NW London Sustainability and Transformation Plan

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

Summary of the 15 April 2016 submission to NHS England

DRAFT, NOT FINAL
Created May 2016

North West London – proud to be London

The North West London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospital trusts

2 mental health trusts

2 community health trusts

North West 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, which include landmarks such as Big Ben, Oxford Street, Heathrow Airport and Wembley Stadium.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in North West London (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:

- There is a 17-year difference in the life expectancy between the wealthiest and poorest parts of our boroughs
- 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
- If we do nothing, there will be a £1bn 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 broader determinants of health and wellbeing such as housing 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'.

Understanding our population – the health and wellbeing of NW London

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** (above 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
- High proportions living in **poverty and overcrowded households**
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- 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**
- State primary school **children with high levels of obesity**
- **19% of our population are unhealthy**

Mostly healthy

- 1.65m people in NW London are mostly healthy
- 81% of the total population
- 37% of care spend in NW London

In 2030:
- 4.3% more people in this segment
- 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 in this segment
- 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 in this segment
- 20% more spend in 2030 on adults

Serious and long term mental health needs

- 15,000 adults in NW London have serious and long term mental health needs
- 0.7% of population
- 7.5% of care spend

In 2030:
- 27% more adults in this segment
- 21% more spend in 2030 on adults

Learning disability

- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8.2% of care spend in NW London

In 2030:
- 29% more adults in this segment
- 35% more spend in 2030 on adults

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 in this segment
- 26% more spend in 2030 on adults

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 in this segment
- 45% more spend in 2030 on adults

The NW London segmentation framework was coproduced by the sector, including lay partners, based on common need, and a regression analysis of cost based on a variety of factors i.e. age. Validation was carried out on a linked data set from H&F. These factors drive considerable need for services and rising costs.

Sources: ONS (2014/15 estimates and 2011 census), HSCIC, Public Health England 2014/15, Greater London Authority, London Health Commissioning Framework

Our ambitions for NW London – helping people to be well and live well

We want people in NW London to **be well and live well,** enabled to live as healthy and full a part of London life as possible. We want to create a truly sustainable health and care system, paying its way as part of the London economic powerhouse. We are on a journey to achieve this, as described below, but realise there is more to do.

This STP is part of our continuing journey of collaboration and transformation

2011	NHS in NW London agreed its 'Case for Change', describing how care, quality and financial sustainability within the NHS could be transformed.
2013	Local NHS sub-regional NW London Programme Board agrees *Shaping a Healthier Future* (SaHF) Decision Making Business Case clinical strategy setting out a vision to localise, centralise and integrate care and reconfigure acute services – endorsed by Secretary of State. Eight clinical commissioning groups form NW London Collaborative.
2014	'Whole Systems Integrated Care' strategy setting out vision for person centered, proactive and coordinated care agreed by NW London Partnership Board of NW London Collaborative and local government – publishes 'the toolkit'. NW London becomes a National Pioneer in Integrated Care with ten Early Adopters implementing new models of care. Better Care Fund established across all Boroughs with pooled budgets to support local joint commissioning. In 2015/16 pooled budgets across eight boroughs is £168m Healthcare Commission publishes 'Better Health for London', ten priorities supported by all stakeholders in NW London.
2015	NW London Programme Board oversees implementation of first phase SaHF service changes: A&E and maternity improvements, plans for pediatric improvements. NW London becomes a Seven Day Services Early Adopter.
2016	NW London agrees 'Like Minded' mental health and wellbeing Case for Change and vision. NW London agrees to be part of 'London Health and Care Collaboration Agreement' and forms Strategic Planning Group of 31 organisations. First established accountable care partnership

Improvements delivered

- Pilot established for multi disciplinary teams in managing the care of selected over 65s, implemented care planning and recruited care navigators.
- Integrated delivery teams for community care.
- 1.9m have access to weekend primary care appointments, supported by Prime Minister's Challenge Fund.
- 280,000 patients have access to web-based consultations.
- Primary Care is working at scale. All eight CCGs have federation population coverage of above 75%.
- Improved maternity pathway including 100 extra midwives.
- Increased maternity consultant cover from 108 to 122 hours per week.
- Paediatric Assessment Units in all major hospitals by end of 2016/17.
- Single points of access for urgent care and mental heath crisis.
- Psychiatric liaison in all A&Es and UCCs in NW London.
- New eating disorder services and perinatal mental health services.
- Single hospital discharge process across health and social care will be piloted across NW London.
- Working together, all of our local organisations published borough-level health and wellbeing strategies.
- Pooled BCF budget of £168m in 15/16, with increased focus on nursing care, rehabilitation and reablement and third sector commissioning.
- Significant social care efficiencies made to protect social care budgets through working at scale across NW London boroughs.
- One emergent Accountable Care Provider in Hillingdon, building on the work of the WSIC Pioneer programme.

Shaping a Healthier Future sets out how we could improve quality of care, save 130 lives a year and address a growing financial challenge through a significant shift of activity into the community from hospital settings and the reconfiguration of acute services to attain the London quality standards. In addition there are a wide range of other areas where we are working closely together to improve care and health in the areas set out in the planning guidance.

We see the STP as an opportunity to create a transformational step change in areas such as prevention, integration and digitisation, and to align our shared objectives and priorities as we collaboratively develop a delivery-focused plan that addresses the big challenges for people in NW London.

Whilst SaHF does not address the full set of challenges described in the Five Year Forward View, and there is not full support for reconfiguration plans, we intend to work together on areas where there is joint agreement and to move forward locally in delivering a health and care system that improves health and wellbeing, care and quality and closes the productivity and financial gap for the whole system.

Building on our strong history of joint working, and as part of the transformational step change set out in our STP plan, we believe that we are well placed to take on additional responsibilities at a local level through a Devolution Deal for NW London. The specific areas of focus that we will be seeking to devolve will be further refined in the final plan.

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:

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

Leadership and collaboration

NW London has meaningful leadership and robust governance to drive transformational change

There is a history of collaboration at a sub-regional level in NW London across both health and local authorities. To help us work most effectively we have in place a robust governance structure and leadership arrangements.

NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership.

With the development of the STP, we have strengthened our ways of working. We will use the Strategic Planning Group as the initial governance forums for the plan's development. The pan-NW London governance structure will be set up to mirror the local governance arrangements. Local governance will retain sovereignty over decisions in line with the London Devolution Deal.

Underpinning all leadership and governance is our partnership with our service users and our workforce

We continue to ensure that people's voices drive our decision-making:

In NW London we collaborate with people, service users and patients at all stages of the commissioning, mobilisation and delivery cycle; **co-production with service users is fundamental to our culture** and we have been recognised for our 130 strong Lay Partner Forum and its approach to co-production, which includes significant engagement with other patient groups including Healthwatch and Patient and Public Participation Groups. The NW London Self-Care Task and Finish Group, whose membership includes voluntary and community group members, lay members, service users, commissioners and providers, has co-developed and continues to support the embedding of the self-care commissioning framework. The Triborough's Community Champion Programme uses a dynamic community engagement process to co-produce local health campaigns and neighbourhood services.

To date we have engaged extensively as we developed our Health and Wellbeing Strategies, Shaping a Healthier Future, and Like Minded. We will be continuing these conversations with people in NW London during the development of the STP, and during its implementation.

We are investing in our workforce and ensuring they are supported throughout all changes:

We have great people working in support, care and health organisations in NW London and a clear vision for change developed with those people. We also understand that the people who live in NW London are a huge part of the 'informal workforce' and also need support.

To deliver our vision we need to make sure that **all our professionals are engaged in the process of change, own that change and then receive the training and development they need to implement those changes**.

STP Leadership Team

The STP is led by the appointed STP System Leadership Team, which meets weekly and includes representation from all of the key stakeholder groups in our system:

Dr Mohini Parmar *System Leader*
(Ealing CCG Chair)

Carolyn Downs *Local Authority Lead*
(Chief Executive, Brent Council)

Clare Parker *Joint NHS Commissioner SRO*
(Chief Officer CWHHE CCGs)

Dr Tracey Batten *Provider Lead*
(Chief Executive, Imperial College Healthcare Trust)

Rob Larkman *Joint NHS Commissioner SRO*
(Chief Officer BHH CCGs)

Matt Hannant *STP Programme Director*
(CCG Director of Strategy & Transformation)

Understanding people's needs

Understanding our people's needs is vital for planning local and NW London wide services and initiatives. Our segmentation approach supports the development of new models of care

- **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 (BME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease

- **Brent**, the most densely populated London Borough, is ranked amongst the top 15% most-deprived areas in the country
- Between 2011 and 2021 the population aged 85+ is expected to grow by 72%
- Brent is ethnically diverse with 65% from BME groups
- There was a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13
- Brent children have worse than average levels of obesity – 11% of children aged 4-5, 24% of children aged 10-11 years

- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 19.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- BME communities, including individuals of mixed ethnicity, made up 46% of the Ealing's total population in 2012
- The main causes of death are cardiovascular disease accounting for 31% of all deaths
- The mortality rate from respiratory disease is 45% higher in Ealing than the NW London average

- **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 2012, Westminster had the seventh highest reported acute Sexually Transmitted Infections (STI) 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 262,000 people, 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 179,000 resident with one in four 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
- Mental health is the most common reason for long term sickness absence

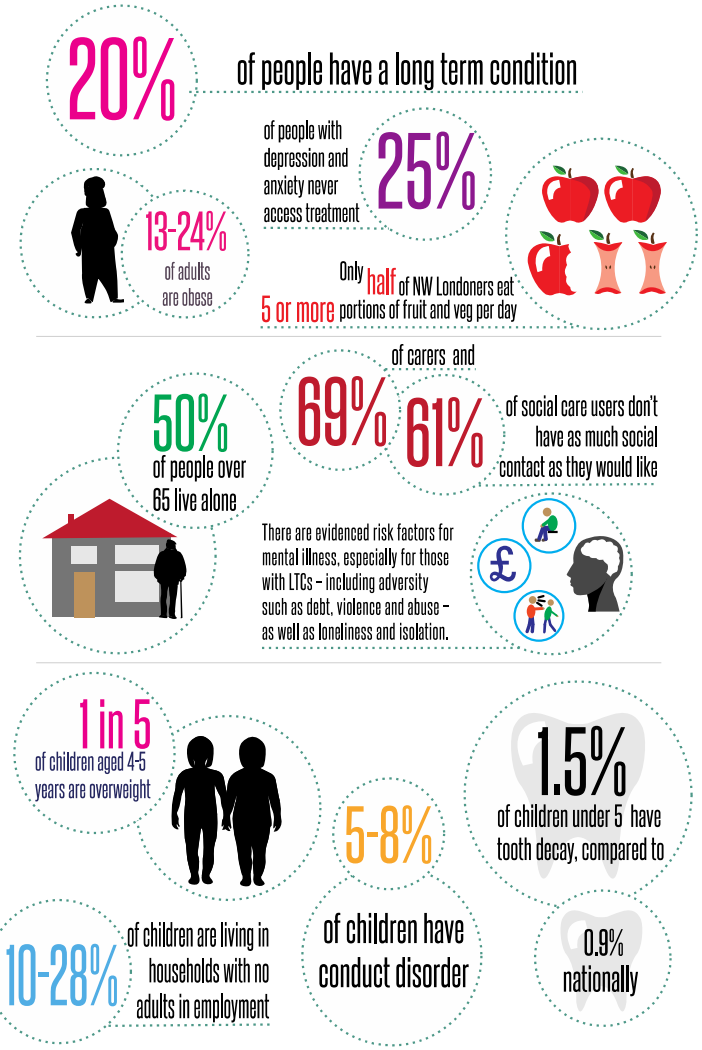
- **Kensington & Chelsea** has a very large working age population and a small proportion of children (the second smallest in London)
- Half the area's population were born abroad
- The principle cause of premature death in the area is cancer
- There are very high rates of people with serious and long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

Sources: HSCIC, Shaping a Healthier Future
Statistics are being updated to reflect most recent data

We will improve the health and wellbeing of people in our area

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…



Our to-be…

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

People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health

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

Our Emerging Priorities

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
2. Reduce social isolation
3. Improve children's mental and physical health and well-being

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"

We will improve care and quality

Our as-is…	Our to-be…	Our Emerging Priorities
Over 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.	4 Ensure people access the right care in the right place at the right time.
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health.	5 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population.
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.	6 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice.
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.	7 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.
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.	8 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease.
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.**	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.	9 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness.

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**.

Our emerging priorities and areas of focus

The table below summarises the emerging priorities identified in Section 2 and addresses the three gaps in the Five Year Forward View. These priorities map to our core themes for addressing the challenges in NW London. Further work will be done on these before the end of June.

Triple Aim		Emerging priorities	Themes for addressing the priorities
Improving health & wellbeing Improving care & quality Improving productivity & closing the financial gap	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	**Prevention** People supported to take responsibility for their own wellbeing and health and making healthy choices
	2	Reduce social isolation	
	3	Improve children's mental and physical health and well-being	
	4	Ensure people access the right care in the right place at the right time	**Integration** Local integration of services across all providers at the place where the person needs it (primary, community, MH, some acute) delivered via joint teams
	5	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population	
	6	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	
	7	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed	
	8	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**Technology & Innovation** Fully digital care and support, integrated health and social care information, right information available in the right place at the right time, paperless services
	9	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	

Appendix 1: Partnership organisations with the NW London STP Footprint