This table describes the existing 'health' perspective on NWL priorities

Do these reflect local government priorities? What priorities around prevention and public health be reflected here? How is the role of patients and communities reflected in your local priorities?

Triple Aim	Vision	As-Is Position	To – Be Position	Priorities
Improving Health and Wellbeing	To improve the quality of care for individuals, carers and families to empower and support people to maintain independence and to lead full lives as active participants in their communities "My wellbeing and happiness are promoted, valued and supported" "I feel lots is done to help me promptly when my health worsens" "The care and support I receive is joined-up, sensitive to my needs, wants and beliefs, and delivered close to me and the people that matter to me"	• 20% of people have a long term condition, and this group consumes 75% of healthcare resources • Half of NWL CCGs are in the bottom quintile for % of children in year 6 with a healthy weight (NHS Atlas of Variation) • Service users sometimes feel disempowered in a reactive care system • Service user experience is sometimes confusing • There are evidenced risk factors for mental illness - including adversity such as debt, violence and abuse – as well as loneliness and isolation	• Wellbeing is seen in its widest sense -it is not only about seeing a doctor and getting medical support. Support and treatment is appropriate for not only the condition, but also for the person and the wider determinants of wellbeing and health such as housing and employment • Mental and physical care are given equal importance in all care settings, ensuring that the person's health care and wellbeing are considered in a more holistic way, resulting in the best outcomes for the person. This is true for children as much as for any other population segment • We recognise that sometimes people's social needs are as great as their medical needs - reduced isolation will impact on people's mental and physical health services. • Care isn't just limited to hospitals and GP surgeries; services provided within the community are considered to help prevent illness and support wellbeing.	1. Transforming support and services for improved wellbeing and supporting people to make healthier choices: • Children and Young People • People with common MH needs • New mothers • *Obesity prevention* • Tackling social isolation • *Addressing the wider determinants of health* 2. Activating those living with health needs to take better care of themselves: • Self-care framework, patient activation and access to community support/services • Digital support and access

Do your local aspirations align with this? Please let us know of any local priorities on the framework template on slide 7

The clinical base case framework to capture local priorities

Triple Aim	Vision	As-Is Position	To – Be Position	Priorities
Improving Health and Wellbeing To improve the quality of care for individuals, carers and families to empower and support people to maintain independence and to lead full lives as active participants in their communities.	**Start Well** To transform children and young people's health and well being. **Live Well** To achieve a step change in patient activation and self care by empowering people to access support throughout the local authority, NHS and 3rd sector services. **Age Well** To support older people to keep themselves healthy and well and to access integrated health and social care	**Start Well** Variable support for children and young people through a complicated range of services that can be difficult to access quickly. Evidence of increased risk of ill health arising from poverty and mental health. **Live Well** Pockets of good practice in patient engagement and participation. Self-care models in development in health and social services. **Age Well** High variation in healthy years of life within the borough. Variable levels of support to those with LTCs eg diabetes 90%; common mental health problems 25%.	**Start Well** Integrated services providing early supporting to the health and well being of young people and their parents. Early years services that identify and address problems in children and their families as early as possible and provide a co-ordinated response from health and social care. Avoiding preventable illness through the promotion of active, healthy lifestyles. **Live Well** An integrated approach to the engagement of the Harrow population in self-care and healthy choices eg diet, exercise Prevention strategies for common LTCs and self-management programmes for those already diagnosed. **Age Well** Enabling people to stay healthy and care for themselves for longer by promoting healthy living and improving access to support by co-ordinating community services and resources.	**Start Well** To develop an integrated model of service for children and young people. To redesign the early help service for children and young people to deliver agreed outcomes. Support frontline health and social care staff to initiate family oriented conversation with children at risk of obesity. **Live Well** Mapping and networking of community assets in health, social and 3rd sector services. Widescale provision of information and brief advice on alcohol, physical activity, diet, smoking and mental health. **Age Well** Promote 5 ways to wellbeing: • To connect • Be active • Keep learning • Take Notice • Give To have a pool of expert patients trained in patient education.

This table describes the existing 'health' perspective on NWL priorities

Do these reflect local government priorities?
Do your local aspirations align with this? Please let us know of any local priorities on the framework template on slide 9
What are the barriers to achieving priorities? What are the big decisions you will need to make to drive transformation?

Triple Aim	Vision	As-Is Position	To – Be Position	Priorities
Improving Quality and Care	*Care is **personalised** enabling people to manage their own care* *Care is **localised** allowing for a wider variety of services closer to home* *Care is **integrated** covering all aspects of a person's health* *Care is **specialised** for those with conditions that require specific services*	• Population set to increase by 106k (5%) over the next five years • Due to people living longer, demand is expected to increase by 10% over the next five years • 3% of admissions are using a third of acute beds • Day of Care surveys have shown over 30% of patients do not meet criteria for needing a hospital bed • It is currently difficult to access GP care • Providers (across health and social care) sometimes find it hard to work together due to the way that organisations or the system is set up • We do not have universal coverage of NICE compliant care for people with all different mental health needs	• People are treated at the right time, by the right person, in the right care setting, appropriate for the person and their condition, regardless of the day of the week. • People are treated in modern facilities with the latest technology available, dealt by compassionate staff across all hospital sites, giving them confidence in their care • A variety of services are provided within the community in buildings that are modern and fit-for-purpose. • People are directed to centres for specialised care, whether that's within hospitals or in out-of-hospital settings, relevant to their condition, considering the patient's choice at all times.	1. Providing more high quality local care that is person-centred and integrated: • Investment in new local models of integrated care, including the delivery of the Strategic Commissioning Framework by 2018 • Developing GP federations and moving to ACPs by 2018 • Integrating and making accessible information and data 2. Reducing unwarranted variation 3. Transforming services for improved mental health: • People with Serious and long term needs – including urgent care pathways • People living with Learning Disabilities 4. Enabling better care in NWL London through the London Quality Standards as evidenced by Royal Colleges and roll out of seven day services: • Paediatrics transition • Local hospital planning • Specialist hospital improvement • Ensuring high quality hospital services every day of the week, including consistent discharge approach across NWL

The clinical base case framework to capture local priorities

Triple Aim	Vision	As-Is Position	To – Be Position	Priorities
Improving Quality and Care	*Care is **personalised** enabling people to manage their own care* *Care is **localised** allowing for a wider variety of services closer to home* *Care is **integrated** covering all aspects of a person's health* *Care is **specialised** for those with conditions that require specific services*	Large scale regeneration planned for Harrow resulting in significant increases in the population, in addition to an expected 5% increase in the NWL population over the next 5 years. The Harrow population is older than is average for London; a third of over 65s have at least one LTC. Highly diverse population with varying levels of understanding of health and healthcare services Right Care Analysis indicates opportunity to reduce the number / improve the quality of interventions in: • Cancer; • Respiratory; • MSK; • Endocrine disorders. The Shaping a Healthier Future Out of Hospital strategy requires the transfer of outpatient activity from hospitals to community settings. Mental health problems are a main cause of unemployment and ill-	Increased capacity in primary care and capability through the Primary Care Transformation Strategy. Routine use of the Health Impact Assessment framework to facilitate joint planning of response to population pressures between care sectors. Virtual ward for management in the community of people with LTCs, including self-care training. Information and advice accessible across the system to increase understanding of health and healthcare among diverse range of communities Patient empowerment and self-help training for older people and for patients with long term conditions. Integrated pathways delivering in community settings for high-volume elective care eg muskulo-skeletal; gynaecology; dermatology. Increased capacity in primary care-led urgent and out of hours operating model.	Develop 3rd walk in centre in the east of the borough to increase capacity and provide more equitable access to primary care through cross-practice working. Develop the three walk in centres into primary care hubs providing an expanded range of services, including diagnostics and minor injuries. Increase the efficiency of health and social care services through the achievement of interoperability between information systems. Collaboration between health, social and 3rd sector care agencies to increase efficient use of facilities. Continuing investment in whole systems integrated care transformation programme focusing on providing personalised care for people with one or more LTCs. Management of diabetic patients in community based services with consultants and GPSI led support. Falls prevention and support to nursing homes to avoid preventable admissions to secondary care. Accountable care partnerships contributing to delivery of integrated services. Psychological therapies available through self-referral for Harrow residents.