Health and Wellbeing Board

AGENDA

DATE: **Thursday 12 January 2017**

TIME: **12.30 pm**

VENUE: **Meeting Room 5, Civic Buildings 5/6, Harrow Civic Centre**

MEMBERSHIP (Quorum 3)

Chair: **Councillor Sachin Shah**

Board Members:

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

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
Paul Jenkins, Interim 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. 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.

3. CHANGE IN MEMBERSHIP

To note the appointment of Dr Shahla Ahmad as a Harrow Clinical Commissioning Group Deputy for Dr Shaheen Jinah.and Paul Jenkins as Interim Chief Operating Officer, Harrow Clinical Commissioning Group during the secondment of Javina Sehgal

4. MINUTES (Pages 5 - 12)

That the minutes of the meeting held on 3 November 2016 be taken as read and signed as a correct record.

5. 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).

6. 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, 9 January 2015. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

7. DEPUTATIONS

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

8. INFORMATION ITEM -TRANSFORMING MODELS OF CARE FOR ADULTS WITH SERIOUS AND LONG TERM MENTAL HEALTH NEEDS (Pages 13 - 50)

Report of the Assistant Director, Harrow Clinical Commissioning Group and Deputy Director, Mental Health and Wellbeing, Collaboration of North West London Clinical Commissioning Groups.

9. INFORMATION REPORT - HARROW CLINICAL COMMISSIONING GROUP (CCG) PATIENT APP PRESENTATION (Pages 51 - 60)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group

10. INFORMATION REPORT - DIABETES UPDATE (Pages 61 - 64)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group

11. INFORMATION ITEM - UPDATE ON THE MENTAL HEALTH AND EMPLOYMENT TRAILBLAZER PROJECT IN HARROW. (Pages 65 - 68)

Report of the Director of Public Health

12. INFORMATION ITEM - TRANSFORMING PRIMARY CARE (Pages 69 - 88)

Report of the Chief Operating Officer, Harrow Clinical Commissioning Group

13. INFORMATION REPORT - BETTER CARE FUND (BCF) UPDATE QUARTER 2 2016/17 (Pages 89 - 96)

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

14. INFORMATION REPORT - DRAFT REVENUE BUDGET 2017/18 AND MEDIUM TERM FINANCIAL STATEMENT 2017/18 - 2019/20 (Pages 97 - 176)

Report of the Corporate Director People

15. INFORMATION ITEM - STP UPDATE (Pages 177 - 254)

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

16. 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.]

HEALTH AND WELLBEING BOARD

MINUTES

3 NOVEMBER 2016

Chair:	*	Councillor Sachin Shah		
Board Members:	*	Councillor Simon Brown		Harrow Council
	*	Councillor Susan Hall (1)		Harrow Council
	*	Councillor Varsha Parmar		Harrow Council
	*	Councillor Mrs Christine Robson		Harrow Council
	*	Dr Amol Kelshiker (VC)		Chair of Harrow CCG
		Dr Shaheen Jinah		Clinical Commissioning Group
	*	Mina Kakaiya		Harrow Healthwatch
	*	Dr Genevieve Small		Clinical Commissioning Group
Non Voting Members:	†	Bernie Flaherty	Director of Adult Social Services	Harrow Council
	*	Carol Foyle	Representative of the Voluntary and Community Sector	Voluntary and Community Sector
	*	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: (Officers)	Carole Furlong	Consultant in Public Health	Harrow Council
	Coral McGookin	Business Manager	HSCB
	Johanna Morgan	Divisional Director Strategy, People	Harrow Council
	Visva Sathasivam	Head of Adult Social Care	Harrow Council
	Susan Whiting	Assistant Chief Operating Officer	Harrow Clinical Commissioning Group

* Denotes Member present
(1) Denotes category of Reserve Member
† Denotes apologies received

165. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Member:-

Ordinary Member	Reserve Member
Councillor Janet Mote	Councillor Susan Hall

166. Declarations of Interest

RESOLVED: To note that there were no declarations of interests made by Members.

167. Minutes

RESOLVED: That the minutes of the meeting held on 8 September 2016, be taken as read and signed as a correct record.

168. Public Questions, petitions and deputations

RESOLVED: To note that no public questions, petitions or deputations had been received.

RESOLVED ITEMS

169. INFORMATION REPORT - Presentation by Speak Up Now Campaign Group

The Board received a presentation by representatives of the Speak Up Now Campaign Group, a project supported by Harrow Mencap that aimed to inspire people with learning disabilities to use their voice and experience to educate and inform the health system. The presentation concerned annual health checks for which additional funding was available from the Directed Enhanced Service.

The Board was informed that all 34 GP surgeries in Harrow had been contacted and asked whether they offered annual health checks for people with learning disabilities. The campaigners sought support from the Board to improve the situation as the response had been:

- 8 said that they offered annual health checks for people with learning disabilities
- 2 said that they did not offer health checks for people with learning disabilities
- 10 did not know what an annual health check for someone with learning disabilities was and
- 14 could not provide an answer, either because the hold time was more than ten minutes or because the campaigner was asked to call back another day to talk to another member of staff.

The Board expressed concern at the findings of the survey. The Vice-Chair stated that GP surgeries should have a register of those with learning difficulties and it was important to ensure that a letter was sent to all on the register to attend for an annual health check at a time suitable for them. He undertook that the CCG would repeat the audit in a structured manner in six months time. It was noted that GP surgeries received funding on completion of the health check.

The need to raise the awareness of receptionists as the first point of contact was discussed. The representative of the Voluntary and Community Sector reported that she undertook training for receptionists and undertook to raise the subject at their next meeting. The Mencap representative reported that patient and understanding receptionists made contact with GP surgeries easier for those with learning disabilities.

The Healthwatch Harrow representative informed the Board of research on GP access which would be reported to the Overview and Scrutiny Committee in February 2017.

The Board was informed of the pilot taking place in two surgeries of the Mencap GP WRAP scheme whereby people with learning disabilities undertook a 6 month placement.

The Chair undertook, together with the Vice-Chair, to write to Harrow GPs regarding the findings of the survey. He thanked the campaigners for their informative presentation stating that the comments made had been taken on board.

RESOLVED: That

(1) the Chair, together with the Vice-Chair, write to Harrow GPs regarding the presentation and its findings;

(2) the report be noted.

170. INFORMATION REPORT - Harrow Safeguarding Children's Board (HSCB) Annual Report 2015-16

The Board received the Harrow Safeguarding Children Board Annual Report for 2015-16. It was noted that a new Independent Chair of the HSCB had been appointed and would be starting in December.

It was noted that the presentation of the report to the Health and Wellbeing Board was a statutory requirement. The key priorities reflected a refocus on core business and continued with existing priorities which included reducing vulnerabilities for young people, actively incorporating the views of young people and staff and to further ensure effective collaboration with other strategic partnerships. It was reported that most issues for the Board reflected national issues and particular attention was drawn to the following:

- two serious case reviews had been undertaken during the year and learning shared. A further review was being undertaken;

- audits showed that the application of thresholds had improved due to a shared understanding across the partnership. The HSCB triangulated its evidence via a number of different auditing processes rather than reliance on one check;

- areas where the need for improvement had been identified included working with fathers, capturing the voice of siblings and obtaining consent from parents when sharing evidence.

In response to a question as to the remit of the Health and Wellbeing Board regarding the monitoring of budget reductions on the voluntary sector, the Chair said that it was something that could be considered. The officer stated that the HSCB's voluntary sector arm (VAH) had proved very successful in reaching smaller and more remote voluntary and faith organisations.

RESOLVED: That the Harrow Safeguarding Children Board Annual Report be noted.

171. Joint Commissioning Strategy for People with Learning Disabilities and Autism

The Board received a report which set out the strategic priorities and commissioning intentions for the provision of support for people with learning disabilities and autism in Harrow.

An officer introduced the report stating that the aim was to develop an inclusive service for users and carers with a whole life approach. The Strategy recognised the whole community need as well as individual need.

RESOLVED: That the Joint Commissioning Strategy for People with Learning Disabilities and People with Autistic Spectrum Conditions be endorsed.

172. Future in Mind Business Case

The business case for investing in and commissioning a joint targeted early intervention emotional health and wellbeing service for children and young people in Harrow was discussed by the Board.

A Clinical representative introduced the report and informed the Board that the CCG and Harrow Council were working closely together to bring together the different strands for a service for children and young people who did not reach the threshold for the Child and Adolescent Mental Health Services (CAMHS) service.

Particular attention was drawn to the introduction of a central form for additional needs for completion by the appropriate officer. The Board was informed of a pilot project for those with mild to moderate needs which offered short to medium term intervention to prevent further escalation of needs. Two special needs schools were involved in the pilot which would also be available to mainstream schools. The preferred option was based on school buy-in as match funding was available but if this was not achieved there was still potential for a core service for those with highest needs.

The CCG stated that it would be interested to hear more detail of cases mentioned by Healthwatch Harrow regarding the position of those with autism following the removal of a statement.

It was noted that the Lee Scott report on Special Educational Needs and Disability (SEND) would be issued shortly.

RESOLVED: That the investment of the allocated 'Future In Mind' funding in an emotional health and wellbeing service in Harrow, jointly with the Local Authority and Harrow schools, with the CCG as the Lead Commissioner be agreed.

173. INFORMATION REPORT - Child Death Overview Panel Annual Report 2015

Board members received a report on the findings of the Child Death Overview Panel in 2015 which had the responsibility to review all deaths in children up to the age of 18 years. It was noted that it was a sub group of the Local Safeguarding Children Board and that the report had been submitted to that Board.

In 2015, four CDO Panels were held and 18 cases were reviewed. As the numbers were small, it was difficult to identify trends or statistical inferences. Two cases had been referred for a serious case review and a third case had resulted in some training on safer sleep for early years workers in both the statutory and voluntary/private sector. It was reported that the Wood report, which reviewed the role and functions of Local Safeguarding Children Boards, recommended that CDOP be moved from the Department of Education to Department of Health and grouped into either 3, 4 or 5 authorities across London. This would enable an analysis of numbers for patterns, trends, and themes of death.

In response to a question it was reported that whilst the low numbers presenting before 12 weeks of pregnancy was a risk factor, it was not considered to be a factor in most cases.

RESOLVED: That the Child Death Overview Panel Annual Report be noted.

174. INFORMATION REPORT - Annual Public Health Report

The Board received the Annual report of the Director of Public Health for 2016. The topic of the report was child poverty and the long term consequences on children's lives.

It was noted that work with community groups, voluntary organisations and the Clinical Commissioning Group had begun in order to develop a Child Poverty Strategy which would be submitted to the Board in the New Year. The officer undertook to liaise with the Voluntary and Community Sector Representative regarding the workshop the following week.

RESOLVED: That the report be noted.

175. INFORMATION REPORT - Better Care Fund Update Quarter 1

The Board received a report which set out the progress of the Better Care Fund (BCF) in the first quarter of 2016/17.

It was reported that the annual plan had been submitted to NHS England in June 2016 and resubmitted in September subsequent to a number of changes by NHS England. As a result of a number of changes made to the reporting template which was released later than anticipated a delay in reporting timelines was incurred. The quarter 2 template had been received the previous week and the deadline for submission to NHS England was 25 November 2016. It was noted that the officers were working closely with the CCG and would meet with NHS England regarding the 2017/18 BCF which was due for submission prior to Christmas.

RESOLVED: That the report be noted.

176. INFORMATION REPORT - Clinical Commissioning Group Intentions

The Board considered the draft Harrow Clinical Commissioning Group's Commissioning Intentions for 2017/19. It was noted that these would evolve throughout its two year lifespan as a result of on-going discussions with the public, health and social care partners and providers of services to ensure that needs were met.

Particular attention was drawn to

- three local hubs and the development of access and provision. A third walk in centre opened on 1 November 2016 in the east of the Borough;

- the introduction of a central appointment system;

- increasing intermediate and community care;

- a whole systems integrated care platform with the integration of emerging care across outer CCGs and the promotion of a joined up urgent care system;

- the launch of the patient app.

The CCG Governing Body had signed off the Intentions for the following two years. Consultation on the commissioning intentions would commence in early October with the aim of making them reactive and proactive and the Board would be updated on progress. In response to a question regarding the part played by the voluntary sector in the delivery of outcomes, the Chair reported that consultation with the voluntary sector had closed at the end of September. The Community and Voluntary Sector representative stated that the voluntary sector had been contributing fully to the budget debate and she was of the view that the Council and CCG could improve their working together. The Vice-Chair stated that the CCG valued the voluntary sector with regard to integrated care and that the large scale of financial problems in Harrow was recognised. The two organisations considered the impact of each others commissioning strategies but there would inevitably be a difference of opinion.

RESOLVED: That the report be noted.

177. INFORMATION REPORT - Smoking Cessation Consultation

The Board received a report on the Council's budget consultation in relation to the proposal to end the Smoking Cessation Services on 1 April 2017, which was due to run until 3 November 2016. The proposals to deliver the agreed savings were set out. It was noted that the proposals had not been decided on. On completion of the consultation a report would be finalised in order to inform the December draft budget report to Cabinet.

The Vice-Chair informed the Board that nationally the CCG had significant concerns as the proposals to cease the service had implications across the strategy, undermined the STP, would impact on the most vulnerable, affect those least able to afford smoking therapies and result in higher costs in the long term.

The Chair responded that, whilst it was recognised that the cessation of the smoking service would be a difficult area in which to make a decision, Harrow Council would be losing half of its budget. He stated that the views of the meeting would be taken into account.

RESOLVED: That the report be noted.

178. Future In Mind Harrow CAMHS Transformation Plan Refresh

A Clinical Commissioning Group representative introduced the report, noting that this updated the previous Transformation Plan approved in December 2015. The direction of travel had been agreed and the Plan had already delivered in a number of areas which included increased access, improved outcomes for eating disorders, and the Anna Freud Centre. The report, due at the end of October, would be shared with the Board.

Particular mention was made of the following:

- some of the NHS England funding would be used to support health and social care for those with learning disabilities. There would also be some additional NHS England funding for YOP pathways;

- the working towards a single point of care 24 hours a day;

- although aware of challenges with regard to access targets, the aim was to be fully compliant;

- Harrow was part of a pilot to model a '3.5' model of care with measurable outcomes.

RESOLVED: That the Transformation Plan Refresh be endorsed.

(Note: The meeting, having commenced at 12.35 pm, closed at 2.10 pm).

(Signed) COUNCILLOR SACHIN SHAH
Chair

REPORT FOR:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	12 January 2017
Subject:	**Transforming Models of Care for Adults with Serious and Long Term Mental Health Needs**
Responsible Officers:	Garry Griffiths, Assistant Director, Harrow CCG NHS Harrow Clinical Commissioning Group Jane Wheeler, Deputy Director, Mental Health & Wellbeing, Collaboration of North West London CCGs
Public:	Yes
Wards affected:	ALL
Enclosures:	The Like Minded Case for Change

Section 1 – Summary and Recommendations

This report sets out the ambition of the proposed new model of care for adults with Serious and Long Term Mental Health Needs for the period 2016/17 to 2020/21, and describes the potential impact on health and social services in during that period. The H&WB Board should note that whilst all eight NW London CCGs have signed up to supporting the principles of the Model of Care, local work has yet to be finalised and no decisions have been made to implement the model at the borough-level. NW London Councils have been involved in the work developing the business case this year.

Recommendations:

This report is for information to provide the Harrow Health and Wellbeing Board with an opportunity to be briefed on the Serious and Long Term Mental Health Model of Care prior to approval by the CCG Governing Body.

Section 2 – Report

Background

1. The Like Minded 'case for change' was approved by the eight North West London CCGs in October, 2015 and endorsed by the 8 HWBBs. The 'case for change' describes the vision for health and social care treatment and support for Serious and Long Term Mental Health Needs (SLTMHN) in 2021. This vision complements current NHS England plans for a 'whole systems' approach to the delivery of health and social care services that embodies a holistic view of health and wellbeing and an integration of treatment and support centred around the patient.

2. Drivers for this work include:
   - The Five Year Forward View for Mental Health - NHSE
   - Implementing the Mental Health Forward View – NHSE
   - The North West London Sustainability and Transformation Plan
   - The Like Minded Case for Change

Current situation

3. Work is currently underway to 'localise' the NWL Model of Care and analyse the financial and activity implications of implementing at borough level. Health and Social Care Working Groups have been established with representatives from the CCG, LA, Trusts and Service Users[1] to determine the subset of the SLTMHN patient cohort that would benefit from treatment in less intensive community settings, and propose a list of community-based alternatives to acute beds.

Why a change is needed

4. Treatment as an inpatient on an acute ward is not always the best intervention for people with Serious and Long Term Mental Health Needs. Currently a significant proportion of patients in acute mental health wards – estimated at c10-20% - would either have benefited more from a community-based alternative to an inpatient admission or from an earlier discharge to community-based treatment and support.

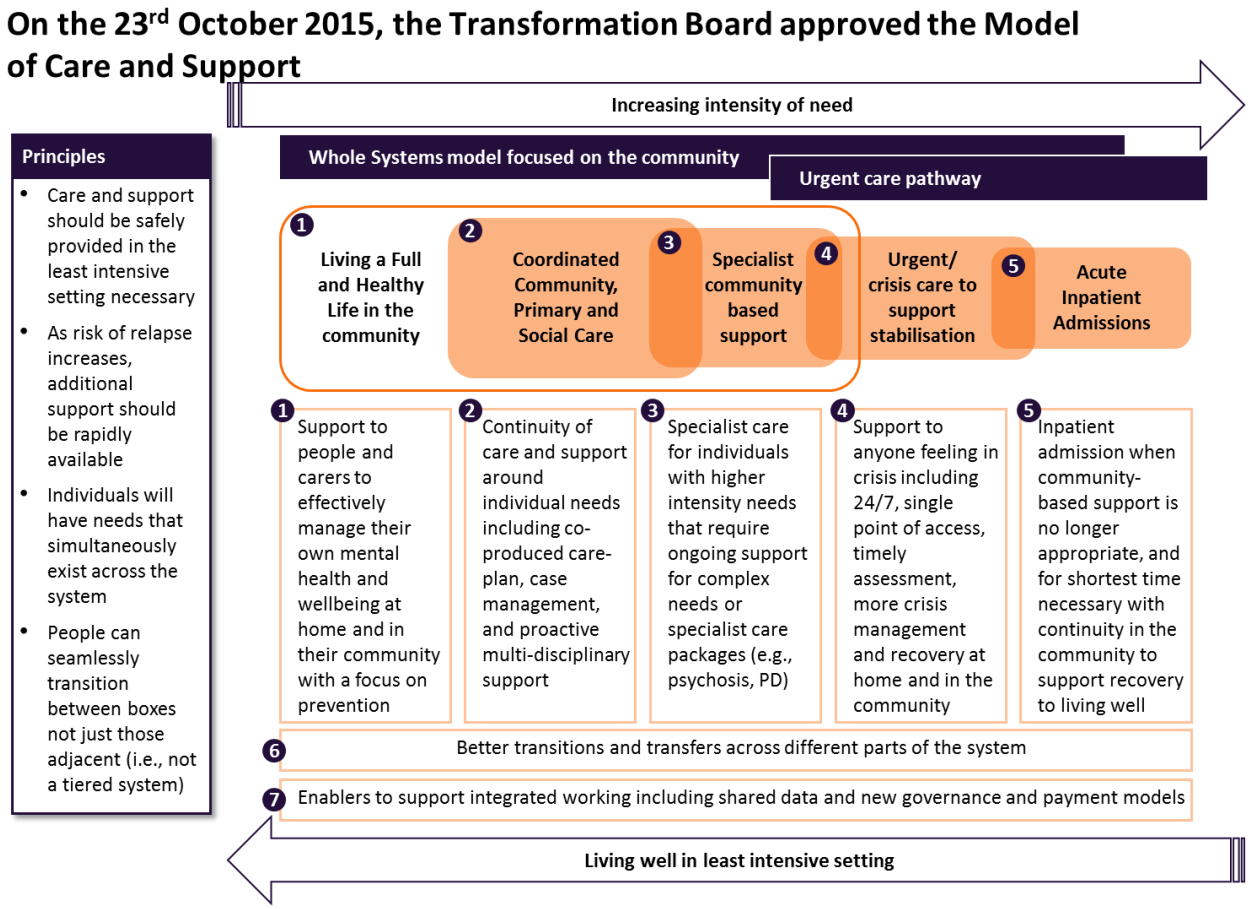
Main options

5. Like Minded's Case for Change identified three ambitions for the support and treatment of SLTMHN that follow the principles of 'patient-centred care', 'treatment in the least intensive settings' and 'whole systems integrated care'; these ambitions are:
   - clarify and simplify pathways
   - develop new community-based care and support, and improve the provision of Primary Care Mental Health Services
   - rebalance resources from inpatient facilities to holistic community-based support

[1] See section below on 'Co-production'

Other options considered

6. The Model of Care involves five settings of care:



7. The initiatives under these five settings are:

		Initiatives
Whole systems community based model	Living a full and healthy life in the community	**Navigation service** - Maintain a database of available system-wide services and make this information available to people, carers and care providers, supported by community navigators
	Coordinated community, primary and social care (WSIC)	Longer **GP appointments** to assist in case management and care planning
		Increased **Primary Care Mental Health (PCMH)** multi-disciplinary resources, working as a wrap-around team
	Specialist community based support	**Technological Advancement** – utilising technology in any area of the model to improve quality of care, efficiency and/or other areas of performance (e.g. using data analytics to centrally schedule community team visits and minimise the time spent on non-face-to-face activities)
		Specialist pathways– implementing specialist pathways in the community, reflecting NICE guidelines and evidence-based care
Urgent care pathway to living well	Urgent/crisis care in the community	**CRHT teams** – Expanded resourcing or other development of urgent/crisis care to further meet national standards of best practice and the recommendations of the Crisis Care Concordat, in order to provide as much intensive home-based care as possible to minimise the need for admission
		Step up/step down facilities in the community, to provide preferred alternatives to inpatient care units (Crisis House)
	Inpatient admissions	**Admission avoidance and earlier discharge** – Development of 'alternative' provision to reduce admissions to acute hospitals and facilitate earlier discharge
		Discharge planning - Greater collaboration on discharge planning between acute inpatient teams and on-going community-based care teams
		Closer **post discharge follow-up**

Implications of the Recommendation

Considerations

8. Over the Five Year Programme successful implementation of the model will reduce the need for acute beds. At a North West London level, the SLTMHN Model of Care suggests that if all the initiatives were to be implemented, by 2021, the eight North West London CCGs would require fewer occupied (acute) bed days (OBDs).
9. However, the current high occupancy rates in Harrow show mental health acute services in Harrow are subject to pressure; and this pressure needs to be alleviated before any reallocation of resources to community-based treatment and support can take place. The impact of this will be to slightly delay – current estimations suggest by one year – the realisation of benefits from investment in community-based alternatives to acute beds. Transition funding will be required for a period of 'dual-running', to fund investment in community-based alternatives to acute beds without any reduction in contract costs for mental health acute services.
10. The SLTMHN business case for investment suggests that following the implementation of community-based alternatives by Quarter 4 of Year 2 of the Five Year Programme, Trusts will see a reduction in the number of occupied bed days commencing in Year(s) 4-5 (allowing for the alleviation of current pressures on acute beds). This will be achieved through reductions in the average length of stay and averting some admissions to acute beds through the availability of community alternatives.
11. The table below illustrates the projected reduction in occupied bed days following implementation of the SLTMHN Model of Care (*note that has not yet been adjusted to take into account the current pressures and high occupancy rate in Harrow and elsewhere*).

CCG	**Optimum bed usage - OBDs**	**2015/16 Outturn**	**Potential reduction in bed usage - OBDs**
NHS Brent	18,600	25,900	-7,300
NHS Central London	17,900	23,000	-5,110
NHS Harrow	12,800	16,400	-3,650
NHS Hillingdon	12,400	16,400	-4,015
NHS West London	20,400	27,300	-6,935
Sub Total CNWL	**81,990**	**109,000**	**-27,010**
NHS Ealing	23,700	29,900	-6,200
NHS Hammersmith & Fulham	13,500	21,200	-7,700
NHS Hounslow	13,900	17,200	-3,300
Sub Total WLMHT	**51,100**	**68,300**	**-17,200**
Total	**133,090**	**177,300**	**-44,210**

Business case considerations

12. Although final figures have yet to be agreed upon, our financial analysis is nearing completion and shows that a small saving can be realised from reducing the number of occupied bed days by investing in more effective community-based treatment.
13. More importantly, however, reallocating investment in community-based alternatives will deliver improved patient outcomes and consequently create efficiencies by reducing the number of related A&E presentations and unplanned admissions, in addition to reducing related social and law and order costs, as people with serious and long term mental health needs receive better, more effective care. Evidence shows that more appropriate community-based treatment and support reduces the incidence of crises amongst this patient cohort.
14. The model assumes the requirement to ensure the right social work input – across the model, recognising the connected health and social care needs of most individuals.
15. Improving services and patient outcomes by implementing the SLTMHN model of Care is necessary for Commissioners and Trusts if they are to continue to meet future demand on services. Projecting trends in current acute bed usage by people with SLTMHN demonstrates clearly that continuing with the current mix of treatment and support weighted towards investment in acute settings is not sustainable in the near future under current budget constraints.
16. Realising efficiencies and savings in the provision of treatment and support for people with SLTMHN is not the key or most important consideration for this Model of Care, although ensuring sustainable services is of paramount importance.
17. *The ambitions and focus of this work are about improving patient outcomes by making available more appropriate treatment and health / social care support in the least intensive settings.* To provide a framework for discussions it has been convenient to refer to a potential reallocation of resources from acute settings to community based support and treatment; by estimating a possible reduction in Occupied Bed Days, we have sought to provide a sense of the size of the potential investment in community alternatives.

Co-production

18. The 'MAD Alliance' (standing for Making A Difference) have received training and an introduction to the Like Minded Programme, and sit on the Health and Social Care Working Groups to give a voice to service users and ensure the Model of Care is co-produced. Further co-production work involving wider stakeholders is planned for the implementation stage (i.e. once the business case has been agreed); but, before this other service user groups and voluntary sector organisations will be briefed on the Like Minded ambitions and plans for Serious and Long Term Mental Illness so our strategic intentions are transparent.

Resources and development of services

19. Analysis is underway to determine the indicative costs of Harrow CCG's investment and the savings to be released through a potential reduction in Occupied Bed Days. The 'roadmap' below describes Harrow's current plans to develop services in each of the five SLTMHN settings:

For Year	Living a Full and Healthy Life in the Community	Coordinated Community, Primary and Social Care	Specialist Community Based Support	Urgent / Crisis Care to Support Stabilisation	Acute Inpatient Admissions	Expected Benefits (sequencing of potential reduction in fewer OBDs)
2016/17	Complete pilot of navigators	PCMH Service launched initially with PCNs	Trust to scope design of community specialist pathways	Single Point of Access CMHT / CRHT HTTs	Community-based Alternatives to Acute Beds Proposed & Evaluated	Reduction in OBDs = '0'
2017/18	Develop Navigation Service with MH Navigators	Enhance GP Provision (TBC) PCMH expanded to include Team Manager Psychological Assistants. An Independent Prescriber Admin Support Access to a Consultant Psychiatrist	•CMHT service with changing profile of patients – more complex and high intensity support levels •New ways of working implemented •Delivering NICE compliance services	Greater provision of CRHT services to support those in crisis and those stepping down from inpatient environment 9 months of 'new' service	Development of alternative services	Reduction in OBDs = -0
2018/19	Enhance navigation service with MH navigators Investment in this setting is complete	Further expansion of PCMH provision, with: 'upgrade' of team manager to Band 8a Access to a Consultant Psychologist Social Worker support Investment in this setting is complete with these enhancements	Enhanced CMHT service – provided for full year **Investment in this setting is complete**	Enhanced CRHT service – provided for full year **Investment in this setting is complete**	Community-based alternatives to Acute Beds implemented	Reduction in OBDs = Phased commencing 18/19
2019/20	No further service change	No further service change	No further service change	No further service change	No further service change	Reduction in OBDs
2020/21	No further service change	No further service change	No further service change	No further service change	No further service change	Reduction in OBDs

Staffing/workforce

20. Implementing the Model of Care will have implications for the development Primary Care Mental Health workforce and workforce associated with community-based alternatives to acute beds in the public, voluntary and private sectors. At the same time workforce in secondary care acute health settings will be dealing with a more complex caseload, with the need for professional and clinical staff to divest themselves of non-specialist and administrative duties and functions. There may be implications also for social care staff and the duties they perform to support the treatment of SLTMHN patients in community-settings.

Equalities impact

21. The Like Minded Equality and Human Rights Impact Assessment, Sept 2015, examined the programme's anticipated impact on several of the protected characteristics (see below).

Legal comments

22. There are no immediate legal implications for the model of care. Development of the community-based alternatives to acute beds may involve, at a later date, the transfer of funding from CCGs to the Local Authority, in which case a Section 75 agreement will be utilised. No closure of beds is proposed, so there is no need for any formal public consultation.

Community safety

23. Community safety will not be compromised. Provisions will be put in place to ensure community safety and the safety of service users treated in the community:
    - The provision of Crisis House(s) could provide an alternative Section 136 place of safety to made available to police;
    - Provision of low-level floating support will mitigate the risk of neglect and social issues arising from treatment in community settings;
    - Protocols and procedures are place for primary and secondary care professionals to risk assess patients prior to referral or discharge.

Financial Implications/Comments

24. By 2021 the transfer of SLTMHN patients' treatment and support from secondary care settings to community-based alternatives to acute beds will involve fewer admissions to hospital and a reduced average length of stay. Although the scale of this impact on social care provision and Local Authority finances is not yet evaluated, it is anticipated that this will increase budgetary pressures on adult social care; this will be off-set partially by the transfer of health resource via Section 75 Agreements

Legal Implications/Comments

25. Existing Section 75 and Section 117 arrangements will need to be re-evaluated.

Risk Management Implications

26. The Health and Social Care Working Groups, in addition to the work of the Like Minded Programme, will evaluate the impact on health and social care services. Regular reporting to the Harrow Health & Wellbeing Board, during the implementation stage, will report on delivery and risks to health and social services.

Equalities implications

27. Was an Equality Impact Assessment carried out? Yes – an initial screening was completed and is summarised below (there will need to be an addition EqIA carried out at the local level)

- Age: The programme is expected to have a positive impact on health outcomes in all age groups.
- Disability: There are approximately 37,500 people in NWL who have either a Severe Mental Illness or a Complex, Longer Term mental illness. The programme directly addresses this group and is expected to have a positive impact on their health outcomes.
- Gender Reassignment: No disproportionate impact on this group is anticipated.
- Marriage / Civil Partnership: No disproportionate impact on this basis is anticipated.
- Pregnancy / maternity: The programme can be expected to have a positive outcome on this group, as being looked after in lower intensity setting is expected to facilitate normal family life.
- Race: The programme is not anticipated to have a disproportionate impact on basis of race. Indeed, being looked after in lower intensity setting, or indeed at home or closer to home, should reduce the stigma that many communities associate with mental illness.
- Religion / Belief: No disproportionate impact on basis of religion is anticipated; again, as with race, the principles of the model of care would support caring for the person closer to home where there religious needs and customs can be fully maintained.

- Sex (Gender): No disproportionate impact on basis of sex is anticipated. Being looked after in a lower intensity setting may reduce trauma for people who have found acute settings quite challenging.

- Sexual Orientation: No disproportionate impact on basis of sexual orientation is anticipated.
- The programme has worked together with a dedicated service user and carer group, the Making a Difference Alliance, who represent some of the protected characteristic. Going forward, this group, together with Mind, will continue to scrutinise our plans, and will seek to bring representative and diverse opinions to better inform the impact analysis of the business case. In planning the following year's work as the business case enters the implementation planning phase we will explicitly:
- Engage stakeholders with an interest in the protected characteristics in gathering evidence or testing evidence
- Engage stakeholders in testing and challenging the programme proposals
- Look to include protected groups in our planning and expand their participation in public life
- Ensure that all services offered are unbiased and non-judgemental and accessible to all groups sharing the protected characteristics
- Seek to create a more representative working group, for example pro-actively include service users who share the interests of those with protected characteristics
- Make arrangements to share the findings of the Equality Analysis
- Aspire to lowering health inequalities
- We anticipate that our work above will also foster and promote good relations between the different protected groups.

Council Priorities

28. The work described implementing the SLTMHN Model of Care also constitutes part of **Delivery Area 4a in the Harrow Sustainability and Transformation Plan** and is therefore aligned with the Council's priorities.

Section 3 - Statutory Officer Clearance (Not required)

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

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Background Papers:
Like Minded Case for Change
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/CaseForChange%20MAIN%20FINAL.pdf

Like Minded
WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

August 2015

Improving mental health and wellbeing in North West London

Case for Change

Improving mental health and wellbeing in North West London

This paper has a bold ambition: to describe the aspirations for mental health and wellbeing in North West London; to identify the issues that we face in meeting our aspirations and ambitions; and to simply and clearly set out what must happen next for us to make progress.

Its purpose is to help us to agree how we move forward; it cannot hope to describe every issue or satisfy every interest or point of view. It is, by its nature, an identification of the common ground; the shared foundations on which we can build a better future for mental health and wellbeing for the people of North West London.

1.1 Introduction: our mental health and wellbeing

Our mental health matters. To each of us, our mental health – and that of our family, friends and colleagues – is vital. It is the very essence of our human experience – our sense of who we are, what matters to us, and how we relate to others and the world around us. Whether you call it wellbeing, contentedness, or happiness – that feeling of choice and life lived well is what most of us strive for each day. We all aim to build a life that we find fulfilling whether that includes loving relationships, happy homes, fulfilling work, meaningful activity, or any of the myriad other ways we can achieve satisfaction.

That old adage – that we don't value our health until we lose it – is more perfectly applied to our mental health. Not only do we not value it, too many of us actively reject the belief that mental health is something that is relevant to us all – and that each of us has varying mental health, better or worse, yet ever-present. Indeed, mental health and illness are used as a way to divide the majority from the minority, not as something that unites us in the very essence of our being.

Mental health needs can affect any of us – children, young people, adults, and older people. Our vulnerability will depend on a number of factors including our resilience to deal with increasing life stressors. Mental illness can be a distressing and debilitating experience, both for us as individuals, our family, friends and others in our lives. When these feelings are combined with physical ill health,

the effect can be devastating – drawing together to create a downward spiral. The effects of dementia and Alzheimer's can cause devastation to entire lives. It is precisely because the impact of mental illness can be so great that treatment, care and support, particularly if provided early, can make such a difference.

Risk factors for mental health needs include a family history, socioeconomic inequalities, debt, smoking during pregnancy, adversity particularly exposure to violence and abuse during childhood, substance misuse, lack of education, unemployment, isolation and inadequate housing.[1] Prevention of mental health needs can occur by addressing some of these factors. Certain groups are disproportionately affected by such factors which in turn require targeted approaches.

Likewise promotion of activities and factors that impact positively on our overall wellbeing can help build resilience to cope with life and maintain wellness.

Throughout North West London there are examples of excellent care – ranging from leading-edge innovations in clinical treatment to the very best examples of holistic support. Care and support are often at their best precisely when they bring together the NHS, local authorities, the third sector and peer support. However, only a minority of our communities receive any treatment, which in turn has broad impacts and associated economic costs.

Various factors promote our wellbeing including good attachment with our parents and carers early in life, educational attainment, meaningful activities and employment, social connectedness, feeling in control, physical activity, resilience and good quality housing. Interventions which promote such factors also promote our wellbeing.

Londoners in our part of the capital often live good and full lives. Recent survey results[2] show that over 90% have good levels of wellbeing. Yet the contrasts can be sharp, with 10% of adults living in London experiencing poor wellbeing. The largest proportion of this group are people who have a mental health need. Many of us find ourselves profoundly alone, with no meaningful conversation with another person this day, this week or even this month. Action is needed to promote wellbeing and target prevention of mental health needs.

[1] *WHO: Social Determinants of Mental Health, 2014*

[2] *Measuring National Well-being: Life in the UK, 2014*

1.2 Our aspiration

We have high ambitions for better mental health and wellbeing for every person living in North West London. We want North West London to be a place where people say:

> "My wellbeing and happiness is valued - I am supported to stay well and thrive"
> "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 and my personal beliefs. It's delivered at the place that's right for me and the people that matter to me"

Underpinning this vision is a set of principles:

- 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

Now is *not* the moment to describe at great length North West London's successes, celebrated though they should be. The voice of services users has been amplified through transitioning to a "co-production" approach. Moving more care to the community, particularly primary care, through Primary Care Plus, has reduced inpatient care in Mental Health hospitals by almost ten per-cent[3]. Standardised acute psychiatric liaison services are now in place at every NWL hospital. Many fewer patients are sent away from home for out-of-area treatments that dislocate them from the people that matter in their lives and are expensive. These successes matter in one sense only: they should give us confidence that we can make future improvements to care because we have done so in the past. We also know that prevention is better than cure and there are a range of cost effective interventions which could prevent people from developing mental health needs and promote mental wellbeing.

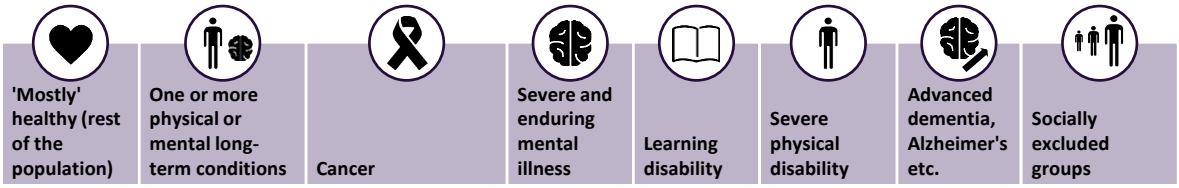
Here, now, in this moment, we are impatient. We are anxious for improvement. We want to focus on what needs to be better in the future rather than to be reminded of what has been done in the past. As you will discover below, there is much work to be done. And all of us are keen to get on with doing it.

[3] *Health and social care information centre, Hospital Episode Statistics, Admitted Patient Care, England - 2009-14*

1.3 This paper

This paper is our case for promoting wellbeing, improving coverage of interventions to prevent mental health needs and for treating mental illness by changing the way that mental health services are provided in North West London. Below, we set out the major issues that we face – and the 12 ambitions that we must sign up to if we are to meet our aspirations. In the weeks and months ahead, we will develop proposals to deliver on these aspirations – and plan to set about the hard graft of making lasting improvements to care and support.

The Like Minded programme set out with a commitment to work with our partners across North West London and build on the good work that already exists – as a basis for an honest shared understanding of where we can do better. We used the approach developed locally and now applied across London to consider different, distinct population groups and their specific needs – across all ages, as set out in the figure below:



With the knowledge that no-one exists in a 'box' we also captured people's thoughts on the transition points between different needs – and in this way were able to understand themes which were positive, or challenging across our North West London population.

As well as talking to people (service users, staff, voluntary sector and the wider public) across our boroughs about their experiences we also looked at a range of information:

- mapping what services and support is currently available
- looking at what data we have on current services and our health and wellbeing more generally – and how we compare to the rest of London
- gathering together a sense of 'what good looks like' from local beacons of good practice – and also other work across London, the UK and more widely.

This paper briefly describes and organises the issues and accompanying challenges and ambitions. It does not set out the full breadth and depth of analysis that has been undertaken in the programme to date, which are published and available for review online (see http://www.healthiernorthwestlondon.nhs.uk/mental-health).

2.1 Issue one: awareness and attitudes to the scale and significance of mental health needs in North West London

One of the main personal factors impacting on our overall wellbeing is the presence of a mental health need. Our mental health has a great impact on our ability to achieve our goals, whether this is to live happy and fulfilling lives, have good social relationships, to contribute positively to society or other personal aspirations.

Mental Health needs affect more people than cancer. They affect more people than heart disease or stroke. They affects more people than diabetes[4]. Over the course of a year, almost one in four people will have a diagnosable mental illness[5]. Perhaps the person in the queue with us at the checkout. Three of the children in the class with our child. Thirteen people on the bus with us in the morning; maybe a hundred on the same tube train. But for example , only a quarter of people with anxiety and depression receive treatment[6] compared to more than 90% of people with diabetes[7].

Depression and anxiety are by far the most common, affecting around one in six of the adult population in London[8]. In North West London, self-reported prevalence of anxiety and depression[9] in 2014 was above the national average in Westminster, West London and Hammersmith and Fulham. Estimates suggest that depression and anxiety disorders may rise steeply in the next decade.[10] At the same time,

- 7% of London's population have an eating disorder,
- 1 in 20 adults have a personality disorder,
- 1% are registered with their GP as having a psychotic disorder such as schizophrenia, bipolar disorder or other psychoses[11].
- approximately 25,000 children[12] experience mental health needs. Indeed, nearly half of all lifetime mental health needs arise by the age of 14[13].

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4 How mental illness loses out in the NHS, Centre for economic performance mental health group, 2012

5 McManus, Meltzer, Brugha, Bebbington, Jenkins. Adult psychiatric morbidity in England, 2009: Results of a household survey: The Information Centre for Health and Social Care, 2009.

6 McManus et al, 2009

7 McShane M, Strathdee G, 'Valuing Mental and Physical Health Together Equally,' Presentation to NHSE; November 2013

8 London Mental Health: The invisible costs of mental ill health, Greater London Authority, 2014

9 GP Patient Survey, NHS England 2015

10 PHE Common Mental Disorders Profiling Tool, 2015

11 London Mental Health: The invisible costs of mental ill health, Greater London Authority, 2014

12 Better Health for London, London Health Commission, 2014

13 Kim-Cohen J, Caspi A, Moffitt T et al. Prior juvenile diagnoses in adults with mental disorder. Archives of General Psychiatry 60: 709–717; Kessler R, Berglund P, Demler O et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-Iv disorders in the national comorbidity survey Replication. Archives of General Psychiatry 62: 593–602, 2003

Mental illness is experienced by our family, it is experienced by our friends, it is experienced by our colleagues – and it's experienced by ourselves. Mental illness is both normal for everyone and yet invisible to many of us at the same time. Despite the large proportion of the population affected by mental health needs, only a minority of people nationally receive any treatment[14]). In North West London, we estimate that two-out-of-three people living with mental health needs are not known to health services[15].

The risks of developing mental health needs in adults and older people varies by age, sex and ethnicity. Some parts of North West London have higher levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness.

Just like physical health, there are significant inequalities in mental health. It is perhaps little surprise that families that live in poverty are more likely to have mental health needs. Similarly, people with mental health needs are more likely to live in poverty too[16].

Inequalities are both a cause and outcome of mental health needs (Campion et al, 2013). There is an important intergenerational effect: children whose parents have mental illness and do not receive appropriate support are five times more likely to experience mental illness themselves[17]. North West London has some of the wealthiest and some of the most deprived boroughs in the capital. It is little surprise then, that the incidence of mental illness varies sharply, with child and adolescent mental health needs three times as common in deprived areas compared to the least deprived parts of the city[18].

Too many of us face mental illness alone, afraid of the stigma of speaking up, or not understanding what support could be available – or trusting that it will be. We don't talk, think, or act enough on our mental health and wellbeing. How can it be that something that matters so much and affects so many, is so poorly understood? The first step is for us to assess the level, impact and cost of local unmet need in treatment and prevention of mental ill health and promotion of wellbeing.

We need to make improvements to services that people access already and to work in partnership to ensure that universal services such as schools, hospitals, criminal justice, housing and workplaces, are more accepting, more knowledgeable, more supportive to people who are experiencing mental ill health needs. We need to work with these services to ensure at a basic level that they do not inadvertently become places where further harm is done.

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14 McManus et al, 2009

15 Prevalence for all conditions: QoF 2013/14; Expected prevalence: Depression and Anxiety: Psychiatry survey, 2007; SEMI: LSE Centre for Economic Performance

16 *Campion J, Bhugra D, Bailey S, Marmot M (2013) Inequality and mental disorder: opportunities for action. The Lancet 382: 183-184*

17 Meltzer H, Gatward R, Corbin T et al (2003). Persistence, onset, risk factors and outcomes of childhood mental disorders. London: The Stationery Office

18 Green et al: Mental Health of Children and Young People in Great Britian, 2005 ONS

Naturally, we give our support to London-wide and national initiatives (such as Time to Change) to create parity of esteem between mental and physical health, to encourage more open and tolerant attitudes, and to de-stigmatise both the experience of mental health needs and care and support for people who experience them.

Ambition 1: We will ensure that mental health needs are better understood and more openly talked about and improve the experience of universal services for people with mental health needs in NWL

2.2 Issue two: the promotion of wellbeing, resilience and prevention of mental health needs for people in North West London

Our sense of wellbeing is necessarily subjective. The Commission on Wellbeing and Policy, chaired by Lord Gus O'Donnell, defines wellbeing as "*perceived* happiness and life satisfaction". Amartya Sen – who won the Nobel prize for his work on welfare economics – pushes the concept further, and describes how wellbeing must take into account the extent to which individuals have freedom of choice and how far society allows them to "enhance their capabilities and to flourish".

As a result, the concept of wellbeing includes a broad range of things that contribute to happiness and life satisfaction. These range from attachment and early life experiences to successful personal relationships, employment satisfying work or something meaningful to do, choice, fulfilling education, good quality housing and an active old age with a purpose in life.

Whilst the causes of mental illness are sometimes poorly understood, evidence shows a range of risk factors for mental health needs include genetic predisposition and environmental factors such as socioeconomic inequalities, adversity such as violence and abuse, debt, as well as loneliness and isolation[19].

The opportunities to improve wellbeing and mental health are found mainly in the places where most people spend most of their time. For children and young people, such places are schools and further education providers. There is a significant opportunity to work with schools to promote mental wellbeing and resilience. Addressing risk factors and promoting protective factors at an early age both prevents a proportion of mental health needs from arising, promotes wellbeing and resilience.

For the majority of the adult population, the workplace represents an important opportunity. Mental health in the workplace is being championed across the capital by the Greater London Authority, as a result of the London Health Commission report 'Better Health for London' (October 2014). This reinforces national efforts driven and coordinated by the Department of Work and Pensions, for example the Working Capital programme. If all the organisations across North West London involved in this work signed up to the Healthy Workplace Charter[20] the impact would be significant. And speaking with honesty, the NHS, for example, has a poor track record of promoting either the physical or mental health of its employees. We have, therefore, much more to learn than to teach.

19 Campion J, Bhui K, Bhugra D (2012) European Psychiatric Association (EPA) guidance on prevention of mental disorder. European Psychiatry 27: 68-80

20 https://www.london.gov.uk/priorities/health/focus-issues/london-healthy-workplace-charter

There is a huge opportunity to improve mental health and wellbeing for older people. Older people are typically frequently in contact with both health and social care – these are people that are usually known to us. We also know that many older people feel lonely and socially isolated – and that loneliness is detrimental to both health and wellbeing. Over time, loneliness and isolation can lead to mental health needs such as depression or anxiety[21].

Older, housebound people are particularly vulnerable, but other life events such as becoming a carer can make it hard to make time to socialise or carry on with hobbies or interests. The number of carers who reported feeling lonely across NWL boroughs is particularly high in some boroughs and varies from a quarter in Brent to half of all carers in Harrow (compared to 36% in London as a whole)[22].

There is potential for the health and care system to identify people who are lonely and connect them to opportunities for positive, substantive, social interactions. There is a particularly important role for the third sector and for peer-led support groups in confronting loneliness. Though there have been positive efforts, there is huge untapped potential outside the public health and care system. For relatively small levels of investment, a huge return can be achieved by partnering closely with the third sector. Furthermore, peer-support represents an essential part of mental health support and should be considered a core part of what happens, not a 'nice to have'.

Ambition 2: We will improve wellbeing and resilience, and prevent mental health needs for people in North West London, by supporting people in the workplace, building resilience in children and young people and reducing loneliness for older people.

21 Griffin J. The Lonely Society, 2010. Mental Health Foundation www.mentalhealthfoundation.ork.uk

22 PHE Fingertips fingertips.phe.gov.uk

2.3 Issue three: the quality of care, coverage and outcomes for people with serious, long-term mental health needs

As the name suggests, serious, long-term mental health needs can have a devastating impact on lives, tearing apart the things that matter most –your place in the world, relationships with family, friends and colleagues, and the sense of purpose– whether in education, work or pastimes. At the same time, when affected we can lead the life we choose. All of us are more than a diagnosis.

Around 23,600 people in North West London have been diagnosed with schizophrenia, bipolar disorder and/or psychosis (approximately 1% of the total population) is around double that of the national average[23]. Around 60% of people diagnosed with a serious mental illness such as schizophrenia or having experienced psychosis are cared for solely in primary care[24].

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70% of those presenting to health and social care settings[25]. In North West London, there is a great variation across the borough in people accessing both mental health services and substance misuse services; it ranges from 13% of people in Hounslow accessing mental health services and alcohol treatment services to as high as 52% in Hillingdon[26].

Outcomes for people are often poor. For example, rapid step-down from inpatient crisis care is known to result in better outcomes: there are wide disparities in North West London – in many boroughs, half of all patients are still in crisis care after 9 months, whereas in others fewer than one-sixth are[27].

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.[28] Further work is needed to support people with serious mental illness to live independently in the community. Pathways for recovery and enablement should be holistic and integrated across the whole health and care economy and include working with local authority and voluntary sector services that promote independence such as leisure, employment schemes, befriending interventions etc.

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23 Quality and Outcomes Framework (QOF) for April 2013 - March 2014

24 QoF 2013/14

25 Reference: Crome, I, Chambers, P. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues. SCIE Research briefing 30. Available from: http://www.scie.org.uk/publications/briefings/briefing30/

26 PHE National Treatment Agency, 2013/14

27 Cluster and patient data January 2014 to September 2014 for CNWL and WLMHT

28 Adult Social Care Outcomes Framework, 2013

Whether we have long-term needs or a short term episode of mental health needs, when we experience, or are close to experiencing, a mental health crisis, there should be services available to provide urgent help and care at short notice which are responsive and easy to navigate.

For routine specialist care, the normal wait for people who have experienced a psychotic episode is two weeks; in some boroughs it is closer to four weeks [29]. Elsewhere in England, one week is the norm. 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. This is all the more so at a time of crisis, and especially for those with little or no prior contact with mental health services (such as friends and family of first onset patients).

The defining characteristics for this group are their *needs* not their diagnosis. There are two broad dimensions on which needs are defined – complexity and duration.

Complexity can come in many different forms. Examples would include relapsing/remitting serious mental health needs such as schizophrenia, recurrent long-term depression, complex interactions between mental and physical conditions, complex social factors ranging from homelessness to being a carer, severe forms of personality disorders. Complexity is much more than a clinical concept.

Conversely a given diagnosis does not always imply complexity. For example a large proportion of young people experiencing their first psychotic episode will make good recovery if treatment is accessed early[30]. Work is underway in North West London to improve Early Intervention in Psychosis – but there is more that can be done. An evidence base exists for even earlier support – during what is known as the prodrome phase, when an early symptom (or set of symptoms) can indicate the start of a disease before specific symptoms occur.

Being cared for in primary care settings does not by default mean that an individual's needs are not complex. In the case of people with depression treated by normally 'effective' means, a substantial minority still fail to meet the criteria for recovery. Depression can become complex and chronic with people reporting continuing symptoms of depression and accompanying distress about these symptoms (increased duration of need).

Similarly, reflecting duration of need, many serious mental illness are relapsing and remitting in their character which means that through excellent care and support, the amount of time that people feel well can increase, improving quality of life. Levels of resilience are typically lower than the general

29 CNWL and WLMHT referral data with first contact January 2014 to September 2014

30 Rethinking Mental Illness: Lost Generation, 2013

population. The goal for this group of people is to support the holistic concept of recovery –focusing care on finding meaningful activities, ensure good housing is maintained, promoting independent living and building the resilience of people with mental illness, not just on treating or managing their symptoms. This can be done through joint working with local authorities and other community organisations that can reach far out outside the usual care settings.

15% of people who experience an episode of psychosis will lead a chronic course experiencing repeated relapses and being substantially handicapped by their condition and 10 will die mainly by their own hand[31]. Reflecting the intensive needs of these individuals, they account for the vast majority of mental health expenditure – indicatively more than 80% of specialist contacts, nearly 90% of inpatient bed days, and 80% of spend by the mental health trusts. Furthermore, they also require support from local authorities, housing, employment, the third sector, and, regrettably, the police and criminal justice system.

There is significant room to improve the quality of care that is provided. Today, no boroughs meet all of the NICE guidelines for psychosis treatment. Patient satisfaction hovers around the London average. People tend to spend longer in inpatient facilities than in other parts of London and nationally. We need to make sure we have the right balance of inpatient beds and community teams. There is a huge opportunity, therefore, to completely redesign and strengthen community-based care through clarified pathways and a new care and support model.

Whilst we focus throughout our strategy on the need to support wellbeing promotion and prevention of mental health needs, for many people who experience serious and long-term mental health needs these result from an experience of trauma – often early in life. Whilst more can be done to address these causes of trauma, we cannot aim to prevent or reduce the severity of all illness – we need our current services to work differently with service users and with other agencies.

Essential features might include transformed peer support, much better support for GPs, first class rapid response both for crisis and to stabilise people, and stronger community based support – wrapped around the needs of the individual and working jointly across organisational divides – social care, health, voluntary sector, employment and housing teams and drawing on the assets of the individual themselves and the community. It is vital that the care model that is designed is placed within – and connected to – the North West London environment.

31 http://www.livingwithschizophreniauk.org/advice-sheets/recovery-strategies-for-schizophrenia/

The result of a better, higher quality, more connected and more consistent model of care and support should be that people remain stable for longer, and exacerbations are less acute as well as less frequent – and that the quality of life for people is made better. It should also lower the demand for inpatient care, and by doing so, help the overall system to achieve sustainability.

Ambition 3: We will clarify and simplify the pathways for people with serious, long-term mental health needs

Ambition 4: We will develop new community-based care and support models that will improve the quality of care and outcomes for people with serious, long-term mental health needs

Ambition 5: We will rebalance resources from inpatient facilities to innovative community based support

2.4 Issue four: identification of common mental health needs and access to good quality care

Common mental illnesses are experienced by nearly a quarter of a million people living in North West London. This includes depression and anxiety, social anxiety, post-traumatic stress disorder and obsessive-compulsive disorder. People with serious mental health problems die on average 20 years earlier than the general population[32]. For people who have a physical long-term condition, having depression increases mortality by at least 45%. [33]Importantly, the suicide rate – though low overall – is 20 times higher for this group than for the rest of the population[34]. The impact is wider than on health – mental health is the most significant cause of lost workdays across England[35].

Many of us in North West London get no access to the care that we need. There are huge variations between expected rates of mental illness, rates of diagnosis, and rates of treatment. When we develop a common mental illness we often do not seek help from healthcare services or if we do mental health needs are not detected. We know there are particular groups who are even less likely to have needs diagnosed – and indeed to access services. Undiagnosed depression is one of the main risk factors for suicide. Suicide rates per 100,000 population in North West London boroughs vary greatly with the rates in Hammersmith & Fulham and Westminster higher than the London and national average.[36]

Better access is a common theme in feedback from local residents but can also be a complicated issue. With barriers to access not solely relating to services, but also to complex factors such as stigma within the service and artificial gateways requiring certain diagnose or behaviours to enable eligibility to then access care. Our services need to consider the reasons why people may choose not to access them, and how this informs how services could be differently delivered.

The result is that as many as two-thirds of people with common mental illnesses are receiving no care whatsoever (versus a quarter of people with a physical illness not receiving care)[37]. With steadily declining expenditure on primary care overall, this is perhaps to be expected. It should remain shocking.

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32 Brown S, Kim M, Mitchell C and Inskip H (2010) Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry 196: 116–121; Parks J, Svendsen d, singer P et al. (2006) Morbidity and Mortality in People with Serious Mental Illness, 13th technical report. Alexandria, Virginia: National Association of State Mental health Program Directors.

33 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

34 Lepine, Biley: The increasing burden of depression. Neuropsychiatr. Dis Treat 2011, 7(Suppl 1): 3-7

35 No health without mental health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages; 2nd February 2011

36 PHE Fingertips, 2013

37 Campion (2015) Mental health needs assessment for North West London. Draft 22-6-15. South London and Maudsley NHS Foundation Trust

For those whose mental health needs are detected, there are drug and psychotherapeutic treatments that are effective for many people at both shortening the duration of the disorder and in reducing the likelihood of relapse. Nonetheless, the quality of primary mental health care for people who are diagnosed with common mental health needs is not always good enough.

Failure to diagnose or late diagnosis and lack of provision of timely access to short term therapies and supported self-care can lead to deterioration and poor outcomes. Typically, people in North West London get poorer care than can be found in other parts of London. For example, just two boroughs achieve the London average for post-diagnosis review (and the London average itself is poor)[38]. Of the eight CCGs in North West London, only Hammersmith and Fulham meets the national target of 15% access to IAPT (Improving Access to Psychological Therapies) services and 50% recovery rate for those people using the service[39].

Going further, many people who use services have pointed out that there ought to be a broader range of offers than just IAPT – and that IAPT services themselves must be more flexible. Treatment and care must take into account people's needs and preferences. Models of care where clinical teams work alongside the voluntary sector and engage as equals with people who have a lived experience of common mental health needs, in peer support roles, provide less rigid and more person-centred support – for example our Primary Care Mental Health services in Westminster and Kensington & Chelsea, Queen's Park and Paddington work with Mind and Depression Alliance respectively. As the London Health Commission described, there are potentially promising avenues in digital mental health support, building on the success of the "Big White Wall" – which is already available in some areas of North West London, such as Hounslow.

Ambition 6: We will improve identification of depression and anxiety recognising that many people may not be engaged with any services at present

Ambition 7: We will improve the quantity, quality and diversity of non-pharmacological therapies for people experiencing depression and anxiety

[38] *Public Health England Local Profiles*

[39] *Public Health England Local Profiles*

2.5 Issue five: mental health needs of Children and Young people are often neglected

The needs of North West London's **children and young people** have for too long been neglected. There are approximately 25,000 children in our part of the capital with mental health needs, of whom more than 8,000 require more specialist interventions[40]. Children and young people have been relatively underserved by the system for too long. Despite the fact that around half of all mental health needs in adults emerges by the age of 14, and three-quarters of lifetime mental health disorders have their first onset before the age of 18, fewer than 10% of CCG mental health spend is invested in their care.[41] There is a compelling case to prioritise their needs.

Parental unemployment is associated with several fold increased risk of mental ill health in their children[42]. The proportion of children living in households with no adults in employment ranges across NWL from 9.6% in Hounslow to 28% in the Westminster borough; a total of 57,480 households across North West London[43].

Our childhood and experiences in our early years have a significant effect on our adult lives. Many mental health needs in adulthood show their first signs in childhood and, if left untreated, can develop into conditions which need regular care throughout adult life.

We know that there is variation across our boroughs of children likely to have conduct disorder (e.g. 5.4% in Harrow to 8.3% in Brent)[44]. This is important because ignoring conduct disorder in childhood has repercussions for the individual and society more broadly. The annual cost of crime by adults who had conduct disorder and sub-threshold conduct disorder during childhood and adolescence varies from £147.4m in Kensington & Chelsea to £452m in Brent[45].

We can sometimes end up focusing on those children with complex and serious needs - which whilst important can mean we miss opportunities to highlight and support those children where early intervention within families could dramatically improve their life chances. Frequently it is our schools, health visitors, school nursing services and GPs who have contact with children with early signs of mental health needs – unfortunately it is also our Youth Offending Teams, social care and acute emergency services that interact with these vulnerable children and young people, where the early opportunities to intervene are missed. This is not due to lack of good will – there are many highly skilled and highly valued staff working with children and young people who want to make a

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40 Public Health England Fingertips

41 NHSE, 2014

42 Royal College of Psychiatrists Position Statement: No Health without Public Mental Health, PS4/2010

43 Office of National Statistics, 2012

44 PHE Fingertips fingertips.phe.gov.uk

45 SCMH, 2009

real and lasting difference to their lives but there are barriers in the system itself which prevent change.

There is a terrific opportunity to work with schools to improve mental health and resilience – and indeed many of our schools, despite the challenges of increasingly pressurised curricula, ensure that wellbeing is a part of the school experience. Speaking with partners working in education, eating disorders are a significant issue that schools attempt to address through their work on resilience and wellbeing. Whilst eating disorders are not restricted to children and young people – the drive for improvements centres on the younger population. Nationally admissions relating to eating disorders continue to rise (8% from 2011/12-2012/13)[46]. Additionally funding is being provided across England to improve services locally.

In 2014 the national Children and Young People's Mental Health and Wellbeing Taskforce sought to identify the problems which stop us from providing excellent mental health care for young people. The publication of the national strategy (Future in Mind) in February 2015 has galvinised teams working with children to articulate how we improve our formal Child and Adolescent Mental Health Services, but also improve how our whole system builds resilience, prevents needs developing and supports a range of growing issues (such as mounting rates of eating disorders and self-harm).

Whilst the national strategy means we can access additional funding, this is also about considering children and young people as a real priority for system-wide focus, to improve immediate experiences, but also to set them up for lives which are meaningful and fulfilling.

Ambition 8: We will ensure that implementation the national strategy responds to our specific local needs – and the variation in access and outcomes across NWL for all children and young people

[46] *HSIC, January 2014*

2.6 Issue six: the quality of care for other population groups with specific needs

The intensity of needs of a relatively small group of people with serious, long-term mental health needs combined with the enormous scale of the challenge of common mental illnesses means that particular groups have been relatively underserved. Our work has identified four groups with defined needs that require significant improvements. These include the following:

- Expecting and new mothers (perinatal)
- People with learning disabilities
- People who are homeless and other underserved groups
- People with dementia

Improvements are required to the care for each of these groups. We now – briefly – explore some of the issues faced.

The early years of life have the power and potential to shape whole lives – for both mothers, infants and children. For example, depression affects more than 1,000 **expecting and new mothers** in Ealing and many thousands across North West London as a whole[47]. Tragically, suicide remains a leading cause of death for expecting and new mothers. Furthermore, when mothers become mentally unwell it increases the likelihood that children will experience behavioural, social or learning difficulties and fail to fulfil their potential. Work is presently underway to implement new perinatal models of care across all 8 boroughs.

People with **learning disabilities** often have mental health needs too. Nationally, 2.2% of the population have learning disabilities. What is often overlooked is the intensity of mental health needs of this population group. Not only do 25-40% have a diagnosable mental illness, the prevalence of schizophrenia is three times that of the general population[48]. Often, people with learning disabilities will already have support from social services or carers or both, making the case for more integrated care even more compelling. Services must be designed to meet their needs – with better, clearer communication and appropriate training so that care is tailored in the right way.

North West London has some of the highest rates of **homelessness** and rough sleeping in Britain (this is particular concentrated in Westminster). Studies have demonstrated that nearly half of all homeless people suffer from mental health needs (45% prevalence) though this may be understated. The homeless population has a life expectancy of only 43-47 years, compared with 80-84 for the general population, and is more afflicted by mental ill health than any other population group. Often, homelessness reflects not only unfortunate circumstances, but a crisis in an individual's ability to cope with life's challenges.

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[47] *Gavin et al, 2005*

[48] *Smiley 2005*

People who are homeless often have the most intense needs in addition to their need for accommodation: 12% of participants diagnosed with mental health issues also reported drug and alcohol issues.[49] This is exacerbated by the fact that often the homeless cannot manage their own conditions, due to a combination of chaotic lives, low literacy, poor access to care, and, regrettably, often hostility from health professionals. This makes it much more likely that care is provided at A&E or the hospital, which is both inefficient, costly, and degrades their quality of care. We will work with the London-wide programme to improve mental health care for people who are homeless.

When considering the needs of the homeless, specialist voluntary sector partners suggested that the needs of many hard to reach groups have wider ranging similarities – for example there is considerable overlap in the needs of sex workers, people with mental health needs who use drugs and alcohol or indeed BME communities. The issues around access, stigma and acceptance by universal services are critical. In North West London our providers report particular challenges in relation to the impact of immigration and a transient population.

A rising challenge for every part of the country – where North West London is no exception – is **dementia**. As of March 2015, 10,000 people on GP registers had diagnosis of dementia compared to 15,115 people estimated to have dementia locally. Over the recent years, diagnosis of dementia in GP practices has increased however the latest data suggest an overall diagnosis gap of 34%[50].

Work is presently underway to implement a NWL Dementia Framework, which is a new model of service based on national guidance and best practice – but tailored to local requirements. What is clear is that diagnosis rates are rising (partly as a result of primary care financial incentives) and as a result, significant effort must now be invested in ensuring that more accurate diagnosis is followed up with best practice interventions.

Ambition 9: We will make targeted improvements to the care and support for underserved groups within existing services

Ambition 10: We will identify which care and support models need to change and how, so that we can improve care for underserved groups

[49] *http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf*

[50] *NHS England Dementia Prevalence Calculator, March 2015*

2.7 Issue seven: the relationship between mental health and physical health

The NHS has historically created a separate institutional, legal and regulatory framework for mental healthcare. Yet just as the health delivery system has been divided, the health of any individual is indivisible.

In 2014, the life expectancy of a man who has experienced psychosis was 65 – 14 years less than the average, and the same as the typical life expectancy for a man in 1954[51]. This is because people with mental health needs are at higher risk of developing significant, preventable physical health problems.

The largest single preventable cause of death in England is tobacco smoking and this is even more so for people with mental health needs who smoke at much higher rates. 42% of all cigarettes smoked in North West London are smoked by people who have a mental health need[52]. Despite the existence of effective interventions to address physical illness and prevent it, such as smoking cessation, monitoring of physical health is often inadequate.

People with schizophrenia are twice as likely to die from cardiovascular disease and three times more likely to die from respiratory disease and the single biggest risk factor for these physical conditions are smoking followed by obesity and lack of exercise. These shocking facts demand that we are pioneers in making improvements to the physical health of people with serious, long-term mental health needs. The crucial need is to fully integrate physical health services into a single care and support model for people with serious, long-term mental health needs.

Similarly, too many people with long-term conditions do not have their mental health needs properly taken into account. The observation is often made that mental health "is a co-morbidity of many long-term conditions". This is hardly surprising: being sick for any period of time is not an enjoyable experience. It can feel terribly disempowering, and all too easy to focus on what an individual can no longer do, with particular issues around employment, mobility, and social isolation. Providing high quality holistic care means empowering us as individuals and enabling everyone to focus on what they can do.

Mental health needs are associated with poorer physical health in general - those with long-term conditions are two to three times more likely to have a mental health need than the general population [53]. Mental health and wellbeing can affect physical health outcomes – depressed co-

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51 *Better Health for London, London Health Commission, 2014*

52 *McManus et al, 2010*

53 *De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Möller HJ, Ndetei DM, Newcomer JW, Uwakwe R, Leucht S (2011a). 'Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care'. World Psychiatry, vol 10, no 1, pp 52–77.*

morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients[54]. It is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental health needs[55].

This is why mental health is an integral part of the whole systems integrated care programme. The question is how to build upon the lessons from the early adopters in the programme and to spread and scale changes across North West London.

Ambition 11: We will fully integrate physical health into the care and support model for people with mental health needs

Ambition 12: We will build upon, spread and scale the lessons learned from the whole systems early adopters in mental health care for people with long-term physical health conditions

[54] *DiMatteo et al: Depression is a risk factor for non-compliance with medical treatment: meta analysis of the effect of anxiety and depression on patient adherence. Arch Intern Med, 2000*

[55] *Naylor et al: Long Term Conditions and Mental Health King's Fund 2012*

2.8 Issue eight: our systems hinder integrated care

When we look across the systems in North West London, it becomes all too apparent that too often they hinder rather than help to deliver high quality care. There are a set of enablers for better care that need to be put in place if North West London is to achieve its aspirations. In this section, we focus on those enablers that are more specific to mental health (where they are the same as physical health, they are captured in the whole systems programme).

The first focus must be on **workforce**. There are three broad areas where progress is necessary. First, we must make sure that the mental health workforce is sufficient. This includes peer support workers, psychiatrists and general practitioners, for example. Second, we must systematically develop the broader mental health workforce – in particular, to think about how we can improve the skills and capabilities of our talented third sector partners and, crucially, of those offering peer support. This may take the form of sharing between different parts of the third sector (some of whom are more skilled than others) as well as targeted training to improve peer support services. Third, we must ensure that those working in other parts of the health and care system – and beyond it such as the police, schools, housing – have appropriate training and awareness of mental health issues.

The second area that needs urgent attention is **information**. There is a paucity of information in mental health that serves, over the long-term, to fundamentally harm the interests of the sector. Outcomes are often not well-defined nor measured. Neither, in many cases, is activity. The information set for community-based services is particularly sparse. Though significant investments have been made in recent years, the sector as a whole is playing catch-up to its cousins in physical health. We have an opportunity to revolutionise the approach to data and information – by placing a sharp focus on measuring the things that really matter.

A related issue to information is **payments**. Today, the payment system does not promote integrated care; it hinders it. Much of the work that has been developed in the whole systems programme more widely has the potential to have huge impact in mental health. For example, consolidating the budget for mental and physical health could enable completely different care models that are much more holistic in their character. The programme should be at the forefront of holistic capitated or personalised budgets – building on recent initiatives in both the NHS and local authorities.

Finally, we know that the mental health **estate** faces even more fragmentation and chronic under-investment that the physical health estate. Reports from the Department of Health, NHS England and Monitor have demonstrated this. Furthermore, evidence has shown that the environment that people are cared in has a significant impact on their recovery. We must look at how the estate can be rationalised and upgraded – a process that must proceed in parallel.

Ambition 13: How can we ensure that our systems help rather than hinder integrated care

3. What's next?

The goal of this document is to build a consensus that the right issues and ambitions have been identified, and that work should commence or accelerate to address them. Nonetheless, it will be necessary to approach the different issues and ambitions in different ways, reflecting the unique circumstances of each of them. We will maintain the importance of co-production; working with service users – the people who access the services we seek to improve – to harness critical experience, creativity and ingenuity and improve care.

LikeMinded

WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT – Harrow Health Help Now Patient App/Website – Update.**
Responsible Officer:	Javina Sehgal – Chief Operating Officer, Harrow Clinical Commissioning Group
Exempt:	No
Wards affected:	All Harrow residents
Enclosures:	Health Help Now – Governance paper.

Section 1 – Summary

This report provides an update for the Health and Wellbeing Board on the CCG's development of a 'self-care' and 'signposting' smartphone App and accompanying website which will promote the self-management of health conditions and signpost to 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 etc. It was agreed that the development of a mobile application (phone, tablet) which focused on empowering patients to learn more about health conditions and effectively manage them would be beneficial for Harrow residents.

Since the last update to the September Health and Wellbeing Board, the App has been developed and was launched on Monday 28 November 2016. The App was developed with a significant amount of patient and public involvement during both the initial and final testing phases.

The App and website were launched on Monday 28 November across a number of app stores e.g. Google and Apple and on the internet.

The following features are available to help Harrow residents to fully benefit from health and associated services provided by organisations such as the Local Authority, voluntary and charitable organisations:

- Symptom checker
- Directory of local NHS services (including hours of service, distance from device and maps) linked in with 111 Directory of Service
- Directory of associated council services to signpost Harrow residents to other services that prove useful. (Social Care depts.)
- Journey planner – based on your home address or current location within Harrow
- Provide user feedback
- Signpost voluntary organisations
- Provide a Health Wallet (to save useful contacts, appointment dates, notes)

As mentioned in the initial paper considered at this board in September, a carefully coordinated and structured plan of patient and public engagement was undertaken over the last 3 months.
The following groups/organisations were seen in person to feedback at all stages of development to seek views and collate suggestions.

- Local Authority - Infinity Project and Communications
- HASVO - Somali Group
- Citizens Advice Bureau
- MIND
- AGE UK
- MENCAP
- Healthwatch
- London Ambulance Service Harrow

Patient Groups

- Youth Action Group
- Harrow Patient Public Network
- St Peters Medical Patient Group
- Enderley Road Patient Group
- Interfaith Committee Group
- Harrow Pharmacy Committee

Schools

- Stanmore College
- Harrow College

To help promote the App and website, 3 short viral videos were produced along with a 1 minute video specifically targeting young people. These will be played in every GP Practice, Walk-In Centres and Urgent Care Centres.

Stanmore College will show the videos to all 12000 pupils as they think the App will benefit students.

Governance

As part of the CCG's commitment to ensuring that the app is embedded as 'business as usual' a clinical assurance group will be formed by Jan 2017. The attached enclosure details how the group will work to review the information on there currently and work on ways to help the tool evolve based on feedback.

Potential Development areas once implemented

- Share data with a patient's GP (if an individual is in agreement)
- As part of the CCG's commitment to encouraging early intervention, a dedicated section for young people which will cover both physical and mental health.
- 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.
- Book Harrow GP appointments & repeat prescriptions.
- Opportunity to further customise the App to accommodate the local healthcare/social care environment.

There will be a practical presentation of the App at the Health and Wellbeing Board January meeting.

Section 3 – Further Information

We would like to return to a future HWBB once the app is completed to demonstrate the full 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 App being available in languages other than English and hope to have this available by June 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 and family carer's 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 – Harrow Patients Participation Network 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
(Not required)

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

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

Background Papers: Report to Health and Wellbeing Board 8 September 2016

HEALTH HELP NOW – HARROW

GOVERNANCE PROPOSAL /TERMS OF REFERENCE

Introduction

Ensuring the safety and efficiency of the Harrow Health Help Now website and mobile app requires a governance process that balances patient safety and the ability to innovate.

The purpose of this document is to provide a model Terms of Reference for Harrow's Health Help Now Clinical Assurance Group (CAG) which describes the interface between GP's, CCG and the SECSU.

Role of the Clinical Assurance Group (CAG)

The CCG Health Help Now Clinical Assurance Group (CAG) comprises a number of primary care clinicians and professionals with health informatics expertise.

The CAG evaluates and assures the clinical content of the Health Help Now website and app every 2 months.

The CAG evaluates existing content and decides pertinent updates to local services, and whether to alter or add new symptoms and advice articles. This could also include design and functionality development requests if required.

Once the group has met the amendments to content will be shared with the SESCU Account Manager for Health Help Now.

The CCG has purchased editing services then upon receiving the documented changes/minutes the website and app will be updated within a working day.

All health edits (with exception to localised service changes) will be shared amongst clients via the SECSU Account Manager.

Whereby there are disagreements between clients as to the publishing of this information then the SECSU Health Help Now Assurance Group will make the final clinical decision.

The CAG's principal functions include:

- To provide clinical website/app content updates and provision of clinical assurance and share this with the SECSU Account Manager and in turn the SECSU Health Help Now Assurance Group through minutes of meetings
- Support to patients on the practical application of Health Help Now
- To drive forward the use of the Health Help Now in improving the health care of the local population
- To report any unintended consequences, patient safety incidents or complaints to the SECSU Account lead for Health Help Now and also through internal CCG reporting mechanisms.

CAG's principal objectives are:

- Improved safety and effectiveness of this information system, reducing risks of harm to patients
- Revision of Clinical terminologies and content as required
- Data protection, consent and confidentiality
- Document local management of the clinical content
- Maintain an accurate Directory of Services (DOS)
- Ensure localised services, symptoms and advice articles are reviewed and updated
- Support and promote discussion between the implementers of the health website and app solutions (SECSU) and the end users of this service.
- To listen to feedback received through the 'contact us' on the website and app

Accountability

- The CAG is accountable to the CCG Unscheduled Care Board
- The Clinical Lead for CAG is accountable to the CCG Clinical Advisory Board.
- With respect to their role on CAG, for example when representing CAG to other agencies, CAG members are accountable to the CAG Clinical Lead. The CAG clinical lead is responsible for ensuring advice and communications on behalf of CAG are in line with its Terms of Reference.
- Those members contributing to CAG on behalf of an associated organisation are accountable through their organisation's governance or management structure.
- Individual Group members are primarily accountable to their own professional bodies and registrations.
- The CAG will report on clinical content updates after every meeting and on any issues to the SECSU Account lead and in turn the SECSU Health Help Now Assurance Group.
- The SECSU Health Help Now Assurance Group is accountable to the SECSU Information Governance Group and will report on compliance with the contract terms and on any internal issues and mitigating actions that may impact on the safety and effectiveness of the website and app.

CCG Group members:

- Dr Krishni Kumar (Clinical lead)
- Dr Shaheen Jinar(Clinical leader)
- Sarah Crouch (PHE Lead) TBC
- Patient rep (TBC)
- CCG management lead
- LAS (optional)
- Representative from education sector (TBC)

Communications

CAG communications:

- There will be a clear process of engagement including communication link for the SECSU system user group, and SECSU Account lead, or other customers to utilise the expertise of CAG and report any system issues/ updates required
- CAG and SECSU will employ electronic media to keep stakeholders informed about CAGs areas of work
- Bi-Annual user group conference managed by SECSU.

Meetings

The CAG Working group will meet bi-monthly. Meetings minutes will be recorded and held in accordance. Minutes will be made available to SECSU account lead as a matter of course as soon after the CAG meeting as possible. Changes to the content needs to be clearly documented.

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT – Diabetes update**
Responsible Officer:	Javina Sehgal – Chief Operating Officer, Harrow Clinical Commissioning Group
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary

FOR INFORMATION

This report provides the Health and Wellbeing Board with an update on the development of the Harrow Diabetes Strategy, the lead responsibility for which sits with the Clinical Commissioning Group.

Section 2 – Report

Harrow has one of the highest rates of type 2 diabetes in the country, with current prevalence estimated to be around 10% with a rise in projection to 13% by 2020. These rates are largely driven by increasing levels of overweight/obesity, changing ethnic composition, and an ageing population. 60% of are overweight or obese, and approximately 50% are Asian or African-Caribbean ethic background (associated with relatively high disease risk).

In Harrow, these ethnic groups, older people, and lower socio-economic status groups are all likely to experience disproportionately high rates of the disease. The data also reveals a huge variation in access to the right care and management for diabetes across different geographic locations and between the GP practices as well, which we would like to reduce.

Given the national burden of disease due to type 2 diabetes, and incidence trends, recent national strategy documents and the All Party Parliamentary Group report on diabetes, note that, in addition to early detection, offer of the NICE recommended 8/9 key care processes and the comprehensive management of disease through the treatment targets, there is a particular need for improving access to the structured education and the preventative action.

There is increasing recognition of diabetes prevention and early recognition. All 34 practices in Harrow are undertaking clinical audits in order to set up pre-diabetes registers and health checks are also helping with the registers.

Public health developed a rapid diabetes needs assessment, using best practice transformational work from other areas of similar demographics like Slough and other London boroughs. Aligned to this Harrow CCG in collaboration with stakeholders are developing a diabetes strategy that will evaluate the whole pathway from prevention to tertiary care.

To help with the understanding for commissioning requirements, Harrow CCG facilitated a stakeholder workshop in collaboration with NHS Rightcare, public health, Diabetes UK and the patient groups to gain some formal feedback to current services and gaps within current services within the borough.

A clinical reference group is going to be established in December 2016 with the aim that it will develop, agree and deliver on the required outcomes of the strategy. It will also be required to ensure best practice and local reviews/evaluations are taken into consideration with any recommendations being made.

The CCG will also establish a sub-group that will evaluate 1) type 1 diabetes, 2) diabetes in children/pregnant women and 3) those that require specialist provision of CGM or Insulin pumps. The final actions will be agreed through the clinical reference group and the strategy updated with the latest NDA (National diabetes Audit) data and published both on the Harrow CCG and the Harrow council websites.

The CCG is committed to ensuring that its strategy and commissioning intentions are aligned to the public health plans on prevention and awareness, the local and NWL STP footprints plans, and will also reflect the core principles of the HWBB.

Section 3 – Further Information

The final strategy will be completed by January 2017 in time for a detailed discussion at the March 2017 H&WBB meeting.

Section 4 – Financial Implications

None at this stage.

The financial and procurement route/s for services to be considered has not been agreed as the strategy is still in development stage.

Section 5 - Equalities implications

N/A

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

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- **Making a difference for the vulnerable**

Patients will be identified through proactive case finding at general practice , working with stakeholders to identify groups for targeted interventions.

- **Making a difference for communities**

The diabetes strategy aims to provide integrated services that are coordinated for the patient and their careers, including social prescribing, prevention and self-care.

- **Making a difference for families**

Families and carers will be better informed about diabetes through Patient Activation Measures (PAMs) and self-care working groups, to facilitate an increased quality of life.

Harrow Health and Wellbeing Strategy

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

Clinical audits in general practice lead by Clinical experts, will provide training and development of the management of Diabetes in general practice. Training and education events have been on-going throughout the year with patients diagnosed with diabetes.

Harrow CCG Corporate Objectives

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

The self-care and PAMs programmes will help patients to self-manage.

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

In collaboration with NHS Right Care, Harrow CCG have held a workshop (more to follow) with local residents to understand the commissioning needs based on service user feedback. Harrow patient participation group have also been involved in discussions around the strategy.

'Objective 3: Manage resources effectively'

Training for clinicians, training and education for patients to self-manage, and a review of the current pathways will enable resources to be managed more effectively through the development of integrative working arrangements.

STATUTORY OFFICER CLEARANCE (Not required)

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Angela Ward (Harrow CCG) Email: angela.ward1@nhs.net
Tel: 020 8966 1163

Background Papers: None

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT –** Update on the Mental Health and Employment Trailblazer Project in Harrow
Responsible Officer:	Andrew Howe, Director of Public Health, Harrow Council
Exempt:	No
Wards affected:	Harrow and Wealdstone Opportunity Area Greenhill Roxbourne Marlborough
Enclosures:	None

Section 1 – Summary

This report sets out a progress update on the Mental Health and Employment Trailblazer project in Harrow.

FOR INFORMATION

Section 2 – Report

As part of the Growth Deal in 2014, the West London Alliance (WLA), and three other areas in England, agreed to be trailblazers for a programme of support for unemployed people claiming Jos Seekers Allowance (JSA), and Employment and Support Allowance (ESA) experiencing common mental health problems*. The WLA is responsible for managing the West London Trailblazer, and Ealing Council the accountable body for the programme.

The programme budget is over £2m, with £1.2M secured from the DCLG Transformation Challenge Award (TCA) and matched from the European Social Fund (ESF). The funds will support over 1,000 west London residents with Mental Health issues. The pilot programme is expected to run until December 2018, possibly longer if the reclaim period for ESF is extended. The funds allocated to Harrow are £224,000.

A joint procurement with Barnet took place in December 2015-January 2016 and the appointed provider for both Barnet and Harrow – Twining Enterprise - already has local connections as a provider of Improving Access to Psychological Therapies (IAPT) based support. The project start date has been significantly delayed because of complications with the ESF due to a range of national and London issues. The contract was signed with the provider in late October 2016 and mobilisation processes have started using the already established Harrow Task and Finish group for the project with several meetings planned in the coming weeks.

The pilot will use an Individual Placement Service (IPS) to support beneficiaries. IPS has been used elsewhere in the UK and the USA to support clients with severe and enduring conditions and has a good evidence base This pilot will test its use in supporting people with *common mental health conditions** and will include a randomised control trial .

IPS principles include

- Access to supported employment for people with mental illness who want to work
- Employment support integrated with mental health treatment
- Competitive employment as a goal
- Access to personalised benefit counselling
- Job search soon after the person expresses an interest in working
- Employment specialists engaging systematically with employers
- Continuous job support
- Clients preferences are honoured

Participation on the programme is voluntary and can be made by self referral. The biggest sources of referral are likely to be JobCentreplus, GP practices, IAPT, voluntary sector groups, and potentially Children's Services (where a working age family member has common mental health problem such as anxiety or depression).

The Harrow trailblazer will target 119 people with the aforementioned conditions in pre determined (i.e. deprived, high ESA recipient) LB Harrow post code areas covering:

- Harrow and Wealdstone Opportunity Area
- Greenhill
- Roxbourne
- Marlborough

*anxiety and depression, obsessive compulsive disorder and post traumatic stress disorder

This project follows on from the 'trailblazing' work that has been led by Barnet Public Health over the past year.

Section 3 – Financial Implications

The project is funded from the bid received from ESF and DCLG. The match funding from Public Health (£37,500) has already been paid and there is no further funding required. This match funding enables £224k to be allocated to Harrow and target 119 individuals.

Additional resource requirements are for officer time to contribute to the monitoring of the project at a local level. This commitment can be contained within the existing staffing establishment.

The contract is monitored by the WLA but any local and engagement issues will need to be supported locally. The monthly Task and Finish Group is chaired and hosted by Harrow and attended by two Harrow Council officers (Mark Billington (Economic Development (chair)) and Anna Kirk (Public Health).

Section 4 - Equalities implications

A full Equalities and Health Impact Assessment will be completed as part of the pilot in 2017.

Section 5 – Council Priorities

This project supports the council's priorities to make a difference for the vulnerable and communities. The service will work intensively with those people within the community who are unemployed and have common mental health problems to ensure they have all the support possible to gain and maintain employment. This group has a profound vulnerability due to their health issues and this is often compounded by being unemployed. We know long term unemployment makes it harder to find a job and this programme will aim to support people back into work quickly and using evidence based support.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Name:Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 24/11/16.		

Ward Councillors notified:	**YES**

Section 7 - Contact Details and Background Papers

Contact: Sarah Crouch, Consultant in Public Health, Public Health, 020 8736 6834

Background Papers: None

REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT – Primary Care Transformation**
Responsible Officer:	Javina Sehgal – Chief Operating Officer CCG report.
Exempt:	No
Wards affected:	All.
Enclosures:	Exploring Delegated Commissioning

Section 1 – Summary

The aim of this report is to inform the HWBB of the various strategies that have been adopted within the CCG in relation to the transformation of Primary Care under the aegis of the nationally mandated SCF – Strategic Commissioning Framework.

The report provides an overview of implementation on each strategy thus far and aims to demonstrate how they can be integrated in a way that can support a move towards a more sustainable model for general practice, support the unscheduled care agenda, and strengthen the whole systems integrated care model currently in place.

FOR INFORMATION

Section 2 – Report

In June 2016 Harrow CCG Governing Body approved a proposed Models of Care Strategy for Harrow. The strategy has been developed to establish a sustainable primary care service that provides high quality care at the right time and the right place integrating services provision that delivers better coordinated for the patients of Harrow.

Harrow CCG has been working collaboratively with NWL CCG's and NHS England to develop robust plans for implementation and is committed to developing primary care services under the Strategic Commissioning Framework (SCF) guidance.

The SCF main premise is to establish;

- Accessible care
- Coordinated care
- Proactive care

In order to do this general practice needs to be commissioned at scale and at pace and GP Federations and Network provision is the key to its implementation and delivery.

The 3 key domains to deliver the strategy are outlined below.

Domain	What it means	How
Accessible	Better access to routine and urgent care from primary care professionals, at a time that is convenient and with a professional of choice	Primary care services outside of working hours Systems for e-access (video, phone, emails etc) Improved experience of appointment choice and availability
Coordinated	Greater Continuity of Care between NHS and Social Services, named clinicians and more time with patients	Support to manage own health Increased involvement in care planning Ownership and control over their own medical records Better information sharing between providers.
Proactive	More healthy prevention by working in partnership to reduce premature mortality and morbidity, and future burden of disease. Treating the causes and not just the symptoms	Support in self-management setting and achieving goals Quick and convenient access to preventative services Opportunities for involvement in co-designing health initiatives trusted source for health promotion advice and information

1) Access

The access model has been developed to compliment the Integrated Urgent Care programme. The programme is reliant on additional capacity in general practice so that other healthcare professionals have access to pre-bookable appointments.

By April 2017 Harrow CCG will have commissioned primary care services that are open 8am to 8pm, 7 days a week.

This model has been developed under strict criteria laid out by NHS England and the work is well on its way to delivery.

2) Co-ordinated

Whole Systems Integrated Care is aimed at patients over 65 at risk of hospital admission, with complex needs and in need of a comprehensive care a plan. This is coordinated through virtual wards and multi-disciplinary team working. A business plan to develop the federation, the service, and to deliver through an Accountable Care Organisation (ACO) was approved at the Governing Body in April 2016. Work is well under way to have that plan implemented.

Over the past couple of months the CCG and its stakeholders have been reviewing the current service lines to look at how the service can be commissioned more effectively going forward.

In order to attempt to simplify the complexity that is Whole Systems Integrated care, the programme has been divided into 3 component parts.

1) Care planning in general practice
2) Care Coordination service
3) Virtual Wards

Care Planning in general practice: Following risk stratification, the GP develops a geriatric assessment care plan and an anticipatory care plan with the patient to help them to self-manage their health and wellbeing. Patients that are complex but can be managed in a community setting are seen by the Enhanced Practice Nurses. Patients that are complex but potentially at crisis are referred to the Virtual Ward.

Care Coordination: This service provides the link between the GP's and the Virtual Ward. The coordination 'team' consists of a GP with special interest in Older Adults (GPwSI) who triages the referrals to the Virtual Ward, non-clinical Care Navigators who identify the eligible cohort that require care planning by the GP, through EMIS Qadmission enquiry. The case managers review the care plans involving the Multi-Disciplinary team from the Virtual Wards and facilitates discharge back to the referring GP when appropriate.

Virtual Wards: There are 3 Virtual Wards who meet fortnightly. The team is made up of representation from the community and acute providers and consists of 3 consultants; Psychiatrist, Palliative Care and Geriatric. In addition the Local Authority is present with representation from Adult Social Care and GP's from the local borough.

In 2016/17, the service specification and outcome measures for care planning in general practice and the Care Coordination service were approved by the Procurement Panel. The later has been commissioned directly with the GP Federation and the former directly with the GP practices.

It is now proposed that the Virtual Ward is reviewed to better understand its functions, the interdependencies between the Care Coordination Service and general practice.

A series of workshops are being scheduled. The aims of the workshops are;

- to work with key stakeholders across health, mental health, social care and the voluntary sector to refine the Whole Systems Integrated Care model
- to review the outcomes, process and interventions
- to enable a service specification to be developed that can be used to contractually commission an Accountable Care Organisation (ACO) to deliver the full service.

3) Proactive

Harrow CCG in collaboration with Right Care are developing strategies across whole pathways of care ranging from prevention to self-care.

These include **Cancer, Diabetes, Atrial Fibrillation, Dementia** and other preventive services within primary care.

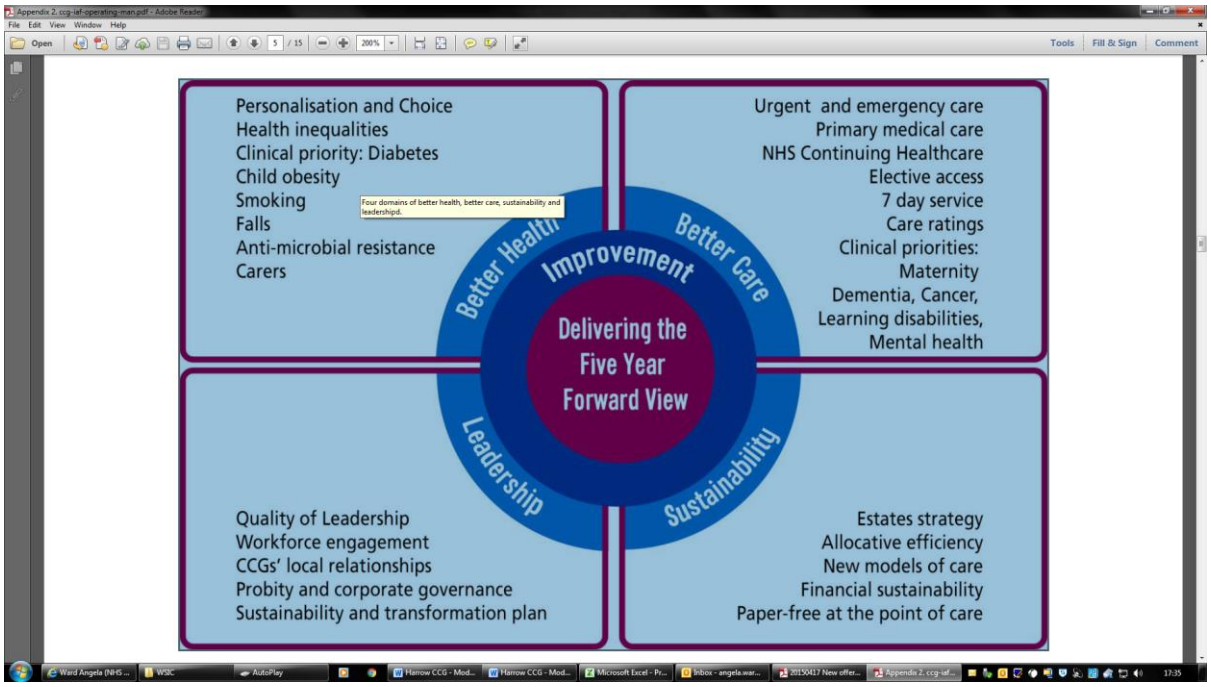
Various stakeholder workshops have been held across the disease areas along with clinical workshops with GP's to ascertain primary and secondary prevention interventions that may be suitable for primary are service provision.

Further workshops will be held over the coming months to continue to develop robust clinical models.

In addition a new NHS England improvement and assessment framework for CCGs became effective from the beginning of April 2016, replacing the existing CCG assurance framework and CCG performance dashboard.

The assurance framework for the CCG is shown below and the CCG will be measured across these domains.

Across the 8 CCG's there is an agreement that collectively the areas in bold and outlined above will be priority.



Section 3 – Further Information

Level 3 Commissioning
Harrow CCG is working in collaboration with NWL CCG's and NHS England to get a joint consensus on the delegation of Level 3 Commissioning.

A delegation board has been established across the 8 CCG's to develop the strategic plans for transition. The board is also responsible for providing sense checks at every level, including outlining what delegated responsibilities can be carried out at NWL collaborative level and what will become more local.

A virtual primary are team has also been established across the 8 CCG's with regular meetings to talk through the 'how to effectively implement the transition to delegation, along with LMC contributions.

The expected date for delegation is April 2017.

Section 4 – Financial Implications

The implementation of the strategy outlined above is dependent on funding allocations from NHS England directly to the CCG.

Procurement routes will be dependent on the service being provided and will go across the spectrum of care. Although the ACO has been debated, there is no indication as of yet who will take on the lead provider role within the stakeholder groups.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? Yes

No adverse impacts have been identified.

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
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

STATUTORY OFFICER CLEARANCE
Not required

Ward Councillors notified:	**NO** .

Section 7 - Contact Details and Background Papers

Contact: Angela Ward, Programme Director for Strategic Commissioning Framework /Models of Care, 07951341373

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.

Primary Care Commissioning in North West London

NHS Harrow CCG

Exploring delegated commissioning

November 2016

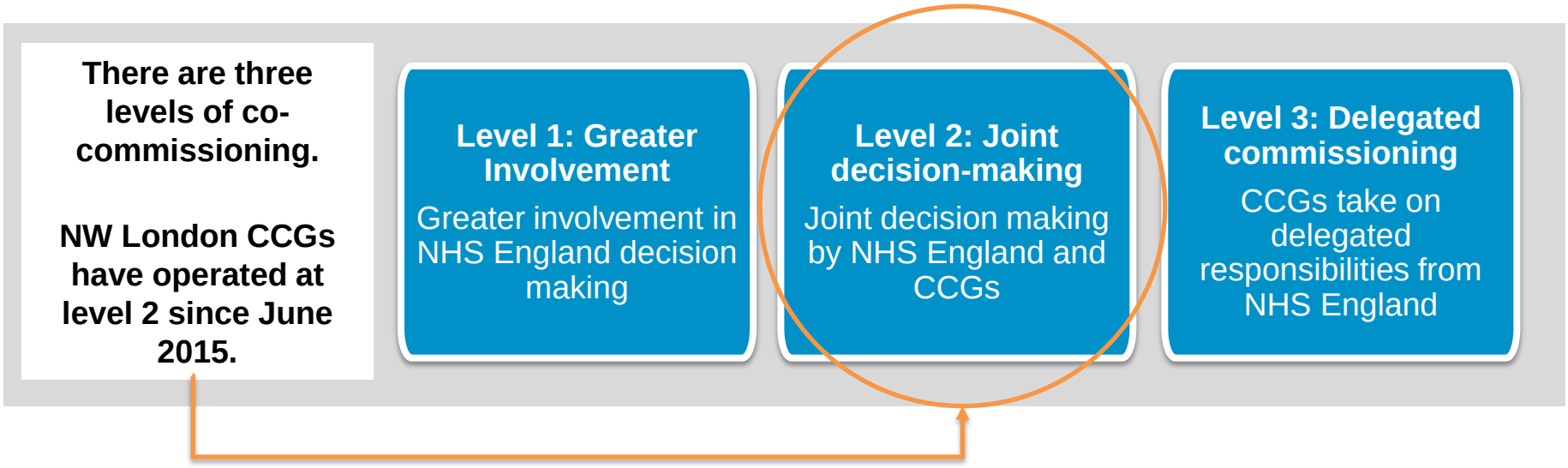
Where are we now?

NHS Harrow Clinical Commissioning Group

Currently NHS England (NHSE) has responsibility for commissioning and management of core primary medical services. They also commission enhanced services, manage the primary care budget, manage patient communications and complaints, estate and revalidation, appraisal and performance. They retain 51% decision making under level 2.

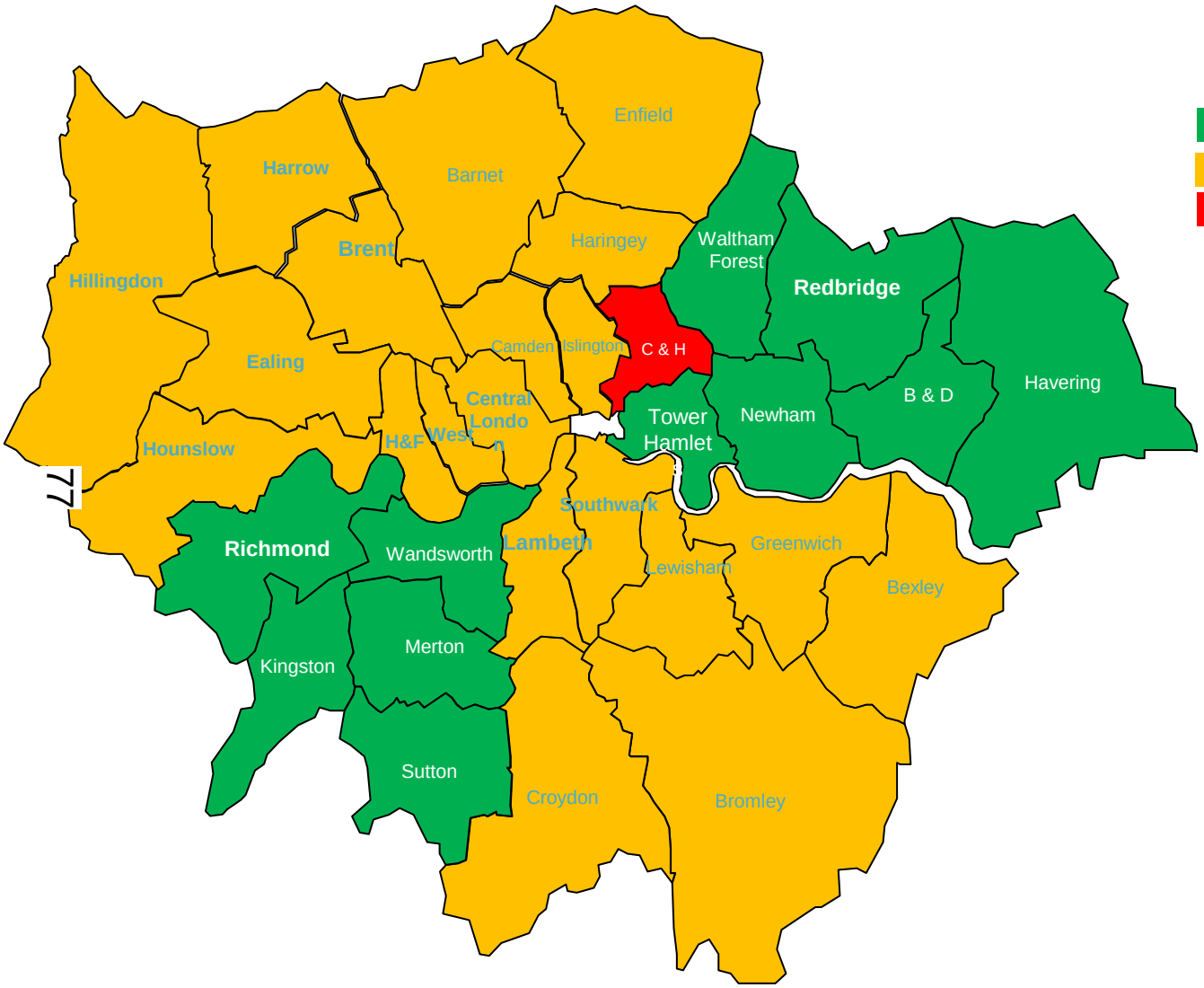
CCG members across North West London (Brent, Harrow, Hillingdon, Ealing, Hounslow, Hammersmith & Fulham, Central London and West London) need to determine whether to move to delegated commissioning – the greatest level of responsibility for primary care commissioning

Initial applications are due on 05 December 2016 for interested CCGs. Any applications submitted are subject to a vote of Member Practices



Where are we now?

NHS Harrow Clinical Commissioning Group



- Delegated (level 3)
- Joint (level 2)
- Greater Involvement (level 1)

- **11 CCGs** are fully delegated (level 3)
- **20 CCGs** are joint commissioners (level 2)
- **NWL, NCL & SEL CCGs considering** going for full delegation from April 2017
- **Nationally 114/209 CCGs are currently Level 3.**

What functions would be delegated?

NHS Harrow Clinical Commissioning Group

CCGs that move to fully delegated arrangements will be responsible for the management of the duties previously carried out by NHS England & their own statutory duties.

Newly Delegated Functions	Reserved NHS England Functions
GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and removing a contract)	Management of the **national performers list**
Newly designed **enhanced services and local incentive schemes** ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)")	Management of the **revalidation** and **appraisal** process
Financial management of primary care budget	**Administration of payments** in circumstances where a performer is suspended and related performers list management activities
Ability to establish **new GP practices** in an area	**Capital expenditure** functions
Approving **practice mergers & closures**	**Section 7A** functions (e.g., screening and immunisation)
Making decisions on **'discretionary' payments** (e.g., returner/retainer schemes)	Functions in relation to **complaints management**

NWL Consideration of Level 3 – Delegated Commissioning

NHS Harrow Clinical Commissioning Group

- Expectation of CCGs, outlined in the FYFV and seen as key to delivery. NHSE keen all London CCGs move to Level 3 from April 2017.
- NWL Collaboration Board 29th September – agreed to engage member practices on the option.
- Engaging across all 8 CCGs with oversight across NWL – Locality meetings and GP Forums underway
- Any NWL application is subject to a formal vote – confirmed by NHSE
- Primary Care leads meeting weekly
- NHS NWL Local Services team supporting planning & comms
- NWL Finance and Governance leads involved in planning and due diligence
- Londonwide & local LMCs invited to contribute views
- Patient information & engagement plans also being developed with NWL Lay Partners Advisory Group (LPAG)

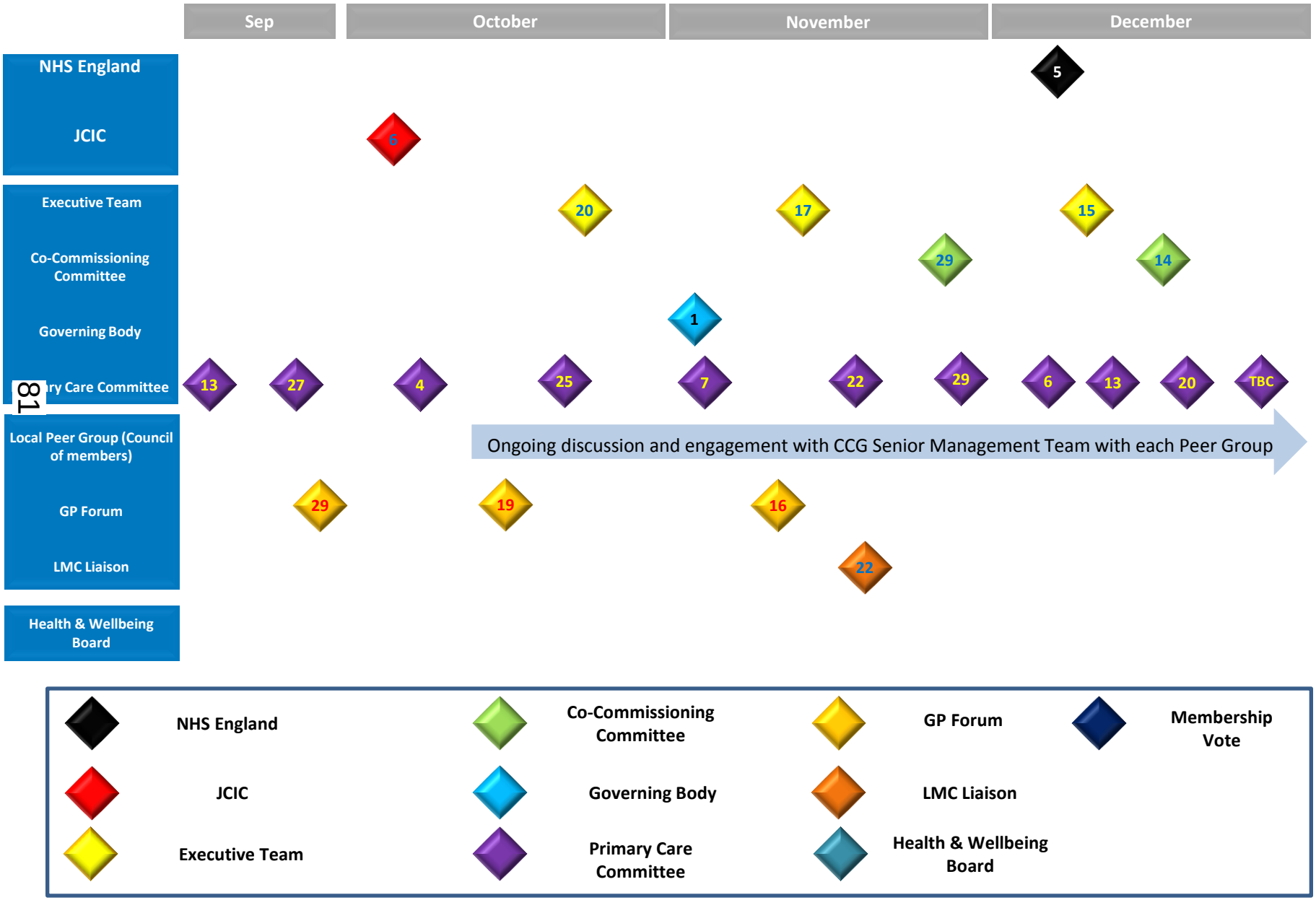
What are the pros and cons?

NHS Harrow Clinical Commissioning Group

Opportunities/Benefits	Risks /Issues
• GPs in CCGs will have more direct influence over investment in general practice. • Ability to redesign local schemes to replace QOF and LES contracts based on local knowledge. • Ability to use innovative commissioning approaches to implement local priorities - set commissioning intentions that cover key primary care issues such as workforce resilience. • Tailored services to meet the local needs of the population. • Opportunity to develop and commission end to end care and integrated out-of-hospital services & drive the Five Year Forward View agenda. • Could drive outcomes based commissioning in primary care by aligning outcome measures and incentives used in PC.	• Resources to deliver/resource intensive e.g contract management & complaint handling and increased expectations from NHSE. • Performance management could cause tension between the CCG and its Members - anxiety about the CCG performance managing practices. • Failure to deliver will undermine the primary care transformation plan. • Reliant on IT and practice data sources being shared outside of Primary Care. • There are governance rules in terms of GPs not being able to make certain decisions: strengthened and transparent processes for decision-making will be needed that avoids this but retains the advantages of the clinically led model. • Perceived conflicts of interest.

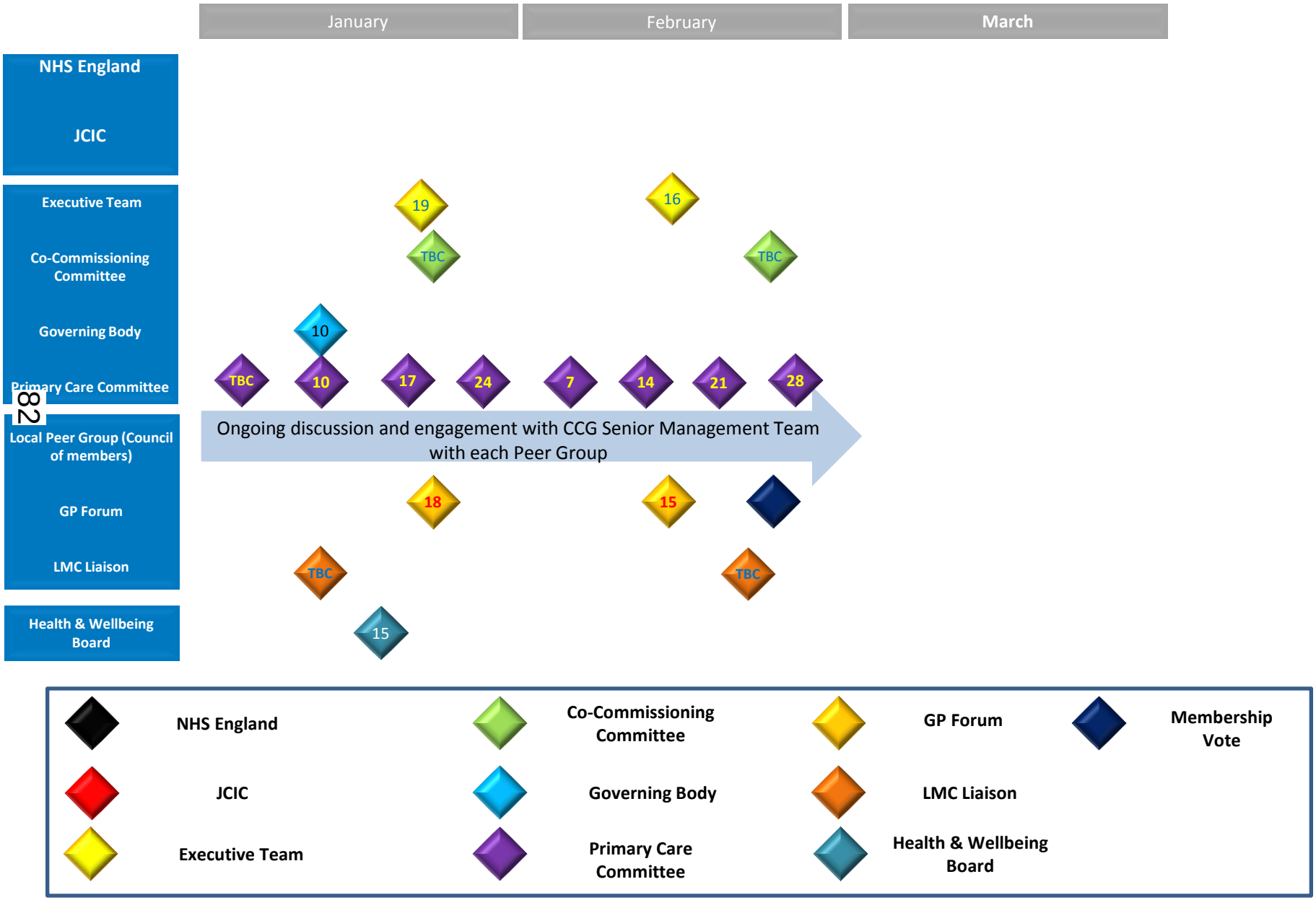
Harrow process & key milestones (Sep-Nov 16)

NHS Harrow Clinical Commissioning Group



Harrow process & key milestones (Sep-Nov 16)

NHS Harrow Clinical Commissioning Group



Qu's from member practices – *will the CCG have sufficient capacity*?

NHS Harrow Clinical Commissioning Group

- Capacity is a challenge we would need to address
- NHSE has commissioned an external organisation to develop options for a NWL Operating Model; this wont be final until we know how many CCGs decide to go to level 3 in 2017
- Considering - functions, processes, teams, roles, skills and the structures in which these would be organised
- Likely elements of Primary Care commissioning will be organised at NWL level (contract mngmt), others may stay centrally (eg Medical Directorate, BI/analytics)
- Would be challenges in the first 12 months as any new model embeds
- Due diligence will include consideration of which teams would play a part eg Primary Care team, Finance, Procurement, Comms & Engagement

Qu's from member practices – *what are the plans for governance?*

NHS Harrow Clinical Commissioning Group

- CCGs are acutely aware of the need to manage real or perceived conflicts of interest.
- Governance leads are working on the implications and looking at models in place elsewhere.
- In areas with delegation out of area GPs and Lay members ensure the GP and patient voice remain heard.
- NWL Joint Co-Commissioning Committees in Common (JCiC) would be reviewed but a NWL-wide body would remain to support alignment across 8 CCGs (decision making is CCG level).
- Due diligence by Governance leads will include pathway for different types of decision.

Qu's from member practices – *what are the financial implications?*

NHS Harrow Clinical Commissioning Group

- Under full delegation CCGs would receive the total published allocation and have access to the contingency and 1% non-recurrent reserve (within the business rules).
- CCGs will have more opportunity to commission models of care that span sectors - primary, community, secondary, mental health.
- Locally decisions can be made about use of funding spent by NHSE on enhanced services (DES, QOF alongside LIS).
- We have heard the need for assurances regarding the primary care budget and whether ring-fenced – primary care monies cannot be used to plug gaps in other budgets.
- Due diligence will need to assess current and future liabilities.

Qu's from member practices – *What due diligence will be done..?*

NHS Harrow Clinical Commissioning Group

- BHH CCGs are appointing external capacity & expertise to support.
- With it comes experience of undertaking due diligence to inform the move to L3-Delegation in other CCGs.
- Will help us identify, understand and mitigate risks and develop a robust transition plan and acceptable ongoing risk profile.
- Will include
  - review of historical financial performance (core contracts, QOF, DESs, LES, discretionary payments, premises costs) over the last 3 years.
  - Consideration of implications for current budget setting process and any implications for future years including any risks from budget transfer known (or likely).
  - current contractual arrangements and any risks associated with transfer including contract renewal dates.
  - Identification of any known regulatory, quality or service issues relating to the services being delivered under the transferring contracts.
  - assessment of the level of resource currently engaged in the management of contracts for core and state of readiness of the CCG.

Qu's from member practices – *how will this improve patient care?*

NHS Harrow Clinical Commissioning Group

- Opportunity to set priorities and commissioning intentions locally based on local needs
- Opportunities to look at primary care offer in totality and to design services alongside patients, carers and practices
- Supports development of new and integrated models of care
- Supports consistent and equitable offer for Harrow patients, at-scale working and high quality care across the patch
- More control over local investment in primary care
- Less fragmented system for patients when they need advice or wish to raise issues
- Doesn't detract from patient care in any way, but has potential to improve it

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REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT – Progress on the Better Care Fund Quarter 2, 2016/17**
Responsible Officer:	Chris Spencer, Corporate Director People Services & Javina Sehgal, Chief Operating Officer, Harrow CCG.
Exempt:	No
Wards affected:	All
Enclosures:	none

Section 1 – Summary

This report sets out progress on the BCF, Better Care Fund in the second quarter – Q2 of 2016/17.

(Report submitted to NHSE 25th November 2016).

FOR INFORMATION

Section 2 – Report

The Harrow BCF annual plan 2016/17 was originally submitted to NHS England on June 17th 2016. The agreed value of the Better Care Fund in Harrow is £16.258m, £1.181m of which reflects the capital funding in relation to Disabled Facility (the Community Capacity Grant having been discontinued). The balance of £15.077m allocated to revenue funding supports two agreed schemes.

NHS England subsequently made a number of changes to the reporting format for the plan which was re-submitted on September 8th 2016 along with the S75 agreement between Harrow CCG and Harrow Council.

As a result of the changes to the plan format a number of changes were made to the reporting template which was released later than anticipated incurring a delay in reporting timelines.

This report covers the Q2 report of the 2016/17 plan.

The BCF agreed schemes within the 2016/17 plan include:

- **Protecting Social Care - £ 6.558m.**

  To ensure that maintaining social care provision essential to the delivery of an effective, supportive, whole system of care is sustained. The scheme includes the provision of access and assessment from the acute and community sector, Reablement services, a diverse range of services to meet eligible needs through personal budgets and comprehensive and effective safeguarding arrangements including support to carer's.

  These schemes are a continuation of schemes established in the 2015/16 BCF plan.

- **Whole Systems & Transforming Community Services - £8.519m.**

  Harrow CCG re-tendered its community service contract late summer 2015. The new contract award was made in December 2015 and the new service became operational in May of 2016 with the Community Rapids Discharge service following on October 4th 2016.

  Through the re-commissioning and re-configuration of community services Harrow CCG has better aligned its community service provision with primary and social care towards establishing a Single Point of Access to community services. The new community service provider transferred its IT operating system to EMIS Community, the system used by Harrow GP's on November 7th 2016.

This development will support the CCG and partners to deliver more integrated and joined up services that will support reducing admissions into acute care and delivery of care in community settings.

The community services model underpins the vision for an Accountable Care Organisation for Harrow which will improve access to care and the patient experience for Harrow registered patients.

Section 3 – Further Information

The 2016/17 BCF plan also agreed a plan to deliver the national conditions as set out by NHS England.

The conditions are as follows:

- Protection of social care services.
- 7 day services to support patients being discharges
- Data sharing – NHS number being used as the primary identifier for health and social care services and appropriate agreements in place
- Joint assessments and lead professionals in place for high risk populations
- Agreement on the impact of changes with the acute sector.

The following are extracts from the Q2 report that indicate our position in relation to the plan. The submission template is no longer pre–populated with activity data 2016.

We have supplied data in narrative form in key areas to give an indication of where we estimate our end position.

National Conditions

Condition (please refer to the detailed definition below)	Please select "Yes" "No" or "No - in progress"	If the answer is "No" or "No –in progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No – in progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services – please confirm:			
(i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings	No – in progress	01/04/2017	There are a number of services operating 7/7 which include an out of hours Emergency Duty Team for social care.

when clinically appropriate			
(ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No – in progress	01/04/2017	On 12/11/2016 Harrow CCG opened a 3rd Walk In Centre located in the East of the borough offering additional appointment capacity. We have also submitted our SCF access plans to NHSE proposing a range of initiatives that will provide enhanced services in primary & community settings to support admission avoidance.
4) In respect of Data Sharing – please confirm:			
(i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
(ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
(iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
(iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No – in progress	01/04/2017	Work is underway to move towards a single assessment process.
6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.	No – in progress	01/04/2017	As the bulk of the fund is used to protect and maintain social care services this is not considered to be a local risk but will need to be subject to on-going review.
7. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range	Yes		

of services including social care.			
8. Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan.	No – in progress	01/10/2016	This work is underway and led by the Systems Resilience Operational Group – it is looking at D2A as a key initiative to support reducing admissions.

National and locally defined metrics

Non-Elective Admission	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	We have experienced a significant spike in activity over the last few months which we attribute to a change in the management of patients in A&E resulting in increased admissions. This is subject to scrutiny and a recovery plan which may affect the outturn position.

Delay Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target.
Commentary on progress:	As a result of increased admissions we have experienced fluctuation in our DToC numbers. We have in place a daily SITREPS report between ourselves and the acute trust and social care. We also have an increasing numbers of fast track cases and increasing numbers of choice delays. The main issue is securing placements for clients with dementia in residential and nursing homes.

Local performance metric as described in your approved BCF plan	Social Care User Satisfaction was identified in the BCF as the local performance metric. This is measured annually
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Annual survey will report after Q4 – 2017.

Local defined patient experience metric as described in your approved BCF plan If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	Overall GP experience
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	We are maintaining our current performance level of 78% (July 2016) but want to improve on this. We are aiming to improve performance through a range of initiatives but cannot accurately predict the

	improvement at this point.

Section 4 – Financial Implications

Both the Council and CCG continue to face financial challenges and optimising the allocation of BCF resources remains a key priority of the plan. The HWBB should note that the amount of funding transferring to the Local Authority for 2016/17 was agreed at £6.558m
The national picture for the finances of the public sector remains very challenging. Projections by London councils based on the government spending plans are for additional reductions of over 30% over the next two years. As a result this is likely to translate into further significant grant cuts in the coming years although projections show on–going pressures on the Councils budgets driven largely by the statutory responsibility on the council to meet the increase in demand relates to individual with complex care needs requiring higher intensity care provision. This national picture is reflected locally as the quarter 2 position reported to Cabinet in December reported an increased overspend of £2.4m on the Adult Social Care budget.

Financial models to support the development of the local and NWL STP are being jointly developed by CCG CFOs. These plans are expected to assist in contributing to and achieving financial balance for health budgets. These plans will be presented as they are developed for consideration and approval through the relevant governance processes (CCG & LA), to ensure that any proposals can be delivered within the existing MTFS and financial plans.

Over the autumn both organisations will review their commissioning intentions and financial plans for 2017/18. The Council's draft budget was agreed by Cabinet in December 2016 and assumed a continued funding of £6.558m towards the Protection of Social Care through the BCF.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

Section 6 – Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

The BCF will improve the following priorities:

- Making a difference for the vulnerable

- Making a difference for communities

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports

Name:Donna Edwards	X	on behalf of the Chief Financial Officer
Date: 9 December 2016		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Garry Griffiths, Assistant Chief Operating Officer, 0208 966 1067.

Background Papers: None

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	**INFORMATION REPORT –** Draft Revenue Budget 2017/18 and Medium Term Financial Strategy 2017/18 to 2019/20
Responsible Officer:	Chris Spencer, Corporate Director People, Harrow Council
Exempt:	No
Wards affected:	All
Enclosures:	December 2016 Cabinet Report and Appendices

Section 1 – Summary

The Board is requested to note the report detailing Harrow Council's Draft Revenue Budget 2017/18 and Medium Term Financial Strategy 2017/18 to 2019/20, as reported to the Council's Cabinet on 8 December 2016.

The budget and MTFS will return to Cabinet in February 2017 for final approval and recommendation to Council.

FOR INFORMATION

Section 2 – Report

The draft budget set out in the attached report shows a refreshed Medium Term Financial Strategy (MTFS) with a number of changes which Cabinet were asked to note.

The report shows a balanced budget for 2017/18 and that further work is needed to achieve balanced budgets for 2018/19 and 2019/20.

The MTFS may be subject to further adjustments following the Local Government Financial Settlement, which will be announced in December.

It is anticipated that, in addition to confirming the funding for 2017/18, the announcement will also provide indicative funding for 2018/19 to 2019/20. Whilst it is intended that Members will approve the MTFS in February 2017, this is subject to a number of assumptions in relation to grant settlements, council tax income, legislation and demographics. The Council will still be required to review the Council's budget on a yearly basis; however approval of the MTFS will allow officers to progress a number of important projects.

All adjustments will be reported to Cabinet and Council in February as part of the annual budget and council tax setting process.

Section 3 – Further Information

See attached report.

Section 4 – Financial Implications

Financial implications are integral to the attached report.

Section 5 - Equalities implications

See attached report.

Section 6 – Council Priorities

See attached report.

STATUTORY OFFICER CLEARANCE
(Council and Joint Reports)

Name: Sharon Daniels	x	on behalf of the Chief Financial Officer
Date: 8 December 2016		

Ward Councillors notified:	**NO, as it impacts on all wards**

Section 7 - Contact Details and Background Papers

Contact:

Sharon Daniels
Head of Strategic and Technical Finance (Deputy S151)
Email: Sharon.daniels@harrow.gov.uk

Background Papers:

None

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REPORT FOR: CABINET

Date of Meeting:	8 December 2016
Subject:	Draft Revenue Budget 2017/18 and Medium Term Financial Strategy 2017/18 to 2019/20
Key Decision:	Yes
Responsible Officer:	Dawn Calvert, Director of Finance
Portfolio Holder:	Councillor Adam Swersky, Portfolio Holder for Finance and Commercialisation
Exempt:	No
Decision subject to Call-in:	Yes
Wards affected:	All
Enclosures:	**Appendix 1A** – Proposed savings and growth 2017/18 to 2019/20 **Appendix 1B** – Proposed savings 2017/18 to 2019/20 to be agreed from 2015/16 and 2016/17 MTFS **Appendix 1C** – Savings shown as amendments in Appendix 1B **Appendix 2** - Medium Term Financial Plan 2017/18 to 2019/20 **Appendix 3** - Schools Budget 2017/8 **Appendix 4** - Draft Public Health Budget 2017/18

This report sets out the draft revenue budget for 2017/18 and draft Medium Term Financial Strategy (MTFS) for 2017/18 to 2019/20. The budget and MTFS will be brought back to Cabinet in February 2017 for final approval and recommendation to Council.

Recommendations:

Cabinet is requested to:

1) Note the Council's position in terms of the Multi Year Finance Settlement and Efficiency Plan, in that the Council have not applied to accept the four year offer. (paragraphs 1.8 to 1.11)

2) Approve the draft budget for 2017/18 and the MTFS 2017/18 to 2019/20 for general consultation as set out in Appendices 1a, 1b and 2.

3) Note the balanced budget position for 2017/18, the balanced budget for 2018/19 subject to £6.978m of proposals being developed, and the gap of £9.661m for 2019/20 (table 2).

4) Note the proposal to increase Council Tax by 1.99% in 2017/18 (Table 2 and paragraph 1.14)

5) Note the proposal to increase Council Tax by 2.0% in 2017/18 in respect of the Adult Social Care Precept (Table 2 and paragraph 1.14)

6) Approve the structure of the Schools funding formula for 2017/18 (un-changed from the 2016/17 formula agreed last year) as set out in Appendix 3.

7) Approve the draft Public Health budget for 2017/18 as set out in Appendix 4.

8) Authorise the Director of Finance, following consultation with the Portfolio Holder for Finance and Commercialisation, to agree Harrow's 2017/18 contribution to the London Borough's Grant Scheme (paragraph 1.37)

Final approval will be sought from Cabinet and Council in February 2017.

Reason: (For recommendations)

To ensure that the Council publishes a draft budget for 2017/18 and 3 Year MTFS to 2019/20.

Section 2 – Report

INTRODUCTION

1.0 The Government continues to reduce its funding to Local Government as part of its nationwide austerity programme. 2017/18 is the eighth year in which Councils have seen reductions in their grant funding. These funding reductions, a continued increase in demand for services and cost inflation mean are that Harrow has to save an estimated £83m over the 4 year period 2015/16 to 2018/19. Harrow Council does not have large cash reserves, and spending them is not a responsible way to offset lost revenue. Harrow Council's gross budget for 2016/17 is £560m. A significant proportion of this funding is ring fenced for services such as housing benefit, schools and public health. The Council's net controllable budget is £165m in 2016/17 and this is the element of the budget that the Council can exercise more control over and from where savings must be found. Harrow's response to the financial challenges faced was to set a three year budget covering the period 2016/17 to 2018/19 to show the Council is being responsible with taxpayers' money, is ambitious for the borough and is prioritising the vulnerable in its spending decisions.

1.1 The Council has a statutory obligation to agree and publish the budget for 2017/18, and approval for this will be sought in February 2017. In preparing the 17/18 budget, and rolling forward the MTFS to cover the three year period 2017/18 to 2019/20, the current MTFS (approved by Council in 2016) has been the starting point for the process.

1.2 The draft budget set out in this report shows an updated MTFS with a number of changes Cabinet are asked to note. The changes achieve a balanced budget position for 2017/18, a balanced position for 2018/19 subject to £6.978m of proposals being developed and a gap of £9.661m for 2019/20. The MTFS will be subject to further adjustments following the Local Government Financial Settlement, which is due for announcement in early to mid December 2016. Whilst it is intended that Members will approve the MTFS in February 2017, this is subject to a number of assumptions in relation to grant settlements, council tax income, legislation and demographics. The Council will still be required to review the Council's budget on a yearly basis; however approval of the MTFS will allow officers to progress a number of important projects.

BACKGROUND

1.3 The budget process is designed to ensure that it is priority led so that resources are aligned with council priorities and statutory responsibilities including equalities implications. The Harrow Ambition Plan 2020 sets out the ambitious council vision of 'Working Together to Make a Difference for Harrow.' Between now and 2020 the Council's Strategy to deliver its vision is to:

- Build a Better Harrow
- Be More Business Like and Business Friendly
- Protect the Most Vulnerable and Support Families

The Council's values, developed by staff, are also a key part of the Harrow Ambition Plan:

- Be Courageous
- Do It Together
- Make It Happen

1.4 Harrow Council has taken a responsible approach to the significant financial challenges it faces. In 2016/17, for the first time, the Council approved a three year budget covering the period 2016/17 to 2018/19 to show its commitment to achieving financial sustainability through a period of unprecedented fiscal challenges. The Councils savings target for the 4 year period 2015/16 to 2018/19 is £83m. In balancing the 2015/16 budget, savings of £30.9m were agreed. The target for the three years 2016/17 to 2018/19 was £52.4m and the final position agreed by Council in February 2016 was a balanced position for 2016/17 and gaps of £985k and £789k for 2017/18 and 2018/19 respectively.

EXTERNAL FUNDING POSITION

1.5 Harrow Council is one of the lowest funded councils in London. In 2015/16 Harrow's revenue spending power per head was £159 (or 17.3%) lower than the London average which ranked Harrow 26th out of 32 London Boroughs. A similar comparison with the England average shows Harrow's revenue spending power per head was £127 (or 14.3%) below average and ranked Harrow 105th out of 120 local authorities.

1.6 The Local Government Finance Settlement for 2016/17 did nothing to readdress this low funding position. The settlement was intended to protect authorities that were heavily dependent on central resources from the full impact of cuts in funding over the next four years. The Settlement allocated central funding in a way that ensured councils received the same percentage change in settlement core funding, i.e. Council Tax and central funding. This methodology therefore benefitted Councils who obtained a relatively small proportion of their income from Council Tax. Harrow has the third highest Council Tax in London and the effect of factoring in overall funding levels, rather than applying a simple percentage cut, result in Harrow losing £6.4m in Revenue Support Grant (RSG) in 2016/17, approximately £4m more than was planned under the previous methodology. Under the new methodology, Harrow was the sixth hardest hit amongst London Boroughs.

1.7 Linked to the revised methodology for RSG allocation, from 2016/17 Care Act Funding was subsumed within RSG and not allocated as a separate funding stream. As Harrow's overall RGS reduced so significantly in 2016/17, there was no capacity to allocate Care Act Funding to the Adult Services division (£1.271m in 2016/17).

1.8 Whilst the Council was grateful to receive Transition Grant funding (£712k in 2016/17 and £699k in 2017/18), the benefit was fully off set by reductions in the Public Health Grant.

DELIVERY OF THE 2016/17 BUDGET

1.9 Delivery of the 2016/17 budget is critical to maintaining the Council's financial standing and to do everything possible to protect front line services. The 2016/17 revenue budget includes a challenging savings target of £17.5m. At Quarter 2 (as at 30 September 2016) performance against the savings target is good in light of the challenging environment:

- £9.5m of savings (54%) are already achieved or on course to be achieved.
- £6.6m of savings (38%) are partially achieved or risks remain.
- £1.4m of savings (8%) will not be achieved.

The Quarter 2 forecast, subject to a separate report elsewhere on the agenda, indicates a directorate overspend of £8.539m net, the key pressures relating to homelessness and front line adults and children's social care budgets. After allocating the corporate contingency budget (£1.329m), centrally held budgets not applied (£766k), containment of Regeneration revenue expenditure within the Regeneration model (£595k) and £2m set aside for homelessness pressures, the forecast pressure is reduced to £3.849m. It is critical to balance the 2016/17 budget and to achieve this; a plan is in place to be as lean and efficient as possible. Specifically, this is the implementation of spending controls, a review of non-essential spend, the improved use of assets, and a range of other efficiency and effectiveness initiatives.

MULTI YEAR FINANCE SETTLEMENT AND EFFICIENCY PLAN

1.10 As part of the December 2015 Spending Review, the Secretary of State for Communities and Local Government (DCLG) made an offer to councils to take up a four year funding settlement for the period 2016/17 to 2019/20. To accept this offer an Efficiency Plan had to be prepared and published by 14 October 2016.

1.11 The offer made by the Government, as part of the Spending Review, was to any council that wished to take up a four year funding settlement up to 2019/20. The purpose of this offer is to help local authorities prepare for the move to a more self-sufficient resource base by 2020 and the devolution of business rates. The multi year settlement is intended to provide funding certainty and stability for the sector that will enable more proactive planning and support strategic collaboration with local partners. For those councils that chose not to accept the offer, they will be subject to the existing annual process for determining the local government finance settlement. Allocations could be subject to additional reductions dependent on the fiscal climate and the need for the government to make further savings to reduce the deficit.

1.12 In these initial stages the funding offer is limited to three funding streams. The current MTFS, agreed by Council in February 2016, incorporates the funding provided within the four year settlement offer as detailed in table 1 below:

Table 1: 4 Year Settlement Offer

	2016/17	**2017/18**	**2018/19**	**2019/20**
	£'000	£'000	£'000	£'000
RSG	21,935	13,019	7,332	1,559
Transitional Grant	712	699	0	0
Rural Services Delivery Grant allocations	N/A	N/A	N/A	N/A
Cumulative reduction in RSG from 2016/17 (%)		**41%**	**67%**	**93%**

1.13 In light of the RSG reduction of 93% over the four year period, leaving a balance of £1.559m by 2019/20, the Council did not apply to accept the offer. A letter has been sent to the Secretary of State for Communities and Local Government explaining why Harrow's funding position does not put it in a position to apply to accept. There is further on going engagement with local MP's and DCLG in respect of the offer.

BUDGET PROCESS 2017/18

1.14 In February 2016 Council approved a three year budget. As the Council's financial position is dynamic and is affected by a number of financial uncertainties and adjustments that will impact upon its financial position over the long and medium term, in preparing the draft budget for 2017/18 the existing MTFS has been refreshed and rolled on a year and the adjustments are summarised in table 2 below, followed by an explanation of the more significant adjustments

Table 2: Changes to MTFS

(Pre December Local Govt Finance Settlement)	2017/18	2018/19	2019/20
	£000	£000	£000
Actual Gap at Feb Council 16 Report	**985**	**789**	**0**
Implications of 2016/17 Budget decisions into 2019/20			
Capital financing			2,800
New homes bonus			300
Education Services Grant estimated reduction	640	751	
Freedom Pass			414
Pay Award 1%			1,000
Employers pension increase - deficit reduction			700
National Minimum Wage		0	1,300
Impact of 2016/17 Budget savings			-312
Increased CT base			-107
Business Rates top-up			-708
RSG Reduction			5,772
Sub Total	**1,625**	**1,540**	**11,159**
Grant and Tax base Adjustments			
Estimated increase in band D properties by 1500	-1835		
Estimated increase in band D properties by 1500		-1839	
Collection Fund Surplus	-3500		
Estimated Public Health Grant Reductions	907	697	487
2% Adult Social Care precept	-2,133		
Increase in CT by 1%	-1071	0	0
Sub Total	**-6,007**	**398**	**11,646**
Growth			
Resources - Business Support	734		
Adults	4,629	-96	-90
Children's	2,838	200	
Community- Housing	2,996	-163	
Funding in base budget	-1,000		
Community - Environment	500		100
Prior MTFS Savings to be reversed or re-phased			
MTFS savings identified for refresh:			
Total Resources and Business Support	1,009	570	
Total Children's	514	651	
Total Adults	2,844	2,102	-4,100
Total Community	-110	-81	124
Total Regeneration	50		
Pan Org savings	1,100		
Savings from 2017/18 Budget Process			
Resources	-844	-557	-550
Adults	-1,120		

Children's	-255		
Public Health	-263	31	
Community and Culture	-896	-140	
Housing	-898	-469	-225
Regeneration	-47		
Sub Total	**5774**	**2446**	**6905**
Technical:			
Estimated cost of the Apprenticeship levy	400		
Capital Financing costs	-285	2,132	2,056
Application of current capital receipts to reduce MRP cost	-1,000	0	0
- Additional New Homes Bonus	-850	-1,639	700
- Budget planning contingency	-1,000	1,000	
Revised gap	**3,039**	**3,939**	**9,661**
Use of Capital Receipts Flexibility	**-3,039**	**3,039**	**0**
Sub total	**0**	**6,978**	**9,661**
Proposals to be developed to reduce gap	**0**	**-6,978**	**0**
	0	**0**	**9,661**

1.15 **Implications of 2016/17 Budget decisions into 2019/20**

- £2.8m is the revised estimated capital financing requirement for year2019/20 of the existing Capital Programme, agreed by Council in February 2016.

- The current MTFS estimates the Education Services Grant (ESG) at £1.658m for 2017/18. The Department for Education (DFE) have announced changes to this grant. The general rate of the ESG provided to Local Authorities (LA's) and existing academies will cease from 01/09/17.This grant is provided to support LA responsibilities towards maintained schools and academies. LA's will continue to receive £15 per pupil for all pupils in state funded schools. However this grant will be transferred into the Dedicated Schools Grant (DSG) rather than being an un ring-fenced grant. Schools Forum will have responsibility for approving the value of the grant to be returned to the LA and will agree this at their meeting in either January or March 2017. The total reduction is estimated at £640k for 2017/18 and £751k for 2018/19.

- A 1% pay award has been assumed for 2019/20 (£1m). This is in line with Government pay policy for public sector awards to be no more than 1% up to 2019/20.

- The current MTFS includes additional contributions to the pension fund of £622k in 2017/18 and £664k in 2018/19. The results of the tri-ennial Pension Fund valuation will be known in early 2017 and any additional contributions for 2019/20 will be in line with the advice from the Pension Fund actuary. A contribution of £700k is currently assumed for 2019/20.

- The indicative Revenue Support Grant (RSG) for 2019/20 is £1.559m, a reduction of £5.8m (as detailed in table 1) and this is reflected in the MTFS.

1.16 Grant and Tax Base Adjustments

- Largely as a result of new properties, the tax base is assumed to increase, over current assumptions, by approximately 1,500 band D equivalent properties in both 2017/18 and 2018/19 generating approximately £1.8m additional income in each year.

- A marginal increase, generating income of £107k, is assumed for 2019/20 which will be refreshed in future MTFS processes.

- There is a report elsewhere on the agenda that estimates the surplus / deficit on the Collection Fund for 2016/17. The report details an overall net estimated surplus of £5.734m on the Collection Fund as at March 2017 of which Harrow's share is £3.760m which is now reflected in the MTFS.

- The Public Heath Grant remains ring fenced to 2017/18 until further notice. Public Health England has notified Harrow that its grant for 2017/18 will be £11.093m, a reduction of £907k. Grant allocations for 2018/19 onwards have yet to be announced however further reductions of £697k in 18/19 and £487k in 2019/20 have been assumed in the budget to reflect the downward trend in Public Health funding.

- The current MTFS assumes no levying of the Adult Social Care Precept beyond 2016/17. This has been refreshed to assume the maximum 2% precept will be levied in 2017/18 to generate approximately £2.1m.

- The current MTFS assumes a 1% increase in Council Tax for 2017/18. This has been refreshed to assume an increase in Council Tax of 1.99%. No further increases are assumed for 2018/19 and 2019/20.

1.17 Budget Refresh, Growth & Savings

Budget Refresh

- When the three year budget was approved in February 2016, there was the commitment to refresh the budget when it was rolled forward a year to ensure it remained reflective of the changing Harrow and Local Government landscape. All savings in the current MTFS for year 2 and 3 have been reviewed and those savings that, for various circumstances, can no longer be taken forward are recommended for removal from the budget. These savings, which total £4.7m in 2017/18 are summarised in table 2 and shown in Appendix 1B against the original saving. They are also separately identified in Appendix 1C. In addition to savings being reversed, there are a number of savings which have been re-profiled between years and, in the case of the original Property Purchase Initiative to buy 100 homes (ref 16/17 MTFS CH9), this saving has been increased to reflect savings to be achieved.

- One of the savings being reversed in Table 5 relates to a saving of £1.1m (saving ref PO 04) for 2017/18 from 'additional commercialisation savings from projects in the pipeline'. This is additional to the individual commercialisation related savings included within the MTFS. Projects have successfully been identified to meet this target, including:

  RES 01 – Customer Services and IT - Increase Harrow Helpline Income (£200k in 2017/18)

  RES 14 – Procurement / HR – Early re-procurement of Agency Staff contract (£150k in 2017/18) and Re-procurement of Occupational Health Contract (£24k in 2017/18)

  RES – Insurance Savings from re-tendering Insurance Contracts (£50k in 2017/18)

  COM G05.3 – Housing / Homelessness – extension of property purchase initiative (£254k in 2017/18)

  COM S01 – Commercial projects under Project Phoenix (£520k in 2017/18)

Savings identified as part of the 2017/18 Budget process

- The 2017/18 budget setting process has identified additional savings of £6.233m over the three years. These are summarised in table 3 below and detailed in Appendix 1A.

Growth identified as part of the 2017/18 Budget process

- Irrespective of funding reductions, the demand for front line Council services continues to increase and, in the main, shows no sign of reducing. Despite a strong performance against the 2016/17 savings target of £17.5m, there remains significant underlying pressures against the adults and children's social care budgets and the homelessness budget. The homelessness budget is showing signs of reducing as a result of Council initiatives such as the 100 homes programmes but, as at quarter 2, the reported pressure is still significant at £3m. The underlying pressures need to be addressed to ensure the budget is robust and financially sustainable as the Council moves forward into continued financially challenging times. Therefore growth of £10.648m has been allocated over the three years to address the underlying pressures. This growth is summarised in table 3 below and detailed in Appendix 1A:

Table 3:Savings and Growth from the 2017/18 Budget setting process

Directorate	2017/18	2018/19	2019/20	Total
Savings	£'000	£'000	£'000	£'000
Resources	844	557	550	1,951
Adult	1,120	0	0	1,120
Children and Family	255	0	0	255
Public Health	263	(31)	0	232
Community and Cultural services	896	140	0	1,036
Housing	898	469	225	1,592
Regeneration	47	0	0	47
Total	4,323	1,135	775	6,233
Growth				0
Resources	(734)	0	0	(734)
Adults	(4,629)	96	90	(4,443)
Childrens and Family	(2,838)	(200)	0	(3,038)
Community and Cultural services	(500)	0	(100)	(600)
Housing	(2,996)	163	0	(2,833)
Funding in Base Budget for homelessness	1,000			1,000
Total	(10,697)	59	(10)	(10,648)
Net Savings/Growth	**(6,374)**	**1,194**	**765**	**(4,415)**

1.18 Table 4 sets out savings proposed as part of the 2015/16 and 2016/17 budget setting process and which were included in the 2016/17 Budget report. Table 4, shows savings of £25.1m over the three year period and this is the net position after allowing for the savings referred to in the budget refresh section above and summarised at table 5, which total £4.7m. The savings totalling a net £25.1m over the three years are detailed in Appendix 1b. The savings in Table 5 are also detailed in a separate Appendix 1c for transparency purposes.

Table 4:Savings from 2015/16 and 2016/17 MTFS

Directorate	2017/18	2018/19	2019/20	Total
Savings	£'000	£'000	£'000	£'000
Resources	1,117	1,970	0	3,087
Adults	1,571	3,228	4,100	8,899
Childrens and Family	167	2,611	150	2,928
Public Health	462	2,295	0	2,757
Community and culture	1,163	2,432	0	3,595
Housing	1,041	353	38	1,432
Regeneration	100	0	0	100
Pan Organisation	350	2,000	0	2,350
Total	**5,971**	**14,889**	**4,288**	**25,148**

Table 5: Reversed Savings from 2015/16 and 2016/17 MTFS

Directorate	2017/18	2018/19	2019/20	Total
Savings	£'000	£'000	£'000	£'000
Resources	(1,009)	(570)	0	(1,579)
Children and Family	(514)	(651)	0	(1,165)
Adult	(2,844)	(2,102)	4,100	(846)
Community	110	81	(124)	67
Regeneration	(50)	0	0	(50)
Pan Organisation	(1,100)	0	0	(1,100)
Total	**(5,407)**	**(3,242)**	**3,976**	**(4,673)**

1.19 **Technical Adjustments**

- The Apprenticeship Levy is a charge being introduced by the government to help fund their plans to deliver a step change in apprenticeship numbers and their quality. The levy will be set at 0.5% of an employers pay bill, where the pay bill is in excess of £3m. The levy for the Council is estimated at £400k and discussions are currently in hand regarding how the levy will be managed within the Council.

- The draft Capital Programme 2017/18 to 2019/20 is subject to a separate report on the agenda, the capital financing implications of the new schemes are currently estimated at £3.9m over three years and the MTFS has been updated accordingly.

- Capital receipts of £6.6m from prior years are being applied to reduce capital financing costs by £1m.

- The New Homes Bonus (NHB) is based upon the number of additional dwellings each year and is payable for 6 years (4 years for more recent new properties.) As a result of additional properties the central government calculator shows additional NHB of £525k in 2017/18, a reduction of £940k in 18/19 and a further reduction of £1m for 2019/20 as the grant received in the earlier years of the scheme drops out. In 2017/18 the grant to be received is estimated at £5.774m. The figures in Table 1 are the additional changes to the NHB estimates since the 2016/17 budget was set and therefore the total amendments included from both the 2016/17 budget and the figures set out in Table 1 are those set out in the Technical Budget Changes section of Appendix 2.

- £1m of the budget planning contingency will be applied in 2017/18.

Capital Receipts Flexibility

1.20 In the Spending Review 2015, it was announced that to support local authorities to deliver more efficient and sustainable services, the government will allow local authorities to spend up to 100% of their fixed asset receipts on the revenue costs of reform projects. This flexibility is being offered to the sector for the three financial years 2016/17 to 2018/19.

1.21 The Council signified its intent to make use of this flexibility in its final budget report to Cabinet and Council in February 2016.

1.22 In terms of the required reporting requirements, DCLG recommend each authority disclose the projects that will be funded or part funded through capital receipts to full Council. This requirement can be satisfied as part of the annual budget setting process. In November 2016, Cabinet approved a number of asset disposals and the capital receipts from these disposals will be applied within the new flexibilities and will be reported to February Cabinet and finally approved by full Council in February 2017.

THE AUTUMN STATEMENT 2016

1.23 The Autumn Statement was released on 23 November 2016. There were a number of announcements in relation to Local Government, the financial implications of which are being evaluated or the detail will become known following receipt of the Local Government Financial Settlement which is due by mid December. This may result in further adjustments to the MTFS which will be reported to Cabinet and Council in February 2017.

SCHOOLS BUDGET 2016/17

1.24 The funding arrangements for the Dedicated Schools Grant and the Schools Budget for 2017/18 are detailed in Appendix 3. Cabinet is required to approve the structure of its funding formula for 2017/18, which it is not proposed to be changed from that in place in 2016/17 (as reported to the Schools Forum on 13th September).

The final cash values of each formula factor will be set following consultation with Schools Forum in January 2017 after the 2017/18 Schools Block funding has been announced which will be based on October 2016 census data.

PUBLIC HEALTH FUNDING

1.25 Following the comprehensive spending review in November 2015, Public Health England wrote to local authorities detailing average real terms savings of 3.9% each year to 2020/21 and notified allocations for 2016/17 and 2017/18. For Harrow this resulted in a reduction in the baseline allocation of £11.636m in 2015/16 down to £11.373m in 2016/17 and £11.093m in 2017/18.

1.26 Grant allocations for 2018/19 onwards have yet to be announced but annual reductions are anticipated to be at similar levels pending the outcome of consultation on options to fully fund local authorities' public health spending from their retained business rates receipts as part of the move towards 100% business rate retention.

1.27 The public health spending detailed in Appendix 4 of £11.093m and reflects the grant allocation published for 2017-18. It will be necessary for the Council to consider the most appropriate way for public health funding to be spent, taking account of the joint strategic needs assessment and the Council's overarching statutory duties including equalities duties.

1.28 The draft commissioning intentions (detailed in Appendix 4) will be presented to the Health and Wellbeing Board at its meeting on 12 January 2017.

BETTER CARE FUND

1.29 The Better Care Fund (BCF) in 2016-17 has national funding of £3.9bn.

1.30 The agreed value of the Better Care Fund in Harrow is £16.258m, £1.181m of which reflects the capital funding in relation to Disabled Facility (the Community Capacity Grant having been discontinued). The balance of £15.077m allocated to revenue funding supports two agreed schemes – Protecting Social Care (£6.558m) and Whole Systems and Transforming Community Services (£8.519m).

1.31 The comprehensive spending review in November 2015 announced that an additional £1.5bn will be made available to the Better Care fund by 2019/20. The funding allocations announced in December 2015

indicated that additional funding of £1.9m would be allocated to Harrow in 2018/19 and £2.2m in 2019/20. The relationship between the existing negotiated BCF and the levying of the ASC precept is not clear and as a result this additional funding cannot be assumed within the MTFS.

1.32 The minimum funding requirements for the 2017-18 BCF will be notified in December and the Council and the CCG must agree how the BCF resources are allocated to deliver the national conditions, including the protection of social care services.

1.33 The draft budget currently assumes that the current funding transfer to the Council of £6.558m will continue in 2017/18. The Adult Social Care budget pressures are considerable and the wider Council savings proposals are significant.

HEALTH INTEGRATION

1.34 Sustainability Transformation Plans (STPs) were introduced by NHS England (NHSE) to support delivery of their Five Year Forward View strategy and represent geographic areas (footprints) across England. Harrow falls under the North West London (NWL) footprint.

1.35 The STP is an opportunity to radically transform the way health and social care is provided, and across NWL both the NHS and local authorities have agreed to work together to deliver a sustainable health and care system. The NWL STP (submitted to NHSE on 21st October 2016) describes the shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well.

1.36 There is a commitment in principle from NHSE / NWL that transformation should enable funding to be provided to cover local authority Adult Social Care funding gaps. Work is underway to establish both the funding gaps and the ability to redirect resources to local authorities arising from health and social care transformation. It is too early to assume additional funding as part of the draft budget and will be included in the future if appropriate and when the extent of any additional funding can be confirmed with reasonable certainty.

RESERVES AND CONTINGENCIES

1.37 Reserves and contingencies need to be considered in the context of their need to protect the Council's good financial standing and in the context of the overall risks that the Council faces during a continuing period of economic uncertainty. The MTFS reflects the Council's need to ensure an adequate level of reserves and contingencies which will enable it to manage the risks associated with delivery of the budget including equalities impacts and unforeseen events. As at the time of writing this report general non earmarked balances stand at £10m and those for specific purposes are detailed:

- Unforeseen contingency £0 (£1.329m currently applied to in year revenue pressures
- Budget Planning contingency (£2m one off for 2016/17)
- Rapid Response reserve (£75k)
- Standing Up for Those in Need (£800k)
- Welfare Reform / Homelessness £0 (£2m currently applied to in year revenue pressures)
- Commercialisation Reserve £430k
- Transformation and Priorities Initiative Fund £2.429m
- Business Risk Reserve £2.029m
- MTFS Implementation Costs £2.355m

1.38 The Director of Finance will report on the adequacy of the Council's reserves as required in the budget setting report in February.

LONDON BOROUGHS GRANTS SCHEME

1.39 Harrow's contribution to the London Borough's Grant Scheme was £245,298 in 2016/17. At the time of writing this report the Council has not been notified of the recommended contribution for 2017/18. To ensure that the Council can respond to London Council's when contribution rates are notified, its is recommended that Cabinet authorise the Director of Finance to agree Harrow's 2017/18 contribution to the London Borough's Grant Scheme, in consultation with the Portfolio Holder for Finance and Commercialisation. The contribution rate will be reported to Cabinet in February 2017 as part of the final budget.

2.0 CONSULTATION

2.1 As a matter of public law the duty to consult with regards to proposals to vary, reduce or withdraw services will arise in 4 circumstances:

- Where there is a statutory requirement in the relevant legislative framework;
- Where the practice has been to consult or where a policy document states the council will consult then the council must comply with its own practice or policy;
- Exceptionally, where the matter is so important that there is a legitimate expectation of consultation and
- Where consultation is required to complete an equalities impact assessment.

Regardless of whether the council has a duty to consult, if it chooses to consult, such consultation must be carried out fairly. In general, a consultation can only be considered as proper consultation if:

- Comments are genuinely invited at the formative stage;
- The consultation documents include sufficient reasons for the proposal to allow those being consulted to be properly informed and to give an informed response;
- There is adequate time given to the consultees to consider the proposals;

- there is a mechanism for feeding back the comments and those comments are conscientiously taken into account by the decision maker / decision making body when making a final decision;
- The degree of specificity with which, in fairness, the public authority should conduct its consultation exercise may be influenced by the identity of those whom it is consulting and;
- The consultation is clear on the reasons why extent to which alternatives and discarded options have been discarded. Are required to be consulted on.

2.2 Public consultation on the overall budget for 2017/18 will commence after 8 December 2016 before the final savings are recommended to Full Council on the 23 February 2017.The public consultation will give residents an opportunity to comment on the 2017/18 overall budget before final decisions are formalised in the council's annual budget.

2.3 In terms of service specific consultations, the council has a duty to consult with residents and service users in a number of different situations including where proposals to significantly vary, reduce or withdraw services. Consultation is also needed in other circumstances, for example to identify the impact of proposals or to assist with complying with the council's equality duties.
Where appropriate, separate service specific consultations have already taken place or are currently taking place for the 2017/18 savings.

3.0 PERFORMANCE IMPLICATIONS

3.1 The in-year measurement of the Council is reported in the Strategic Performance Report. The Corporate Plan, which will be developed alongside the Budget Report, will have measures within it which will set out how Council delivery in 2017/18 will be measured and this again will be reported through the Strategic Performance Report.

4.0 RISK MANAGEMENT IMPLICATIONS

4.1 As part of the budget process the detailed budget risk register will be reviewed and updated. This helps to test the robustness of the budget and support the reserves policy. This will be reported to February Cabinet.

5.0 LEGAL IMPLICATIONS

5.1 Section 31A of the Local Government Finance Act 1992 requires billing authorities to calculate their council tax requirements in accordance with the prescribed requirements of that section. This requires consideration of the authority's estimated revenue expenditure for the year in order to perform its functions, allowances for contingencies in accordance with proper practices, financial reserves and amounts required to be transferred from general fund to collection fund.

5.2 Local authorities owe a fiduciary duty to council tax payers, which means it must consider the prudent use of resources, including control

of expenditure, financial prudence in the short and long term, the need to strike a fair balance between the interests of council tax payers and ratepayers and the community's interest in adequate and efficient services and the need to act in good faith in relation to compliance with statutory duties and exercising statutory powers.

5.3 Cabinet is approving these proposals for consultation after which a cumulative equalities impact will be drafted. These proposals will be referred to Council so that Council can approve the budget envelope and set the Council Tax. There will be contingencies within the budget envelope so that decision makers have some flexibility should any decisions have detrimental equalities impacts that cannot be mitigated.

6.0 FINANCIAL IMPLICATIONS

6.1 Financial Implications are integral to this report.

7.0 EQUALITIES IMPLICATIONS / PUBLIC SECTOR EQUALITY DUTY

7.1 Decision makers should have due regard to the public sector equality duty in making their decisions. The equalities duties are continuing duties they are not duties to secure a particular outcome. The equalities impact will be revisited on each of the proposals as they are developed. Consideration of the duties should precede the decision. It is important that Cabinet has regard to the statutory grounds in the light of all available material such as consultation responses. The statutory grounds of the public sector equality duty are found at section 149 of the Equality Act 2010 and are as follows:

A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

(a) Tackle prejudice, and

(b) Promote understanding.

Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act. The relevant protected characteristics are:

- *Age*
- *Disability*
- *Gender reassignment*
- *Pregnancy and maternity*
- *Race,*
- *Religion or belief*
- *Sex*
- *Sexual orientation*
- *Marriage and Civil partnership*

7.2. Directorate proposals will be subject to an initial equalities impact assessment followed by a full assessment where appropriate. These will be published along with the final budget and MTFS report to February Cabinet. An assessment will also be carried out on the whole budget, when all proposals have been identified, to ensure that decision makers are aware of any overall equalities impact on the protected characteristics listed above..

8.0 COUNCIL PRIORITIES

8.1 The Council's draft budget for 2017/18 has been prepared in line with the Council's vision:

Working Together to Make a Difference for Harrow

- Making a difference for the vulnerable
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

Section 3 - Statutory Officer Clearance

Name: Dawn Calvert Date: 29 November 2016	x	on behalf of the Chief Financial Officer
Name: Jessica Farmer Date: 29 November 2016	x	on behalf of the Monitoring Officer

Ward Councillors notified:	**No, as it impacts on all Wards**
EqIA carried out: **EqIA cleared by:**	**To be reported on as Part of the Feb Budget report** **N/A**

Section 4 - Contact Details and Background Papers

Contact: Sharon Daniels, Head of Strategic Finance and Business (Deputy S151), tel: 0208 424 1332, sharon.daniels@harrow.gov.uk

Background Papers: Final Revenue Budget 2015/16 and MTFS 2015/16 to 2018/19

Call-In Waived by the Chairman of Overview and Scrutiny Committee	**NOT APPLICABLE** ***[Call-in applies]***

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*** Please Note, all SAVINGS shown as POSITIVE and Growth as Negative**

Total Savings & Growth - 2017/18 Budget Process					Appendix 1a						
											Key Stakeholders to Consult
Item No	Unique Reference No.	Specific Service Area	Headline Description re: saving / reduction INTERNAL	2016/17 Service Budget	2017/18	2018/19	2019/20	Total	EQIA Required Yes/NO	Does this proposal impact on another directorate? Y/N	Consultation Required (Y/N)
(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
Resources											
								-			
1	RES_01	Customer Services and IT	**Increase Helpline Income** Developing a robust multi-channel marketing plan to build the brand and promote the Helpline service to generated additional income through the existing service.	(544)	200	500	500	1,200	N	Y	N
2	RES_13	Customer Services and IT	Technology and Transformation Services Reduce level of support on SAP.	300	64	-	-	64	N	Y	N
3	RES_14	Procurement / HR	Early re-procurement of Agency Staff Contract	£21 million spend across services	150			150	Y - as part of the report to Cabinet on 17th November	Y	N
4	RES_15	Procurement / HR	Re-procurement of Occupational Health contract delivering an overall cheaper pricing model on the service.	114	24			24	Y	Y	N
5	RES_16	Strategic Commissioning	**VCS funding** - This saving reduces community grants and transfer funding from the emergency relief fund, to support the information and advice strategy as the December cabinet report.	1,446	110	57	50	217	Y- separate report to December 2016 Cabinet	Y- separate report to December 2016 Cabinet	Y- separate report to December 2016 Cabinet
6	RES_17a	Strategic Commissioning	**Member Development** Reducing the frequency in spend of the member development budget.	31	26	-		26	N	N	N
7	RES_10	Legal	**Political Office Support** Councillors are supported by a variety of administrative arrangements. The proposal reduces the amount allocated to each member /group office.		100			100	Y	N	Y - will follow HR procedures
8	RES 18	Finance	**Finance** - 'Insurance Savings from re-tendering of Insurance contract.		50			50	N	N	N

Total Savings & Growth - 2017/18 Budget Process												Appendix 1a	
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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
			Total Resources excluding Business Support		**724**	**557**	**550**	**1,831**			
Business Support								**£0**			
9	**BSS_02**	**Business Support**	**PA Support** The creation of a new Central PA Hub to support the Chief Executive, Corporate Directors and Directors offering a fixed catalogue of services.		100			100	Y	Y	Y - will follow HR procedures
10	**BSS_07**	**Business Support**	**Community Hub** A reorganisation of the Community hub will re-allocate a prioritised workload over a smaller team.		20			20	Y	Y	Y - will follow HR procedures
			Total Business Support	-	**120**	**-**	**-**	**120**			
			Resources Total		**844**	**557**	**550**	**1,951**	-	-	-
People Services											
Adults											
11	PA_01	**Adults**	**Voluntary Sector** - cessation of all services other than those required under the Care Act. There is a separate cabinet report to the December 2016 cabinet in respect of this saving.	799	420			420	Y- separate report to December 2016 Cabinet	N	Y and has been widely consulted on as part of the report to Dec Cabinet,
12	**PA_ 03**	**Adults**	**Commissioning -** Cessation of Adults commissioning function (2.6FTE) from People's commissioning team resulting in spot purchasing only, and limited strategic commissioning for the Adult's services.	303	187			187	Y		Y - will follow HR procedures
13	**PA_ 04**	**Adults**	**Management -** further reduction in strategic management function, reducing by 1FTE (Head of Service) from 4FTE down to 3FTE i.e.; DASS plus 2 Heads of Service	564	127			127	Y		Y - will follow HR procedures

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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
14	**PA_ 05**	**Adults**	**Contracts & Admin -** in line with the voluntary sector proposals and move to personalisation model, the function of this team (4FTE) will be deleted. Any residual duties will be accommodated within already stretched social work teams.	161	161			161	Y		Y - will follow HR procedures
15	**PA_ 06**	**Adults**	**Reduce Safeguarding Quality Assurance Team** - Deletion of 2 FTE – reduction in ability to visit all 750 Community Providers and over 300 Care Homes in the year and respond to safeguarding alerts.	410	112			112	Y		Y - will follow HR procedures
16	**PA_ 08**	**Adults**	**Reduce Occupational Therapy Team** - Deletion of 4FTE – will increase the current 6 month waiting list with more vulnerable people delayed in hospital, and an increased number of vulnerable people placed unnecessarily in costly residential and nursing units	494	113			113	Y		Y - will follow HR procedures
			Total Adult		**1,120**	**-**	**-**	**1,120**			
Childrens											
17	**PC_S05**	**Education Services**	**Virtual School** Transfer funding for 1fte PEP Co-ordinator and 0.88fte Education Welfare Officer to external grant funding	179	90			90	N	N	N
18	**PC_S06**	**Children & Young People**	**Children & Young People Services Additional Savings** Reduction 1.3fte posts and cessation of procurement contract	267	165			165	Y	N	Y
			Total Childrens Services		**255**	**-**	**-**	**255**			
Public Health											
19	**PH**	**PH**	Reduction in wider health improvement function.	456	107			107	Y		N
20	**PH**	**PH**	Reversal of Public Health wide growth to deal with small projects.	456	60			60	Y		N

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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
21	PH_01	PH	**Wider Health Improvement** - bring forward approved 2018/19 savings in relation to wider determinants of health to 2017/18. Warmer Homes £50k retained until 2018/19.	117	96	(96)		-	Y		N
22	PH_02	PH	**Wider Health Improvement - breast feeding -** saving scheduled for 2018/19 to allow service to develop alternative model.	65		65		65	Y for 2018/19		Y - 2018/19
			Total Public Health		**263**	**(31)**	**-**	**232**			
			People Total		**1,638**	**(31)**	**-**	**1,607**			
Community											
Community and Culture											
23	COM_S01	Commissioning & Commercial	Commercial projects under Project Phoenix - The Revenue Maximisation business case has identified commercial opportunities in parking, waste services, events, advertising and increased rental income. Implementation Costs: Projects will start during 16/17, and it is anticipated that implementation costs can be met from income raised in 16/17 achieving a break-even position.	(115)	520			520	Y	N	Y for some of the proposals
24	COM_S04	Environment & Culture	Sports & Physical Activity - 2 options: either cease all activities or seek alternative funding to meet the costs including the use of S106 funding and/or funding the post by working together with other funding partners.	48	48			48	Y	N	This is dependant on the final option.
25	COM_S13	Commissioning & Commercial	Additional cost recovery in Network Management - Additional cost recovery from street works by having better use of traffic orders to manage street works	(268)	50			50	Y	N	N

Total Savings & Growth - 2017/18 Budget Process						Appendix 1a					
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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
26	COM_S08	Environment & Culture	Phase 2 of Environment & Culture Review - Regulatory Services Review of Enforcement functions across the Division and the Council. Revised approach to prioritise commercial / cost recovery generating work and health and safety issues and to undertake all other services at minimum standards meeting the minimum level of Food Standards Agency and other regimes.	1,587		200		200	Y	Y	Y but for 2018/19
27	COM_S12	Environment & Culture	Route Optimisation on food waste collection	900	-	150		150	Y	N	N
28	COM_S11	All	Reduce staff training, stationery and conference budgets across the directorate	131	68			68	Y	N	N
29	COM_S10	Commissioning & Commercial Division	Neighbourhood Investment Scheme (NIS) - cease funding. This is already an agreed MTFS saving for 18/19. This proposal is to bring forward the saving to 17/18.	210	210	(210)		-	Y		N
			Total Community & Culture		896	140	-	1,036			
								-			
Housing											
								-			
30	COM_S09	Housing	Supporting People - savings from contract renegotiation and/or review of service delivery	610	50			50	Y	Y	Y
31	COM_S02	Housing	Home Improvement Agency - increase in fee income as a result of increased capital expenditure on Disabled Facilities Grants - savings are conditional on capital budget increases being approved with additional amounts being administered by HIA.	445	100			100	N	N	N

Total Savings & Growth - 2017/18 Budget Process											**Appendix 1a**		
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(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(8)**	**(9)**	**(10)**	**(11)**					
				£000	**£000**	**£000**	**£000**	**£000**					
32	COM_G05.3	Housing	Homelessness - Extension of Property Purchase Initiative (Additional 50 homes) - Purchase of a further 50 homes for use as TA to reduce pressure on B&B.		254	469	225	948			N	N	N
33	COM	Housing	Homelessness Invest to save - Reduction in expenditure resulting from work undertaken by temporary additional staff resources taken on to undertake additional prevention work, local procurement of properties and arears recovery.		494			494			N	N	N
			Total Housing		898	469	225	1,592					
			Community Total		1,794	609	225	2,628					
Regeneration													
34	REP_S01	Development Control	Planning income - Increase of pre-application charges to a competitive level (subject to the approval as part of annual F&C review process)	(1,377)	20			20			Y	N	N
35	REP_S03	Economic Development	Economic Development & Regeneration – Reduction in activity to support economic development and regeneration	598	27			27			Y	N	N
			Regeneration Total		47	-	-	47					
			Total Savings		4,323	1,135	775	6,233					
GROWTH								-					
	Resources												

Total Savings & Growth - 2017/18 Budget Process					Appendix 1a						
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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
1	BSS_G01	Business Support	Business Support required for growth in Childrens Services. Significant case load pressures on the front line of Childrens Services have resulted in the need to increase Business Support staffing levels. A new model for Early Intervention Services also requires higher levels of Business Support and these pressures lie behind the growth being put into the service.		(734)			(734)	N		N
			Resources Total		(734)	-	-	(734)			
People Services											
2	Adults		Growth - Underlying ongoing pressure less identified mitigation		(4,353)			(4,353)			
3	Adults		Growth - reinstatement of an operational budget for The Bridge to be phased out over a three year period so that by 2020/21, the service can be provided at nil cost.		(276)	96	90	(90)			
			Total Adults		(4,629)	96	90	(4,443)			
Childrens											
4	PC_G01	Education Services	Special Needs Transport There are significant pressures on SEN Transport of over £1.2m. There is a savings target in the current MTFS for £514k. An updated travel assistance policy was approved by Cabinet in September 2016 however It is not anticipated that there will be any significant changes as the regulations have remained largely unchanged. However, discretionary travel arrangements will be removed for under 5's. Since 2014 a new SEN Code has led to an increased demand Post 19 as well as the pressures of the additional demand from the 5-19 demographic growth. There has been an increase in post 18 young people of nearly 40%	3,040	(1,000)			(1,000)	N	N	

Total Savings & Growth - 2017/18 Budget Process						Appendix 1a					
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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
5	PC_G02	Children & Young People	Children & Young People Staffing There is a rise in demand on children's social care which is on an upward trajectory based on all the metrics available. In order to meet this demand additional staffing across the children's social care pathway from MASH through to Leaving Care at the cost of £0.944m which is based on ensuring there are enough practitioners and managers to support the service. This would include 3 team managers, 5 deputy team managers and 9 social workers	7,664	(944)			(944)	N	N	
6	PC_G03	Children & Young People	Children's Placements & Accommodation and No Recourse to Public Funds & Other Client Spend Increase in the number of children in high cost residential placements. A number of these placements have been needed in response to significant risks relating to child sexual exploitation and gangs involvement. Increase in number of families with NRPF supported by the Council. The welfare reforms, along with stricter enforcement of Asylum Legislation are the main causal factors for this demand, which is unpredictable in terms of volume and costs.	6,935	(894)	(200)		(1,094)	N		
			Total Children and Family		(2,838)	(200)	-	(3,038)			
			People's Total Growth		(7,467)	(104)	90	(7,481)			
Community & Culture											
Community and Culture											
7	COM_G01	Environment & Culture	West London Waste Authority (WLWA) - increase in disposal levy arising from waste growth and population growth	8,093			(100)	(100)			

Total Savings & Growth - 2017/18 Budget Process					Appendix 1a						
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(1)	(2)	(3)	(4)	(5)	(8)	(9)	(10)	(11)			
				£000	£000	£000	£000	£000			
8	COM	Environment & Culture	Dry recycling disposal costs – Significant pressure is anticipated in this area when the contract is re-procured, based on some benchmarking data and recent market conditions.		(500)			(500)			
			Total Environment		(500)	-	(100)	(600)			
Housing											
9	COM	HGF	Homelessness growth - growth required to build the ongoing homelessness pressure into the base budget.	-	(2,996)	163	-	(2,833)			
			Total Community		(3,496)	163	(100)	(3,433)			
10	RES		Funding in Budget from 2016/17 - LEP top slice		1,000			1,000			
			Total Growth		(10,697)	59	(10)	(10,648)			
	Net Savings/Growth				**(6,374)**	**1,194**	**765**	**(4,415)**			

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Appendix 1b

Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
1	16.17 MTFS Review	RES_SC01	Strategic Commissioning	Income from Communications Through Gain Share Model	0	25	25	13		38	N	Not required	N
2	16.17 MTFS Review	RES_SC02	Strategic Commissioning	Additional Income from Communications Provider and Further Savings	375	0		107		107	N	Not required	N
3	16.17 MTFS Review	RES_SC03	Strategic Commissioning	Alternative Funding of domestic violence budget			21	61		82	N	Not required	N
4	16.17 MTFS Review	RES_SC04	Strategic Commissioning	Proposed savings in Health watch Funding	112	13		50		50	N	Not required	N
5	16.17 MTFS Review	RES_SC05	Strategic Commissioning	SIMS Team Contribution to Overheads and Additional Income	0	30	20	20		40	N	Not required	N
6	16.17 MTFS Review	RES_SC06	Strategic Commissioning	Commissioning Capacity in the Council	861	371	10	50		60	N	Not required	N
7	15.16 MTFS Review	RES16	Strategic Commissioning	Retender of the Communications Service to take account of reductions in spend phased in the following way: 2015/16 - 20% reduction, 2016/17 - 10% reduction, 2017/18 - 10% reduction.			57			57	N	Not required	N
				Total Strategic Commissioning	**1,348**	**439**	**133**	**301**	**0**	**434**			

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
8	16.17 MTFS Review	RES_HR01	HR	Shared HR Service with Buckinghamshire County Council - Business Case Under Development	837		140	110		250	Y	Not required as submitted as a separate Cabinet report in Feb 2016.	Consultation will be done in accordance with HR policies
9	16.17 MTFS Review	RES_HR03	HR	Organisational Development - Review existing shared OD service provision	244	0	155			155	N	Not required	N
				Total Human Resources & Shared Services	**1,081**	**0**	**295**	**110**	**0**	**405**			
10	16.17 MTFS Review	RES_F02	Finance & Assurance	Improved Treasury investment return from increased Risk appetite (Primarily lending for longer and to institutions with lower credit ratings)		180	595	625		1,220	N	Not required	N
11	16.17 MTFS Review	RES_F03b	Finance & Assurance	Audit and Fraud - deletion of Fraud Investigation Officer post		30	15			15	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
12	16.17 MTFS Review	RES_F04	Finance & Assurance	Investment Portfolio			350	350		700	N	Not required	N
				Total Finance & Assurance	**0**	**210**	**960**	**975**	**0**	**1,935**			
13	16.17 MTFS Review	RES_LG02	Legal & Governance	Committees - Savings reversed	640		100			100	N	Not required	N

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
14	16.17 MTFS Review	RES_LG02	Legal & Governance	Reversal of saving - 'This was a proposal to consolidate the Committee structure, which is not being progressed.			(100)			(100)	N	Not required	N
15	16.17 MTFS Review	RES_LG04	Legal & Governance	Expansion of the Legal Practice	(116)	140	210	210		420	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
16	16.17 MTFS Review	RES_LG05	Legal & Governance	Delayed implementation of land charges transfer of service	(656)	350	(250)	(250)		(500)	N	Not required	N
17	15.16 MTFS Review	RES12	Legal & Dem Services	Reduction in Legal cost, in the initial instance by growing the business		0	144	144		288	N	Not required	N
18	15.16 MTFS Review	RES14	Legal & Dem Services	Local land charges growth pressure. An element of the land charge function (including chargeable services) is expected to move to the Land Registry during 2015		0				0	N	Not required	N
				Legal & Governance	**(132)**	**490**	**104**	**104**	**0**	**208**			
19	16.17 MTFS Review	RES_CP01	Commercial, Contracts & Procurement	Selling services through shared procurement arrangements.			(19)	29	0	10	Y	Not required as submitted Feb 2016 Cabinet.	N

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
20	15.16 MTFS Review	RES15	Procurement	Restructuring of the Commercial, Contracts and Procurement Division's function.	864	108	201	151		352	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
				Commercial, Contracts & Procurement	**864**	**108**	**182**	**180**	**0**	**362**			
21	16.17 MTFS Review	RES_CS02	Customer Services and IT	Revenues and Benefits - Domestic and NNDR Site Review and Collection Rate				250		250	N	No - saving is reversed	N
22	16.17 MTFS Review	RES_CS02	Customer Services and IT	**Reversal of saving** - 'Revenues and Benefits - Domestic and NNDR Site Review and Collection Rate. This saving come through as additional collection Fund income and therefore the saving cannot be made in the Directorate Budget.				(250)		(250)	N	Not required	N
23	16.17 MTFS Review	RES_CS06	Customer Services and IT	Assumed savings from the completion of the roll out of universal credit and the opportunity this provides to simplify the CTS scheme.	1,378			300		300	N	Not required	N
				Total Customer Services & IT	**1,378**	**0**	**0**	**300**	**0**	**300**			
24	16.17 MTFS Review	BSS 01	BSS	**Business Support Review**.	2,957	649	352	320		672	N	Not required	N

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
25	16.17 MTFS Review	BSS 01	BSS	**Reversal of saving** - 'A thorough review of Business Support has been undertaken in the last year, as a result of which over £1m of savings have been identified that are being delivered. However it has been decided that further reduction in these areas are not appropriate, and therefore savings proposed in previous budgets will not be progressed and need to be reversed. This is reversing the 2017/18 and 2018/19 savings.			(352)	(320)		(672)	N	Not required	N
26	16.17 MTFS Review	BSS 01	BSS	**Reversal of saving** - 'A thorough review of Business Support has been undertaken in the last year, as a result of which over £1m of savings have been identified that are being delivered. However it has been decided that further reduction in these areas are not appropriate, and therefore savings proposed in previous budgets will not be progressed and need to be reversed. This is reversing £557k of the 2016/17 saving of £649k.			(557)			(557)	N	Not required	N
				Sub Total Business Support	**2,957**	**649**	**(557)**	**0**	**0**	**(557)**			
	Total Savings Resources & Commercial				**7,496**	**1,896**	**1,117**	**1,970**	**0**	**3,087**			

Peoples Directorate													

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
	Childrens												
27	16.17 MTFS Review	PC12	Children & Young People	Review of posts in Quality Assurance & Improvement Service	802			223		223	N	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies for 47,49,50,51,52,53, will need to check impact on the service provision other consultation may be needed
28	16.17 MTFS Review	PC13	Children & Young People	Early Intervention & Youth Development Integration and restructure of childrens centres, early intervention and youth development service	2,463	416	266			266	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be required
29	16.17 MTFS Review	PC14	Children & Young People	Review of Adoption Contract	223			86		86	Y	Not required for 2017/18 budget	N
30	16.17 MTFS Review	PC15	Children & Young People	Review of posts in MASH	319			100		100	N	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
31	16.17 MTFS Review	PC16	Children & Young People	Review of posts in Family Information Service	61			61		61	Y	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies
32	16.17 MTFS Review	PC17	Children & Young People	Review of posts in Access to Resources	599			57		57	Y	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies
33	16.17 MTFS Review	PC19	Children & Young People	Review of Leaving Care, Children Looked After & Unaccompanied Asylum Seeking Children Teams				173		173	Y	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies
34	16.17 MTFS Review	PC24	Education & Commissioning	Enhancing Achievement within Education Strategy Post should be 75% funded by grant management fees from April 2016, post holder redundant from August 2016	99	61	8			8	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
35	16.17 MTFS Review	PC28	Cross Service	Non-pay inflation	150	150	150	150	150	450	N	Not required	N

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Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
36	16.17 MTFS Review	PC33	Special Needs Service	Review of Special Educational Needs Transport	3,070	257	257			257	n/a		Will be required depending on impact on service
37	16.17 MTFS Review	PC33	Special Needs Service	**Reversal of Savings - Special Educational Needs Transport** There are significant pressures on SEN Transport of over £1.2m. There is a savings target in the current MTFS for £514k. An updated travel assistance policy was approved by Cabinet in September 2016 however It is not anticipated that there will be any significant changes as the regulations have remained largely unchanged. However, discretionary travel arrangements will be removed for under 5's. Since 2014 a new SEN Code has led to an increased demand Post 19 as well as the pressures of the additional demand from the 5-19 demographic growth. There has been an increase in post 18 young people of nearly 40%.		(257)	(514)			(514)	n/a		
38	16.17 MTFS Review	PC36	Children & Young People	Review of posts in Quality Assurance & Service Improvement.	922			248		248	Y	Not required for 2017/18 budget	Will need to follow Hr policies

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
39	16.17 MTFS Review	PC38	Children & Young People	Review of Children Looked After & Placements Service.	8,733			1,000		1,000	Y	Not required for 2017/18 budget	Will need to follow Hr policies
40	16.17 MTFS Review	PC42	Special Needs Service	Review of Special Needs Service	2,483			1,164		1,164	Y	Not required for 2017/18 budget	Will need to follow Hr policies
41	16.17 MTFS Review	PC42	Special Needs Service	Reversal of Savings - Special Educational Needs Placements In respect of PC41 approved February 2016. New funding regulations mean there will no longer be flexibility to further charge these costs to grant				(651)		(651)	n	Not required	N
				Total Childrens Savings	**19,924**	**627**	**167**	**2,611**	**150**	**2,928**			

	Adults												
42	16.17 MTFS Review	PA_3	Adults	Wiseworks - commercialisation opportunities and to be self financing by end of MTFS period	175	50	69	56		125	Y	Not required as submitted Feb 2016 Cabinet.	N
43	16.17 MTFS Review	PA_4	Adults	Milmans Community tender	359		175	184		359	Y	Y	Y

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Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
44	16.17 MTFS Review	PA_5	Adults	New Bentley [formerly Byron NRC] Community Tender	446		446			446	n/a		Y
45	16.17 MTFS Review	PA_5	Adults	Full reversal of saving - following the unsuccessful Community Tender at Kenmore it is not currently possible to deliver savings via this route. The commercialisation approach now being considered for Kenmore may indicate the potential for future savings to be explored for New Bentley if the approach is successful.			(446)			(446)	n/a		
46	16.17 MTFS Review	PA_6A	Adults	Vaughan NRC - service review to identify efficiencies in supporting the most complex	634		100			100	Y	Y	Y
47	16.17 MTFS Review	PA_9	Adults	Sancroft - contract management and service renegotiation	1,691	166	334			334	Y	Not required as submitted Feb 2016 Cabinet.	Completed
48	16.17 MTFS Review	PA_10A	Adults	Transport - review transport provision	1,079	200	200	350		550	Y	Not required as submitted Feb 2016 Cabinet.	Completed
49	16.17 MTFS Review	PA_11A	Adults	MOW/Catering Service - review of service	(13)		65			65	Y	Y	Completed
50	16.17 MTFS Review	PA_14	Adults	Shared Lives - commercialisation through selling model to neighbouring boroughs.	427	50	150			150	Y	Not required as submitted Feb 2016 Cabinet.	Completed

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Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
51	16.17 MTFS Review	PA_15	Adults	Bedford House / Roxborough Park - review provision within Bedford House	1,286	150	650			650	Y	Not required as submitted Feb 2016 Cabinet.	Completed
52	16.17 MTFS Review	PA_15	Adults	Reversal of £400k of the saving in 2017/18 - given the complexity of the client group attending the merged facility it is not possible to deliver the level of savings originally estimated			(400)			(400)	n/a		N/a
53	16.17 MTFS Review	PA_16	Adults	7 Kenton Road - review provision through supporting living and shared lives	228		228			228	Y	Y	Y
54	16.17 MTFS Review	PA_26	Adults	My Community ePurse - commercialisation of My Community ePurse			1,000	600		1,600	N	Not required	N/a
55	16.17 MTFS Review	PA_26	Adults	Rephasing - remove original phasing			(1,000)	(600)		(1,600)	N	Not required	N/a
56	16.17 MTFS Review	PA_26	Adults	Rephasing - add in new phasing				1,000	600	1,600	N	Not required	N/a
57	16.17 MTFS Review	PA_27	Adults	Our Community ePurse - explore new commercialisation opportunities			998	1,250		2,248	N	Not required	N/a
58	16.17 MTFS Review	PA_27	Adults	Re-phasing - remove original phasing			(998)	(1,250)		(2,248)	N	Not required	N/a

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
59	16.17 MTFS Review	PA_27	Adults	Re-phasing - add in new phasing				998	1,250	2,248	N	Not required	N/a
60	16.17 MTFS Review	PA_28	Adults	Community Wrap - explore new commercialisation opportunities				640		640	N	Not required	N/a
61	16.17 MTFS Review	PA_29B	Adults	Total Community ePurse - explore new commercialisation opportunities				2,250		2,250	N	Not required	N/a
62	16.17 MTFS Review	PA_29B	Adults	Re-phasing - remove original phasing				(2,250)		(2,250)	N	Not required	N/a
63	16.17 MTFS Review	PA_29B	Adults	Re-phasing - add in new phasing.					2,250	2,250	N	Not required	N/a
				Total Adult Savings	**6,312**	**616**	**1,571**	**3,228**	**4,100**	**8,899**			
Public Health													
64	16.17 MTFS Review	PH_3	PH	Sexual Health - consolidation of activity within new contract efficiency 17-18	714		105			105	n/a	n/a	N/a
65	16.17 MTFS Review	PH_3	PH	Reversal of Sexual Health saving - procurement and wider London Sexual Health Transformation will determine savings in future years	714		(105)			(105)	n/a	n/a	N/a

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Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
66	16.17 MTFS Review		PH	Contract Efficiencies within Health Visiting contract	2,848		105			105	N	N	N
67	16.17 MTFS Review	PH_5	PH	Tobacco Control & Smoking Cessation - reduction of service	299		279			279	Y	Y	Y
68	16.17 MTFS Review	PH_9	PH	Health intelligence & Knowledge - reduction in staff costs	211		48			48	Y	Y	N
69	16.17 MTFS Review	PH_10	PH	Staffing & Support - reduction in budget & deletion of additional procurement support	134	54	30			30	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
70	16.17 MTFS Review	PH_11	PH	Drug and Alcohol - reduction in service (contract related costs. Employee costs included in PH_12)	2,480	0		1,500		1,500	Y	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies
71	16.17 MTFS Review	PH_12	PH	Reduction to service - staffing reductions	4,603	41		795		795	Y	Not required for 2017/18 budget	Consultation will be done in accordance with HR policies
				Public Health Total	**12,003**	**95**	**462**	**2,295**	**0**	**2,757**			
	Net Savings People				**38,239**	**1,338**	**2,200**	**8,134**	**4,250**	**14,584**			

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
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Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
Community													
72	16.17 MTFS Review	CE_5	Directorate Wide	Reduction of supplies & services budget	300	31	50	50		100	N	Not required	
73	16.17 MTFS Review	CE_8	ESD - Technical Services	Staff efficiency once Towards Excellence fully embedded - Deletion of 2 posts.	382	0	34	34		68	Y	Y	Consultation will be done in accordance with HR policies
74	16.17 MTFS Review	CE_9	ESD - Public Protection	Efficiencies arising from Selective Licensing - Through full cost recovery and reduction in failure demand. Net income.	(503)	200	35			35	Y	Y	
75	16.17 MTFS Review	CE_10.2	ESD - Management	Management savings Savings on a **management post** across the Environmental Service Delivery division.	150	0	75			75	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies

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Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
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Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
76	15.16 MTFS Review	E&E_18	Directorate wide	Staff Efficiencies following the merger of the Business & Service Development and Commissioning Services Divisions - Delete one performance management officer post and a cemetery superintendent post as of 31 March 2015. In addition, further efficiencies to be achieved in Environmental Services Delivery and Commissioning Divisions in 17/18.			30	50		80	Y	Not required as submitted Feb 2015 Cabinet.	Consultation will be done in accordance with HR policies
77	15.16 MTFS Review	E&E_20	Directorate-wide	Contractual/commissioned/SLA savings - To seek maximum value in savings from existing contracts, Service Level Agreements and all services commissioned, from third parties by re-negotiating terms that will yield cashable savings. To secure on-going cashable benefits from gain share and third party income arrangements.		0	200			200	N	Not required	
78	16.17 MTFS Review	CE_12	Commissioning Services	Project Phoenix - Commercialisation projects	19,000	40	0	1,525		1,525	N	Not required	Yes - depending on project
79	16.17 MTFS Review	CE_14	Commissioning Services	Highways Services - revenue savings on utilities and maintenance costs due to acceleration of the Street Lighting replacement programme and extension of the variable lighting regime.	1,001	70	10			10	Y	Not required as submitted Feb 2016 Cabinet.	N

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Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
80	16.17 MTFS Review	CE_15	Commissioning Services	Highways Services - Reduction in revenue budget for reactive maintenance due to accelerated capital investment from 2014/15.	1,033	60	20	20		40	Y	Not required as submitted Feb 2016 Cabinet.	N
81	16.17 MTFS Review	CE_16	Commissioning Services	Staff efficiencies in Parking and Network Teams - reduction in team leader and inspector posts. Staff consultation completed in June 15. The reduction in posts will be phased over the next 2 years to ensure minimal impact on service level.	2,103	75	80	20		100	Y	Not required as submitted Feb 2016 Cabinet.	Consultation will be done in accordance with HR policies
82	16.17 MTFS Review	CE_17	Commissioning Services	General efficiencies across the Division (Policy, Community Engagement, Facilities Management and Contracts Management) - including capitalisation of senior contracts officer post, removal of some supplies & services budget.	1,009	12	9	80		89	Y	Not required as submitted Feb 2015 Cabinet.	Consultation will be done in accordance with HR policies
83	16.17 MTFS Review	CE_18	Commissioning Services	Income Generation - Facilities Management Service Level Agreements (SLAs) and Energy SLAs to schools.	(190)	46	20	20		40	N	Not required	N
84	16.17 MTFS Review	CE_19	Commissioning Services	Road safety officer post - externally funded by Transport for London (TfL)	40	0	40			40	Y	Y	N
85	16.17 MTFS Review	CE_20	Commissioning Services	Further contract efficiencies following the re-procurement of Facilities Management contract.	3,200	0	80			80	N	Not required	N

Appendix 1b

Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
86	15.16 MTFS Review	E&E_01	Commissioning Services	Trading Standards - Further cost reduction in Trading Standards service by re-negotiating the Service Level Agreement with London Borough of Brent		0	40			40	N	Not required	N
87	15.16 MTFS Review	E&E_05	Commissioning Services - Contract Mgt & Policy	Staff Efficiencies across the Division - Deletion of 3 posts			86			86	Y	Not required as submitted Feb 2015 Cabinet.	Consultation will be done in accordance with HR policies
88	15.16 MTFS Review	E&E_06	Commissioning Services - Facilities Mgt	Reduction in Facilities Management costs - reduce the controllable budget by 20% in the first 2 years through re-structuring and changing ways of service delivery and a further 5% over Years 3 & 4 through additional efficiencies post re-structuring. Consultation with staff already underway and it is proposed to delete 8 posts, 3 of these are currently vacant.		0	44	22		66	Y	Not required as submitted Feb 2015 Cabinet.	Consultation will be done in accordance with HR policies
89	15.16 MTFS Review	E&E_08	Commissioning Services - Highway Services	Reduce highways maintenance budget - Changes to the response times on non urgent works i.e. respond to these in 48 hours instead of existing 24 hours.		0	45			45	Y	Not required as submitted Feb 2015 Cabinet.	Completed
90	15.16 MTFS Review	E&E_09	Commissioning Services - Highways	Highways Contract - Extend the scope of the Highways Contract to include scheme design and / or inspection services when the contract is re-procured (current contract will expire in 16/17).			120	120		240	Y	Y	N

Appendix 1b

Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
91	15.16 MTFS Review	E&E_10	Commissioning Services - Highways	Review salary capitalisation of highway programme & TfL funded projects		0	50	50		100	N	Not required	N
92	15.16 MTFS Review	E&E_11	Commissioning Services - Network Mgt	Additional income - from street works		0	10			10	N	Not required	N
93	15.16 MTFS Review	E&E_12	Commissioning Services - Street Lighting	Changes in Street Lighting Policy to include variable lighting solutions.		0	10	12		22	N	Not required	N
94	15.16 MTFS Review	E&E_13	Commissioning Services - Street Lighting and Drainage	Street lighting and Drainage budgets - capital investment allows for lower maintenance costs		0	40			40	N	Not required	N
95	15.16 MTFS Review	E&E_14	Commissioning Services - Winter Gritting	Reduction in winter gritting budgets - renegotiation of winter gritting contract - adopt a risk sharing approach and move away from the current fixed pricing for the service		0		10		10	Y	Not required for 2017/18 budget	N
96	16.17 MTFS Review	CE_21	NIS	Neighbourhood Investment Scheme (NIS) - a base budget of £210K is available for all 21 wards. A one-off saving has been offered as part of the early year saving. It is now proposed that the full budget is removed from 16/17 onwards.	210	0		210		210	Y	Not required for 2017/18 budget	N
				Total Communities	**27,735**	**534**	**1,128**	**2,223**	**0**	**3,351**			

					Appendix 1b								
Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
97	16.17 MTFS Review	CC_2	C&C	Library Strategy Phase 2 - delivery of network of libraries and library regeneration	2,138	180	108	209		317	Y	Not required for 2017/18 as EQIA agreed for 2016/17 budget setting	Y
98	16.17 MTFS Review	CC_4	C&C	Arts & Heritage - delivery of business plan (reallocation of savings based on Cabinet report May 2015)	623	(342)	282			282	N	Not required	N/a
99	16.17 MTFS Review	CC_4	C&C	Arts & Heritage Services - Total saving in the original MTFS proposal in relation to the proposed transfer of the services to Cultura London was £455k (£173k of which was profiled in 16/17). At this stage the service remains in-house, subject to any further decisions regarding the future of the arts centre and therefore at this stage the saving is being reversed. Should this position change, adjustments would be made to the MTFS and be reflected in the Final Budget report.			(455)			(455)	N	Not required	N/a

					Appendix 1b								
Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
100	15.16 MTFS Review	CHW12	C&C	Redevelopment Harrow Leisure Centre Site. This will need to link with Regeneration Programme. 17/18 saving is expected to be met from one-off income through the improvement to playing pitches at Bannister Sports Centre.			100			100	Y	Y	Y
				Total Cultural Services	**2,761**	**(162)**	**35**	**209**	**0**	**244**			
101	16.17 MTFS Review	CH_3	HGF	Supporting People - cessation of funding for Handyperson Scheme, which is intended to become self-supporting through commercialisation	678	62	25			25	Y	Not required for 2017/18 as EQIA agreed for 2016/17 budget setting	Y
102	16.17 MTFS Review	CH_4	HGF	Supporting People **- Sheltered Housing floating support** - savings assumed to result from contract renegotiation or review of service delivery.	678		60			60	Y	Y	N/a
103	16.17 MTFS Review	CH_7	HGF	Watkins House - Options review	402	(25)	100	100		200	n/a		N/a

					Appendix 1b								
Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
104	16.17 MTFS Review	CH_7	HGF	Full reversal of saving - as part of the review It became apparent that rather than savings being made as a result of the closure of Watkins House, additional costs would need to be incurred to ensure an appropriate level of care was being provided to residents of the scheme. This is now in place and will continue until such time as the scheme is completely vacated. It is not yet clear what the costs of the care needs of the existing residents will be, so it was felt prudent to remove the assumed savings so as not to reduce the level of funds available to provide this care. £25k growth was allowed in 2016/17 and therefore the net reduction of £175k is required.			(75)	(100)		(175)	n/a	n/a	N/a
105	16.17 MTFS Review	CH_8	HGF	Private lettings agency - projected income from establishing a lettings agency	0	54	130	174	120	424	n/a	n/a	N/a
106	16.17 MTFS Review	CH_8	HGF	Full reversal of saving - the business plan for the lettings agency indicates that as a result of a slower than anticipated start and an increased level of overhead costs compared with those originally envisaged, it is unlikely to be able to deliver the level of benefits to the Council assumed in the MTFS calculations within the MTFS period.			(130)	(174)	(120)	(424)	n/a	n/a	N/a

					Appendix 1b								
Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
107	16.17 MTFS Review	CH_9	HGF	Property purchase initiative - net benefit to Council of proposals to purchase 100 homes, per Cabinet report appendix. Homelessness savings are part of the equation.	0	230	31	(2)	42	71	N	Not required	
108	16.17 MTFS Review	CH_9	HGF	Additional income - 'Property purchase initiative - net benefit to Council of proposals to purchase 100 homes, per Cabinet report appendix. Homelessness savings are part of the equation.			770	355	(4)	1,121	N	N	N
109	16.17 MTFS Review	CH_10	HGF	Home Improvement Agency - savings arising from a combination of reducing the service and increasing the charge to the HRA in respect of the Occupational Therapist service	378	(10)	130			130	Y	Y	
				Total Housing	**2,136**	**311**	**1,041**	**353**	**38**	**1,432**			
	Net Savings Community and Culture				**32,632**	**683**	**2,204**	**2,785**	**38**	**5,027**			
Regeneration													
110	15.16 MTFS Review	E&E_36	Planning - Development Mgt	Planning Fees: following an increase in 2013, the government may increase the statutory planning fees at some point over the next four years			100			100	Y	Y	N

Appendix 1b

Savings Proposed from 2015/16 and 2016/17 Budget Setting					Savings								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
111	16.17 MTFS Review	REG_6	Economic Development	Commercialisation of work space, subject to agreement with St Edwards (income net of running costs)	0	0	50			50	n/a	n/a	N
112	16.17 MTFS Review	REG_6	Economic Development	Full reversal of saving - The opportunity to acquire Stanmore Place Innovation Centre no longer exists as St Edward has sold the property to a 3rd party, albeit several attempts to reach an agreement with St Edward over the last 12 months.			(50)			(50)	n/a	n/a	N
	Net Savings Regeneration				**0**	**0**	**100**	**0**	**0**	**100**			
113	16.17 MTFS Review	PO 04	Pan Organisation	Additional Commercialisation savings from projects in the pipeline		1,100	1,100			1,100	n/a	n/a	N
114	16.17 MTFS Review	PO 04	Pan Organisation	Full reversal of saving - Savings on commercialisation have been proposed as part of the directorate savings proposals and therefore need to be reversed as a pan organisation saving.			(1,100)			(1,100)	n/a		N
115	14.15MTFS Review	PO 03	Pan Organisation	Regeneration - Indicative net income realised from a long term regeneration strategy for the borough, to be formalised following consultation launched in early 2015.	0	350	350	2,000	0	2,350	N	Not required	N

					Appendix 1b								
Savings Proposed from 2015/16 and 2016/17 Budget Setting					**Savings**								
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**	**EQIA Required**	**EQIA already submitted Yes/ No**	**Key Stakeholders to consult 'Yes/No Completed**
Resources & Commercial					**£000**	**£000**	**£000**	**£000**	**£000**	**£000**			
	Net savings Pan Organisation				**0**	**1,450**	**350**	**2,000**	**0**	**2,350**			
			Total Net Savings		**78,367**	**5,367**	**5,971**	**14,889**	**4,288**	**25,148**			

Reversed Savings Proposed from 2015/16 and 2016/17 Budget Setting					Appendix 1c Savings					
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**
					£000	**£000**	**£000**	**£000**	**£000**	**£000**
Resources & Commercial Directorate										
1	16.17 MTFS Review	RES_LG02	Legal & Governance	Reversal of saving - 'This was a proposal to consolidate the Committee structure, which is not being progressed.			(100)			(100)
2	16.17 MTFS Review	RES_CS02	Customer Services and IT	**Reversal of saving** - 'Revenues and Benefits - Domestic and NNDR Site Review and Collection Rate. This saving come through as additional collection Fund income and therefore the saving cannot be made in the Directorate Budget.				(250)		(250)
3	16.17 MTFS Review	BSS 01	BSS	**Reversal of saving** - 'A thorough review of Business Support has been undertaken in the last year, as a result of which over £1m of savings have been identified that are being delivered. However it has been decided that further reduction in these areas are not appropriate, and therefore savings proposed in previous budgets will not be progressed and need to be reversed. This is reversing the 2017/18 and 2018/19 savings.			(352)	(320)		(672)
4	16.17 MTFS Review	BSS 01	BSS	**Reversal of saving** - 'A thorough review of Business Support has been undertaken in the last year, as a result of which over £1m of savings have been identified that are being delivered. However it has been decided that further reduction in these areas are not appropriate, and therefore savings proposed in previous budgets will not be progressed and need to be reversed. This is reversing £557k of the 2016/17 saving of £649k.			(557)			(557)
Total Resources					0	0	(1,009)	(570)	0	(1,579)
People's Directorate										
Childrens										

Reversed Savings Proposed from 2015/16 and 2016/17 Budget Setting					Appendix 1c Savings					
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**
					£000	**£000**	**£000**	**£000**	**£000**	**£000**
5	16.17 MTFS Review	PC33	Special Needs Service	**Reversal of Savings - Special Educational Needs Transport** There are significant pressures on SEN Transport of over £1.2m. There is a savings target in the current MTFS for £514k. An updated travel assistance policy was approved by Cabinet in September 2016 however It is not anticipated that there will be any significant changes as the regulations have remained largely unchanged. However, discretionary travel arrangements will be removed for under 5's. Since 2014 a new SEN Code has led to an increased demand Post 19 as well as the pressures of the additional demand from the 5-19 demographic growth. There has been an increase in post 18 young people of nearly 40%.		(257)	(514)			(514)
6	16.17 MTFS Review	PC42	Special Needs Service	Reversal of Savings - Special Educational Needs Placements In respect of PC41 approved February 2016. New funding regulations mean there will no longer be flexibility to further charge these costs to grant				(651)		(651)
				Total Children Savings	**0**	**(257)**	**(514)**	**(651)**	**0**	**(1,165)**
Adult										0
8	16.17 MTFS Review	PA_5	Adults	Full reversal of saving - following the unsuccessful Community Tender at Kenmore it is not currently possible to deliver savings via this route. The commercialisation approach now being considered for Kenmore may indicate the potential for future savings to be explored for New Bentley if the approach is successful.			(446)			(446)

Reversed Savings Proposed from 2015/16 and 2016/17 Budget Setting					Appendix 1c Savings					
Item Number	**Savings Year**	**Unique Reference No.**	**Specific Service Area**	**Headline Description re: saving / reduction**	**2015/16 Service Budget**	**Total Saving in Current MTFS**	**2017/18**	**2018/19**	**2019/20**	**Total**
					£000	**£000**	**£000**	**£000**	**£000**	**£000**
9	16.17 MTFS Review	PA_15	Adults	Reversal of £400k of the saving in 2017/18 - given the complexity of the client group attending the merged facility it is not possible to deliver the level of savings originally estimated			(400)			(400)
10	16.17 MTFS Review	PA_26	Adults	Re-phasing - remove original phasing			(1,000)	(600)		(1,600)
11	16.17 MTFS Review	PA_26	Adults	Re-phasing - add in new phasing				1,000	600	1,600
12	16.17 MTFS Review	PA_27	Adults	Re-phasing - remove original phasing			(998)	(1,250)		(2,248)
13	16.17 MTFS Review	PA_27	Adults	Re-phasing - add in new phasing				998	1,250	2,248
14	16.17 MTFS Review	PA_29B	Adults	Re-phasing - remove original phasing				(2,250)		(2,250)
15	16.17 MTFS Review	PA_29B	Adults	Re-phasing - add in new phasing.					2,250	2,250
				Total Adult Savings	**0**	**0**	**(2,844)**	**(2,102)**	**4,100**	**(846)**
Community										0
16	16.17 MTFS Review	CC_4	C&C	Arts & Heritage Services - Total saving in the original MTFS proposal in relation to the proposed transfer of the services to Cultura London was £455k (£173k of which was profiled in 16/17). At this stage the service remains in-house, subject to any further decisions regarding the future of the arts centre and therefore at this stage the saving is being reversed. Should this position change, adjustments would be made to the MTFS and be reflected in the Final Budget report.			(455)			(455)

Reversed Savings Proposed from 2015/16 and 2016/17 Budget Setting					Appendix 1c Savings					
Item Number	Savings Year	Unique Reference No.	Specific Service Area	Headline Description re: saving / reduction	2015/16 Service Budget	Total Saving in Current MTFS	2017/18	2018/19	2019/20	Total
					£000	£000	£000	£000	£000	£000
				Sub Total Cultural Services	**0**	**0**	**(455)**	**0**	**0**	**(455)**
17	16.17 MTFS Review	CH_7	HGF	Full reversal of saving - as part of the review It became apparent that rather than savings being made as a result of the closure of Watkins House, additional costs would need to be incurred to ensure an appropriate level of care was being provided to residents of the scheme. This is now in place and will continue until such time as the scheme is completely vacated. It is not yet clear what the costs of the care needs of the existing residents will be, so it was felt prudent to remove the assumed savings so as not to reduce the level of funds available to provide this care. £25k growth was allowed in 2016/17 and therefore the net reduction of £175k is required.			(75)	(100)		(175)
18	16.17 MTFS Review	CH_8	HGF	Full reversal of saving - the business plan for the lettings agency indicates that as a result of a slower than anticipated start and an increased level of overhead costs compared with those originally envisaged, it is unlikely to be able to deliver the level of benefits to the Council assumed in the MTFS calculations within the MTFS period.			(130)	(174)	(120)	(424)
19	16.17 MTFS Review	CH_9	HGF	Additional income - 'Property purchase initiative - net benefit to Council of proposals to purchase 100 homes, per Cabinet report appendix. Homelessness savings are part of the equation.			770	355	(4)	1,121
				Total Housing	**0**	**0**	**565**	**81**	**(124)**	**522**
		Regeneration								0

Reversed Savings Proposed from 2015/16 and 2016/17 Budget Setting					Appendix 1c Savings					
Item Number	Savings Year	Unique Reference No.	Specific Service Area	Headline Description re: saving / reduction	2015/16 Service Budget	Total Saving in Current MTFS	2017/18	2018/19	2019/20	Total
					£000	£000	£000	£000	£000	£000
20	16.17 MTFS Review	REG_6	Economic Development	Full reversal of saving - The opportunity to acquire Stanmore Place Innovation Centre no longer exists as St Edward has sold the property to a 3rd party, albeit several attempts to reach an agreement with St Edward over the last 12 months.			(50)			(50)
Total Regeneration					**0**	**0**	**(50)**	**0**	**0**	**(50)**
21	16.17 MTFS Review	PO 04	Pan Organisation	Full reversal of saving - Savings on commercialisation have been proposed as part of the directorate savings proposals and therefore need to be reversed as a pan organisation saving.			(1,100)			(1,100)
Total Pan Organisation					**0**	**0**	**(1,100)**	**0**	**0**	**(1,100)**
										0
Total Reversed Savings					**0**	**(257)**	**(5,407)**	**(3,242)**	**3,976**	**(4,673)**

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MEDIUM TERM FINANCIAL STRATEGY 2016/17 to 2019/20

	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000
Budget Requirement Brought Forward		164,987	162,955	156,106
Corporate & Technical		-2,435	16,211	9,757
People		3,629	-7,999	-4,340
Community		-1,502	-3,557	-163
Resources & Commercial		-1,227	-2,527	-550
Regeneration		-147	0	0
Pan Organisation		-350	-2,000	0
Total		**-2,032**	**128**	**4,704**
FUNDING GAP		**0**	**-6,978**	**-9,661**
Total Change in Budget Requirement		**-2,032**	**-6,850**	**-4,957**
Revised Budget Requirement	**164,987**	**162,955**	**156,106**	**151,148**
Collection Fund Deficit/-surplus	-3,494	-3,760	0	0
Revenue Support Grant	-21,935	-13,019	-7,332	-1,560
Top Up	-21,113	-21,529	-22,164	-22,872
Retained Non Domestic Rates	-13,189	-13,189	-13,189	-13,189
Amount to be raised from Council Tax	**105,256**	**111,458**	**113,421**	**113,527**
Council Tax at Band D	**£1,283.61**	**£1,334.83**	**£1,334.83**	**£1,334.83**
Increase in Council Tax (%)	**3.99%**	**3.99%**	**0.00%**	**0.00%**
Tax Base	82,000	83,500	84,970	85,050
Collection rate	97.75%	98.00%	98.00%	98.00%
Gross Tax Base	83,887	85,204	86,704	86,786

MTFS 2017/18 to 2019/20 – Proposed investments / savings

TECHNICAL BUDGET CHANGES			
	2017/18	**2018/19**	**2019/20**
	£000	**£000**	**£000**
Capital and Investment			
Capital financing costs and investment income Increased Minimum Revenue Provision costs of the capital programme and interest on balances changes	3,747	7,994	4856
Application of Capital Receipts to reduce borrowing costs	-1,000		
One of use of MRP capacity	-500	500	
Total Capital and Investment Changes	**2,247**	**8,494**	**4,856**
Grant Changes			
New Homes Bonus Estimated Grant changes	-525	940	1000
Top slice allocated to homelessness	0	0	
Total New Homes Bonus	*-525*	*940*	*1,000*
Better Care Fund *Estimated additional grant from 2016/17*			
Education Support Grant. Projected reduction in grant received	1,285	751	0
Total ESG	1,285	751	0
Transition grant	13	699	
Public Health Grant Reduction	907	697	487
Total Grant Changes	**1,680**	**3,087**	**1,487**
Other Technical Changes			
Freedom Pass Levy increase. Cost of Freedom passes charged to Harrow by Transport for London	380	390	
Amendment 2016/17 review - extension to 2019/20	0	0	414
Total Freedom Pass Levy change	*380*	*390*	*414*
Remove original energy price contingency	*-350*	*0*	
Increase energy contingency	*260*	*-64*	
Contingency - reduction back to £1.248m	*-81*		
Estimated Cost of the Apprenticeship Levy	400		
Budget planning contingency.	-2,000	370	0
One off use from 2016/17	-1,000	1,000	TBC
Total Budget planning contingency.	*-3,000*	*1,370*	*0*
Total Other Technical Changes	**-2,391**	**1,696**	**414**
Pay and Inflation			
Pay Award @ 1% pa	1,000	1,000	1,000
Pay inflation total	1,000	1,000	1,000
National Minimum Wage			1,300
Employer's Pension Contributions lump sum increases agreed with actuary Required to reduce the pension deficit	622	664	700
Inflation on goods and services @ 1.3% p.a.	1,270	1,270	0
Reduction in inflation provision	-870	0	TBC
Inflation Provision total	*400*	*1,270*	*0*
Total Pay and Price Inflation	**2,022**	**2,934**	**3,000**
OTHER			
Contribution to MTFS Implementation Reserve - one off in 2016/17	-2,954		
Capital Receipts Flexibility	-3,039	0	
Total Corporate & Technical	**-2,435**	**16,211**	**9,757**

MTFS 2017/18 to 2019/20 – Proposed investments / savings

PEOPLE DIRECTORATE			
	2017/18	2018/19	2019/20
	£000	£000	£000
Children & Families			
Proposed Savings - see appendix 1a	-255	0	0
Proposed Growth - see appendix 1a	2,838	200	
Proposed Savings - see appendix 1b	-167	-2,611	-150
Sub total Children & Families	2,416	-2,411	-150
Adults			
Proposed Savings - see appendix 1a	-1,120		0
Proposed Growth - see appendix 1a	4,629	-96	-90
Proposed Savings - see appendix 1b	-1,571	-3,228	-4,100
Sub total Adults	1,938	-3,324	-4,190
Public Health			
Proposed Savings - see appendix 1a	-263	31	0
Proposed Growth - see appendix 1a			
Proposed Savings - see appendix 1b	-462	-2,295	0
Sub total Public Health	-725	-2,264	0
Total People Directorate	**3,629**	**-7,999**	**-4,340**

MTFS 2017/18 to 2019/20 – Proposed investments / savings

COMMUNITY			
	2017/18	2018/19	2019/20
	£000	£000	£000
Environmental Services			
Proposed Savings - see appendix 1a	-896	-140	0
Proposed Growth - see appendix 1a	500		100
Proposed Savings - see appendix 1b	-1,128	-2,223	0
Sub total Environmental Services	-1,524	-2,363	100
Cultural Services			
Proposed Savings - see appendix 1a			0
Proposed Growth - see appendix 1a			
Proposed Savings - see appendix 1b	-35	-209	0
Sub total Community & Culture	-35	-209	0
Housing - General Fund			
Proposed Savings - see appendix 1a	-898	-469	-225
Proposed Growth - see appendix 1a	2,996	-163	
Growth funded from topslice	-1,000		
Proposed Savings - see appendix 1b	-1,041	-353	-38
Sub total Housing General Fund	57	-985	-263
Total Community	**-1,502**	**-3,557**	**-163**

MTFS 2017/18 to 2019/20 – Proposed investments / savings

RESOURCES & COMMERCIAL			
	2017/18	2018/19	2019/20
	£000	£000	£000
Resources & Commercial			
Proposed Savings - see appendix 1a	-844	-557	-550
Proposed Growth - see appendix 1a	734		
Proposed Savings - see appendix 1b	-1,117	-1,970	0
Total Resources & Commercial	**-1,227**	**-2,527**	**-550**

MTFS 2017/18 to 2019/20 – Proposed investments / savings

REGENERATION			
	2017/18	2018/19	2019/20
	£000	£000	£000
Proposed Savings - see appendix 1a	-47		
Proposed Growth - see appendix 1a			
Proposed Savings - see appendix 1b	-100		
Total Regeneration	**-147**	**0**	**0**

MTFS 2017/18 to 2019/20 – Proposed investments / savings

Pan Organisation			
	2017/18	**2018/19**	**2019/20**
	£000	**£000**	**£000**
Proposed Savings - see appendix 1b	0	0	0
Proposed Savings - see appendix 1a	-350	-2,000	0
Total Pan Organisation	**-350**	**-2,000**	**0**

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Schools Budget 2017-18 **Appendix 3**

1. Introduction

The Dedicated Schools Grant (DSG) is a ring fenced grant of which the majority is used to fund individual school budgets. It also funds certain central services provided by the local authority such as Early Years (private and voluntary sector and maintained nurseries) and Special Educational Needs (SEN) including fees for out of borough pupils at independent special schools.

2. School Funding for 2017-18

There are minimal changes proposed to how local authorities can fund schools through their individual funding formulae. However, in July 2016 the EFA carried out an exercise to 're-baseline' the blocks of the DSG for each local authority to make sure that the starting point is the pattern of planned spending by local authorities within their annual DSG allocation rather than how central government has allocated funding since 2013. The new 2016-17 baselines have then been used to calculate allocations for the schools block and high needs block in 2017-18.

As a result of this exercise, the Schools Block Unit of Funding (SBUF) which is the funding generated per pupil on the October census has been reduced for 2017-18 to reflect the actual funding allocated through the Schools Block in 2016-17. The revised SBUF will be £4,845.80. This is a reduction of £68.82 per pupil. This therefore limits the amount of funding which can be top-sliced from the Schools Block to fund pressures in High Needs.

3. Setting 2017-18 Budgets

In 2015-16 and 2016-17 the schools funding formula has been set at a deficit of £1.6m and £2.07m respectively. In 2016-17 it is proposed to fund the deficit from the schools brought forward contingency totalling £5.5m. Beyond 2016-17 there will be limited funds to set a school funding formula with a deficit position. The schools brought forward contingency is a one off sum of money and therefore it is not sustainable to continue to use this to support a budget gap.

In March 2016 the DfE launched a first stage consultation with proposals for a new National Funding Formula (NFF) for Schools and High Needs to be introduced from April 2017. On 21st July 2016 the government announced that the full response to the first stage of the consultations will be published in autumn 2016. At the same time the proposals for a second stage consultation will also be published and decisions made in the new year. Therefore the new system will be delayed and instead apply from April 2018. With limited information as to how a NFF will impact on school funding and school budgets there are few changes proposed to the 2017-18 schools funding formula.

Schools are protected annually by the Minimum Funding Guarantee (MFG) from *per pupil* losses capped at -1.5% of the per pupil budget from the previous financial year. This means that schools cannot lose more than -1.5% of their previous years' per pupil budget. This will continue into 2017-18.

Cabinet is required to approve the structure of the funding formula for 2017-18 in relation to the factors applied within the formula. The values attached to each factor will be decided in consultation with Schools Forum in January 2017 in order to minimise the formula deficit. There are no changes proposed for the funding formula structure from the current 2016-17 formula. The current factors in the school funding formula are:

- Basic per pupil entitlement (Age Weighted Pupil Unit)
- Free School Meals
- Income Deprivation Affecting Children Index (IDACI)
- Looked After Children
- English as an Additional Language (EAL)
- Mobility
- Prior Attainment
- Lump Sum
- Rates
- Private Finance Initiative (PFI) Funding

Schools will also receive the Pupil Premium Grant in respect of pupils who have ever been eligible for Free School Meals (FSM) in the last six years.

Central Services

Services currently funded from centrally retained DSG are included in either the High Needs Block or Early Years Block where appropriate, with the remaining falling into the Schools Block. All the funding in the schools block has to be passed to schools apart from the following named exceptions which can still be retained but are frozen at 2012-13 levels:

- Co-ordinated Admissions
- Servicing of Schools Forum

Schools Forum has agreed to continue to de-delegate funding in respect of Trade Union Facilities Time.

Additional Class Funding

At its meeting in October 2016 Schools Forum agreed to continue to maintain a ring fenced Growth Fund from the DSG in order to fund in year pupil growth in relation to additional classes in both maintained and academy schools but not Free Schools, which create additional classes at the request of the local authority.

High Needs Block

In line with the SEND Reforms being introduced from September 2014, the high needs funding system is designed to support a continuum of provision for pupils and students with special educational needs (SEN), learning difficulties and disabilities, from their early years to age 25. The following are funded from the High Needs Block:

- Harrow special schools & special academies
- Additional resourced provision in Harrow mainstream schools & academies
- Places in out of borough special schools and independent special schools

- High value costed statements in mainstream schools & academies
- Post 16 SEN expenditure including Further Education settings
- SEN Support services and support for inclusion
- Alternative provision including Pupil Referral Units and Education Other than at school

In 2016-17 high needs pupils are funded on a mixture of places and pupils, the "place-plus" approach. This will continue in 2016-17. There are continued concerns about the financial risks posed by the changes to the funding for SEN provision. Harrow has seen significant growth in the number of places through the expansion of the three special schools and the addition of three SEN units at mainstream schools from Sept 2015. There was no additional DSG funding awarded for these places and therefore they have been funded from a top slice from the Schools Block, which limits the funding available to distribute to schools. High Needs pupils in special schools, specialist provision and pupil referral units do not attract funding through a census, unlike pupils in mainstream settings. The DfE have also carried out a 're-baseline' exercise on the High Needs Block and confirmed that no local authority will see a reduction in 2017-18, based on its 2016-17 baseline.

Early Years Block

3 and 4 year old nursery entitlement

The DfE launched its Early Years National Funding Formula consultation in August 2016.

The main principles of the funding reform are to:

- Maximise funding to early years providers
- Allocate funding fairly to Local Authorities and different types of providers
- Distribute funding efficiently and effectively to ensure value for money
- Allocate funding transparently so LAs and providers can understand how their funding rates were derived.
- Target effectively additional funding to those children who need it
- Allow adequate time to transition to the new funding arrangements

As the implementation date is proposed to be 1st April 2017 local authorities have to consult on its local Early Years Single Funding Formula in advance of the outcome of the DfE consultation. Harrow launched its consultation on 14th October 2016, which closes on 30th November 2016. The outcome of the consultation and proposed new funding formula will be reported to Cabinet for approval in January 2017.

Early Years Pupil Premium Grant

In addition to the funding through the funding formula settings also receive Early Years Pupil Premium Grant (EYPPG) for eligible children. In 2016-17 this is £302 per year for each eligible child that takes up the full 570 hours (pro rata for children who take up fewer hours). The eligible groups for the EYPPG are children from low income families (defined as meeting the criteria for free school meals); children that have been looked after by the local authority for at least one day; have been adopted from care; have left care through special guardianship; and children subject to a child arrangement order setting out with whom the child is to live (formerly known as residence orders).

2 year old nursery entitlement

From September 2013 free entitlement became a statutory requirement for eligible two year olds. In 2016-17 the funding is based on participation being 5/12ths of the January 2015 census and updated for 7/12ths of the January 2016 census. Harrow currently receives £5.53 per hour per eligible child. The hourly rate for 2016-17 will be confirmed after the spending review in December 2016.

Draft Public Health Funding Appendix 4

Mandatory Services		
Sexual Health (incl Family Planning)	2,641,502	
Health Visiting	2,898,000	
Health Checks	76,450	
Supporting Child Health	673,509	
		6,289,461
Discretionary Services		
Tobacco Control	0	
Drug & Alcohol Misuse	2,445,632	
Physical Activity	0	
		2,445,632
Staffing & Support Costs		
Staffing	990,781	
Non-Staffing	47,941	
Overheads	245,525	
		1,284,247
Health Improvement	129,000	
Wider Determinants of Health	945,161	
		1,074,161
Total Expenditure		**11,093,501**
Funded by		
Department of Health Grant	11,093,501	
Total Income		**11,093,501**
		0

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REPORT FOR: HEALTH AND WELLBEING BOARD

Date of Meeting:	12 January 2017
Subject:	North West London (NWL) Sustainability & Transformation Plan (STP)
Responsible Officer:	Javina Sehgal, Chief Operating Officer Harrow CCG Chris Spencer, Director People Services, Harrow Council
Public:	Yes
Wards affected:	All Wards
Enclosures:	Summary of North West London Sustainability And Transformation Plan November 2016 North West London Sustainability And Transformation Plan 21 October Final Submission to NHSE

Section 1 – Summary and Recommendations

This report accompanies the final North West London (NWL) Sustainability & Transformation Plan (STP) submitted to NHSE on 21st October 2016.

The quality of health and social care collaboration in support of the NWL STP will be one determining factor in the eventual allocation of a national fund of up to £3.8 billion over the next 5 years.

Recommendations:
The Board is requested to note the plan.

Section 2 – Report

Background

Sustainability and Transformation Plans (STPs) are a key element of the local implementation of the Five Year Forward View including delivery of the health and care 'gaps' described in the Five Year Forward View:

- The health and wellbeing gap;
- The care and quality gap;
- The funding and efficiency gap.

North West London, which includes the 8 boroughs and CCGs, is one of the designated 44 footprints required to submit a STP.

To support delivery of the STP the boroughs in NW London are required to collaborate as 'place based systems' across health and local government to address the ambition set out in the FYFV.

To support delivery of the FYFV a nominal additional fund allocation of up to £3.8 billion will be available across the five year period. Access to a portion of the funds to support delivery of the NWL STP will be largely determined by the content and local system-wide (Council, Commissioners, Providers, 3rd sector) support for and commitment to the local STP.

The NWL STP will describe plans at different levels of 'place'– across the whole system in North West London, from the local to the sub-regional, as appropriate. Local plans, including those jointly developed for Harrow, form the building blocks of the NWL STP.

Harrow Response to the STP

The care commissioning and delivery organisations serving the Harrow population have come together to form the Harrow Sustainability and Transformation Plan Group (HSTPG). Harrow CCG is acting as the convenor of the HSTPG and also acts as the conduit across the sub-regional and regional arrangements to coordinate the STP process.

The HSTPG has members from the London Borough of Harrow, London North West Hospitals Trust, Central London Community Health Services, Central and North West London Mental Health Trust, patient groups and 3rd sector providers.

An initial high level draft submission was agreed by the HSTPG and made to the NWL STP team in mid-April, and contributed to the NWL draft submission on 15th April 2016.

A further draft was submitted in June.

These iterations of the plan were discussed at the Harrow Health and Wellbeing Board meetings in May and August and at the Overview and Scrutiny Committee in June.

The final version of the North West London Sustainability and Transformation Plan was submitted to NHSE on 21st October 2016.

The HSTPG will meet in December 2016 to agree a process for the development of a local STP implementation plan by March 2017.

Stakeholder Engagement

The Harrow STP partners have prioritised local stakeholder engagement in the development of the plan including presentations to:

- Harrow Voluntary and Community Services Forum
- HealthWatch Harrow
- Harrow Mind Service User Group (HUG)
- Interfaith Network meeting
- Carers (Carers Harrow and Mencap)
- Harrow Patients Participation Network
- Voluntary Sector Forum Health & Well-being Subgroup

- A public event in October, incorporating our draft commissioning intentions, attended by individuals, representatives of local community groups and stakeholders

- An online survey for members of the public to provide feedback on the STP and commissioning intentions

The focus of the events was to provide members of the public, voluntary sector, front line staff and key stakeholders from each organisation with an understanding of the STP and its implications for Harrow's health and social care economy.

A final draft of the plan was circulated to member organisations of the STP for comment to the North West London Strategy and Transformation team by Wednesday 7th September.

Performance Issues

The STP's delivery will be coordinated across the Harrow health and care economy.

It is anticipated that there will be a positive impact on resident outcomes that are delivered either by partners or by joint working with partners.

These anticipated benefits will be quantified for each programme or project as they are developed in detail. The benefits will be linked to existing or new measures or outcomes, quality, access and productivity as they evolve.

Environmental Impact

At this point in time there is no anticipated environmental impact of the STP.

This will be reviewed on an on-going basis at a programme and project level as the evolving strategies and plans are further developed into change and delivery action plans.

Financial Implications/Comments

The STP is an opportunity to radically transform the way health and social care is provided, and across NWL both the NHS and local authorities have agreed to work together to deliver a sustainable health and care system.

The national £1.8 billion Sustainability and Transformation Fund resources are part of the recurrent real-terms uplift for the NHS in 2016/17 of £3.8 billion. The content of the regional STP submissions, including NWL, will be a determining factor in the allocation decisions nationally.

The national picture for the finances of the public sector, both health and social care, remains extremely challenging. Financial models to support the development of the local and NWL STP are being jointly developed by CCG CFOs. These plans are expected to assist in contributing to and achieving financial balance for health budgets, together with a commitment in principle from NHSE / NWL that transformation should enable funding to be provided to cover local authority Adult Social Care funding gaps.

Work is underway to establish both the funding gaps and the ability to redirect resources to local authorities arising from health and social care transformation.

Legal Implications/Comments

None

Risk Management Implications

To date no formal risk assessment has been undertaken on the potential local impact of the STP. This will be reviewed on an ongoing basis at a programme and project level as the evolving strategies and plans are further developed into change and delivery action plans.

Equalities implications

Was an Equality Impact Assessment carried out? ~~Yes~~/No

A key focus of the STP for Harrow is to address inequalities in both provision and outcomes over the 5 year period.

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

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

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.

Section 3 - Statutory Officer Clearance (Council and Joint Reports)

Name:Donna Edwards	x	on behalf of the Chief Financial Officer
Date: 3 January 2017		

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Javina Sehgal, Chief Operating Officer, Harrow Clinical Commissioning Group

Background Papers: None

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North West London

Sustainability and Transformation Plan Summary

Being well, living well: a sustainability and transformation plan for North West London

November 2016

Have your say

We want to hear your views as we develop this plan. We welcome your comments on any aspect of this plan.

You can send us your comments either online at www.healthiernwlondon.commonplace.is or email healthiernwl@nw.london.nhs.uk.

This document is a summary. More details are available on our website www.healthiernorthwestlondon.nhs.uk.

Our vision

Everyone living, working and visiting North West (NW) London should have the opportunity **to be well and live well** – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers.

For this to happen, the health service needs to turn the current model, which directs most resources into caring for people when they become ill, on its head. The new model must support patients to stay well and take more control of their own health and wellbeing, as close to home as possible.

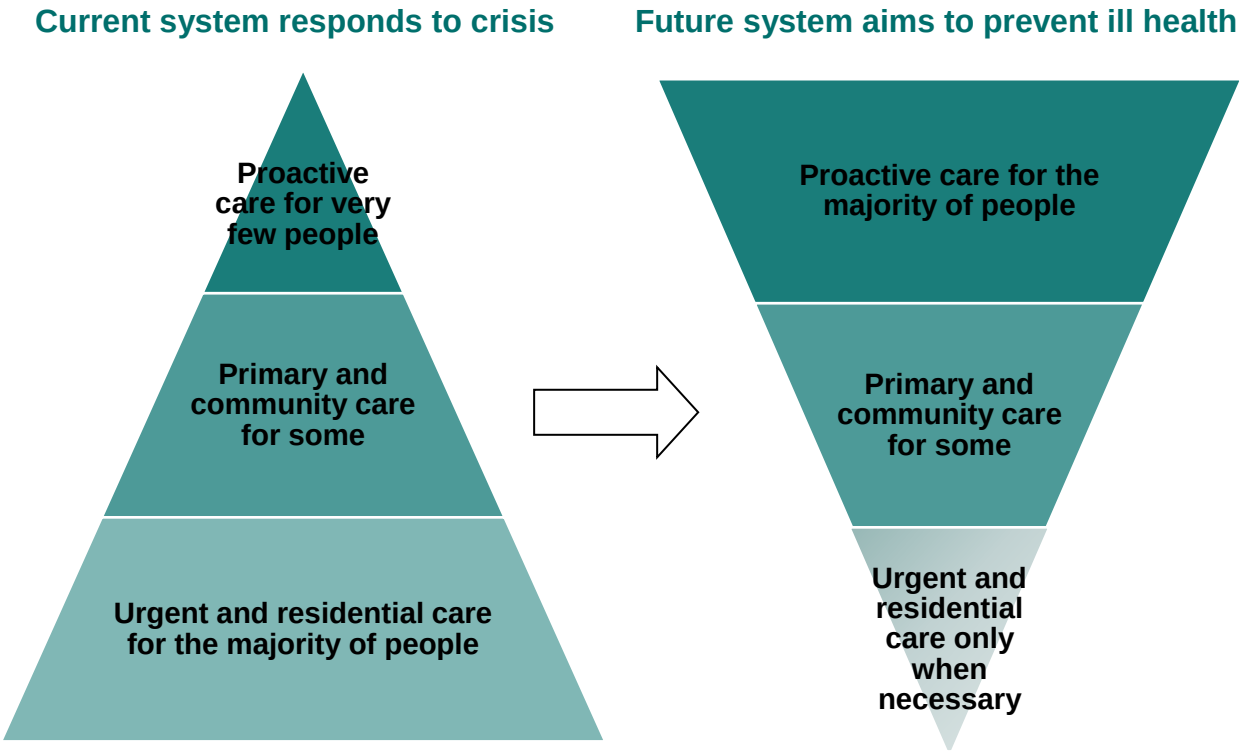
Sustainability
Using resources to meet the needs of people today without causing problems for future generations.

The NHS and councils of NW London have developed this draft Sustainability and Transformation Plan (STP). The STP takes its starting point from the ambitions and knowledge in the national **NHS Five Year Forward View** strategy and translates it for our local situation.

NHS Five Year Forward View

The NHS Five Year Forward View is a strategy for the NHS in England. It describes the gaps in health and social care; how the quality of NHS care can be variable; with widespread health inequalities and preventable illnesses. People's needs are changing, new treatments are emerging every day, and there are challenges in areas such as mental health, cancer and support for frail older patients.

The NHS Five Year Forward View also sets out the benefits of new ways of delivering care; the critical importance of better public health and preventing ill health; how services across health and social care need to be joined up and patients and communities need to be empowered; why primary care needs to be strengthened; and the need for further efficiencies in the health service.



Working together to achieve change

Over four billion pounds a year is spent on providing NW London's health and care services for our two million residents. There are 400 GP practices, ten hospitals and four mental health and community health trusts across the eight boroughs.

Doctors, nurses and other clinicians have worked with key stakeholders to propose how care should evolve to provide a high quality and sustainable system that meets your needs. The 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 and has involved over 30 organisations:

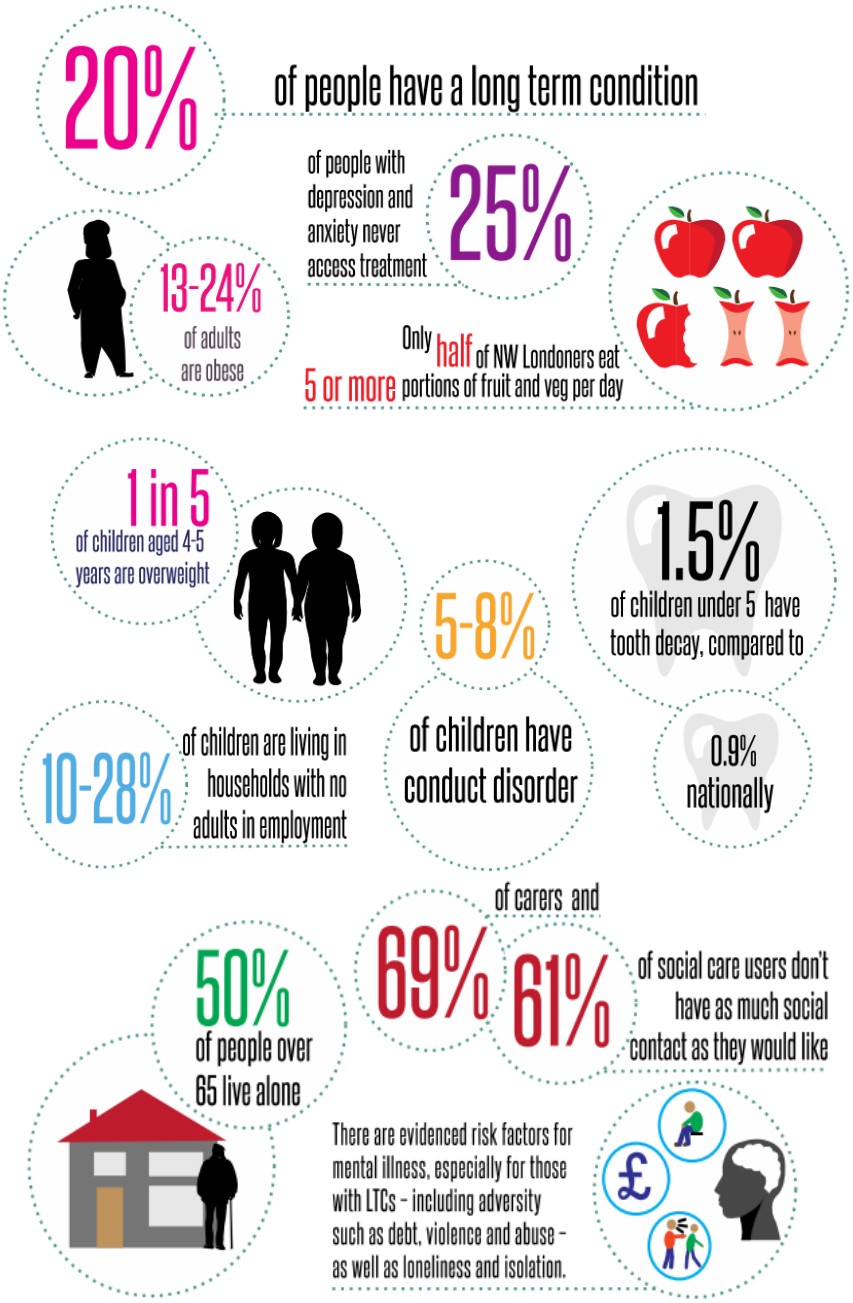
- **Clinical commissioning groups (GP-led groups responsible for planning and buying NHS services):** Brent; Central London; Ealing; Hammersmith and Fulham; Harrow; Hillingdon; Hounslow; and West London.
- **Local authorities:** Brent; Hammersmith & Fulham, Harrow; Hillingdon; Hounslow; Kensington and Chelsea; and the City of Westminster.
- **NHS providers (hospitals, community services and mental health services):** West London Mental Health NHS Trust; Central and North West London NHS Foundation Trust; Chelsea and Westminster Hospital NHS Foundation Trust; London North West Healthcare NHS Trust; The Hillingdon Hospitals NHS Foundation Trust; Hounslow and Richmond Community Healthcare NHS Trust; The Royal Marsden NHS Foundation Trust; Royal Brompton and Harefield NHS Foundation Trust; London Ambulance Service NHS Trust; Imperial College Healthcare NHS Trust; Central London Community Healthcare NHS Trust

We are also working with colleagues from a range of regional and national health and care organisations and federations.

Why we need an STP

Many people live in an unhealthy situation and make unhealthy choices:

- Only half of our population is physically active
- half of over-65s live alone and over 60 per cent of adult social care users want more social contact
- many people are living in poverty
- people with serious long-term mental health needs live 20 years less than those without.



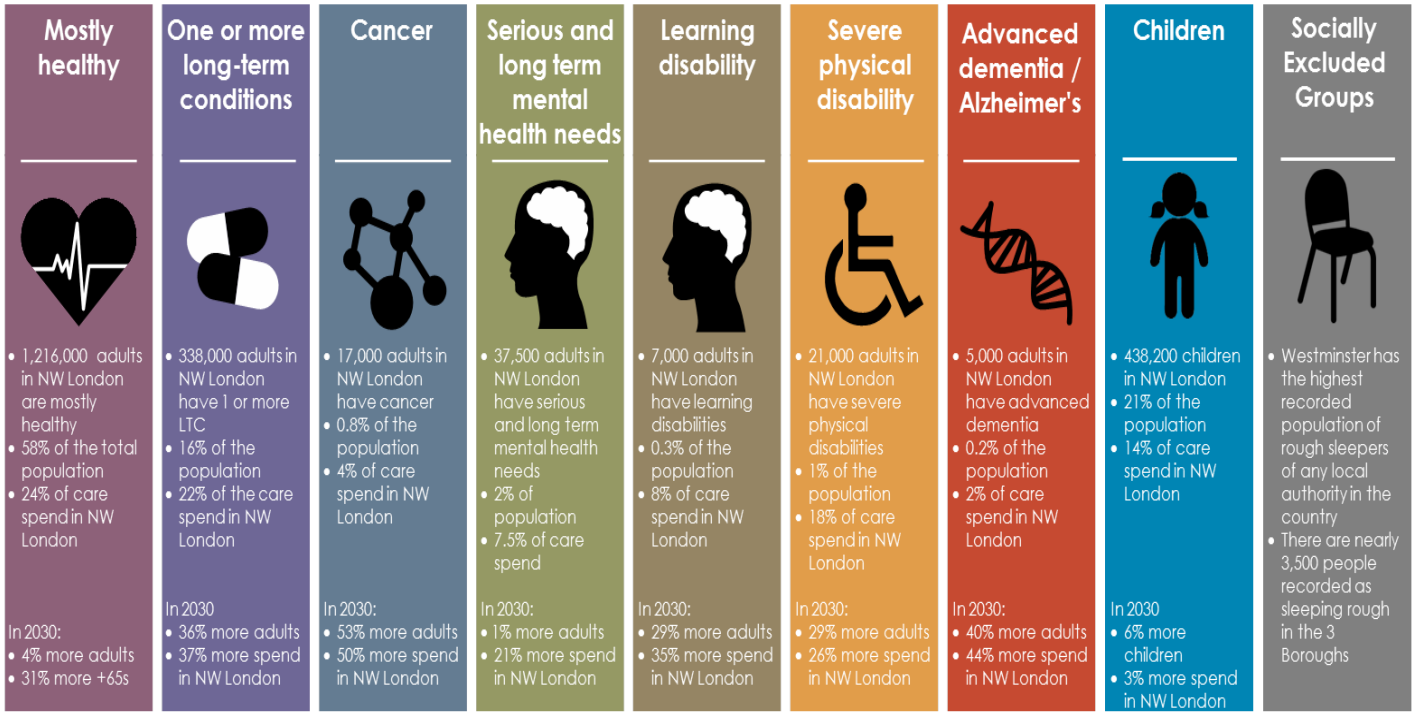
Some of our services are of poor quality and inefficient

- Over 30 per cent of patients in acute hospitals do not need to be there, and could be treated in or nearer to home
- 1,500 people under 75 die each year from cancer, heart diseases and respiratory illness. If we were to reach the national average, we would save 200 people a year
- over 80 per cent of people want to die at home, but only 22 per cent do so.

The cost of health and social care is outstripping the budget

- Despite a growing NHS budget, if we don't take action, there will be a £1.3billion shortfall by 2021. Local authorities have faced cuts in adult social care budgets.

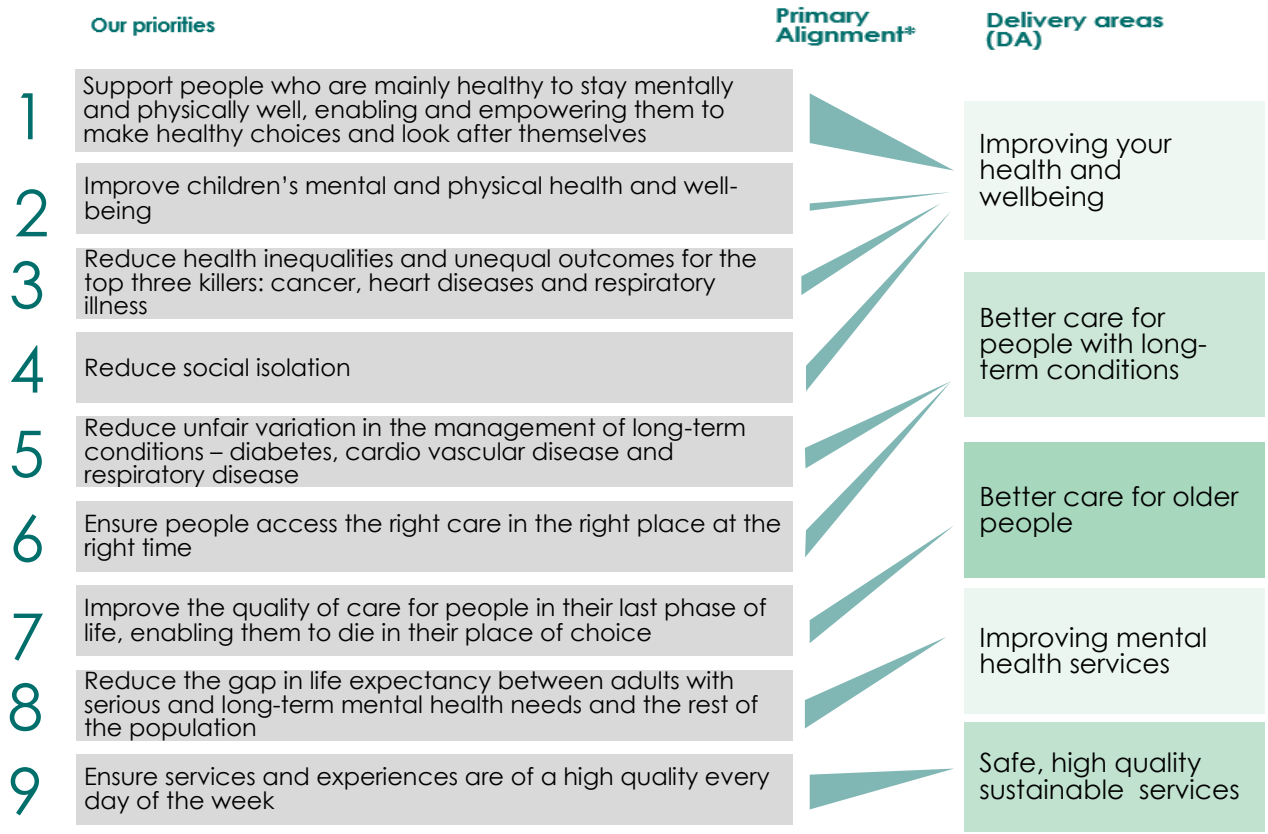
Our population and some likely changes over the next 15 years if we don't take action now



Our aims and priorities

We aim to improve:

1. health and wellbeing
2. care and quality
3. efficiency, to balance the budget



Delivery areas

Delivery area 1: Improving your health and wellbeing

Your health is affected by the environment and communities you live and work in and the choices you make. Your local NHS and councils want to support you to have a healthy life by:

- Reducing loneliness by encouraging everyone to be part of their local community
- supporting campaigns to increase self-care; to prevent cancer; and to reduce the stigma of mental health problems
- encouraging exercise and healthier eating; and reducing smoking and drinking
- encouraging employment for people with a learning disability or mental health problem
- tackling issues that affect health such as housing, employment, schools and the environment
- supporting children to get the best start in life by increasing immunisation rates, tackling childhood obesity and providing more mental health care and support.

Delivery area 2: Better care for people with long-term conditions

With many different organisations involved in care for people with health conditions, services can be confusing and vary in quality. We want to coordinate services better, and help every patient with a long-term mental or physical condition to get the care and support they need to manage their condition by:

- Catching cancers earlier and starting treatment more quickly
- developing new ways of preventing and managing long-term conditions, like diabetes
- improving access to mental health services
- helping the voluntary sector to support self-care; for instance offering people with long-term conditions access to expert patient programmes; and increasing the availability of personal health budgets.

Delivery area 3: Better care for older people

We are pleased that so many of our residents are living longer than previous generations thanks to better medicines, new treatments and cures. We want to improve care for our older people by:

- Tackling the lack of nursing and care homes
- providing specialist teams which can react quickly when there is a problem
- commissioning all services for older people with local government and coordinating care between the NHS, social care and other organisations
- improving end of life care, supporting people to die in the place of their choice.

Delivery area 4: Improving mental health services

We all have mental health. Most of us have a difficulty with our mental health at some point in our lives. Poor mental health has the potential to affect our physical health. We want to support people with serious and long-term mental health problems, learning disabilities, autism or challenging behaviour by:

- Providing a more proactive service focused on recovery
- supporting more GPs to become experts in mental health care
- improving early intervention services and crisis support services; and introduce 24/7 mental health A&E teams
- improving child and adolescent services - particularly in the evenings and weekends.

Delivery area 5: Safe, high quality and sustainable services

Whilst the vast majority of care in NW London is of a high quality, we know there is more to do and we can make services more efficient. Our buildings and ways of working make it difficult to take advantage of new technology. This means the health service is not as efficient or patient-focused as other public or high street services. We want to:

- Provide more services at night and weekends - particularly assessments by a consultant and access to vital tests

- introduce specialist children's assessment units and improve children's services, for example by recruiting more children's nurses
- make the most of new technology to save everyone time and worry, and improve services
- concentrate our skills and experience where they make the biggest difference for patients.

What will primary, intermediate and hospital care look like?

Primary care

- There will be a greater focus on keeping people healthy, like more health screening and better management of long-term conditions
- there will be more appointments earlier in the day, later at night, and at weekends. Already 280,000 patients can use online consultations and 60,000 can use video consultations. We want everyone to be able to use online advice if they wish.
- GP practices will work together and in partnership with other services. Patients won't have to go to lots of different places to get simple treatments. Other health professionals will take on some responsibilities from GPs, like treating coughs, colds and minor injuries.

Our residents' responsibilities

Our plans are dependent on people recognising their responsibility to:

- Look after themselves
- ask for help when necessary
- use services sensibly and fairly
- be an active part of their own community.

In 2016/17 we will produce a People's Health and Wellbeing Charter so that people can understand their responsibilities and access the right care in the right place at the right time.

Intermediate care

- Intermediate health and social care will respond more quickly when people become ill
- to help people get home as soon as they are medically fit, more services will be available in, or close to people's homes; in GP practices; in local services hubs or in hospitals.

Hospital services

- Concentrating specialist doctors, teams and equipment in 24/7 units leads to better outcomes for patients. In 2012 the NHS agreed to reduce the number of major hospitals in north west London from nine to five. This will improve urgent care, planned surgery, maternity services and children's care.

- major hospitals at Chelsea and Westminster, Hammersmith, Hillingdon, Northwick Park, St Mary's and West Middlesex, will be supported by local hospitals at Charing Cross, Central Middlesex and Ealing.
- all three local hospitals will have a local A&E and a range of services to meet the needs of the vast majority of the local population e.g. services for elderly people; access to appropriate beds; and a range of outpatient and test facilities. No substantive changes to A&Es in Ealing or at Charing Cross will be made until there are sufficient alternatives in place through local services or in other major hospitals.

Supporting the transformation

To transform services and make them sustainable, we need to invest in our workforce and digital technology, improve our buildings and make services more efficient.

Workforce

- We need to **recruit and retaining a permanent workforce** that works in multi-disciplinary teams with new roles and careers
- invest £15million in **developing, educating and training staff**, to support changing population needs
- establish **leadership development forums** to drive transformation and share good practice and learning.

Digital

- Increase the use of technology to **reduce unnecessary trips to and from hospital**
- reduce paper and **share electronic care records** across the NHS to make sure patients are properly cared for at all times
- **patient records, online information and support** should be readily available and understood by patients and carers so they can become more involved in their own care
- use **population care data** to make better decisions about future services and to support integrated health and social care.

Buildings and facilities

- **Share facilities** between health, social care and local government and develop local services hubs to maximise the use of space, be more efficient and make services more integrated
- use an investment fund of up to £100million **to improve the condition of primary care buildings and facilities**
- improve hospital buildings and facilities and introduce new ways of working which will **reduce the £625million we need to maintain outdated buildings.**

Make every contact count

Everyone in the NHS who comes into contact with members of the public has the opportunity to have a conversation to improve their health, whether they are a receptionist, heart surgeon or GP. We want to help those staff in having (sometimes difficult) conversations with people.

We welcome your comments on any aspect of this plan but in particular:

- Do you think we have chosen the right priorities and overall vision?
- Are there specific ideas that you agree or disagree with?
- Are there bits missing?

You can send us your comments either online at www.healthiernwlondon.commonplace.is or email healthiernwl@nw.london.nhs.uk

We look forward to hearing from you.

NW London Sustainability and Transformation Plan

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

V01

21 October 2016

Foreword

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

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

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.4bn 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. We have listened to the feedback we have received so far from our patients and residents and updated our plan in particular around access to primary care and the delivery of mental health services. We will continue to engage throughout the lifetime of the plan.

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

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Chief Executive of Brent Council

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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 (e.g. schizophrenia) have a life expectancy up to 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 £1.4bn 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

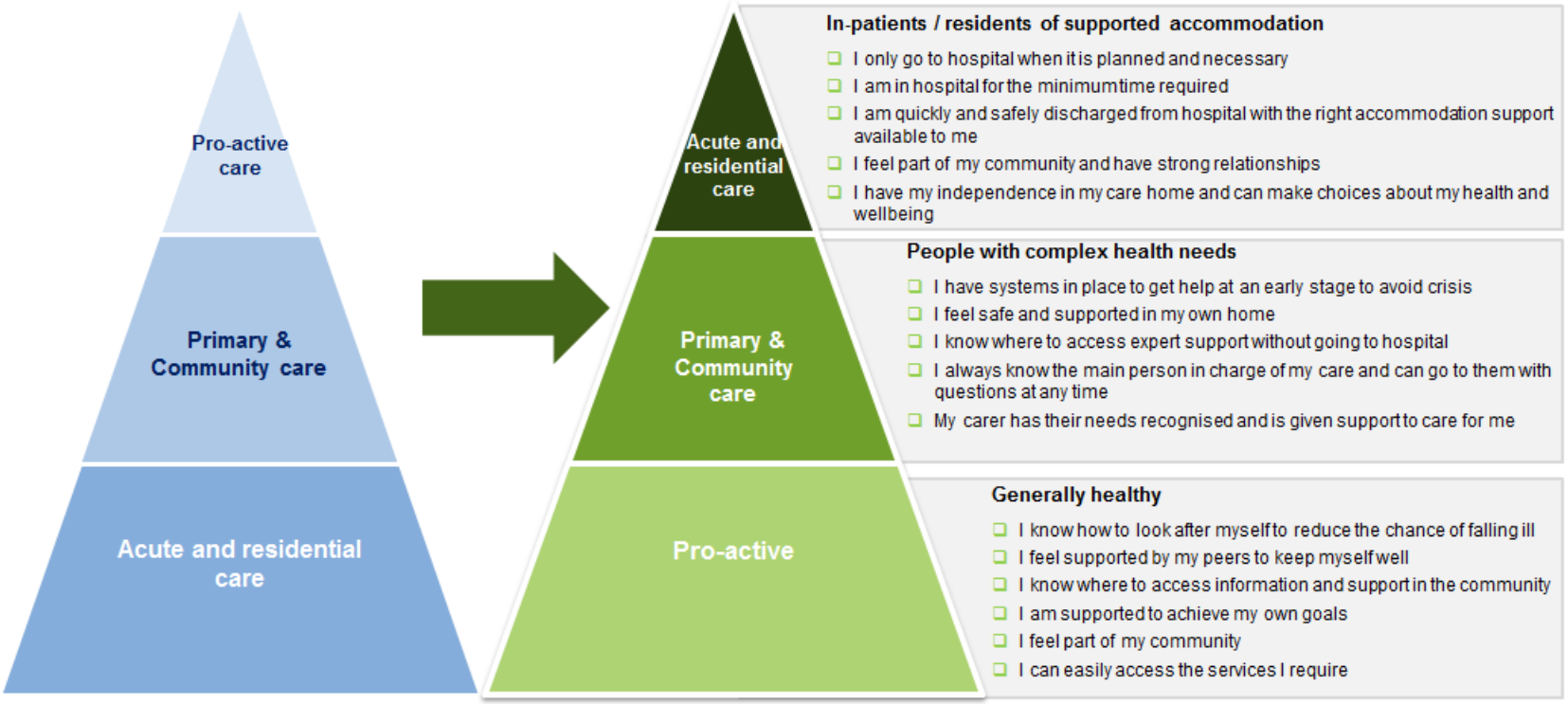
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,000	458,000	26,000	43,300	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	16%	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



Current system: Reactive care often responding to crises, under resource and capacity pressures

Future system: proactive care focusing on self-care, wellbeing and community interventions

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

i. Executive Summary:
How we will close the gaps

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

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

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children the get the best start in life
	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. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. Improve self-management and 'patient activation'
	4	Reduce social isolation					
Improving care & quality	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. 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	482,700 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. Focussed interventions for target populations 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 benefits from specialisation and innovation. The benefits of senior clinical advice available at most parts of the day are now well documented to improve outcomes as it enables the right treatment to be s delivered to the patient at the right time We know from our London wide work on stroke and major trauma that better outcomes can be achieved by consolidating specialist doctors into a smaller number of units that can deliver consistently high quality, 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 STP sets out how we will meet the needs of our population 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. 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, 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 allow us to deliver primary care to scale with an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs. Due to the on-going uncertainty of the future of Ealing Hospital 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. As Ealing 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, the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

A joint statement from six boroughs is at Appendix A. Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute services in the two respective boroughs. Both councils remain fully committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

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 will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

There is a similar vision for Charing Cross Hospital. Here, again, we plan to deliver ambulatory care, primary care to scale and an extensive range of diagnostic services. However at Charing Cross, during this STP period, there are no planned changes to the A&E services currently being provided.

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 £1,113m funding gap by 20/21 with a further £298m gap in social care, giving a system wide shortfall of £1,410m.

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 health sector is a £15.1m surplus, and the social care deficit is £35m, giving an overall sector deficit of £19.9m.

Table: North West London Footprint position in 20/21

£'m	CCGs	Acute	Non-Acute	Spec. Comm	Primary Care	STF Investment	Sub-total (Health)	Social Care	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Do Nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	**-**	**(1,112.4)**	**(297.5)**	**(1,409.9)**
Business as usual savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	**108.5**	**680.6**
DA 1-5 - Investment	(118.3)	-	-	-	-	-	**(118.3)**	**-**	**(118.3)**
DA1-5 - Savings	302.9	120.4	23.0	-	-	-	**446.3**	62.5	**508.8**
Additional costs of delivering 5YFV	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	**-**	**1,127.5**	**262.5**	**1,390.0**
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	**-**	**-**	**-**	**15.1**	**(35.0)**	**(19.9)**

Schemes have been identified which 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 areas of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes These schemes, as well as improving patient outcomes, are expected to cost less – requiring £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings.

In addition, 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.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, mainly attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for most providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing, once it can be demonstrated that reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.

The remaining deficit is due to London Ambulance Service (NWL only) and Royal Brompton & Harefield, who are within the NWL footprint but primarily commissioned by NHS England.

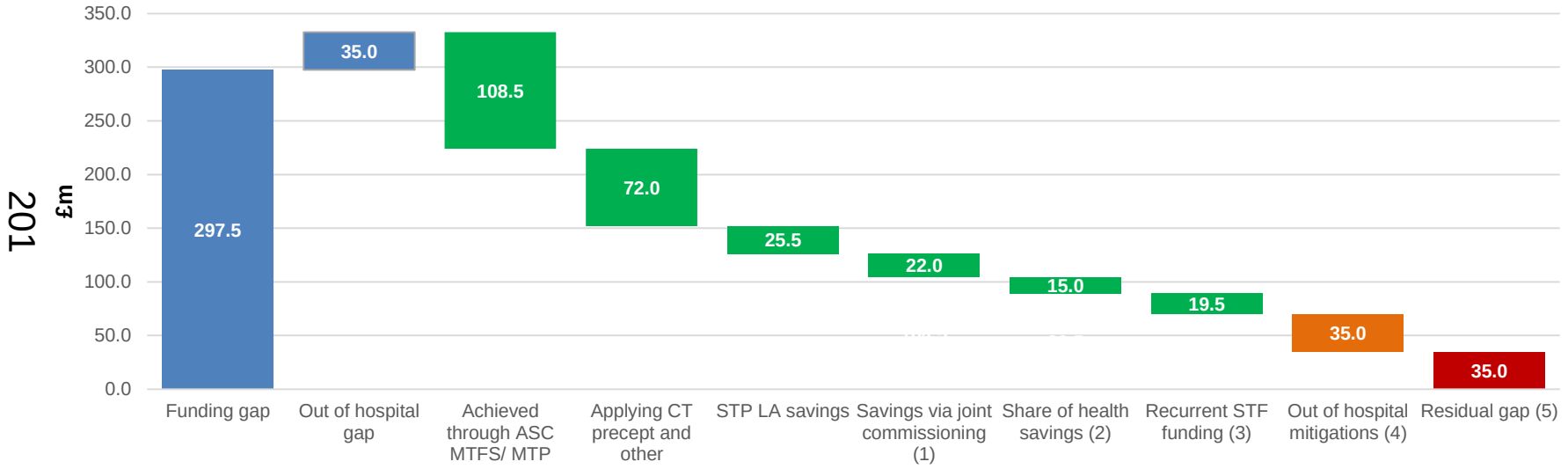
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

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 (I)

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. In addition to this there continues to be a significant level of service and demographic pressures putting further strain on the service. 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 chart below sets out below the projected gap and how this will be addressed. The savings are further broken down on the following slide.



The following assumptions and caveats apply:
The residual gap of £35m by 20/21 will be addressed through further joint working between health and social care. An initial estimated cost pressure of £35m illustrates the likely shift from hospital activity into adult social care, which is to be addressed through a robust business case process. £19.5m is assumed to be funded by STF on a recurrent basis, leaving an unresolved recurrent gap of £35m.

(1) Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3;
(2) The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;
(3) Assumed that £19.5m will be recurrent funding from 2020/21through the STF fund;
(4) Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;
(5) The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.
NB Confirmation of what the final on-going sources of funding will be from 2020/21 is being sought.

i. Executive Summary:
Social Care Finances (2)

The table below sets out how the savings accruing to local authorities from joint work with Health on the Delivery Area business cases will be delivered through the 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**	**-**	**7.7**	**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 non-recurrent transformational investment from the NHS Sustainability and Transformation Fund of an estimated £110m over 3 years (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services. 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
DA1	i. 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 ii. 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	i. A shared understanding of public and professional responsibility for use of services ii. Maximising opportunities working jointly to support people with mental health problems, resulting in benefits to the health system and wider local economy
DA2	i. Increased accessibility to primary care through extended hours and via a variety of channels (e.g. digital, phone, face-to-face) ii. Enhanced primary care with focus on providing more proactive and co-ordinated care to patients iii. Comprehensive diabetes performance dashboard at practice and CCG level iv. Delivery of Patient Activation Measure Year 1 targets as part of the self care framework	i. Delivering extended access for Primary Care, 8am – 8pm, 7 days a week, leading to additional appointments available for patients out of hours, every week, as well as a reduction in NELs and A&E attendances ii. Unique, convenient , efficient and better care for patients as well as supporting sustainability and delivering accountable care for patients iii. Improve health and wellbeing of local diabetic population iv. Enable more patients with an LTC to self-manage
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. 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. 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 safer staffing 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]

1. Case for Change:

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

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 £1.4bn financial gap in our health and social care system and potential market failure in some sectors

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

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

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

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

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

Responsibilities of our residents

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

Responsibilities of our system

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

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

Principles underpinning our work

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

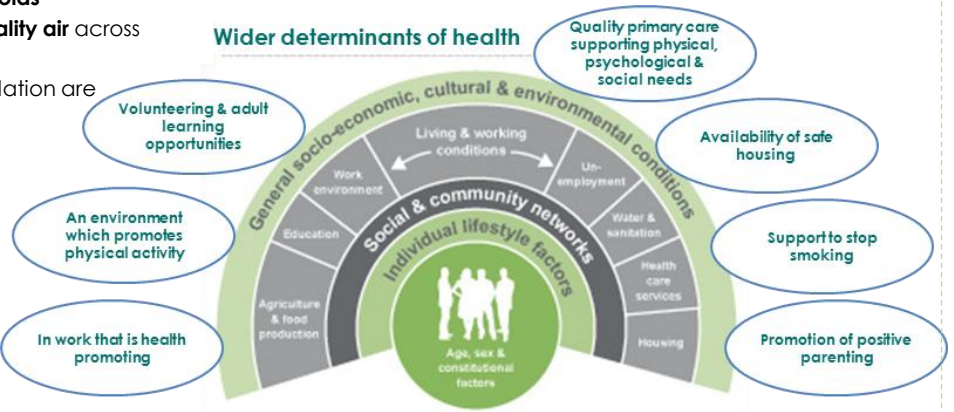
1. Case for Change:
Understanding our population

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

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

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

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



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:
- 35% more adults
- 37% more spend in NW London

Cancer

- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4.5% 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:
- 16% 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.

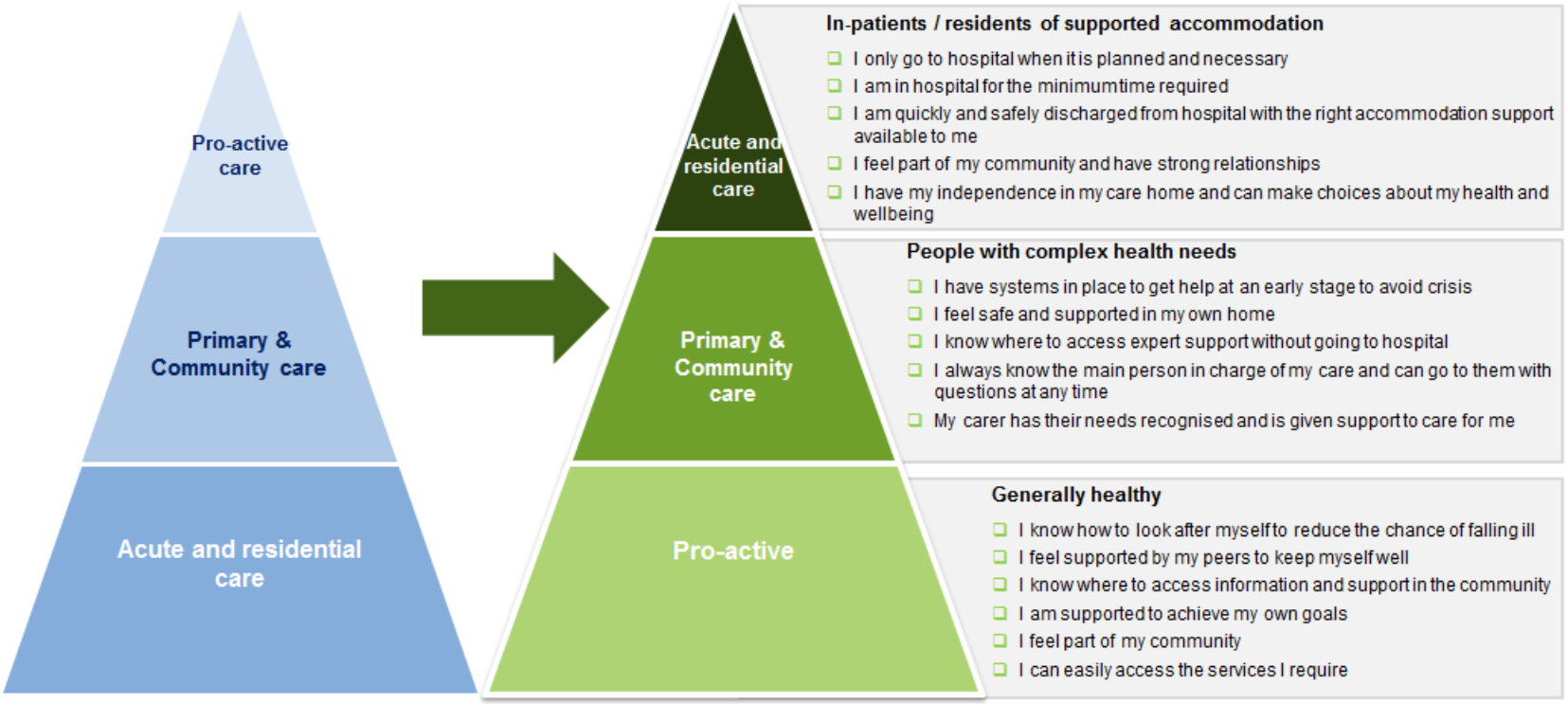
Please note that segment numbers are for adults only with the exception of the children segment

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



Current system: Reactive care often responding to crises, under resource and capacity pressures

Future system: proactive care focusing on self-care, wellbeing and community interventions

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

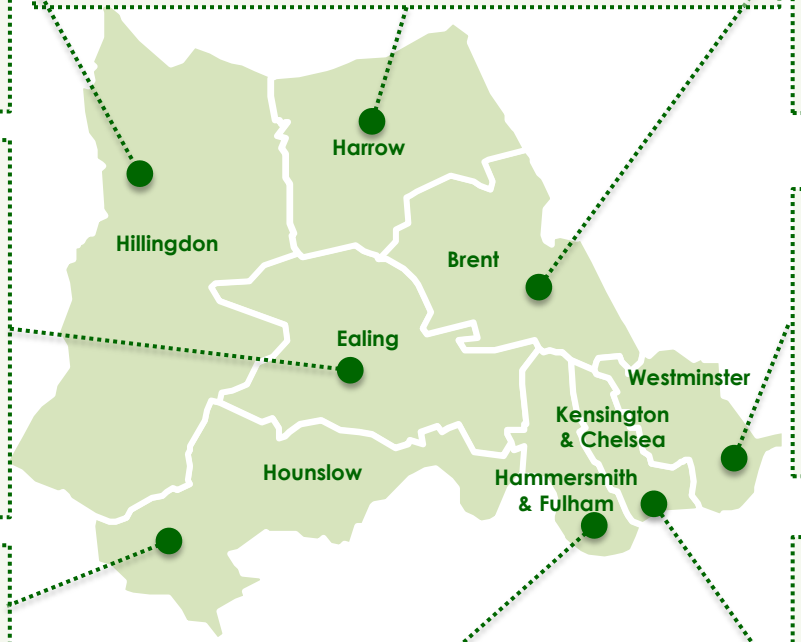
While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **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 5% rise in the number of people over years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)



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

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

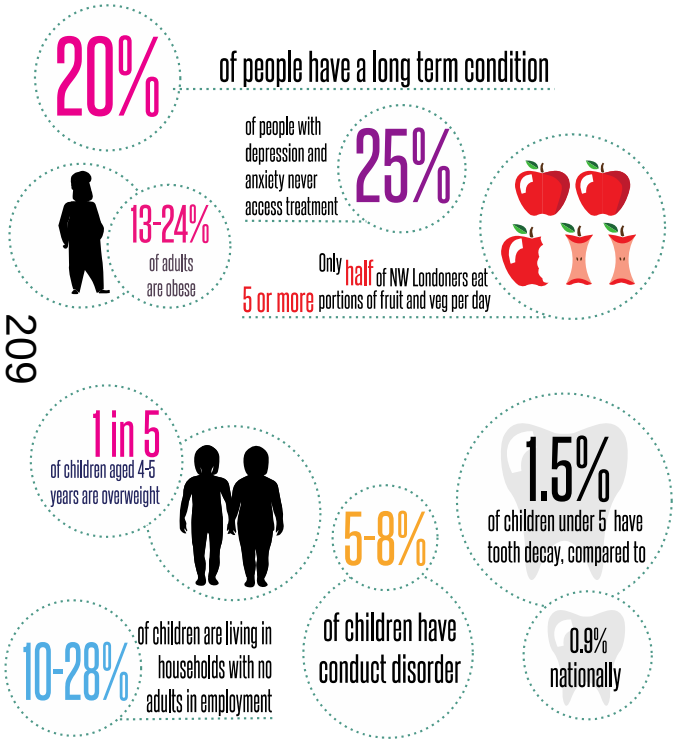
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature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

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

1. Case for Change:
Health and Wellbeing Current Situation

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

Our as-is…



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

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

Our to-be…

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

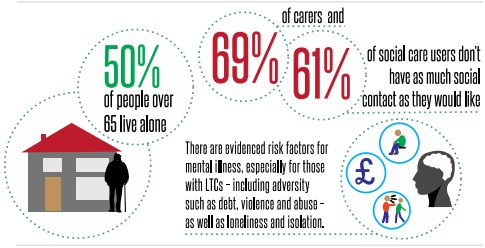
As soon as I am struggling, appropriate and timely help is available

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 are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health and preventing escalation of mental health needs	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
210 er 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 circa 20 years less than the average and the number of people in this group in NW London is double the national average.	People are supported holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

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

Localised

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

Coordinated

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

Specialised

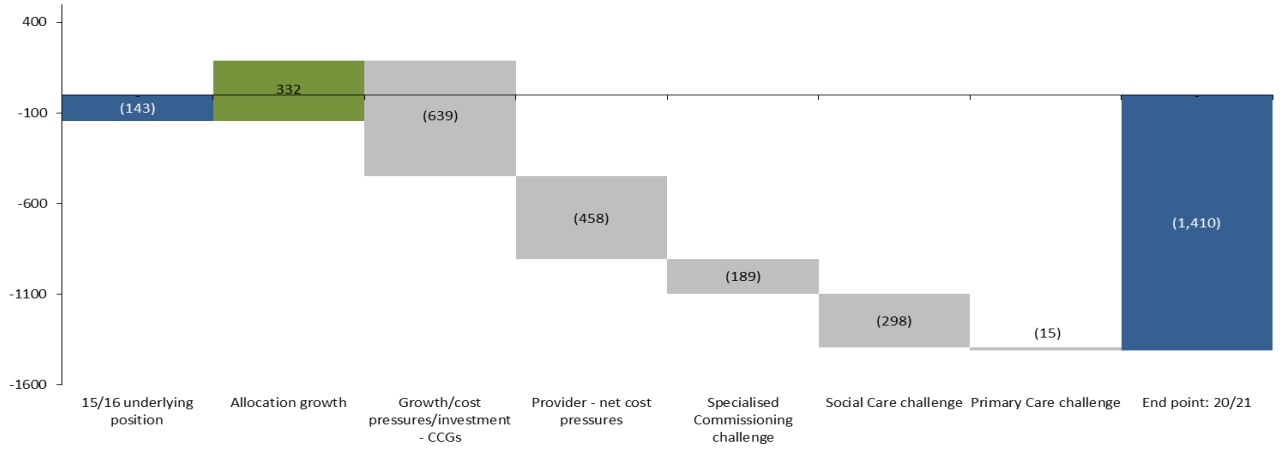
Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

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

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,113m funding gap by 20/21 with a further £297m gap in social care, giving a system wide shortfall of £1,410m.

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.

Profile of the 'Do nothing' movement in financial position 2015/16 to 2020/21



Profile of the 'Do Nothing' financial challenge by organisation outturn 17/18 to 20/21

Sector	17/18	18/19	19/20	20/21
	£'m	£'m	£'m	£'m
Providers	(403)	(493)	(579)	(661)
CCGs	(77)	(140)	(198)	(248)
Spec Comm	(44)	(90)	(138)	(189)
Primary Care	(1)	(12)	(19)	(15)
Total NHS	**(525)**	**(735)**	**(934)**	**(1,113)**
Social Care	(74)	(148)	(223)	(297)
Total Health & Social Care	**(599)**	**(883)**	**(1,157)**	**(1,410)**

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 for the population of NW London b. Keeping people mentally well and avoiding social isolation c. Helping children to get the best start in life
	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. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care b. Improve cancer screening to increase early diagnosis and faster treatment c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions d. Reducing variation by focusing on Right Care priority areas e. 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. Upgraded rapid response and intermediate care services d. Create an integrated and consistent transfer of care approach across NW London e. 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	482,700 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. Focussed interventions for target populations 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

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

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

- **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. We will support positive choices through sexual health service transformation. Our residents who have a learning disability are also sometimes not receiving the full 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:

- Developing a number of cross cutting approaches which will amplify the interventions described below and overleaf – embedding Making Every Contact Count and supporting national campaigns being 2 such examples.
- Interventions that are focused on **keeping our whole population well** 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 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].
- Targeted work with the population who **need mental health support** – the mortality gap is driven largely through unhealthy lifestyles and barriers to accessing the right support. We will work to address the wider determinants of health, such as employment and housing, where there is good evidence of impact. Social isolation, whether older people, single parents, or people how need mental health support affects around 200,000 people in NW London and 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].
- 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].

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 number of cross cutting approaches and new ways of working will support activity in this area and through working across health and social care, with public health leadership will help increase our ability to deliver the interventions and outcomes described below: - **Embedding principles of Making Every Contact Count in all services commissioned across Delivery Areas 1-5** - **Supporting and publicising national campaigns and work such as on cancer prevention, mental health stigma and self care**				
A **Enabling and supporting healthier living – for the population of NWL**	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 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: • Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London • Implement NW London wide programmes for physical activity for adults • Widespread availability of Long Acting Reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss	3.5	9
B **Keeping People Mentally Well and avoiding Social Isolation**	The healthy living programme plans will also cover how Boroughs will address social isolation, building on current local work: 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 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	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: • 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 Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda Provide digitally enabled support to people , including Patient Reported Outcome Measures (PROMs), online communities, digital engagement via online and apps (especially for young people), social prescribing and sign posting to relevant support 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 Target smoking cessation activities at people with mental illness to support reducing ill-health as a consequence of tobacco usage.	0.5	6.6
C **Helping children to get the best start in life**	• Implement the prevention priorities within the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services – especially in schools – as part of a wider new model of care • 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 • Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity	TBC	TBC

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

The NW London Ambition:

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

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

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

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

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

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

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

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

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

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas. Improving the strength and sustainability of primary care is critical in tackling unwarranted variations and improving LTC management and outcomes. Taking action on the key SCF areas of proactive and co-ordination will equip primary care to do so.
- 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].
- Children and young people with special education needs and disabilities are a vulnerable group that can require access to specialist support, often delivered by multi-agency services. Implementing CCG responsibilities for SEND under the Children & Families Act 2014 is therefore a NW London priority.

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
216
Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care
	• For Accessible care:
	  • provide extended access specs with quantification of reduced attendances and admissions
	  • Deliver affordable access solutions for the 8-8, 7 day requirements
	  • Create minimum standards for appointment requirements
	  • Achieve accessible read/write patient records
	  • Deliver operational access and a communications programme for patients, key providers and stakeholders
	  • Align extended access provision with urgent care and 111
	• For Co-ordinated care:
	  • define key features for primary and integrated care teams and deliver consistent outcomes for care team models across NW London
	  • Deliver consistent outcomes for care team models across NW London
	  • Agree targeted population within CCG as priority for co-ordinate care management across NWL
	  • Design standard approach to risk stratification and case finding across NWL. Maximise use of WSIC dashboard to monitor patients and case find
	  • Define core intervention for care teams for core population
	  • Define roles that the care team will carry out daily with patients
	• For Proactive care:
	  • finalise key outcome measures for preventive care in LTC
	  • Develop two clinical pathways (including diabetes) and test against provider-models and outcome-measures
	  • Define key outcome measures for needs-based client groups (adults) and explore gap-analysis locally
	  • All eight CCGs supported in implementation of Patient Activation Measure (PAM) programme with target patients receiving PAM assessment and tailored approach to self-care
	• Support CCGs to deliver their GP Access Fund objectives with a consistent and systematic approach, including delivery of the Extended Primary Care Service providing significantly higher levels of access to NW London residents
	• Continue to support the development of federations, enabling the delivery of primary care at scale
	• Host workshops and service-user survey in key geographical areas, building on existing Healthwatch, Patient Participation Group and Lay Partner Advisory Group priorities (e.g. to review I-statements and test outcome measures)
	• Develop two clinical pathways (diabetes, atrial fibrillation) and test against provider-models and outcome-measures
	• Identify four to eight geographical areas to test the draft pathways against the defined outcomes with pilot clinical teams
	• Review of key pressure-points in clinical working day
		• Fully implement the primary care outcomes within the SCF 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
		• Deliver this range of co-ordinated and population-based care through a system of networked hubs, with facility for both physical and digital access by patients, including services for people with dementia
		• Enable general practices and multi-disciplinary hubs to access and share digital patient records, including crisis care-plans and LTC pathway management
		• Provide access to a spectrum of care, for appropriate population-based interventions for urgent LTC and on-going care needs
		• Ambulatory and emergency care schemes in place
		• Develop relevant LTC clinical pathways in light of co-ordinated and proactive care experience
			18	26.4

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)
Improve cancer screening to increase early diagnosis and faster treatment	Our Primary Care Cancer Board will take the learning from Healthy London Partnership's (HLP) 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. • 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 to ensure sufficient capacity within NW London. • Roll out improved information regarding patient choice and 2 week wait to support patients referred from primary care with suspected cancer • Implement straight to test endoscopy at Imperial, Ealing, Northwick Park and Hillingdon hospitals. • Begin to work with the voluntary sector to research primary care learning from Significant Event Audits • Work with Trusts to create more effective and efficient inter Trust referrals to support the delivery of national standards.	In partnership with Healthy London Partnership' s Transforming Cancer Programme and the Royal Marsden and Partners Cancer Vanguard, we will develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, These actions will reduce variation in acute care and ensure that patients have effective, high quality cancer care wherever they are treated in NW London.	TBC	TBC
…tter 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

Reduce variation by focusing on 'Right Care' priority areas	• Three key areas identified to be the largest priority to focus on at sector-wide level: diabetes prevention, atrial fibrillation and reducing hypertension
	• Identified and/or commenced work in 2016/17 in following areas:
	  • Mobilisation of National Diabetes Prevention Programme
	  • Comprehensive diabetes performance dashboard at practice and CCG level
	  • Comprehensive referral process for patients with non-diabetic hyperglycaemia into the National Diabetes Programme
	• Aside from these three deliverables, each CCG will be addressing the issues that cause the most unwarranted variation in care in their locality
	• 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. Brent and Harrow have are also national 1st wave delivery sites and are focussing on diabetes and MSK.
		• 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

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)
Improve self-management and 'patient activation'	• Develop protocols for approved health apps to support self-care in collaboration with Digital Health London • Develop a package of evidence and case studies to support local areas to adopt innovative approaches such as AliveCor, a digital device being rolled out by Hounslow GPs which uses smartphones to detect Atrial Fibrillation in patients Develop best practice approaches to online-management solutions • Host NW London symposium series, commencing with Activating the Workforce in November • Support delivery of IG Governance toolkit L2 compliance within targeted CCG and develop case study for wider support. • Development of Third sector programme framework, supporting development of the voluntary sector infrastructure to support self-care • Patient Activation Measurement (PAM) programme implemented across NW London with target patients receiving assessment and tailored approach to self-care (target 43,920 patients). Self-Care programmes delivered in NW London to be aligned to PAM levels, supporting a tailored approach to self-care and a NW London mental health and wellbeing guidance to PAM levels to be developed.	• Full delivery of Self-Care framework across NW London • NW London workforce supported by embedded self-care training programmes • Technology, including online management solutions, in place to support self-management and health education for people with LTCs • PAM embedded across health and social care supporting tailoring of care for all people with LTC (target 428,700 patients) • Third Sector fully integrated within Accountable Care Partnerships with single point of access and geographically based consortiums • Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes • 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 co-ordinated care and continuity with a named clinician to support them with LTCs • Increase availability of, and access to, personal health budgets, taking on integrated personal commissioning approach, including building on good practice from within and outside NW London around the use of brokerage to manage access to such personalised services	3.4	6.2

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

219

2020/2021

Contribution to Closing the Financial Gap

£72.1m

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 partnerships • 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 Partnerships, 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	Upgraded 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 by identifying opportunities and agreeing transformational improvements to NW London models, either locally or NW London-wide • Improve the rate of return on existing services, reducing NEL admissions and reducing length of stay • Enhance integration with other service providers • Establish an older people's reference group to guide this work • Agreed the older person's pathway across community, acute and last phase of life • Agreed areas for standardisation across NW London for IC/RR and acute frailty • Agreed outcomes and standards for intermediate care function and acute frailty	• Use best practice model across all eight boroughs, creating standardisation wherever possible to enable additional capacity to decrease the inappropriate time that a person is cared for in an institutional setting • Operate rapid response and integrated care as part of a fully integrated ACP model	20.2	64.9
D	Create an integrated and consistent transfer of care approach across NW London	• Agree an integrated health and social care model to improve transfer of care • Implement a single needs-based assessment to support appropriate transfer of care 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 transfer of care across NW London	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • Transfer of care correspondence is electronic with the single assessment process built into the shared care records across NW London • Fully integrated health and social care transfer of care process for all patients in NW London	7.4	9.6
E	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

221

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. The NW London STP has mental health threaded throughout our delivery areas – within prevention and within work on long term conditions. But we know that focus is also required as 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 – and the outcomes described in the implementation guidance are reflected in our plans[2].

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 impacted by their condition and **10% will commit suicide**
- 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 the age of 18 .
- 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 – thresholds to access services can be barriers to access care – and stigma remains a challenge for many people – and in particular within some communities,

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

- Implementing a new model of care for adults 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 the very specific needs that relate to some of our populations – such as for people with learning disabilities (through the Transforming Care Partnership) and for new mothers
- 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 – building on current Early Intervention in Psychosis and Liaison Psychiatry services.
- Implementing 'Future in Mind' 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[3].

- 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 through locally commissioned services – 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
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
		• More support available in primary care through locally commissioned services
			• Full roll out of the new model across NW London providing tailored evidence based support available closer to home to service users and carers, which will include:
			  • 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
			 
				11	16

B	**Focussed interventions for target populations**	• 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	• Provide vulnerable individuals and their families with best practice support • 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	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), Metropolitan police and other services – meeting access targets
		• Round the clock mental health teams in our A&Es and support on wards, progress towards 'core 24'
		• Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)
			• Ensure care will be available for service users and carers when they most need it through:
			  • 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
				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 • Digital enablement to share information between care settings to support new care models • 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

223

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 important 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
- Ensure all patients receive prompt treatment in accordance with the national referral to treatment (RTT) standards,
- Consolidate acute services onto five sites (the local government position on proposed acute changes is set out in Appendix A)
- 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 Fully deliver on the vision for maternity set out in *Better Births* national maternity review – through our 15/16 reconfiguration programme we have already made significant progress delivering this vision for maternity. In 16/17 we will focus on providing continuity of care for women, so that maternity care is provided by a small team of midwives during the antenatal, intrapartum and postnatal period.	Reduce demand for acute services through investment in the pro active out of hospital care model, enabled by investment in the Hubs. Develop the hospital in Ealing and jointly shape the delivery of health and social care provision of services from that site, including: • a network of ambulatory care pathways • a centre of excellence for elderly services including access to appropriate beds • 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. Deliver on the full recommendations set out in *Better Births* national maternity review, in order to achieve joined-up, sustainable continuity of care for women in NW London.	33.6	89.6
D **NW London Productivity Programme**	A Chief Transformation Officer has been appointed to lead a collaborative transformation programme across all NHS Trusts in NW London and a team of interim senior programme directors have been appointed. By the end of 16/17 we will agree and resource a sustainable team to ensure these priorities are delivered. This is a big ticket cost reduction transformation programme within the STP and we should secure investment proportionate to the costs savings. Implement and embed the NW London productivity programme across all provider NHS trusts, focusing on the following four areas: • **Orthopaedics**: mobilise 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) to reduce unwarranted variation and increase efficiency, thus generating both quality improvements and financial savings. Ensure all Acute Providers in North West London have agreed Best In Sector Performance Metrics and establish a NW London dashboard. Agree priorities and interventions and commence delivery. • **Procurement**: deliver £3m of immediate tactical non-pay savings. Agree plan to reduce unwarranted variation in NHS supplies prices, and make £15.2m savings in non-pay spend. Develop options and agree a NW London operating model, in line with best practice and Carter and identify any structural changes required to the way procurement is currently delivered. , Establish common procurement competencies and staff development plan. Ensure robust plans in place with ownership from Procurement leads, CFOs and clinical lead and identify any investment required. • **Safer Staffing**: Agree a three year delivery plan with trajectory of benefits and any required investment identified. Agree detailed proposal for reduction in agency costs via more effective staff bank, supported by technology. All e-nursing rosters agreed six weeks in advance and plan for medical roster implementation, benchmark and share all data. • **Back Office**: this is **new and additional priority** agreed in September 2016. Deliver additional collaborative productivity opportunities. Agree priorities, geographic clusters and three year delivery plan with trajectory of benefits and any required investment identified. Integrated Procurement and Safer Staffing work within the wider Back Office plans.	Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together to deliver added value. **Rolling programme of pathway redesign and quality improvement initiatives to ensure trusts are consistently in the top quartile of efficiency (Getting It Right First Time principles).** Shared records is a key enabler of all pathway redesign. • **Orthopaedics:** Implement plan agreed in 16/17. Agree a consolidated service model for a NWL collaborative elective Orthopaedic centre, agree a business case and implement subject to investment. • **Identify and implement priorities for rolling programme following Orthopaedics.** • **Procurement:** Implement a pan-NWL procurement operating model which is compliant with the National Interim Future Operating Model, Deliver Carter compliant Procurement Transformation Plans with quantified (and delivered) financial savings which all leads to Collaborative and shared service models in place for NWL procurement operating within a sustainable financial footprint assessed by improving year on year saving: cost ratios. • **Safer Staffing:** build on work from 2016/17 such that rostering is optimised, bank fill rates are maximised and reliance on agency is minimised. (quantified benefits will emerge from 16/17 business case) Developed a workforce plan summarising the total workforce numbers and competencies required across NWL. Collective workforce planning and collaborative resourcing to include recruitment, development and retention with the right balance of permanent and flexible workers . • **Back Office**: Implement priorities as described in business case.	4.1*	143.4

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 enable more services to be delivered in a community setting and support the delivery of primary care at scale • 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 • **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• **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 • **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 • **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care • **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care • **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence	• **Target recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers: Estates

Context

The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.

Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings

Our model requires investment in the development of local hubs to enable the provision of integrated, co-located health care, social care and voluntary support across the eight local authority/CCG areas, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care.

London has developed and submitted a joint 'One Public Estate' bid to erage 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.

A joint health and council estates group has been established to oversee the work and minimise gross spend through aligning health and local authority plans for regeneration and seeking innovative financial solutions to provide estate cost-effectively, realising value from surplus assets.

There has been significant local progress 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 £614m[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
  - The hub strategy and plans include community Mental Health services, such as IAPT
  - Hubs will support delivery of the GP 5 Year Forward View and are critical in enabling reconfiguration of acute services
  - Hubs will also help deliver the access and coordinated care aspects of the Strategic Commissioning Framework
- **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).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local Population
  - Trusts have developed proposals with the resultant capital requirement being presented in the Shaping a Healthier Future business case which is due to go to the NHSE investment committee for approval

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:
- Local services hubs will provide the physical location to support integrated public health, prevention and out-of-hospital care delivered by health , social care and voluntary organisations.
- 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 day access to all residents

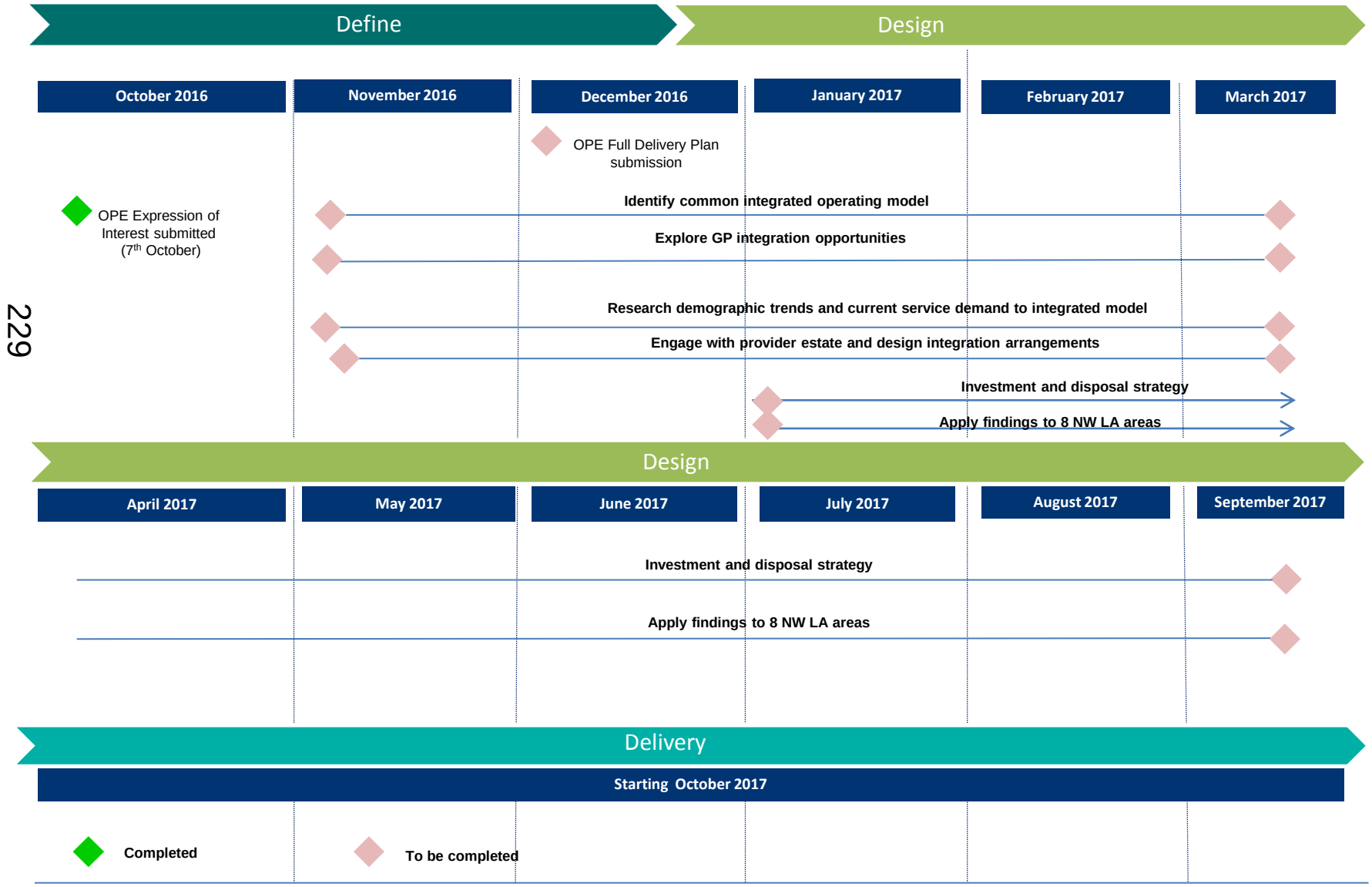
Delivery Area 3 - Outcomes for older people:
- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management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

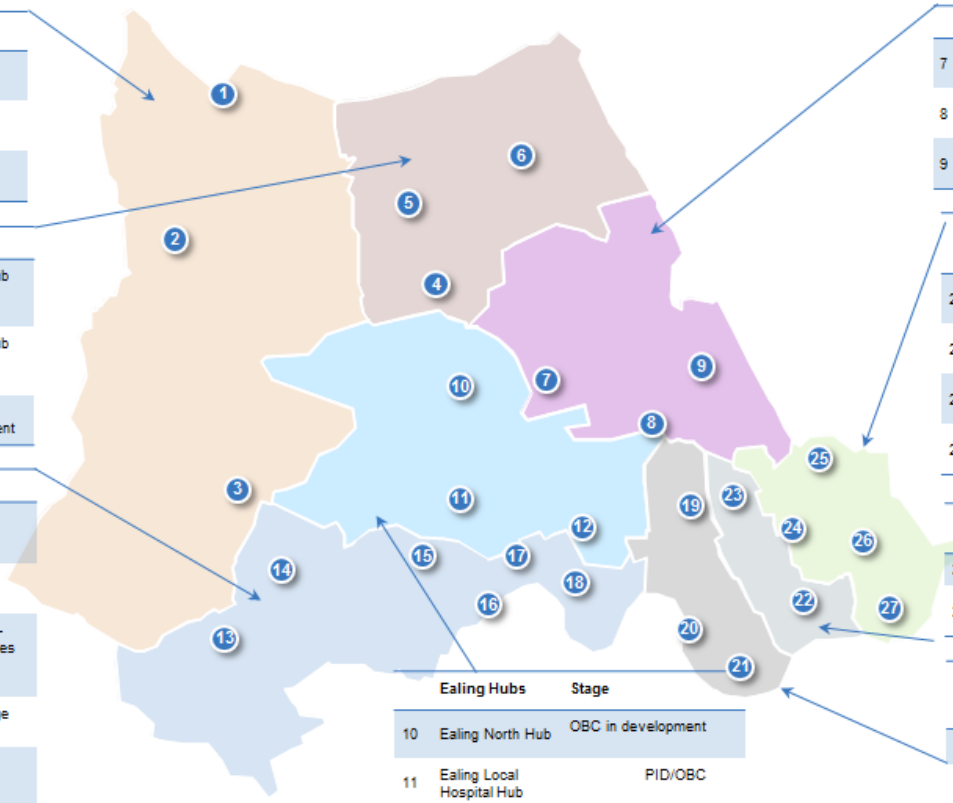
3. Enablers:
Estates

Estates Strategy to deliver Out of Hospital through One Public Estate (OPE) – High level timeline to Oct 2017



3. Enablers:
Estates

Proposed Local Services Hubs map



	Hillingdon Hubs	Stage
1	North Hillingdon Hub	Strategic stage (pre-PID)
2	Uxbridge and West Drayton Hub	Strategic stage (pre-PID)
3	Hesa Primary Care Centre	Operational

	Harrow Hubs	Stage
4	The Pinn Medical Centre	Existing hub – adding services
5	Alexandra Avenue Health and Social Care Centre	Existing hub – adding services
6	NE Harrow	OBC in development

	Hounslow Hubs	Stage
13	Feltham Health Centre	Operational
14	Heston Health Centre	OBC in development
15	Heart of Hounslow Centre for Health	Existing hub – adding services
16	West Middlesex Hospital Hub	Strategic stage (pre-PID)
17	Brentford Health Centre	Operational
18	Chiswick Health Centre	Operational

	Ealing Hubs	Stage
10	Ealing North Hub	OBC in development
11	Ealing Local Hospital Hub	PID/OBC
12	Ealing East Hub	OBC in development

	Brent Hubs	Stage
7	Wembley Centre for Health and Care	OBC in development
8	Central Middlesex Hospital 'Hub Plus'	OBC in development
9	Willesden Centre for Health and Care	Strategic stage (pre-PID)

	Central London Hubs	Stage
24	St Mary's Hospital Hub	SOC in development
25	Church Street Hub	OBC in development
26	Central Hub Moxon Street	Strategic stage (pre-PID)
27	South Westminster	Operational

	West London Hubs	Stage
23	St Charles Centre	OBC in development
22	South Locality Hub	OBC in development

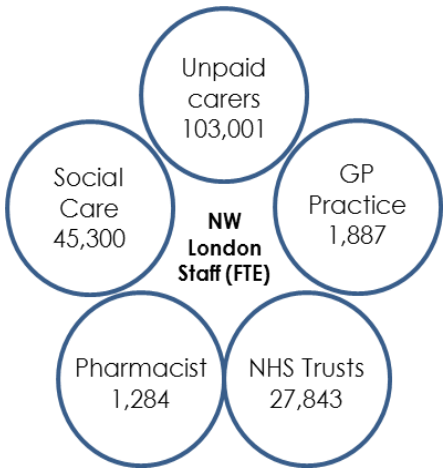
	Hammersmith & Fulham Hubs	Stage
19	Park View (formerly known as White City)	Operational
20	Charing Cross Hospital Hub	Pre OBC in development
21	Parsons Green	OBC in development

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work. It will also be key to achieving our collective vision of improved quality of care through delivering sustainable new models of care that meet our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly to expand work across social care[1].
- Carers are also 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 to achieving our vision.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Appropriate workforce planning and actively addressing workforce issues will, however, be instrumental in addressing the five delivery areas in the STP.

The NW London workforce



The challenges our workforce strategy will address 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

Achievements to date

Workforce planning and addressing workforce shortages

- Developed Infrastructure for workforce planning and analytics
- Established annual workforce planning processes for acute healthcare professionals
- Extended workforce planning to cover primary care including new models of care such as the Cancer Vanguard
- Worked with Skills for Care and engaged with national project work to ensure integrated workforce planning for Social Care
- Invested in a team of 4 workforce planners to support primary care and integration. Work includes the Day of Care Audit designed to improve efficiency in General Practice
- Worked with the Healthy London Partnership to understand the demand and supply of staff in primary care and identified opportunities to close the gaps.
- Led a centralised Pan-London placement management and workforce development programme for paramedics with an investment of over £1.5m, contributing to increasing workforce supply and staff retention
- Utilised health education funding to ensure high quality education for medical trainees is on-going.

Improving recruitment and retention

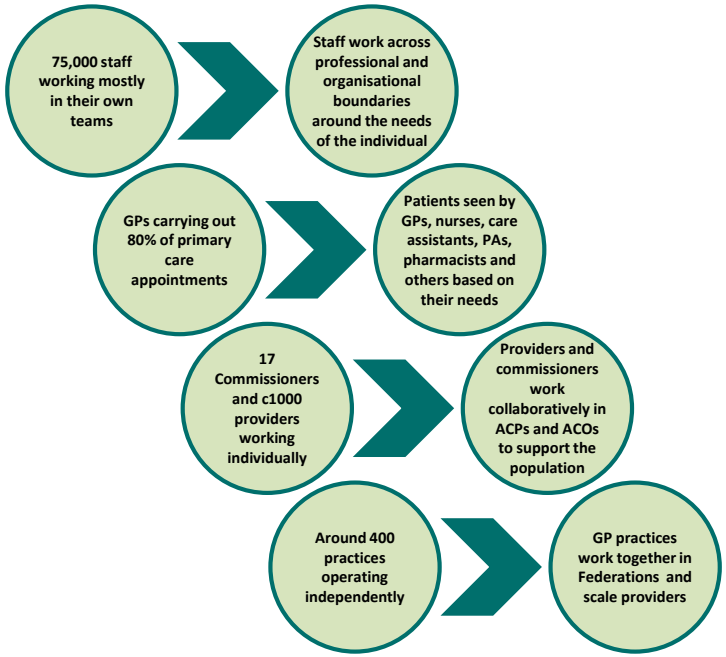
- With Capital Nurse we have started recruitment of 350 newly qualified nurses onto a rotational programme with educational and development support, this covers all NHS trusts in NW London as well as primary care. This investment will demonstrate the benefits of a rotational programme in improving retention rates and developing nurses within NW London to move on from their training to more senior nursing posts.
- We have programmes to improve the recruitment of nurses in general practice including a funded course with placements for nurse from outside of practice nursing to develop skills and experience to move into the sector. In 16/17 we have recruited 26 nurses across NW London.
- 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, 31started training in September, a further 15 will start in February 2017. 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, 95 paediatric nurses and 9 consultants paediatricians.

Governance

Governance has been improved to deliver a comprehensive STP workforce strategy. This is supported by a strengthened collaboration between Health Education England and the CCG collaborative, local councils and other stakeholders. A CCG and HEE joint STP workforce team reports to a newly established Board that is co-chaired by the CCG, Social Care and HEE is a **key enabler** to delivery. This approach encompasses critical experience and expertise. It also maximises efficiency and ensures clinically led decision making and input from key stakeholders including health and social care providers, CEPNs (Community Education Providers Network) and the Healthy London Partnership.

A new robust governance structure to deliver the STP workforce strategy

What will be different in 2020[6]?



3. Enablers: Workforce

Current Transformation Plans and Benefits

Workforce planning and addressing workforce shortages

Effective workforce planning is essential for securing our future workforce, it underpins all further interventional activity and investment to support the workforce. We have the infrastructure in place to forecast shortages and develop plans to address them. This includes Primary Care and work is underway to ensure it covers new models of care such as the Cancer Vanguard. Critically this work will also include social care working with Skills for Care and through engagement and national project work.

Improving recruitment and retention

Improving recruitment and retention across health and social care will be critical to closing the financial gap and addressing workforce shortages. Modelling in London and the south east shows £100.7 million could be saved in the next 10 years by retaining new staff for 1 extra year. Recruitment and retention issues lead to high use of agency staff costing £172m.

To reduce spend on agency we will control demand for bank shifts by improving rostering and encourage more staff to work through banks instead of agencies to reduce agency costs.

Delivering the improvements in CAMHS Eating Disorder services will require an increase in numbers of staff with these specialist skills , we know we will face competition for these staff. We will work with our Like[illegible]inded programme to make sure NW London is an attractive place to come and work to retain cu[illegible]t staff and improve recruitment

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W[illegible]rce Transformation across health and social care workforce to support integrated care

Care in NW London will be delivered differently in 2021. Building on existing work we will support staff to work in new ways. To deliver the Strategic Commissioning Framework and the 10 point plan for Primary Care we will support workforce to improve productivity and build capacity in general practice and develop the whole care team. We will work with the Time for Care programme at an NW London level and develop local CCG plans based on local priorities and areas where the 10 High Impact Actions will have the greatest effect.

We have established the Change Academy. This is a collaborative programme across NW London to address workforce transformation, organisational development between providers and systems leadership. Through Change Academy High Performing Care programme we will support system change through high performing teams and improvement methodology underpinned by data enabled evidence-based decision-making. The scope of this programme will be multi-organisational change teams charged with delivery of STP on actual delivery issues in real time.

Leadership and Organisational Development to support future services

We understand that effective leadership underpins the transformation we need to achieve in NW London. As part of the Change Academy there are programmes targeted at supporting leaders across health and care:

I. STP/SPG systems leadership
II. Joint commissioning skills development
III. Emerging GP leaders network
IV. Practice manager development programme

This work will support staff and carers across all settings through the changes required by the STP and to develop the right culture to make sure changes are successfully delivered.

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:

- Using **£1.5m HEE funding** to support new models of care, self-care and LTCs
- Train up to 180 health and care professionals **to support self-care**
- Supporting 24 professionals to become **health coach trainers** to enable patients to take greater responsibility for their health
- Expand the programme in 2017/18 to develop carers as health trainers.
- Embed the NW London **Healthy Workplace Charter** to promote staff health and wellbeing initiatives and ambassadorship

Delivery Area 2 - Reducing variation:

- The seven day services programme is receiving an additional investment of £750K to trial new models of care and to further support the Radiography workforce.
- The Cancer Vanguard is being supported through instigating new project leads to drive evidence based service design

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
- Delivery of the SCF and 10-pont plan for Primary Care through workforce transformation
- Consultant outreach into primary care
- CEPNs focused on developing the primary care and community workforce
- 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 were supported through an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.
- Using £600k of HEE funding to support the transformation of Serious and long term mental health and children and young people's mental health

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 by improving recruitment and more effective rostering and thereby the cost of service

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London CCGs, with good progress with Information Governance across care settings.
- Each of the eight CCGs has a single IT system across their practices, and six of the eight CCGs are implementing common systems across primary and community care.
- In the acute space, Imperial and Chelsea & Westminster have a strong track record with digital clinical systems and are working together on a common Electronic Patient Record. Imperial (with Chelwest) is expected to be nominated by NHS England as a Global Digital Exemplar and will provide leadership to the rest of the footprint in the provision of improved patient outcomes and enhanced business efficiencies.
- Digital technology will support Primary Care transformation with new models of care that support out of hospital Local Services, through shared records across care settings, including new GP provider networks/hubs and ultimately via Accountable Care Partnerships. Potential funding from the Estates & Technology Transformation Fund (ETTF) will help upskill the primary care workforce and encourage patients to use new digital channels to access care, and use digital tools to become more involved in their own care.
- The footprint has a good track record in delivery of shared records, e.g. the NW London Diagnostic Cloud. The NW London Care Information Exchange is under way, funded by the Imperial College Healthcare charity, to give patients and clinicians a single view of care across providers and platforms, and provide 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 in primary and community care. In the longer term, it is our ambition for the NWL Exchange to interface with the wider London Health and Care Information Exchange.
- There is good support from the NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London information exchange, record locator, and IG register.
- Imperial College Health Partners (ICHP), Academic Health Science Network (AHSN) for NW London, is working closely with local health and care partners to ensure that innovation plays a major part in achieving the goals set out in our STP. One example of this is the roll-out of the Intrapreneur programme which to date has enabled over 100 local executives and frontline clinicians to integrate innovation with their everyday role.

Key Challenges

- There is a significant challenge for digital to transform current delivery models and enable new, integrated models of health and social care, shifting care out of hospitals through shared information between care settings and a reduced emphasis on traditional face-to-face care delivery.
- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access information about the patient[1]. This will be mitigated by sharing care records and converging with other footprints via national and pan-London NHS systems and capabilities (e.g. Summary Care Record, e-Referrals, Co-ordinate My Care, electronic discharges); and in the longer term addressed through the NW London Care Information Exchange and (for the 16% outside the footprint) a pan-London information exchange.
- Due to different services running multiple systems, achieving shared records is dependent on open interfaces, which primary and community IT suppliers have not yet delivered. This will require continued pressure on suppliers to resolve – in particular TPP and EMIS.
- 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 requested from NHSE to define and fund interfaces nationally.
- Clinical transformation projects are invariably costly and time consuming, which needs to be allowed for in the LDR plans
- Some citizens and care professionals have rising expectations for digital healthcare which we cannot deliver; for others, there is a lack of digital awareness and enthusiasm, requiring a greater push for communication around the benefits of digital solutions and education on how best to use them.

Strategic Local Digital Roadmap (LDR) 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. **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more 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 own care
5. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, 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**
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education.
- **Digital Health** to leverage innovations such as remote monitoring, point of care and self-testing, mobile applications, interoperability of IT systems, big data analytics and AI.

The NW London Digital Programme Board will oversee delivery of the LDR, integrated with the governance of the STP.

3. Enablers: Digital

STP Delivery Area	LDR Work Stream	Key Digital Enablers for Sustainability & Transformation Plan
1. Radically upgrading prevention and wellbeing	• Tools for self-management and self-care • Enable Patient Access • Build a shared care record	**Deliver digital empowerment to enhance self-care and wellbeing:** • Easier access for citizens to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • Innovation programme to find the right **digital tools** to: help people **manage their health and** wellbeing through digital apps of their choice, connected to clinical IT systems; **create online communities** of patients and carers; get children and young people involved in health and wellness • **New digital channels** (e.g. online and video consultations) to help people engage more quickly and easily with primary care **Embed prevention and wellbeing into the 'whole systems' model:** • Support for integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care plans that are shared with patients and carers)
2. Eliminating unwarranted variation and improving LTC management	• Automate clinical workflows and records • Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Deliver digital empowerment by increasing patient engagement to better self-manage their LTCs:** • Delivery of Patient Activation Measures (PAM) tool for every patient with an LTC to develop health literacy and informed patients • Innovation programme to help people **manage their LTCs (conditions and interventions)** through digital apps of their choice, extending clinical systems to involve patients (e.g. SystmOne for diabetes) and potentially telehealth (e.g. wearable technology) **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience • Support for new models of multi-disciplinary care, delivered consistently across localities, through shared care records • **Automation of clinical workflows and records**, particularly in secondary care settings, and support for new pathways and transfers of care through interoperability and development of a shared care record to deliver **integrated health and care records and plans**
3. Achieving better outcomes and experiences for older people	• Enable Patient Access • Build a shared care record • Use dynamic data analytics	**Provide fully integrated service delivery of care for older people** • **Shared clinical information and infrastructure** to support new primary care and wellbeing hubs and ACPs with clinical solutions • Citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange, new digital channels** (e.g. online and video consultations) • Support for a **single transfer of care** approach, and **new models** of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care (NW London and pan-London CIEs) • **Integration of Co-ordinate My Care (CMC) for last phase of life plans** with acute, community and primary care systems; and promote its use in CCGs. through education and training and support care planning and management • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care **dashboards** across 350 GP practices will deliver direct, integrated patient care
4. Improving outcomes for children and adults with mental health needs	• Tools for self-management and self-care • Build a shared care record • Use dynamic data analytics	**Enable people to live full and healthy lives with the help of digital technology** • Innovation programme supported by the AHSN and industry leaders to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities – for example Patient Reported Outcome Measures (PROMs); **create online communities** of patients and carers; get children and young people involved through apps **Implement new models of care and 24/7 services where required** • Support for **new models** for out-of-hours and inter-disciplinary care, such as **24x7 crisis support services** and **shared crisis care plans** to deliver the objectives of the Crisis Care Concordat, through shared care records **Reduce variation** • **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience
5. Ensuring we have safe, high quality, sustainable acute services	• Automate clinical workflows and records • Enable Patient Access • Build a shared care record	**Invest in digital technology in Hospitals** • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Support new models for out-of-hours care through **shared care records and the NWL diagnostic cloud**, such as 24x7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks • Better digital tools to ensure **optimisation of acute resources**, e.g. radiology Clinical Decision Support, referral wizards and decision support tools, greater use of NHS e-Referrals including Advice & Guidance capability • Integrated **discharge planning and management**, and support for **acute-to-acute transfers**. through shared care records • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients • **Dynamic analytics** to track consistency and outcomes of out-of-hours care • **Partnership model for informatics delivery** that makes best use of specialist technology skills across organisations

4. Primary Care

Primary Care in the context of out of hospital transformation

The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (FYFV). In NW London, our STP sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans.

Our plans are for the development of integrated out of hospital care – Local Services – that will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be enabled to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. This will improve health and wellbeing and care and quality for patients.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London.

We will transform General Practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all, as set out in the Transforming Primary Care in London: a Strategic Commissioning Framework.

We will implement a substantial up scaling of intermediate care services, available to people locally, offering integrated health and social care teams outside an acute hospital setting.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP. Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

'There is arguably no more important job in modern Britain than that of the family doctor'

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

We are determined that NW London succeeds.

Enhanced Primary Care: Locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care, and co-ordination across key parts of the system against a single shared care-plan

Self-Care: Embedding the self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

Upgrading Rapid Response and Intermediate Care Services: delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

Transfer of Care: implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

4. Primary Care
The local services landscape including primary care

Achieving an effective model of integrated out of hospital services is key to the delivery of the NW London STP. Within NW London, we have a highly diverse population, which is supported within Primary and Community Care by a mix of out of hospital services with varying levels of capacity.

We have achieved much since we began implementing Primary Care transformation across NW London in 2015, and Whole Systems Integrated Care in 2014, but we do not underestimate the remaining challenges. We now have Primary Care operating at-scale across NW London (diagram, bottom right). Our current plans for further transformation are underpinned by national and local policies and initiatives:

- **The 5 Year Forward View (5YFV)**

As part of our Local Services Transformation, we aim to tackle the triple gap identified in the 5YFV: Finance, Sustainability and Quality. All of our initiatives have had these priorities in the forefront of our planning, and are key components of NW London's STP.

- **The General Practice Forward View (GPFV)**

The GPFV sets out a plan, backed by a multi-billion pound investment, to stabilise and transform General Practice. The focus of the plan centres around workforce (incentivisation for recruitment and retention), workload (practice resilience) , infrastructure (estates and technology) and care redesign.

- **The Strategic Commissioning Framework (SCF)**

This is London's agreed approach to supporting the focus on Accessible, Proactive and Co-ordinated Care within Primary Care. Self-care is an integral part of proactive care contributing towards Enhanced Primary Care offer.

- **The GP Access Fund (GPAF)**

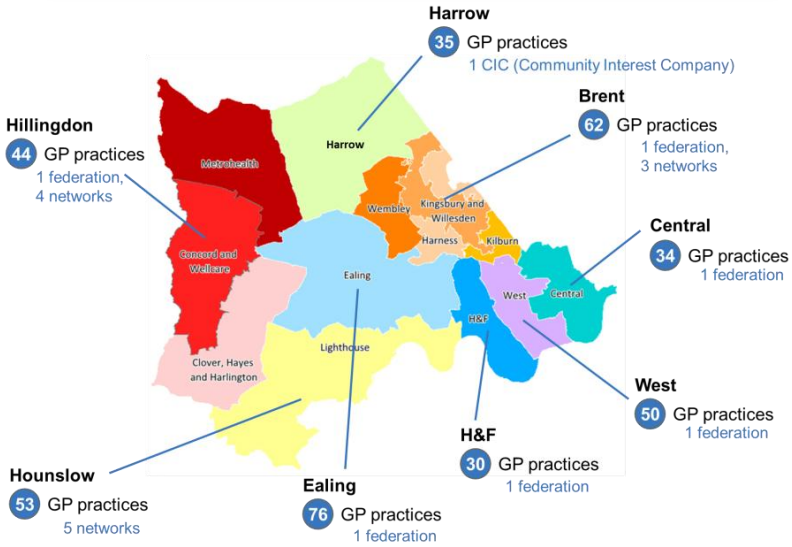
As part of the extended access aspects of Accessible Care, NW London will meet the extended access specifications by the end of Mach 2017, in order to better support our population to access Primary Care services more efficiently, at a time and place that suits them.

- **King's Fund and related reports**

Evidence based, national reports have indicated areas of focus for NW London. We have also utilised local knowledge from reviews and evaluation to assess our current status quo (blue box) and areas for development.

In NW London, we have:

- 1,093 GPs
- 473 practice nurses
- 273 clinical support staff
- Average list size 5,560
- GP and nurse workforce supply is the lowest in London
- 392 GP practices with 31 sites open at weekends
- 17 groups of GP providers
- 388 dental care practices
- 1,284 pharmacists
- Pharmacy and dental practice supply one of the best in London
- 5 different IC/RR services
- Multiple Single Points of Access (SPAs)
- Many care homes, often in disparate locations
- Differing provision of bedded and non-bedded care across NW London



4. Primary Care: CCGs have agreed to support Primary Care providers in delivering a clear set of standards over the next five years, in support of our vision

Proactive care	
Co-design	Work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve health and wellbeing
Developing assets and resources to improve health and wellbeing	Work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected and supported
Conversations focused on individual 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	Enable and assist people to access (inc. in schools, community and workplaces) information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing.
Patients not accessing Primary Care services	Design ways to reach people who do not routinely access services and may be at higher risk of ill health.

Accessible care	
Patient choice	Patients have a choice of access (e.g. face-to-face, email, telephone, video)
Contacting the practice	Patients make one call, click, or contact to make an appointment. Primary care teams will actively promote online services to patients (inc. appointment booking, viewing records, prescription ordering and email consultations)
Routine opening hours	Patients can access pre-bookable appointments with a primary health 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 7days a week, 12 hours per day (8am -8pm or alternative equivalent based on local need), for unscheduled and pre-bookable appointments
Same-day access	Patients can have a consultation (inc. virtually) with a GP or skilled nurse on the same day, in their local network
Urgent and emergency care	Patients can be clinically assessed rapidly. Practices will have systems and skilled staff to ensure patients are properly identified and responded to
Continuity of care	Patients are registered with a named team member, responsible for providing coordination and continuity, with practices offering flexible appointment lengths

Co-ordinated care	
Case finding and review	Practices identify patients, through data analytics, who would benefit from coordinated care and continuity with a named clinician, regularly and proactively reviewing those patients
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 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 the use of digital tools and education, such as health coaching.
Multi-disciplinary working	Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving. Care will be coordinated via shared electronic care records.

4. Primary Care: A whole population approach to delivering integrated out of hospital care in NW London

We have developed a whole population approach to delivering integrated out of hospital care in NW London.

Majority of activity

Population segments

Service needs	Mostly healthy people	People with complex conditions
Planned	**Prevention measures as per defined protocols** • Lifestyle interventions, health education in schools, smoking cessation, screening • Choice of access options and centralized scheduling across multiple channels • Services are available at convenient times (e.g. evenings and weekends) • Prevention programs in collaboration with Local Authorities, e.g. walk-in classes	**Care by the same team in core hours** • Support with adhering to a care plan under the guidance of a care-coordinator • Tailored advice and support with self-management that includes social interventions and support • Preferred service and a named clinician are available for pre-planned appointments • Discharge coordination with hospital services • Infrastructure to support home-monitoring
Unplanned	**Easy access and information sharing** • Walk-in, telephone and tele-consultation options available, including out of hours • Support for self-care (e.g. online advice) • Advanced information sharing between services and professionals exclusively through Electronic Health Records (EHR), also accessible to the patient	**Rapid access, preferably to the core team** • Single telephone line to direct patients out of hours; otherwise care coordinator is main point of contact • Core team keeps sufficient capacity for unplanned appointments • All professionals use EHR; feed back most important events to the core team

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Episodic Care[1]

- Main emphasis on ease of access
- Episodic care, overseen by a qualified GP on duty during normal and extended hours at a hub / dedicated practice or call centre
- Patient-self management of limiting illnesses

Continuous Care[1]

- Main emphasis on continuity
- Continuous care provided mainly during core hours by the same team, according to a care plan
- Care coordinator to serve as the first point of contact for the patient, and all other providers

1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)

4. Primary Care: Primary care and Intermediate Care transformation is the foundation for Local Services Transformation

The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP.

Our challenges

- **Demand for health and care services is increasing.**
- **There is unwarranted variation in care, quality and outcomes across NW London.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

How Local Services areas of focus fit within STP delivery areas

DA2 — **Improve quality and reducing variation across Primary Care (for LTC management)**

DA3 — **Achieving better outcomes and experiences with a focus on older people**

What are the ways of working

- **Developing sustainable services**
- **Changing how we work together to deliver the transformation required**

Our areas of focus

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

- Joint commissioning and delivery models across CCGs and providers
- Evolving **Primary Care at-scale**
- Managing demand across boundaries through pathway redesign
- **Strengthening care teams** to provide effective care

- Effective **joint governance** able to address difficult issues
- Working **cross-boundary**; across acute and social care
- Collaborating to improve quality and efficiency, e.g., through the Virtual Primary Care Team
- Building upon **Whole Systems Integrated Care**

The impact of our plans

A healthier NW London

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care.

More productive care:

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

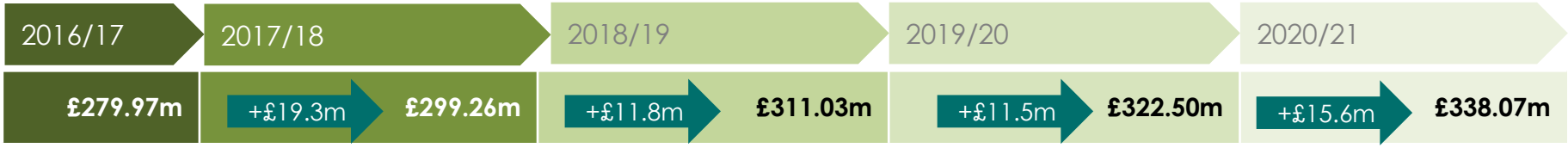
More effective system:

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

4. Primary Care: There will be significant investment in General Practice within NW London

This diagram shows NW London's:

- Efficiency targets
- Increases in primary care medical allocations (blue arrows)
- The planned delivery of the Strategic Commissioning Framework and the Strategy and Transformation Plan



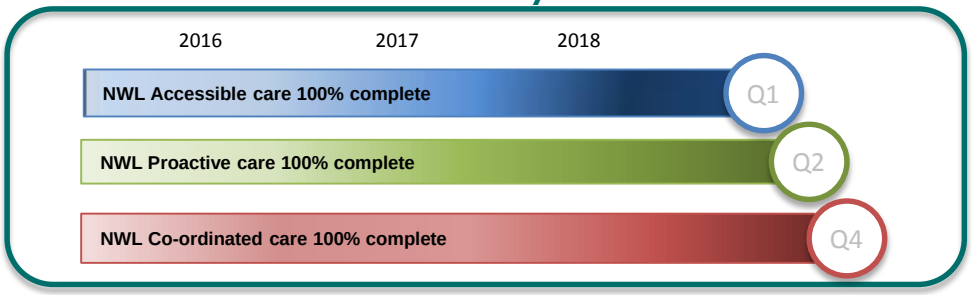
Key

Increases in Primary Care medical allocations

The diagram does not show funding from national programmes (such as the General Practice Access Fund) from which NW London is aiming to access approximately £4.5m in 2016/17 – announced in the GP Forward View.

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. Transforming general practice in line with the standards set out in the Strategic Commissioning Framework is critical to delivery of the ambitions set out in the STP. The diagram below shows the milestones to full delivery.

Milestones for SCF delivery across NW London



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 overall the footprint including social care has a small deficit of £19.9m.

£'m	CCGs	Acute	Non-Acute	Specialised Commissioning	Primary Care	STF Investment	Sub-total	Social Care	Total	
Do nothing Oct 16	**(247.6)**	**(529.8)**	**(131.6)**	**(188.6)**	**(14.8)**	-	**(1,112.4)**	**(297.5)**	**(1,409.9)**	**Note 1**
BAU Savings (CIP/QIPP)	127.8	341.6	102.7	-	-	-	**572.1**	108.5	**680.6**	**Note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	**(4.0)**	-	**(4.0)**	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	**15.6**	8.0	**23.6**	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	**(5.4)**	-	**(5.4)**	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	**18.5**	-	**18.5**	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	**(52.3)**	-	**(52.3)**	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	**134.9**	33.1	**168.0**	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	**(11.0)**	-	**(11.0)**	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	**22.8**	6.4	**29.2**	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	**(45.6)**	-	**(45.6)**	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	**254.5**	15.0	**269.5**	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	**(55.7)**	-	**(55.7)**	**Note 4**
STF - funding	24.0	-	-	-	14.8	55.7	**94.5**	19.5	**114.0**	**Note 4**
Other	-	-	-	188.6	-	-	**188.6**	72.0	**260.6**	
TOTAL IMPACT	**336.4**	**462.0**	**125.7**	**188.6**	**14.8**	-	**1,127.5**	262.5	**1,390.0**	
Final Position Surplus/(Deficit)	**88.8**	**(67.8)**	**(5.9)**	-	-	-	**15.1**	**(35.0)**	**(19.9)**	
				Note 5				**Note 3**		

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

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since Jun '16 STP due to changes in the underlying position of social care, and inclusion of the Royal Brompton & Harefield and the London Ambulance Service deficit attributable to NWL.

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 6: As we have developed our project plans we have more clearly articulated the focus of our delivery areas. This has resulted in 'Delivering the SCF' moving from DA3 to DA2. The individual DA totals have therefore changed although overall investment and saving totals remain constant.

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 break even position .

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.

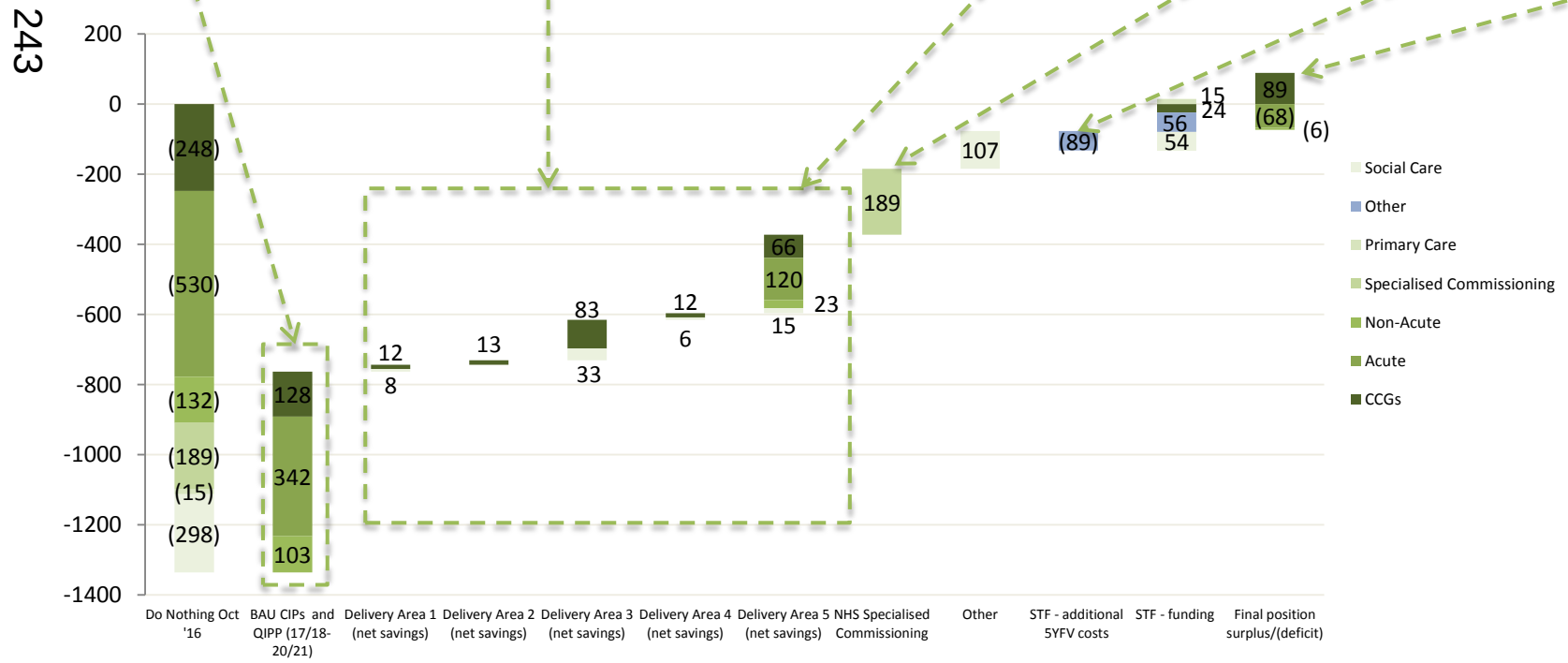
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

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

Final position CCG Surplus (£89m) Acute deficit (£68m) Non-acute deficit (£6m)



5. Finance:
Next steps

Financial risks to delivery of the STP

There are a number of risks facing NWL commissioners and providers which are inherent in the STP. These are:

- Delivery of business as usual efficiency savings
- Delivery of the service transformations set out in the five delivery areas, and the realisation of the associated savings
- Financial challenges on the provider side that remain at the end of the STP period
- Plans to close the specialist commissioning gap are not yet available
- Deterioration in underlying organisational financial positions since 2016/17 plans were agreed
- Closing the remaining social care funding gap
- Accelerating delivery of transformation plans to enable recently notified NHS financial control totals to be achieved.

The key risk to achieving sector balance is the delivery of the savings, both business as usual efficiency savings and those associated with the service transformations described in the five delivery areas.

There are also particular challenges in relation to:

- The deficit on the Ealing Hospital site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging;
- The deficit at the Royal Brompton and Harefield, which although mostly commissioned by NHSE Specialised Commissioning, is included in the NWL footprint;
- The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution.

The plans to close the Specialised Commissioning gap are not yet available in enough detail to allow an assessment of the level of risk facing the NWL Specialised service providers. This may pose a significant risk to the viability of some providers.

Next steps to address the risks

There are a number of processes in place to quantify and mitigate the risks set out above. These include:

- A robust process of business case development to validate the investments and savings that have been identified so far, and the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered
- A portfolio management approach with clear governance to ensure that project directors are held accountable for delivering agreed savings, with a change control process to close projects and agree new ones as required to deliver the planned patient outcomes and associated savings
- The work through DA5d on productivity will support the development of trust internal infrastructures to support the business as usual efficiency savings
- The acceleration of the changes relating to Ealing hospital, once out of hospital capacity is in place
- Joint pathway planning with specialist commissioning and other CCGs across London to confirm the plans to reduce demand and to quantify the impact on providers
- Quantification of changes in underlying financial positions and differences between the STP financial assumptions and notified control totals, feeding into a sector approach to the 2 year contracting round to ensure that effective risk management processes are in place.

This work will be developed and will continue over the next few months.

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. The STF funding being use to support provider deficits has already been notified to Trusts for 17/18 and 18/19, and is not included below. The funding below is being sought **in addition** to provider STF funding.

Sustainability and Transformation funding requirement for North West London

Investment Area	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Investment in Prevention & Social Care	21.0	25.0	30.0	34.0
Social Care funding gap	-	-	-	19.5
Total Social Care and prevention	**21.0**	**25.0**	**30.0**	**53.5**
Seven Day services roll out through to 2019/20	4.0	7.0	12.0	24.0
General Practice Forward View and Extended GP Access	10.0	10.0	5.0	5.0
Increasing capacity in Child and Adolescent mental health services and reducing waiting times in Eating Disorders services	5.0	5.0	8.0	10.0
Implementing recommendations of mental health task force	10.0	10.0	10.0	5.0
Cancer taskforce Strategy	3.0	5.0	10.0	3.0
National Maternity Review	7.0	7.0	2.0	2.0
Local Digital Roadmaps supporting paper free at the point of care and electronic health records	3.0	10.0	10.0	6.7
Total Health	**42.0**	**54.0**	**57.0**	**55.7**
Improvement Resources	2.0	2.0	-	-
Additional Investment in Primary Care services	1.0	12.0	19.0	14.8
System support funding	-	-	-	24.0
Total	**66.0**	**93.0**	**106.0**	**148.0**

5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £978m (funded by £713m from internal resources, £37m from disposals and £228m 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. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

The table below details the 'Do something' capital for the 5 year STP period.

Table : Do Something Capital

Key Capital Schemes	17/18-20/21 £m	Less: disposals £m	Other funding sources £m	Total £m
	Gross Capital			Net capital
Outer NWL (SOC1)[1]	385	(9)		375
Inner NWL (SOC2)[2]	222	(222)		-
IT Digital Roadmap[3]	60			60
CNWL - strategic investments	79	(53)	(26)	-
Royal Brompton	100	(100)		-
Total	**845**	**(384)**	**(26)**	**435**

Note 1 – The Outer NWL business case (SOC1) is modelled on an 'accelerated' approval timeline in order to address the sustainability issue at Ealing Hospital;
Note 2 – The Inner NWL Business Case (SOC2) is funded through the disposal of a charitable asset, thus placing a restriction on the use of the sale proceeds;
Note 3 - IT digital roadmap funding is expected to be funded via the Estates and Technology Transformation Fund (ETTF).

6. Risks and Mitigations:
Strategic Risks

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	• Maintain system attention on importance of delivery over the next five years through focus on Delivery Areas 1, 2 and 3 • Continue to develop delivery plans using learning from vanguards and other areas • Establishment of robust governance process across NW London system focussing on both delivery and assurance • Clear metrics agreed to monitor progress	
There is insufficient capacity or capability in primary care to deliver the / model of care	Quality and sustainability	• Support development of GP federations • Early investment in primary care through joint commissioning • Identification and support to vulnerable practices • Digital solutions to reduce primary care workloads	• Support in developing a reliable understanding of sector demand and capacity for primary care
Can't get people to own the responsibility for their own health	Self care and empowerment	• Development of a 'People's Charter' • Closer working with local government to engage residents in the conversation, primarily through DA1	• 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, and the sustainability issues at Ealing Hospital	Finance and estates	• Submit a business case for capital to NHS England • Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment • Identification of further opportunities through One Public Estate • Submit a business case for capital to NHS England that sets out the clinical and financial rationale for an accelerated timeline	• Support for retention of land receipts for reinvestment, and potential devolution asks • Support for an accelerated timeline for the capital business cases
Information Technology systems are not in place to enable seamless integrated care and a shift towards out of hospital activity.	Information and technology	• Work within new national standards on data sharing to support the delivery of integrated services and systems. • Keep pressure on primary and community IT system providers to deliver open interfaces which will enable record sharing	• 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 • Continued focus at a national level on open API

6. Risks and Mitigations:
Other Risks

Risks	Category	Proposed mitigations	Support from NHSE
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	• On-going quality surveillance to reduce risk • Contingency plans developed should a service be flagged as *fragile* • Strengthened governance structure with clear joint leadership maintaining focus on delivery and enabling more rapid and effective responses to a situation	
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	• Development of a joint market management strategy lead by the Joint Health and Care Transformation Group • Specific project of work in this area through DA3 • On-going support to homes to address quality issues	
Provider and system sustainability targets result in competing local priorities	Quality and sustainability	• Joint Health and Care Transformation Group provides forum for system wide discussion.	• Alignment of NHS England and NHS Improvement positions on provider sustainability versus system sustainability
248 are unable to recruit or retain kforce to support the old model e training and transforming to the new model of care	People and workforce	• Establishment of Workforce Transformation Delivery Board to provide system leadership and focus • Development of cross-sector workforce strategy • Close working with HEENWL	
There is resistance to change from existing staff	People and workforce	• OD support and training for front line staff and system leaders • Wide staff engagement in the design and delivery of new models through project delivery groups.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	• Work closely with partners to understand the implications of 'Brexit' • Provide staff with support to ensure they feel valued and secure.	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	• Developing relationships between health and local authority organisations, supported by joint governance via the Joint Health and Care Transformation Group • Joint statement agreed and areas of commonality identified to enable progress	

7. References

Section	Slides	References
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Section	Slides	References
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Partnership organisations with the NW London STP Footprint

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