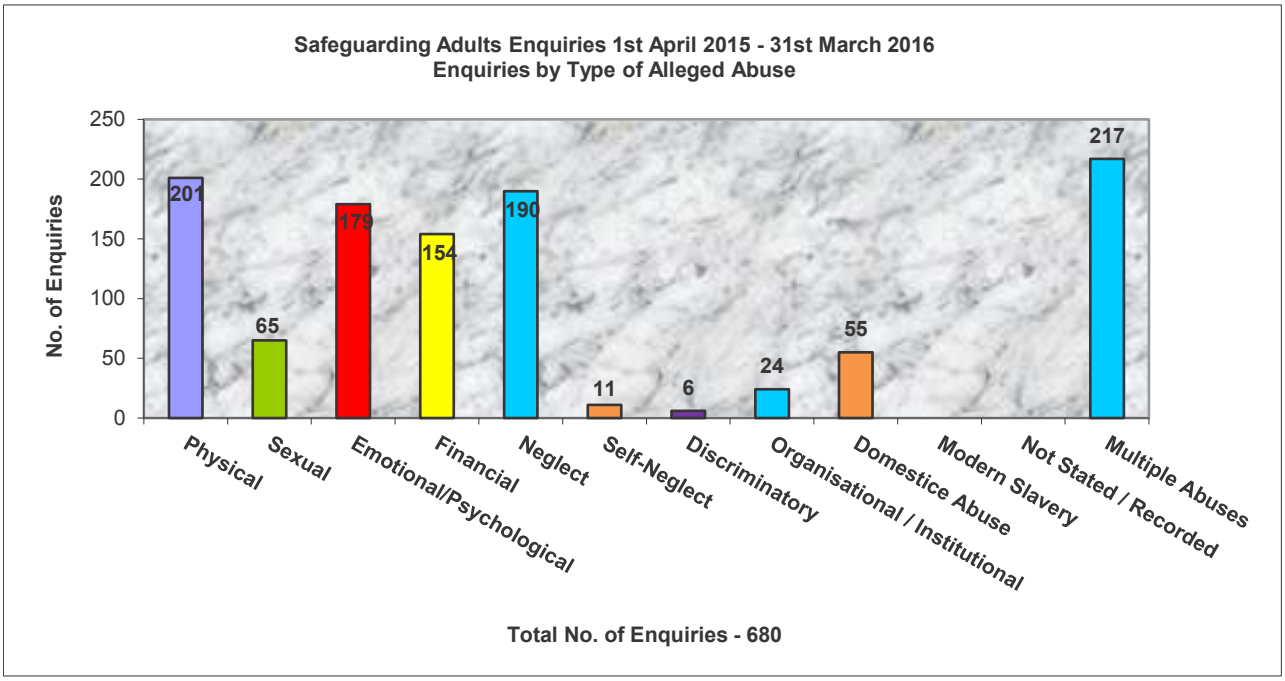
Total No. of Enquiries - 680 (23 did not state / record ethnicity but did record gender)
% of overall Enquiries - 48%

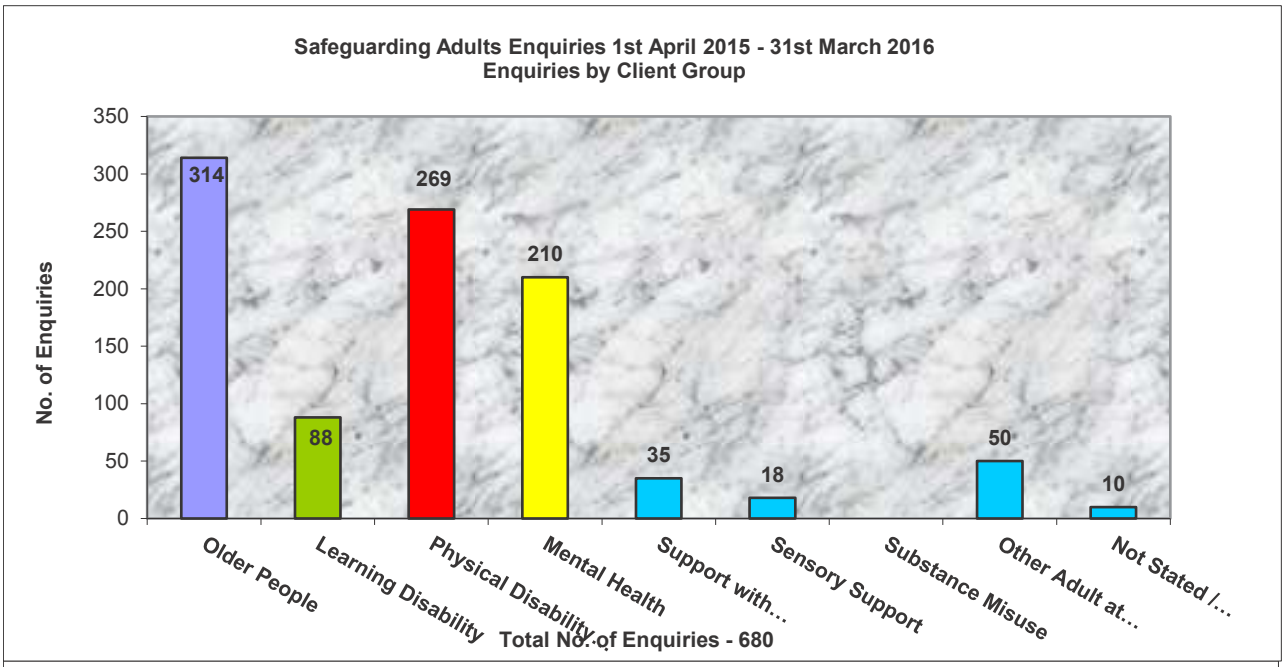
Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
W/UK / BME Ratio

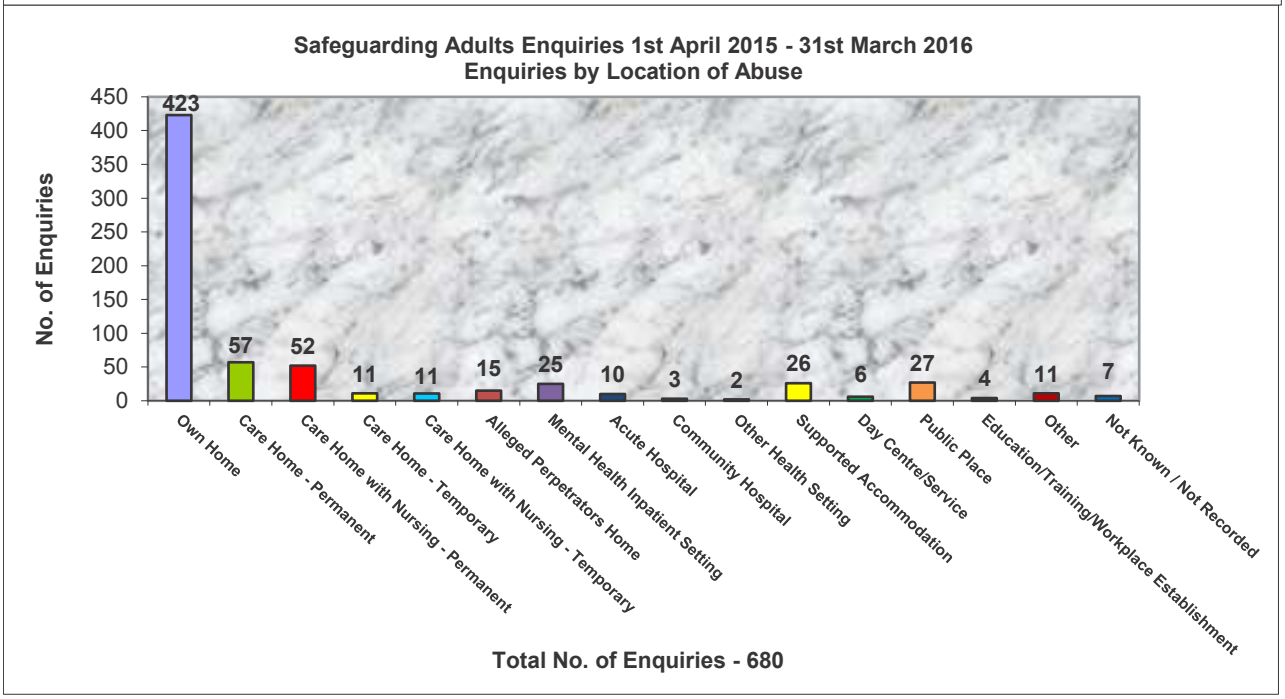


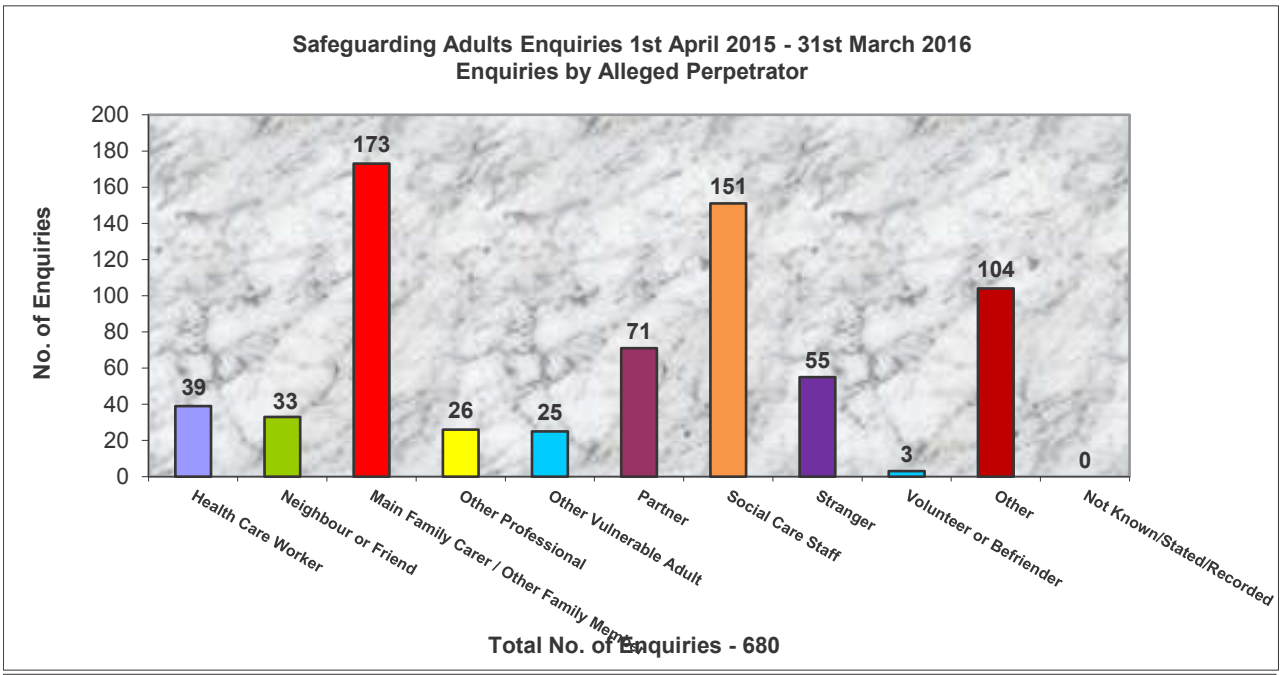
% Adult BAME Community in Harrow
(from 2011 Census) - 42%

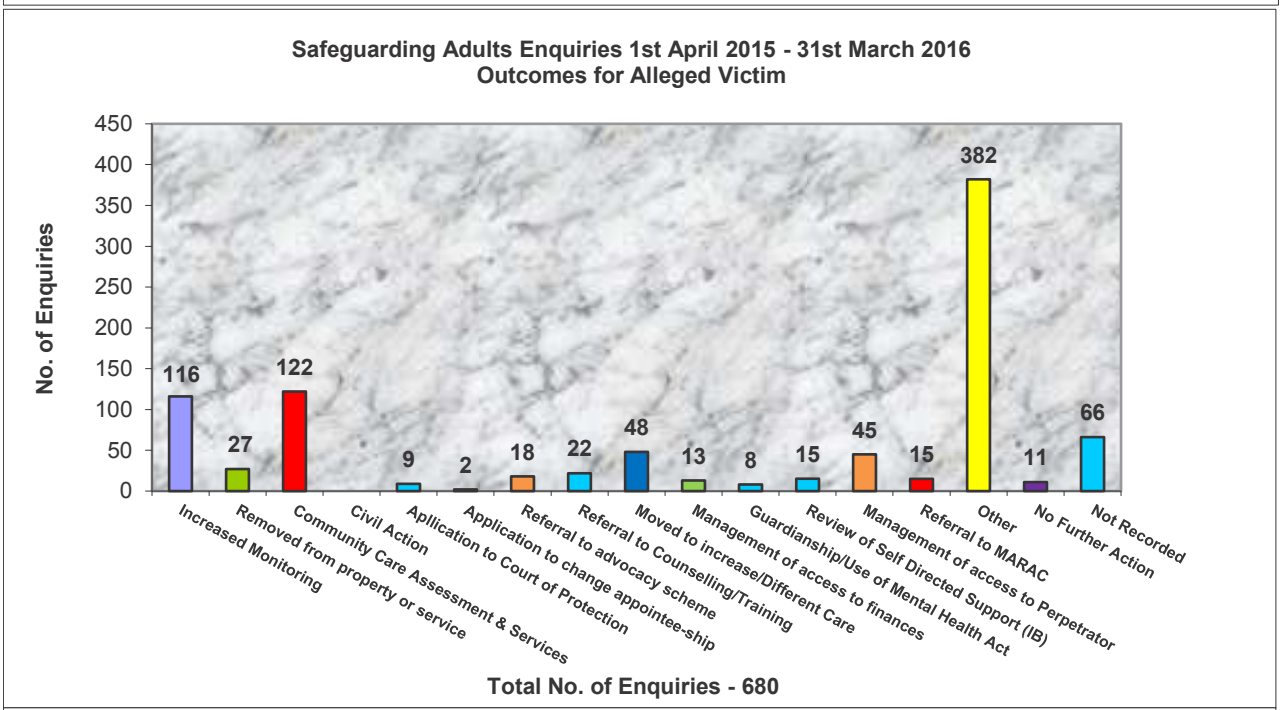
% BME Safeguarding Concerns - 51%
% BME Safeguarding Enquiries - 48%

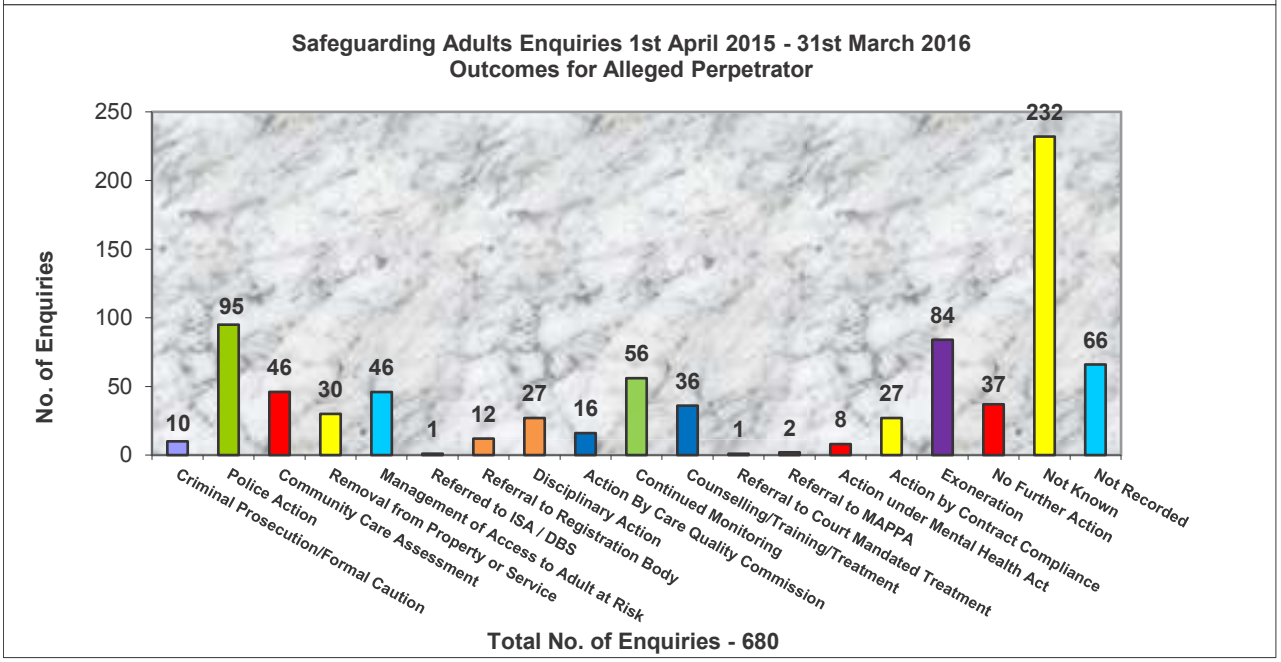

Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Type of Alleged Abuse
No. of Enquiries
250
200
150
100
50
0
201
65
179
154
190
11
6
24
55
217
Physical
Sexual
Emotional/Psychological
Financial
Neglect
Self-Neglect
Discriminatory
Organisational / Institutional
Domestic Abuse
Modern Slavery
Not Stated / Recorded
Multiple Abuses
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Client Group
No. of Enquiries
350
300
250
200
150
100
50
0
314
88
269
210
35
18
50
10
Older People
Learning Disability
Physical Disability
Mental Health
Support with...
Sensory Support
Substance Misuse
Other Adult at...
Not Stated /...
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Location of Abuse
No. of Enquiries
450
400
350
300
250
200
150
100
50
0
423
57
52
11
11
15
25
10
3
2
26
6
27
4
11
7
Own Home
Care Home - Permanent
Care Home with Nursing - Permanent
Care Home - Temporary
Care Home with Nursing - Temporary
Alleged Perpetrators Home
Mental Health Inpatient Setting
Acute Hospital
Community Hospital
Other Health Setting
Supported Accommodation
Day Centre/Service
Public Place
Education/Training/Workplace Establishment
Other
Not Known / Not Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Enquiries by Alleged Perpetrator
No. of Enquiries
200
180
160
140
120
100
80
60
40
20
0
39
33
173
26
25
71
151
55
3
104
0
Health Care Worker
Neighbour or Friend
Main Family Carer / Other Family Member
Other Professional
Other Vulnerable Adult
Partner
Social Care Staff
Stranger
Volunteer or Befriender
Other
Not Known/Stated/Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Outcomes for Alleged Victim
No. of Enquiries
450
400
350
300
250
200
150
100
50
0
116
27
122
9
2
18
22
48
13
8
15
45
15
382
11
66
Increased Monitoring
Removed from property or service
Community Care Assessment & Services
Civil Action
Aplication to Court of Protection
Application to change appointee-ship
Referral to advocacy scheme
Moved to Counselling/Training
Management of access to finances
Guardianship/Use of Mental Health Act
Review of Self Directed Support (IB)
Management of access to Perpetrator
Referral to MARAC
Other
No Further Action
Not Recorded
Total No. of Enquiries - 680


Safeguarding Adults Enquiries 1st April 2015 - 31st March 2016
Outcomes for Alleged Perpetrator
No. of Enquiries
250
200
150
100
50
0
10
95
46
30
46
1
12
27
16
56
36
1
2
8
27
84
37
232
66
Criminal Prosecution/Formal Caution
Police Action
Community Care Assessment
Removal from Property or Service
Management of Access to Adult at Risk
Referred to ISA / DBS
Referral to Registration Body
Disciplinary Action
Action By Care Quality Commission
Continued Monitoring
Counselling/Training/Treatment
Referral to Court Mandated Treatment
Referral to MAPPA
Action under Mental Health Act
Action by Contract Compliance
Exoneration
No Further Action
Not Known
Not Recorded
Total No. of Enquiries - 680

Appendix 3

HSAB Membership (as at 31st March 2016)

HSAB Member	Organisation
Christine-Asare-Bosompem	Harrow Clinical Commissioning Group (CCG)
Karen Connell	Harrow Council Housing Department
Sarah Crouch	Public Health, Harrow Council
Jonathan Davies	London North West Healthcare NHS Trust (hospital services)
Julie-Anne Dowie	Royal National Orthopaedic Hospital (RNOH)
Andrew Faulkner	Brent and Harrow Trading Standards
Bernie Flaherty (Chair)	Adult Social Services, Harrow Council
Mark Gillham	Mind in Harrow
Garry Griffiths	Harrow Clinical Commissioning Group (CCG)
Sherin Hart	Private sector care home provider representative
Vicki Hurst	London Ambulance Service
Patrick Laffey	London North West Healthcare NHS Trust (Provider Organisation)
Jules Lloyd	London Fire Service
Nigel Long	Harrow Association of Disability
Coral McGookin	Harrow Local Safeguarding Children's Board (HSCB)
Avani Modasia	Age UK Harrow
Cllr Chris Mote	Elected Councillor, Harrow Council
Mike Paterson	Metropolitan Police – Harrow
Tanya Paxton	CNWL Mental Health NHS Foundation Trust
Deven Pillay	Harrow Mencap
Visva Sathasivam	Adult Social Care, Harrow Council

Chris Spencer	People Services, Harrow Council
Karen Tiquet	Westminster Drug Project
Cllr Anne Whitehead	Elected Councillor (Portfolio Holder), Harrow Council
In attendance	
Arvind Sharma	Healthwatch Harrow
Officers supporting the work of the HSAB	
Sue Spurlock	Manager Safeguarding Adults and DoLS Services – Harrow Council
Seamus Doherty	Safeguarding Adults Co-ordinator - Harrow Council

Appendix 4

Harrow Safeguarding Adults Board Attendance Record 2015/2016

Organisation	26/6/2015	16/9/2015	9/12/2015	16/3/2016	Total meetings attended
Brent and Harrow Trading Standards	x	x	x	✓	1
Harrow Council - Housing Department	✓	✓	✓	✓	4
London Ambulance Service	x	x	✓	✓	2
London Fire Service	x	x	x	x	0
Westminster Drug Project	x	x	✓	x	1
Harrow Council - Adult Social Services	✓	✓	✓	✓	4
Harrow Council - elected portfolio holder	✓	✓	✓	✓	4
Harrow Council - shadow portfolio holder	x	✓	✓	✓	3
Mind in Harrow	✓	✓	✓	✓	4
NHS Harrow (Harrow CCG)	✓	✓	✓	✓	4
Ealing Hospitals Trust (Harrow Provider Organisation)	✓	✓	✓	✓	4
North West London Hospitals Trust	✓	x	x	✓	2

Harrow CCG – clinician	x	x	x	x	0
Local Safeguarding Children Board (HSCB)	✓	✓	✓	x	3
Royal National Orthopaedic Hospital	✓	x	✓	✓	3
Metropolitan Police – Harrow	✓	x	x	✓	2
Age UK Harrow	✓	✓	x	✓	3
Harrow Mencap	✓	✓	✓	✓	4
CNWL	✓	✓	✓	✓	4
Harrow Association of Disabled People	✓	✓	x	x	2
Private sector provider representative (elected June 2013)	x	✓	x	x	1
Public Health	x	✓	x	x	1
Department of Work and Pensions	x	x	x	x	0
In attendance					
Care Quality Commission (CQC)	x	x	x	x	0
Healthwatch Harrow	x	x	x	x	0
Safeguarding Adults & DoLS Service – to support the Board	✓	✓	✓	✓	4

Further information/contact details

For further information about this report or any aspect of safeguarding vulnerable adults at risk of harm in Harrow, the website is:

www.harrow.gov.uk/safeguardingadults

If you would like information or advice (including how to access the multi-agency training programme) the Safeguarding Adults Service can be contacted on the telephone number below or via e-mail at:

safeguarding.adults@harrow.gov.uk

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for an older person or an adult with a disability, this can be done through Access Harrow on: 020 8901 2680
(ahadultsservices@harrow.gov.uk)

If you are concerned about an adult with care/support needs that might be at risk of harm and want to make a referral for a younger person with mental health difficulties, this can be done through 0800 023 4650 (CNWL single point of access).

(cnw-tr.mentalhealthsafeguardingharrow@nhs.net)

Any enquiries about the Deprivation of Liberty Safeguards (DoLS) including requests for authorisations can be e-mailed to: DOLS@harrow.gov.uk

DoLS requests can also be sent to the safe haven fax: 020 8416 8269.

The address for written correspondence (to either Access Harrow or the Safeguarding Adults and DoLS Service) is:

Civic Centre
PO Box 7,
Station Road,
Harrow, Middx. HA1 2UH

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	8 September 2016
Subject:	**INFORMATION REPORT – Harrow Health Help Now Patient App/Website**
Responsible Officer:	Javina Sehgal – Chief Operating Officer for Harrow Clinical Commissioning Group
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary

This report sets out to inform the Board on the CCG's development of a self-care and signposting smartphone App and accompanying website which will promote the management of health conditions and signpost services which improve wellbeing.

FOR INFORMATION

Section 2 – Report

One of the priorities of the 'Harrow Health and Wellbeing Strategy' is to reduce unwarranted variation in the management of long term conditions such as diabetes, cardio vascular disease and respiratory disease. It was identified that the development of a mobile application which focused on empowering patients to learn more about health conditions and effectively manage them would be beneficial for Harrow residents.

In March 2016 the CCG sought quotes from app developers and chose the South East London Commissioning Support Unit (SECSU) as the preferred choice. They provide an 'off the shelf' App solution that has been implemented in 22 other CCGs. NHS England have confirmed that it was a major contributing factor in reducing A&E attendances.

The app and website will cost £31K and will include updates for 1 year. There is an additional £4K cost identified in order to implement the feeds into the app. Work is being done to negotiate this cost.

The scope of this project is to develop a mobile healthcare application and website, to aid the above objective, whilst providing an innovative and effective interface for users. The intention is to design and develop an application in 5 months and align a communications / marketing strategy to provide residents with key information and promote the uptake and utilisation of this application. The core functionality will include:

- Symptom checker
- Directory of local NHS services (including hours of service, distance from device and maps) linked in with 111 Directory of Service(we need the full form of acronyms
- Directory of associated council services to signpost Harrow residents to other services that prove useful. (Social Care depts.)
- Book GP appointments & repeat prescriptions
- Journey planner –Urgent Care Centre / Walk in Centre's and General Practices- same here
- Provide user feedback
- Signpost voluntary organisations
- Provide a Health Wallet (to save useful contacts, appointment dates, notes)
- A 'live' feed which would give patients an idea of the waiting times at the Walk in Centres/Urgent Care Centres and here within Harrow

Potential Development areas once implemented

- Share data with a patient's GP (if an individual is in agreement)
- Book Harrow GP appointments & repeat prescriptions
- Provide a Health Wallet (to save useful contacts, appointment dates, notes)

- Opportunity to further customise the App to accommodate the local healthcare/social care environment

High-level milestones for project

JUNE 2016	
	Attend the Harrow Patient Participation Network (HPPN) and East Harrow Hub public meeting as an AOB to demonstrate the app and discuss the proposal in order to gather input and suggestions.
	Clinical lead assigned to the project
JULY	
	Attend the Local Authority event on Information, Advice and Advocacy strategy
	In July work commenced with the preferred provider South East Clinical Commissioning Unit.
	Discussions with EMIS (GP clinical system), Urgent Care Data team to agree method to have 'live stream
	Contact voluntary organisations and council to have appropriate links included
	Development commenced
AUGUST	Development continues
SEPTEMBER/OCTOBER	User acceptance testing of both the App and website
	Demonstration to CCG
	Attend HPPN to demonstrate
	Implement communications strategy
	App and Website released

Section 3 – Further Information

We would like to return once the app is completed to demonstrate the functionality of the App and to take comments and suggestions on what other features could be included in future iterations.

Section 4 – Financial Implications

There is no funding implication for the Local Authority as the CCG has funded this project.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? Yes

The findings focused on the fact that a multi-lingual option should be included as soon as the functionality is available. It was identified that having the ability to do this for the top 5 spoken languages in Harrow would improve appeal and usage.

The developer has stated that they are working on the ability of the App being available in languages other than English and hope to have this available in mid 2017.

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

Please identify how the report incorporates the administration's priorities.

- **Making a difference for the vulnerable**

Having the App and website will greatly improve the visibility and signposting of key support services, both health and council that can support residents. For example, having information about mental health services and Female Genital Mutilation (FGM) will be featured

- **Making a difference for communities**

Using the App will promote in communities a change in behaviours in terms of how people care for their own conditions and how they access the appropriate services.

- **Making a difference for local businesses**

Not applicable

- **Making a difference for families**

The App will bring all health and associated council services together in one convenient and easily accessible place so that families can get the latest advice on a condition, what to do if they need immediate health assistance and how they can support a member of their family that has a complex condition

Harrow Health and Wellbeing Strategy

'*local priority of reducing unwarranted variation in the management of long term conditions*'

The development of the Harrow Health Help Now App and website directly addresses this area as use of the app will encourage the user to follow the clinically approved pathway and suggestions with regards to managing a condition and seeking the appropriate help.

Harrow CCG Corporate Objectives

'Objective 1: Improve the health and wellbeing of the local residents of Harrow'

The App will greatly improve sign-posting and shape how residents access health services and those provided by the Local Authority which overlap. The inclusion of a symptom checker will encourage the user to be proactive in seeking the appropriate medical advice from a professional.

'Objective 2: Engage patients and the public in decision-making'

Throughout the process we have engaged patients to seek their view on what would be useful to have in the App by attending 3 patient group meetings. A member of the HPPN is supporting the project as a 'super-user' to assist with testing. There are plans to attend patient events which are held on weekends so that we can raise awareness of the App's benefits.

'Objective 3: Manage resources effectively'

As mentioned earlier in the report, the App is a key lever in reducing the inappropriate use of A&E and urgent care pathways. The App will be key in creating a shift of historical cultural dependence on the A&E department into on where residents are able to look at all the services which are closer to home that can meet their medical need.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Not applicable

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Kwesi Afful, Programme Manager, Harrow CCG
kwesiafful@nhs.net

Background Papers: List **only non-exempt** documents relied on to a material extent in preparing the report. (eg previous reports) Where possible also include electronic link.

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	8 September 2016
Subject:	**Sustainability & Transformation Plan (STP) Update**
Responsible Officer:	Javina Sehgal, Chief Operating Officer Harrow CCG
Exempt:	No
Enclosures:	June 2016 Submission of the North West London Sustainability and Transformation Plan Harrow Sustainability and Transformation Plan Local Executive Summary

Section 1 – Summary

The latest version of the North West London Sustainability and Transformation Plan was submitted to NHSE on 30th June. This report provides information on the development of the latest versions of the NWL STP and the Harrow Local STP (attached). To date, NWL CCG's have engaged with local governance boards and lay-partners to develop the content in the current plan.

The CCG has circulated the final versions of the NWL STP and the Harrow Local Plan to the member organisations of the STP, including LB Harrow, to request formal feedback which the CCG will collate and submit to the North West London Strategy and Transformation team by Wednesday 7th September. In addition, the report describes the work required prior to the submission of the final NWL Sustainability and Transformation Plan on 21st October 2016. (See Recommendation overleaf)

Recommendation

The Board is being asked to receive the NWL and associated Harrow STP submissions, note progress and comment on work to date.

The Board is also asked to note that the Harrow local chapter developed did not form part of the formal submission to NHS England.

Section 2 – Report

Background

STPs were introduced by NHS England to support delivery of their Five Year Forward View strategy and there are 44 STP geographic areas (footprints) across England. The STP is an opportunity to radically transform the way NW London provides health and social care. The STP sets out how we address the 'Triple Aims' identified in the Five Year Forward View:

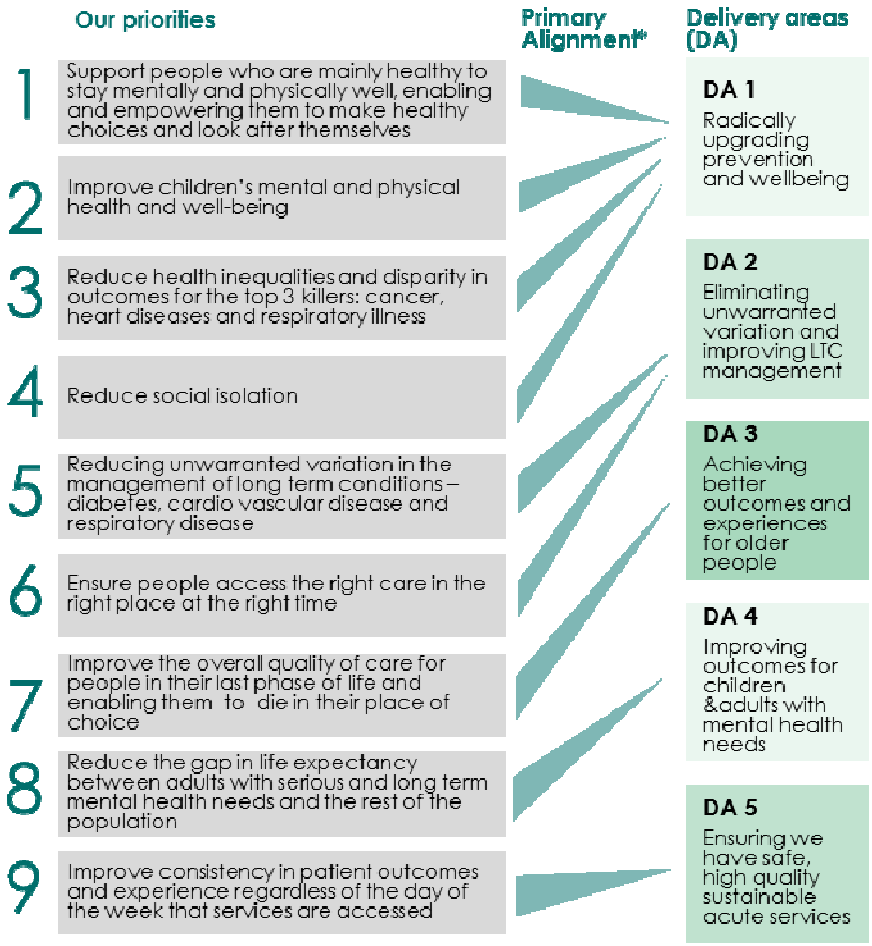
- Health and wellbeing – preventing people from getting ill and supporting people to stay as healthy as possible
- Care and quality - consistent high quality services, wherever and whenever they are needed
- Finances and efficiency - making sure we run and structure our services as effectively as possible

NW London's STP

The NHS and local authorities across NW London have agreed to work together to deliver a better health and care system. Patient groups and other stakeholders have been involved in developing the plan. This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well.

- If we are to address the Triple Aim challenges, we must fundamentally transform our system. Our vision for NW London involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible.
- We have developed 9 Priorities for NW London which we must address if we are to transform our system.
- From these priorities, we have identified 5 Delivery Areas that we need to focus on to deliver at scale and pace across NW London. The diagram below sets out how our Priorities align to the Delivery Areas
- Local areas have created 'Local Executive Summaries' which show how their plans are aligned to NW London priorities. These summaries also reflect local priorities and activities to address specific local challenges.

The NWL Sustainability Plan priorities, aligned to key deliver areas are contained in the table below.



Harrow's Local STP Process

The Care Delivery organisations serving the Harrow population have come together to form the Harrow Sustainability and Transformation Plan Group (HSTPG).

Harrow CCG has acted as the convenor for the HSTPG which met bi-weekly during the development of the first draft of the Harrow component of the plan, and also acts as the conduit across the sub-regional and regional arrangements as NWL work together to coordinate the STP process.

The latest draft NWL Sustainability and Transformation Plan was submitted to NHSE on June 30th 2016 (see attached).

Since submitting the plan in June, the NWL Strategy and Transformation team have met with NHS England to discuss the plans in more detail and are currently awaiting formal feedback.

Harrow stakeholders are currently finalising the approach to the ongoing development and implementation of its local STP.

As part of our engagement activity we are planning to hold public meetings, co-hosted by NHS and local councils where possible, in each borough in September (date to be confirmed).

NWL Governance
In order for the STP to work across the system to deliver the transformation set out in the STP, an effective governance approach is required.

The NWL Strategy and Transformation team are in the process of developing the Joint Health and Care Transformation Group which will have representation from across local government and health, including commissioners, providers and patient representatives.

The purpose of this group will be to oversee the development of the STP and its delivery and its first meeting will take place in late September.

Submission of the Final STP
The final NWL Sustainability Plan will be submitted to NHSE on 21st October 2016.

Next Steps
- Completing the plan – incorporating feedback from local governance boards and from public and staff engagement and creating detailed plans for the next 2 years

- Establishing governance and delivery arrangements – to support the implementation of the STP

- Mobilising projects outlined in the STP and accelerating delivery against the 16/17 priorities

Feedback Process
To date, NWL CCG's have engaged with local governance boards and lay-partners to develop the content in the current plan.

The CCG has circulated the final versions of the NWL STP and the Harrow Local Plan to the member organisations of the STP, including LB Harrow, to request formal feedback which the CCG will collate and submit to the North West London Strategy and Transformation team by Wednesday 7th September.

Section 3 – Further Information

Further updates will be given to future meetings of the Harrow HWB.

Section 4 – Financial Implications

The financial models to support the development of the local and NWL STP are being jointly developed by the CFOs and will be presented as they are developed.

Section 5 - Equalities implications

No Equality Impact Assessment has been carried out at this stage. This will be reviewed as the plans develop.

Section 6 – Corporate Priorities

By its nature and intent the STP supports the following corporate priorities:

- United and involved communities: A Council that listens and leads.
- Supporting and protecting people who are most in need.

STATUTORY OFFICER CLEARANCE

Not applicable

Section 7 - Contact Details and Background Papers

Contact: Hugh Caslake, Harrow CCG, Head of QIPP and Delivery

Background Papers:

June 2016 Submission of the North West London Sustainability and Transformation Plan.

Harrow Sustainability and Transformation Plan Local Executive Summary

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NW London Sustainability and Transformation Plan

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

V1.0

30 June 2016

DRAFT

Foreword

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

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

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

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

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

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

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

Carolyn Downs
Chief Executive of Brent Council

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

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

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

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

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

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

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

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

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

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

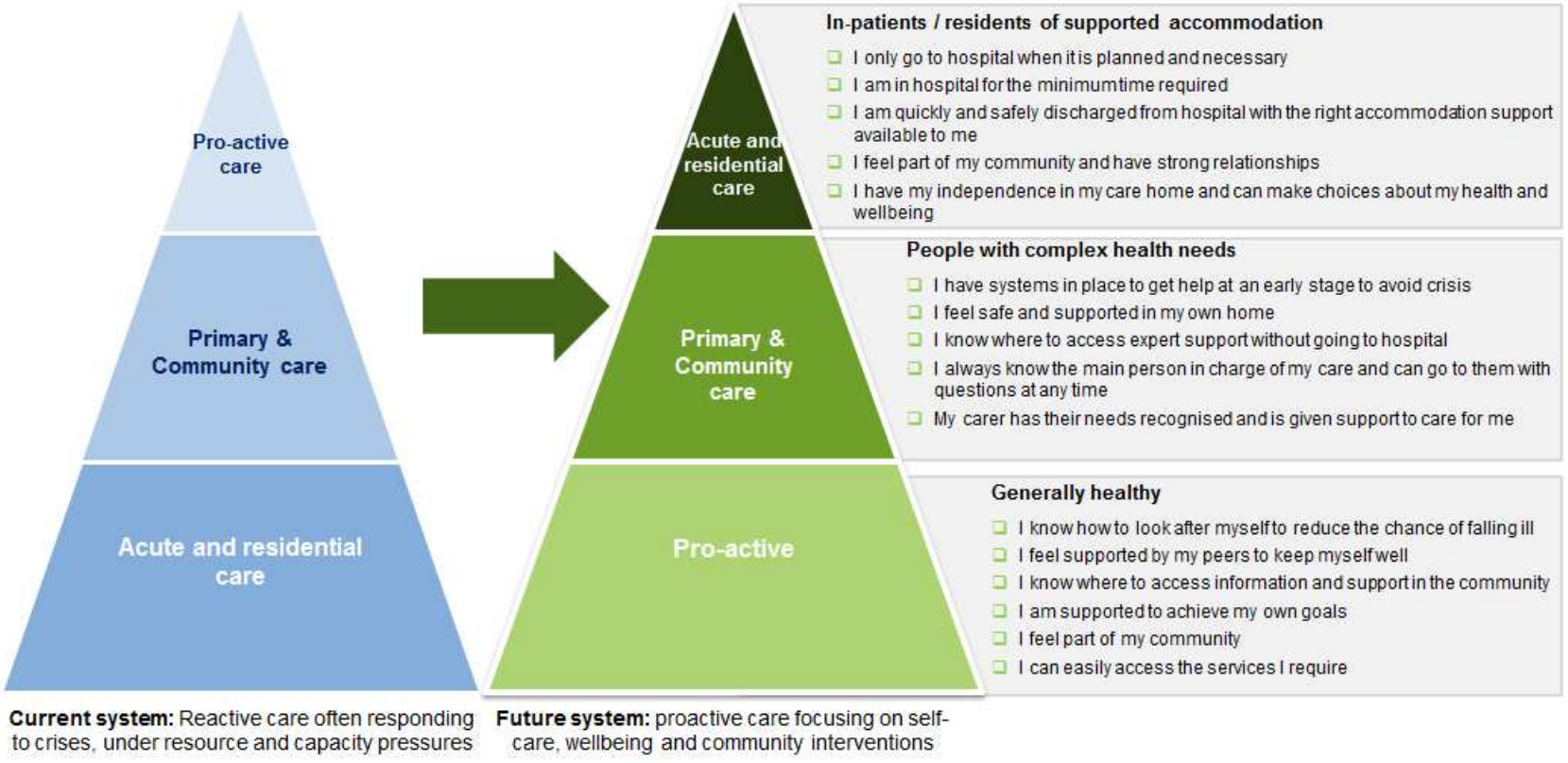
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500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

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

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

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

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



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

i. Executive Summary:
How we will close the gaps

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

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

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

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

i. Executive Summary:
Existing health service strategy

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

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

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

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

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

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

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

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

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

i. Executive Summary:
Finances

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

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

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

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

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

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

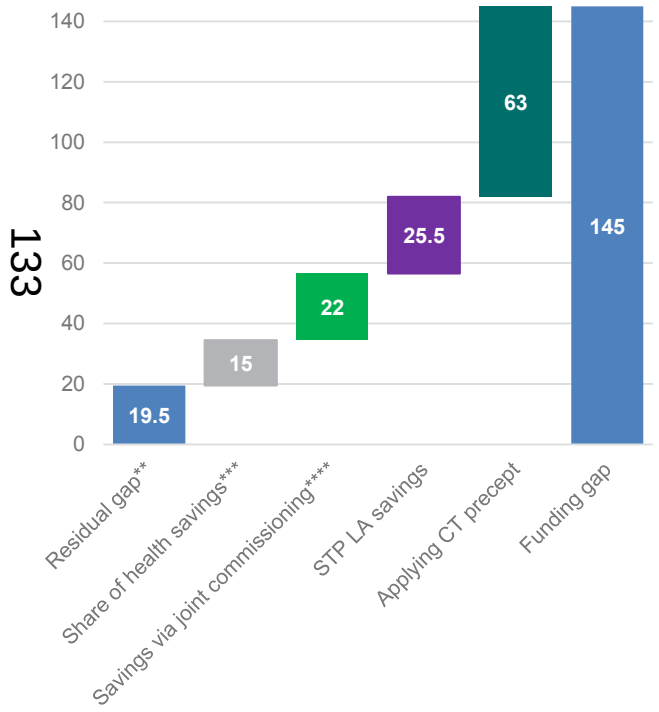
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

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

i. Executive Summary:
Social Care Finances

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

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



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

The following assumptions and caveats apply:

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

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

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

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

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

i. Executive Summary:
16/17 key deliverables

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

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

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

Areas with impact in 2016/17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Case for Change:

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

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

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

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

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

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

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

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

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

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

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

Responsibilities of our residents

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

Responsibilities of our system

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

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

Principles underpinning our work

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

1. Case for Change:
Understanding our population

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

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

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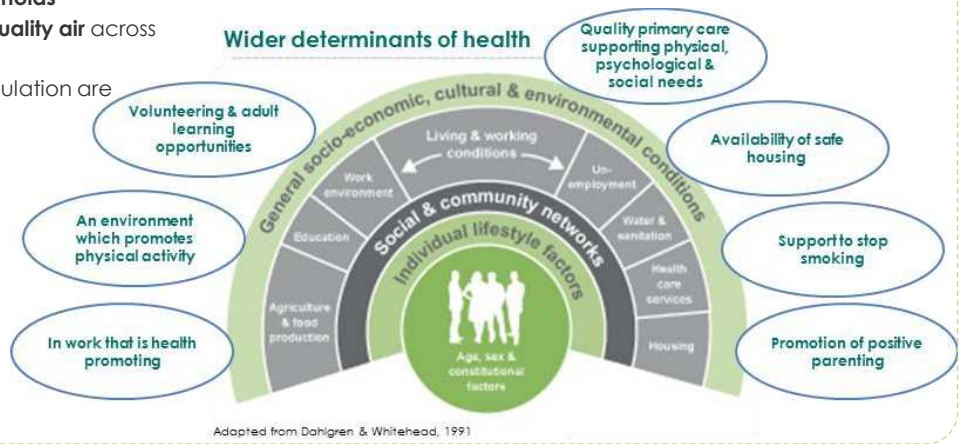
In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

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



Adapted from Dahlgren & Whitehead, 1991

Population Segmentation for NW London 2015–30[3]

Mostly healthy
- 1,216,000 adults in NW London are mostly healthy
- 58% of the total population
- 24% of care spend in NW London

In 2030:
- 4% more adults
- 31% more +65s

One or more long-term conditions
- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030
- 36% more adults
- 37% more spend in NW London

Cancer
- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4% of care spend in NW London

In 2030:
- 53% more adults
- 50% more spend in NW London

Serious and long term mental health needs
- 37,500 adults in NW London have serious and long term mental health needs
- 2% of population
- 7.5% of care spend

In 2030:
- 1% more adults
- 21% more spend in NW London

Learning disability
- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8% of care spend in NW London

In 2030:
- 29% more adults
- 35% more spend in NW London

Severe physical disability
- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults
- 26% more spend in NW London

Advanced dementia / Alzheimer's
- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults
- 44% more spend in NW London

Children
- 438,200 children in NW London
- 21% of the population
- 14% of care spend in NW London

In 2030
- 6% more children
- 3% more spend in NW London

Socially Excluded Groups
- Westminster has the highest recorded population of rough sleepers of any local authority in the country
- There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

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

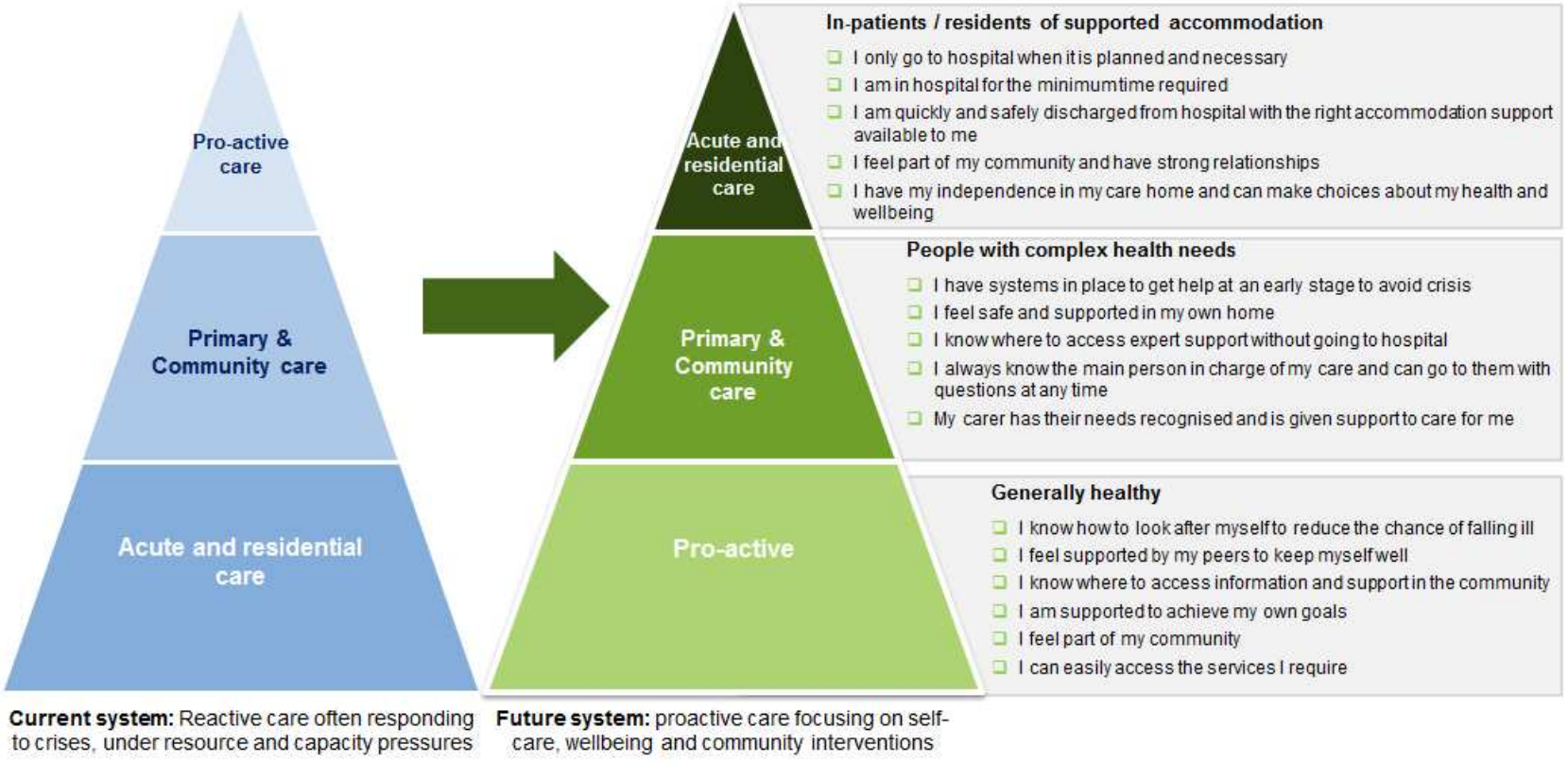
Please note that segment numbers are for adults only with the exception of the children segment

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

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

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

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



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

1. Case for Change:
Understanding people's needs

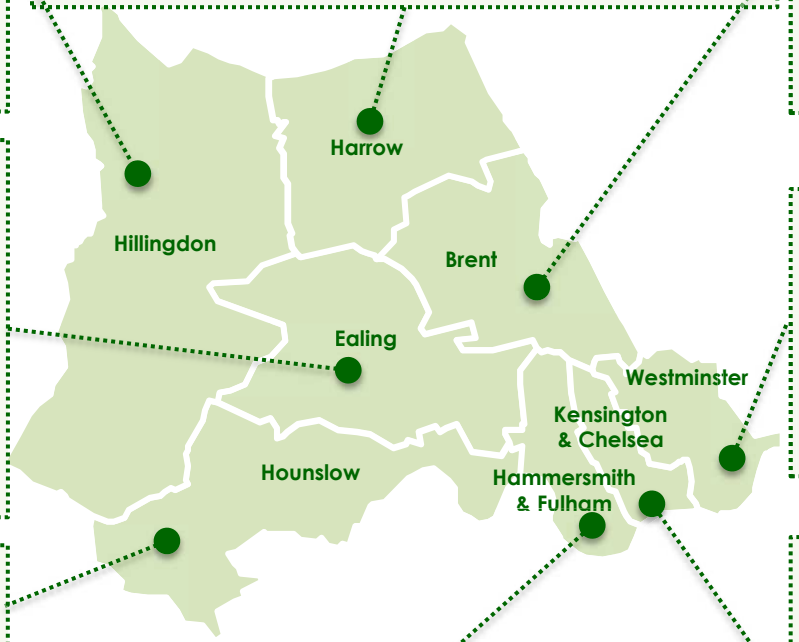
While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

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

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

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

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



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

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

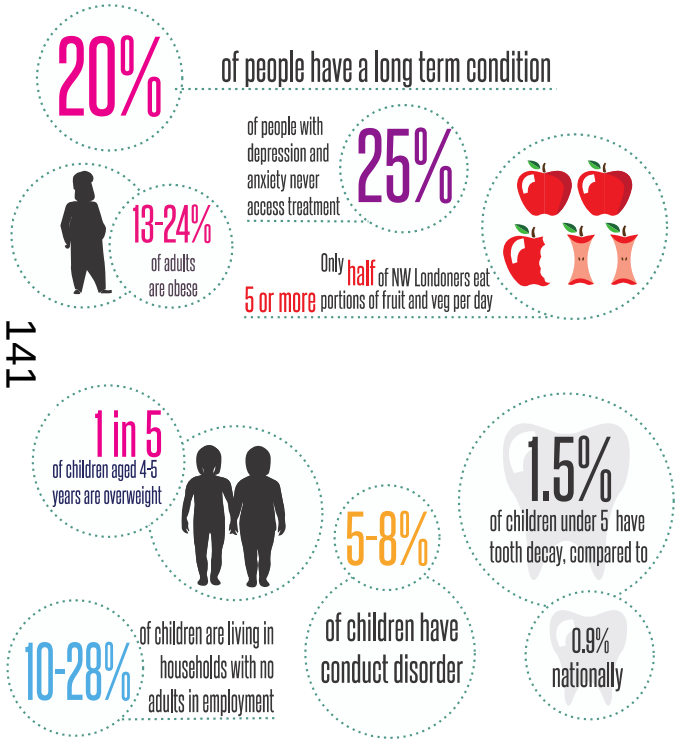
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature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

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

1. Case for Change:
Health and Wellbeing Current Situation

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

Our as-is…



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

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

Our to-be…

Our Priorities

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

1 Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

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

2 Improve children's mental and physical health and well-being

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

3 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

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

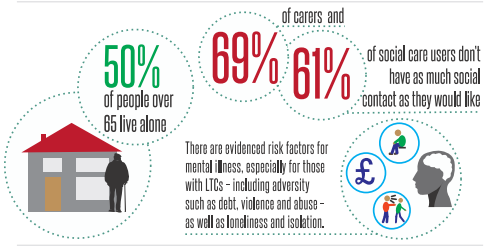
As soon as I am struggling, appropriate and timely help is available

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

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

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

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
		
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
142 r 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health	4 Reduce social isolation

Our vision for care and quality:

Personalised

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

Localised

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

Coordinated

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

Specialised

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

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

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

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

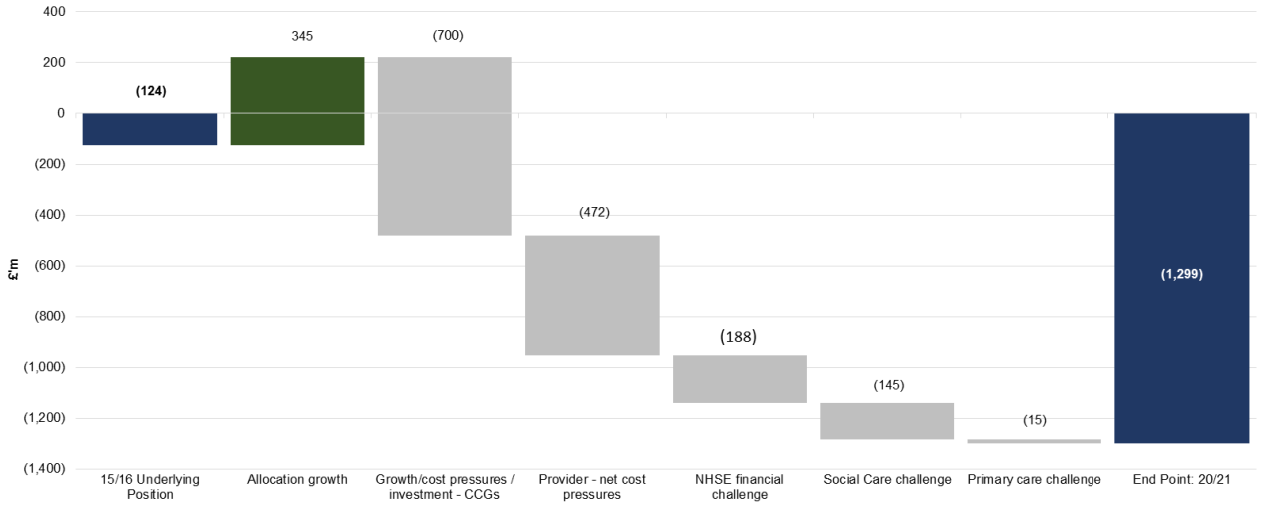


Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

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

2. Delivery Areas:
How we will close the gaps

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

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

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

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

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

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

2020/2021

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Target Population:

All adults: 1,641,500

Mostly Healthy Adults at risk of developing a LTC: 121,680

All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

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

Why this is important for NW London

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

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

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

2. Delivery Area 1: Radically upgrading prevention and wellbeing

What we will do to make a difference

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

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

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

The NW London Ambition:

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

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

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

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

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

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

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

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

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

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

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

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

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

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

What we will do to make a difference

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

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

The NW London Ambition:

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

149

2020/2021

Contribution to Closing the Financial Gap

£82.6m

Target Population:

311,500

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

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

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

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

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

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

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

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

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

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnership(s) • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnership(s), with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	150 …lement new …dels of local …vices integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes in each of the eight boroughs and across NW London • Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working • Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers	18	26.3
D	Upgrade rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want. • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

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

The NW London Ambition:

No health without mental health

2020/2021

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Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

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

Why this is important for NW London

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

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

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

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

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

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

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

What we will do to make a difference

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

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

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

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

The NW London Ambition:

High quality specialist services at the time you need them

153

2020/2021

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

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

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

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

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

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

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

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

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

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

What we will do to make a difference

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

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

What we will do to make a difference

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

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

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

3. Enablers:
Supporting the 5 delivery areas

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

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

3. Enablers: Estates

Context

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

Key Challenges

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

3. Enablers: Estates

Current Transformation Plans and Benefits

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

Key Impacts on Sustainability & Transformation Planning

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

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

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

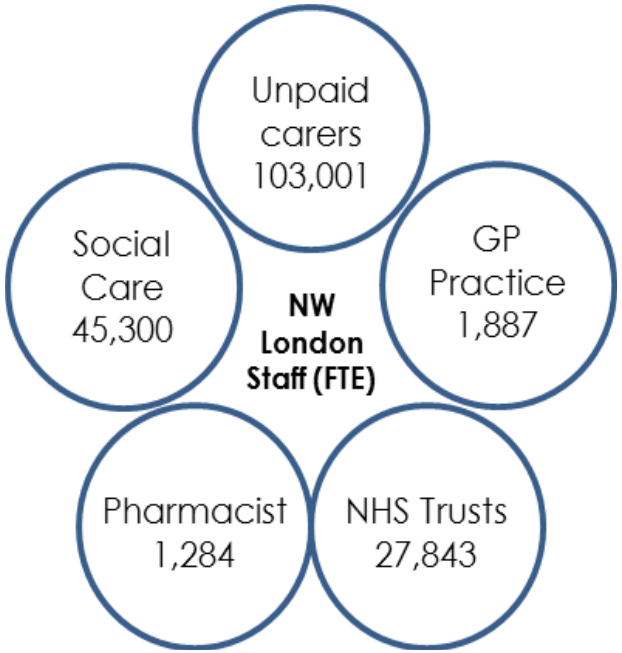
Delivery Area 4 - Supporting those with mental health needs:
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services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

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

3. Enablers: Workforce

Context

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



What will be different in 2020[6]?

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

Addressing workforce shortages

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

Improving recruitment and retention

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

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

Workforce Transformation to support new ways of working

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

Leadership & Org. Development to support services

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

3. Enablers: Workforce

Current Transformation Plans and Benefits

Addressing workforce shortages

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

Improving recruitment and retention

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

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

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

Leadership and Organisational Development to support future services

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

Key Impacts on Sustainability & Transformation Planning

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

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

Delivery Area 1 – Prevention and self management:

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

Delivery Area 2 - Reducing variation:

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

Delivery Area 3 - Outcomes for older people:

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

Delivery Area 4 - Supporting those with mental health needs:

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

Delivery Area 5 – Providing high quality, sustainable services:

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

3. Enablers: Digital

Context

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

Key Challenges

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

Strategic Local Digital Roadmap Vision in response to STP

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

Enabling work streams identified:

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

3. Enablers: Digital

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

4. Primary care in NW London

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

T are, nevertheless, significant challenges. These include:

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

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

Some other statistics: achievements and challenges

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

Some of our achievements so far

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

Additional work already under way

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

4. The future of primary care in NW London

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

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

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

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

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

4. Delivering the ambitions of the primary care strategy

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

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

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

SCF implementation

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

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

August
The CCG primary care teams will, with the Local services team, then:
- undertake a gap analysis;
- translate the gaps into high-level prioritised annual commissioning intentions to 2020/21, based on confirmed allocations; and
- form a detailed plan for the design and implementation of 2017/18 priorities.

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

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

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

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

Shared CCG materials

HLP SCF costing and impact analysis

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

A **recurring annual cycle of primary care commissioning**: engagement, confirmed commissioning intentions, business case development, detailed planning, and implementation, based on the model of care and prioritisation approved by the governing body in September 2016.
Commissioning intentions that directly support the SCF will be prioritised before April 2019.

SCF commissioning intentions

SCF+ commissioning intentions

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

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

5. Finance:

Overall Financial Challenge – 'Do Something' (1)

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

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

Specific Points to note are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

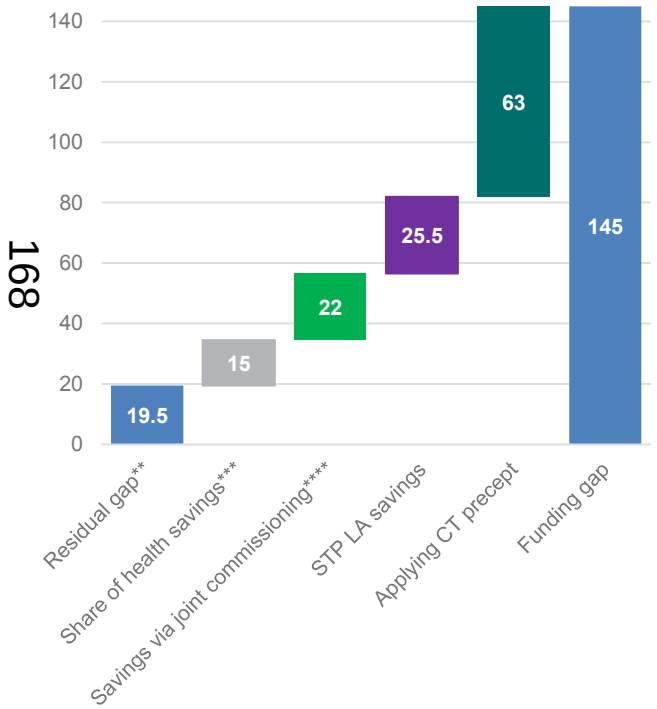
STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

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

5. Finance:
Social Care Finances

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

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



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

The following assumptions and caveats apply:

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

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

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

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

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

5. Finance:

STP financial enablers – Sustainability and Transformation Funding

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

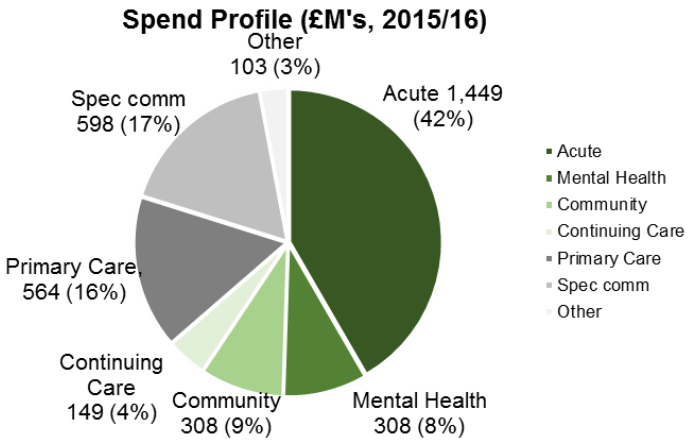
	16/17	17/18	18/19	19/20	20/21
	£m	£m	£m	£m	£m
Sustainability funding	-	112.4	82.3	61.6	0.0
Investment in prevention and social care	-	21.0	25.0	30.0	34.0
Social care funding gap	-	-	-	-	19.5
Seven day services	3.0	4.0	7.0	12.0	20.0
Mental health transformation and invetment in services - integrated care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

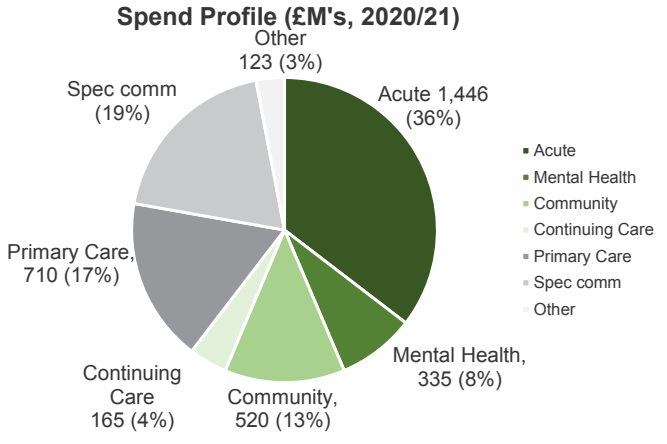
£53.5m

£55.7m

169

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





5. Finance:
STP financial enablers – Capital

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

Table 1: Do Something Capital

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

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

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

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

Table 2: Accelerated timeline

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L[illegible]t progress with the provider productivity programme

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

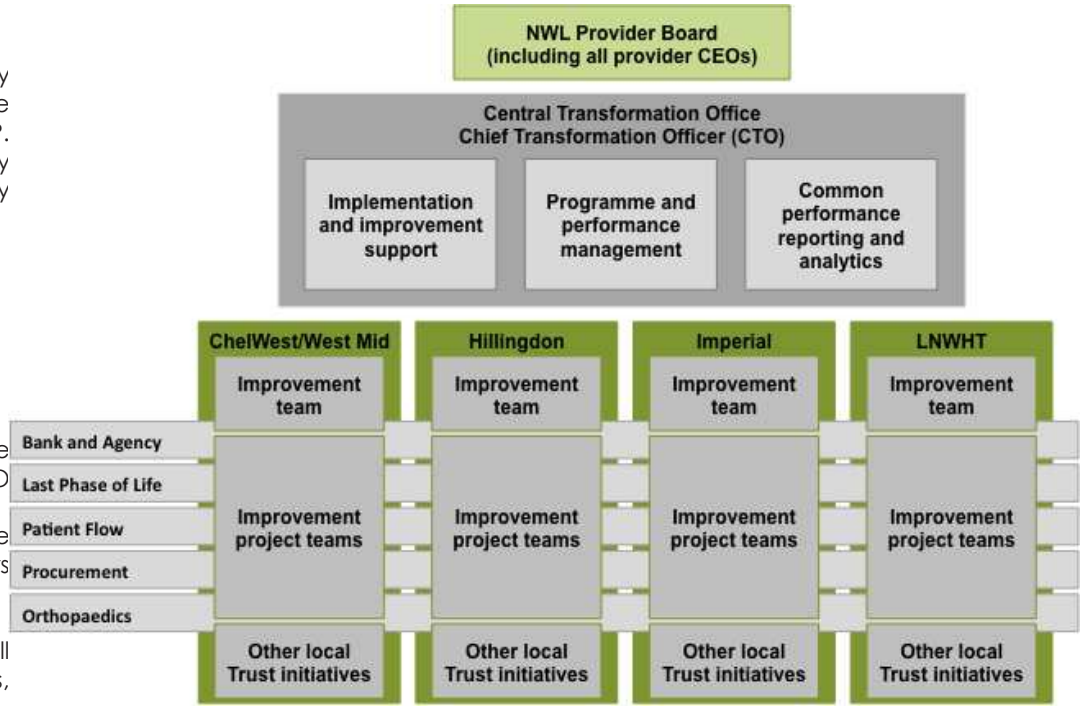
- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.

To achieve this providers are working together to:

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

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



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

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

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

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

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

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
Case for Change	12-19	[1] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea. [2] NOMIS profiles, data from Office for National Statistics [3] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [4] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs

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Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) Management	23-24	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] Cancer Research UK [3] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf [4] Fund Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund [5] Pan-London Atrial Fibrillation Programme [6] NHS London Health Programmes, NHS Commission Board, JSNA Ealing [7] Kings Fund, 2010 [8] Initial analysis following review of self-care literature [9] http://dvr.sagepub.com/content/13/4/268

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Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	25-26	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
Delivery Area 4: Improving outcomes for children and adults with mental health needs	27-28	[1] Tulloch et al., 2008 [2] Royal College of Psychiatrists, 2012 [3] http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spmin1
Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	29-31	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
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Section	Slides	References
Enablers: Workforce	35-36	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
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Partnership organisations with the NW London STP Footprint

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Harrow Executive Summary on Local Input to the NWL Sustainability and Transformation Plan

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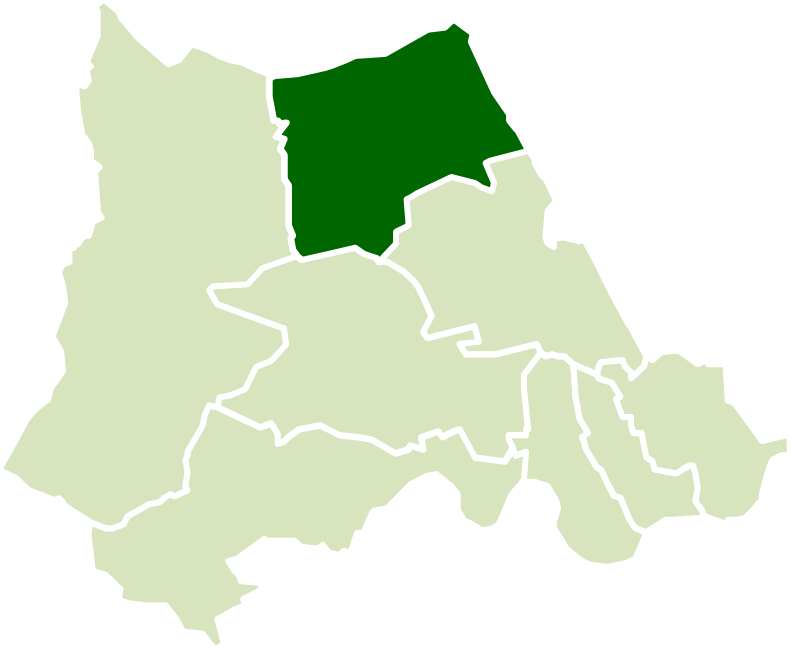
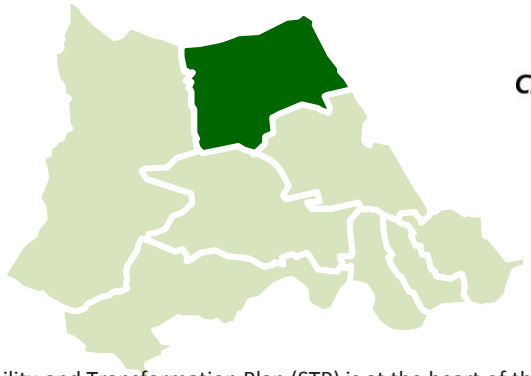


This is a working document and content is not final

The local picture in Harrow



NHS Harrow Clinical Commissioning Group

Harrow COUNCIL LONDON

The Sustainability and Transformation Plan (STP) is at the heart of the planning process. The Harrow STP process brings together providers and commissioners of care (both local government and NHS) to deliver a genuine place based plan for the borough, with a strong focus on Primary Care Transformation as a key enabler for sustainable system change.

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268* GP registered in Jan 2016 / **247,130** ents – ONS, mid year 2015
£0,700,000* - 16/17 CCG allocation
34 GP Practices
Mental Health is provided by Central North West London

Community Health is provided by Central London Community Healthcare
Acute Hospital Care is mainly provided by London North West Hospitals (~60% of budget)

Harrow has:

- A greater older population than London, a third of over 65s have at least one long term health problem or disability
- People living longer with ill health (approx. 20 year gap in healthy life expectancy and life expectancy).
- One of most ethnically and religiously diverse boroughs in country – implications for rates of e.g. diabetes and heart disease in BAME.
- Large scale regeneration plans providing opportunities to influence local wider determinants of health
- A strong focus on Primary Care Transformation, delivered locally to unlock broader system changes

LIST OF PLANS THAT HAVE BEEN USED TO FORM THE LOCAL EXECUTIVE SUMMARY:

The contents of the pack are built on current local plans within Harrow and across NW London including (but are not limited to):

- Harrow Health and Wellbeing Strategy 2016-2020
- Base Harrow STP submission - April 2016
- Harrow Joint Strategic Needs Assessment 2015-2020
- Harrow 2016/17 Better Care Fund Plan
- The NWL Digital Strategy
- Shaping a Healthier Future
- NWL Whole Systems Integrated Care
- CCG 2016/17 Operational Plans
- The London-wide Strategic Commissioning Framework for Primary Care
- The NWL Primary Care Transformation Programme
- The Harrow Ambition Plan 16/17 – 18/19
- Harrow Out of Hospital strategy
- NWL Like Minded strategy
- Harrow LD and Autism Strategy

Public and partner engagement have been central to both the development of the above plans and strategies and the STP. The Harrow STP is going through an ongoing process of co-design with key partners, including the CCG, Local Authority, providers and patients. This summary is a distillation of the work to date and will continue to evolve over Qrt 2 &3 of 2016/17.

The Harrow STP is designed to feed into the wider North West London plan, and should be read with this context in mind.

The financial situation in Harrow

- Harrow is the most financially challenged health and care system in NWL
- In 2015/16 Harrow CCG achieved a surplus of £2m against a planned deficit of £5.3m in 15/16. The underlying exit deficit for the CCG was £11m.
- The total place 2016/17 allocation is -£12.565m below target reducing to -£10.036m by 2020/21.
- In July 2015 the Local Authority reaffirmed the total budget gap of £52.4m over the three year period 2016/17 to 2018/19.
- Significant net savings (QIPP) are required each year to close the CCG financial gap by 2021.

QIPP Required £m	16/17	17/18	18/19	19/20	20/21
CCG*	(9.8)	(11.6)	(5.8)	(3.8)	(3.8)

** Harrow CCG Sustainability Plan 2016/17 – 2020/21, Draft June 2016*

Understanding our population – the health and wellbeing of Harrow

In Harrow our Health and Wellbeing Strategy and our Joint Strategic Needs Assessment, developed locally between the Local Authority and the CCG, are the basis for our understanding of the changing needs and issues facing our population which include:

We will ensure that young people of Harrow Start Well:

- Approx 17% (8000) children live in poverty and large inequality by deprivation – poorest ward has significantly higher rates than London or England average
- About 3,100 children were in need of a service from Social Care between 01/04/2013 and 31/03/2014
- High rates of low birth weight babies, with rising trends of smoking in pregnancy
- Currently 9.2% of Reception aged children being obese (PHOF 2014/15) increasing to 21.2% for children aged 10 to 11 years old in year 6 which above England

We will enable people of Harrow to Live Well

- Of people with long term health problems or disability living in the borough, 15% reported that day to day activities are limited either a lot or a little compared to 17.6% in England and 14.1% in London.
- Harrow has high rates of obesity across the population , with reported low amount of exercise taken
- Cardiovascular Disease is the leading cause of death (all ages)
- COPD deaths in females are rising in contrast to national trends
- Amongst highest rates of Type 2 Diabetes in England (and highest rate of 'pre-diabetes')
- Hospital admissions due to drug related mental health and behavioural disorder are amongst highest in London, with higher prevalence of schizophrenia, bipolar affective disorder and other psychoses in the population
- Low rates of bowel, breast and cervical cancer screening

We will support the people of Harrow to Work Well

- Harrow has reducing rates of unemployment but higher/static rates in those with mental health conditions
- Skills gap in the caring services which is concern given ageing population

In their latter years we will help people in Harrow to Age Well

- High percentage of adult social care users who do not have as much social contact as they would like
- Projected increase in falls in older people and associated NHS and social care costs with ageing population.
- Poorer outcomes association linked to deprivation.
- Rate of readmission after hip fracture in women rising and higher than England/London rate. Proportion returning home rather than into institutional care significantly lower than England.

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Reduce Childhood Obesity

- Currently 9.2% of Reception aged children being obese (PHOF 2014/15) increasing to 21.2% for children aged 10 to 11 years old in year 6 which above England
- In 2021:
- Significant reductions in both cohorts

Enabling & supporting Self Care

- Estimates indicate 10.1% of adult population has Type 2 Diabetes which is amongst highest in England and Harrow has the highest rate of 'pre-diabetes'
- In 2021:
- Increased early diagnosis of pre-diabetes

Increase Physical Activity

- 31% of the adult population is classed as physically inactive and at higher risk of ill health
- Current utilisation of outdoor space is 18.0%

In 2021:

- Increased proportion of population taking exercise

Help Improve Peoples Mental Health

- Harrow's dementia diagnosis rate is below the 48% England average
- About one fifth of people accessing substance misuse services are having concurrent contact with mental health services.

In 2021:

- Improved access to IAPT driving better care and management

Reduce Social Isolation

- **26% of Adult Social care users do not have as much social contact as they would like**
- High rates of fuel poverty 11.3% (2013 PHOF) – worse than England - associated with poor health outcomes

In 2021:

- Improves access and use of day services

Support to Manage LTCs

- Cancer, heart disease and stroke biggest causes of death and driving inequality
- Cervical screening rates declining in young women
- COPD is under recorded in general practice

In 2021:

- Future Outcomes
- Xxx
- Xxx

Improve the Last Phase of Life

In 2021:

- Increasing the percentage of patients at the end of life dying to achieve their preferred place of care and death

Delivering Care Closer to Home

- Current Outcomes
- xxx

In 2021:

- Future Outcomes
- Xxx
- xxx

The 2021 Vision for care and support in (BOROUGH)

Below we have outlined the Harrow vision for how we will close the three gaps outlined within the Five Year Forward view and the STP guidance:

Health & Wellbeing

We will help all in Harrow to start, live, work and age well, concentrating particularly on those with the greatest need, supported by jointly developed digital sign-posting and self care tools and delivered in partnership with a sustainable voluntary sector .

Care & Quality

Through the continuing development and delivery of innovative integrated health and social care services we will deliver the right care in the right place at the right time for all of our residents, supporting a “whole person” approach to care planning and enabled by efficient use of system-wide estates and digital information technologies.

Finance & Efficiency

We will deliver best cost health and social care for the residents of Harrow, maximising our local system opportunities to pool resources, integrate delivery models and incentivise innovation and underpinned by our ongoing progress towards a sustainable system finance structure enabled by a fairer funding base for Harrow.

What are we doing this year (16/17) against the 9 NWL priorities? Harrow Deliverables (1 of 3)

The next three slides represent a summary of 16/17 activities and are not meant to be an exhaustive account of deliverables across our partners through 16/17 – Some deliverables are still being discussed and finalised.

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves.	• Develop and promote existing mechanisms for signposting residents to facilities, information, advice and services which promote health and wellbeing. • Implement a joined up approach to new technologies which links to internet of things and big data, developing local and regional apps to signpost self care tools and information • Explore options to support prevention programmes and overcome funding challenges facing a sustainable VCS/ 3rd sector model for Harrow, including a review of funding and sustainability options for the Harrow Communities Click model or similar strategies • Through Project Infinity develop the My Community ePurse for Personal Health Budgets by Q3 2016, including development of a self-service e-marketplace for people funding their own care and support. • Healthy workplace programme developed and deployed across health and care staff in Harrow with lead from health & care partners, aligned with the GLA Healthy Workplace Charter
2. Improve children's mental and physical health and wellbeing	• Progress Tier 2.5 service development, ensuring links to Primary Care Transformation to improve access to local care and support for carers and patients. • Develop and pilot an integrated model of service for children and young people, including options to provide additional health and care services for unaccompanied asylum seeking children • Complete an options appraisal for CAMHS service transformation across West London, including a review of workforce training needs • Redesign the early help service for children & young people in collaboration with staff & users • Review the Health Visiting service against the needs of the local population • Commission a new eating disorder service across 5 boroughs • Improve data collection & recording to provide more reliable data set in particular for children with learning disabilities aged under 5 years old, carers and young people in transition to support 'whole life' planning and service reviews. • Joint working between the Council and the CCG to ensure GP data on lifestyle and screening for those with LD can be monitored and compared with the general population.
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	• Develop a Community Cardiology service • Support the development of a NWL-wide cancer strategy group that focuses on prevention and early detection and living with and beyond cancer. • Using Right Care as a framework, develop joint cancer action plans across BHH. • Agree joined up approaches with Acute and primary care to improve early detection and access to treatment • Enhance the local acute oncology services • Partnership working to improve screening uptake, particularly in marginalised and seldom heard groups in Harrow. • Finalise plans for an enhanced respiratory service with specific aim to reduce acute activity, developing integrated model to include Consultant input into community clinics for rapid access referrals • Recruit additional staffing for the new community respiratory service, includes acute consultant input and a new pulmonary rehabilitation service

What are we doing this year (16/17) against the 9 NWL priorities? (BOROUGH) Deliverables (2 of 3)

4. Reduce Social Isolation	• Complete gap analysis of current day service provision in meeting the needs of target population groups to inform strategy development • Deliver better alignment, information sharing and joint delivery between services eg. IAPT • Deliver clear plans for a whole systems approach including development of options to maximise the integration of voluntary services and increased social prescribing models • Develop a service specification for employment/ mental health services which meets local needs, integrated with current local provision • Procure a provider for a employment mental health service and ensure the service fits well with other related local services such as Talking Therapies
5. Reduce unwarranted variation in the management of long term conditions	• Implement asthma and diabetes audits at practice levels to review variation, with actions linked to local LIS schemes as required • Develop integrated Diabetes Strategy including acute, community, primary and social care services • Move to management of diabetic patients in community based services with consultants and GPSI led support. • Education programme for insulin initiation and GLP training with the aim of delivery via primary / community care • Patient empowerment and self-help training for diabetes patients within primary care • Roll out virtual wards initiative, ensuring an integrated approach to health and social care is adopted • Focus use of technology to enable patients to manage their own self care • Deploy PAM (Patient Activation Measure) pilot with those patients engaged in Whole Systems care in Harrow e.g. virtual wards, with a view to improving outcomes.
6. Ensure people access the right support in the right place at the right time	• Mapping and networking of community assets to support increase collaboration between health, social and 3rd sector care agencies to increase efficient use of current estates and resources. • Develop 3rd walk in centre in the east of the borough to increase capacity and provide more equitable access to primary care through cross-practice working. • Accelerate deployment of the Integrated Urgent Care Pathway in Harrow • Develop Accountable Care Partnerships (ACP/ACO) business model contributing to delivery of integrated services • Review Discharge to Access models and develop appropriate local options. • Falls Service re-procured as part of the Community Services project, improving falls prevention and support to nursing homes to avoid preventable admissions to secondary care. • Protecting adult social care activity levels through BCF funding

What are we doing this year (16/17) against the 9 NWL priorities? (BOROUGH) Deliverables (3 of 3)

7. Improve the overall quality of care for people in their last phase of life and enable them to die in their place of choice	• Proactive signposting to last phase of life resources for both patients and carers, redesigned pathway, reduce NEL and LOS. • Streamline processes to improve access to of the palliative care funding to enable people to make choices and have a degree of control over their own EOL care pathways. • Extend the EOL Single Point of Access pilot • Develop systems to identify early potential EOLC patients (and therefore improved management), and increased staff training on EOLC management across the Trust (including community) • Develop wider partnership with Brent CCG and LNWH to progress joint redesign of EOL pathway, reduce NEL admissions and LOS. Strategy leading to increase in • STARRS Nursing Home in-reach pilot implemented, evaluated and future options agreed
8. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population	• Improve service effectiveness and patient facing time through reduction of duplication and increased staff access to enablers of off site working, clinical processes to be mapped and re-aligned into new clinical system. • Embedded physical health check assessments within Inpatients and EIS community teams, ensuring outcomes are factored into care plan management • Improve specialist community-based support, opening up EIS team access to all age patients - specifically for the over 35 cohort and including embedding link worker model for delivery of interventions to over 35 patient cohort • Improved Urgent/Crisis care in the community including 24/7, single point of access timely assessment, more crisis management and recovery at home in the community by embedding CRHT - rapid response. • Enhancement of pathways between Single point of Access and Local Teams • Promote Talking Therapies services to increase uptake of amongst Harrow residents, aligned with Like Minded strategy
9. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.	• Prioritise deliverables for 7 day services and Primary Care Transformation • 3rd walk-in centre contract awarded for Harrow East, linked to emerging Integrated Urgent Care strategy for Harrow • Progress the key initiative to support enhanced access is the establishment of GP Network hubs to deliver primary care services, especially at evenings and weekends. • Complete implementation of care models for 2 primary care HUBS - full integrated delivery for identified pathways • Planning for the New East Harrow Hub, due to open in 2018/19 • Implement an integrated solution utilising EMIS Clinical Services which will provide real time integration between GP Practices and the new Harrow Community Services provider by October 2016

What are we doing in 2017/18 – 2020/21 against the 9 NWL priorities.

Conversations are ongoing about post 16/17 Harrow priorities – **Below priorities are currently being iteratively developed with partners**

1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves.	• Signposting enhanced through digital information and self care mobile apps integrated with Personal Health Budgets and Project Infinity, aligned with a clear VCS/3rd Sector strategy • Healthy Workplace programme strategy deployed across large scale employers in Harrow, building on model tested across health & care partners, aligned with the GLA Healthy Workplace Charter • Ongoing alignment of local Health & Wellbeing Strategies to maximize opportunities arising from Harrow regeneration
2. Improve children's mental and physical health and wellbeing	• Harrow Council and the CCG to ensure diagnostic, assessment and integrated care pathways are in place for people with learning disability, autism and complex and challenging behaviour. • Ensure access to clear accurate and consistent information and advice. Ensure materials are produced in easy read format. • Implement a joint LD & Autism strategy aligned with broader Transforming Care Programme.
3. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and re atory illness	• Respiratory service implementation - Service in place for 17/18 start, staff recruited • 2018/19 - Possible expansion of service e.g. include a home oxygen service, addressing unmet demand or include further respiratory conditions • Better integration with social services including local authority Re-ablement team
4 duce Social Isolation	• Expand scope and reach of current day services, closely aligned with the VCS and 3rd Sector to enhance early at-risk cohort identification and locally delivered support for isolated and vulnerable residents
5. Reduce unwarranted variation in the management of long term conditions	• Continuing investment in whole systems integrated care transformation programme focusing on providing personalised care for people with one or more LTCs. • Risk Stratification Dashboard deployed locally to supported integrated care teams and primary care to progress proactive monitoring and target self care interventions. • Strategies for local needs in MSK and COPD implemented and aligned with new primary care models enabling preventative intervention delivery.
6. Ensure people access the right support in the right place at the right time	• Progress local innovative delivery of Whole Systems Integrated Care and Primary Care Transformation, aligned with the broader NWL strategies • Procure Develop Accountable Care Partnerships (ACP/ACO) business model contributing to delivery of integrated services • Deploy subsequent phases of Integrated Urgent Care, aligned with the evolving NWL plans and BCF developments. • Roll out local models of Integrated Health and Social Care assessment processes to supported early interventions and accelerate discharge to appropriate non-acute care settings

What are we doing in 2017/18 – 2020/21 against the 9 NWL priorities.

Conversations are ongoing about post 16/17 Harrow priorities – **Below priorities are currently being iteratively developed with partners**

7. Improve the overall quality of care for people in their last phase of life and enable them to die in their place of choice	• Improve and Implement Proactive signposting for patients and carers • Develop partnership with Brent CCG and LNWH to progress redesign of EOL pathway, reduce NEL and LOS. • Streamline processes to improve access to of the palliative care funding to enable people to make choices and have a degree of control over their own EOL care pathways. • Extend the EOL Single Point of Access pilot, review and evaluate outcomes • Review and system integration of Palliative Care nursing team
8. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population.	• Use integrated data analytics to centrally schedule community team visits and minimise the time spent on non-face-to-face activities; install hard/software infrastructure to allow for video conferencing • Implement Community Based Packages – implementing the NICE guidelines packages in the community • Scope out alternatives to admissions, crisis houses/recovery house • Increase different types of accommodation moving towards independent living with floating support, includes Implement a Supported Housing Strategy to address the needs of people with mental health issues to access good quality, affordable housing with tenure options (strategy in development for July 16) • Enhance investment in PCMH model, expanding skill mix , including peer support provision, and treatment types in line with proposed Like-Minded model
Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.	• Implement Ongoing programme to restructure and consolidate services in line with SaHF • 3rd Hub established by 2018/19, integrated with Walk-in Centre and Integrated Urgent Care models • 7 day-services progressed, aligned with risk stratification dashboards to track improvements against 2016/17 baseline

Setting Out Local STP Activities – Local Harrow Priorities

The 9 emerging priorities have been agreed across NW London. Other important harrow priorities which are not reflected at the pan-NW London level are:

	Harrow Emerging Priorities	Local Programmes	Key 16/17 Plans
Local 1	Assess the health impact of Harrow regeneration schemes	• Take the opportunity to consider how to enhance the positive impact regeneration schemes will have on health, wellbeing and health inequalities and to minimise any possible negative impacts.	• Pilot the use of a Health Impact Assessment framework on Grange Farm re-development and make recommendations to promote health and wellbeing • Evaluate the effectiveness of the piloted HIA framework • Conduct an HIA on Civic Centre redevelopment
Local 2	Improve joint approaches and communications and promote effective engagement with all Harrow residents to help bridge inequalities in Harrow and meet the needs of marginalised groups	An integrated approach to communication and engagement will enable health and wellbeing messages to be more co-ordinated, targeted and powerful, culminating in residents feeling more informed about progress and future developments.	• Set up an engagement working group tasked with developing an integrated plan for communications • To look for synergies between planned activities of partners to increase efficiency and integration of messages
Local 3	Progressing the digitisation of shared information and patient records to enable integrated care monitoring, planning and care delivery models aligned with social, primary and community care transformation	Implementing EMIS Web .	• Progress to integrated health and social care records using EMIS Web as the local platform .

A summary of the main challenges facing delivery

Many of these gaps are being addressed through Harrow's planning process, and Harrow's Executive Summary has being developed iteratively with input from all partners and content included within this summary is only a snap-shot of current progress.

Harrow Health & Wellbeing Gaps	• How to deliver the self-care and prevention agendas in a multi-language, culturally diverse population • Harrow Regeneration – how to ensure that regeneration projects are designed to positively impact the wider determinants of health
Harrow Care & Quality Gaps	• How to accelerate change in Primary Care Transformation within constrained resources • Implementing new pathway and staffing models while maintaining current service levels • Mapping community, health and social care assets to deliver a joined up estates and delivery strategy for care closer to home • Coordination and delivery of innovative and cutting edge digitisation programmes across multiple providers, agencies and the voluntary sector to improve access to real time care pathway information
Harrow Finance & Efficiency Gaps	• How to fund transformation from within existing resources within the context of the historical funding gap for Harrow which could put at risk successful delivery of innovative delivery solutions • Developing innovative approaches to pooled funds and risk share incentives across commissioners and providers • Reducing Council budgets as the Revenue Support Grant reduces

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