City of Westminster

Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	**General Release**
Title:	Central London CCG business plan 2016/17
Report of:	Matthew Bazeley, Managing Director, Central London Clinical Commissioning Group
Wards Involved:	All
Policy Context:	Central London CCG is currently in the process of establishing its commissioning plans for 2016/17, which will be used to inform contract notices issued to NHS providers in October. This report gives an overview of the vision and priorities for the CCG, an overview of the document (including transformational projects in the appendix) and next steps. The draft plan has been endorsed at the Governing Body session for approval by chair's action.
Financial Summary:	Financial implications of the plan are still being developed as projects and transformational programmes are currently in discussion.
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1. Executive Summary

1.1 Commissioning plans help identify potential provider impacts of any transformational projects the CCG is looking to undertake in the following year, reflecting the North West London Vision (in areas such as Acute Reconfiguration; Primary Care Transformation; Whole Systems Integrated Care; and, Mental Health Transformation), as well as the local CCG priorities. Projects below include transformational initiatives for all settings of care as well as support in Public Health interventions.

1.2 Members of the Health and Wellbeing Board are asked to review and endorse the projects as described in this paper. This paper provides an overview of the CCG's strategy and vision and current plans.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are asked to note Central London CCG's draft business plan for 2016/17 (appended to the document).

3. Background

3.1 CCGs are required to provide contract notices six months in advance of any potential changes to NHS providers. Projects included in the document relate to the North West London Vision and the CCG priorities, outlined below.

3.2 NORTH WEST LONDON VISION
All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals. Our vision is to deliver care which is:

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

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

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

- Acute Reconfiguration;
- Primary Care Transformation;

- Whole Systems Integrated Care; and,
- Mental Health Transformation.

3.4 CENTRAL LONDON CCG'S PRIORITIES

Central London CCG has been undertaking process of establishing its annual objectives for 2015/16. At the Public meeting of the Governing Body on 3rd June 2015, the CWHHE strategic objectives were presented and accepted as the CCG's long term goals. These objectives are outlined in below:

- Enabling people to take more control of their health and wellbeing through information and ill-health prevention.
- Securing high quality services for patients and reducing the inequality gap.
- Strengthen the organisation's infrastructure to help us deliver high quality commissioning.
- Working with stakeholders to develop strategies and plans.
- Delivering strategic change programmes in the areas of primary care, mental health, integrated care and hospital reconfiguration.
- Empowering staff to deliver our statutory and organisational duties.

3.5 PRIORITY AREAS

The CCG agreed its priority areas should focus on having clarity of purpose and outcomes to be achieved, leading to sustainable change with measurable results, supported by well-established processes. Our three transformational objectives for the year are:

1) Confirm clear, aligned models of care for key areas by establishing clear, shared models of care and supporting incentive approaches for:
    - Integrated care (link to business case)
    - Primary care (link to out of hospital and co-commissioning)
    - Unscheduled care (link to Vanguard)
    - Mental Health (link to borough redesign and current review)
    - Planned Care (offer definition)

2) Address Westminster's priority inequalities by, working with the Local Authority, developing a clear plan to address key areas of focus arising from the JSNA
3) Establish priorities for contracting by, developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs

4. Options / Considerations

4.1 The Health and Wellbeing Board is asked to consider and endorse the below transformational projects which will be undertaken by the CCG (including joint commissioning teams during 2016/17).

5. Legal Implications

None

6. Financial Implications

6.1 The CCG has been able to identify between 60%-70% of the financial target for the year. Additional work is being undertaken to identify North-West London-wide transformational opportunities in areas such as diagnostics, pathology, end of life, urgent care centres, orthopaedics; paediatrics, frail elderly; and sector-wide collaboration on bank and agency staffing. The CCG is also working closely with the Provider Network for Whole Systems Integrated Care to identify additional opportunities.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

- Central London CCG Draft Business plan 2016/17

BACKGROUND PAPERS:

None

NHS
Central London
Clinical Commissioning Group

Central London CCG Draft Business plan 2016/17

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Central London
Clinical Commissioning Group

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Vision

North West London (NWL) is changing. We are undertaking a historic transformation of the healthcare system that will dramatically improve care for over two million people. We are on the cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals.

All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement this change. Our vision is to deliver care which is:

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

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

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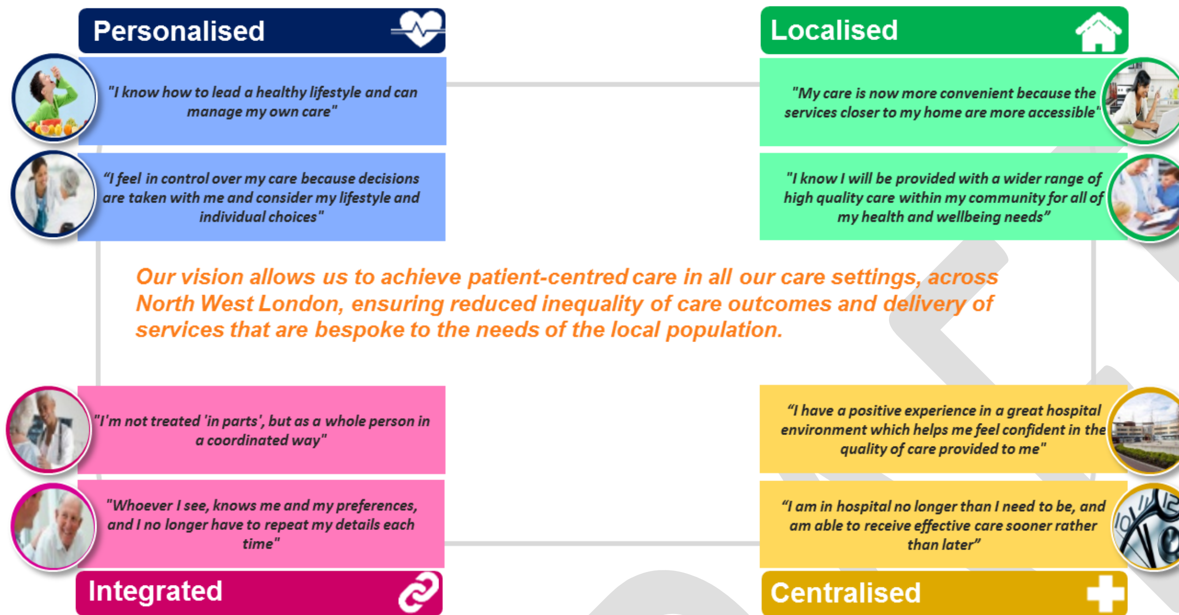

We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan- NWL level:

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

Acute Reconfiguration: *Improved hospitals delivering better care 7 days a week, and ensuring there are more services available closer to home.*

In NWL, we have recognised the changes in population demographics and lifestyles, and, as such, are changing the way we organise our hospitals and community health services. By making these changes, we can ensure that the highest standards of care are met; that our hospitals have the specialist doctors and facilities in place to deal with

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your specialist needs round-the-clock, and out-of-hospital services are on hand to treat your everyday health needs as quickly and conveniently as possible, either closer to or within your own home. Acute Reconfiguration aim to deliver:

- A major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes;
- The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:

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

Primary Care Transformation: *Placing Primary Care at the heart of whole system working, and improving access to GP services*

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

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

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

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

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

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

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

Whole Systems Integrated Care: *Coordinating care across commissioning bodies and provider, centred around the patient.*

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

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

- Jointly commissioned population level outcomes that span health and wellbeing;
- Accountable care partnerships (ACPs) delivering co-produced models of care and managing the clinical and financial risk for their registered populations;
- During 16/17 Early Adopters will begin the transition to WSIC through the roll out of new care models, the development of shadow ACP boards and the roll out of key enablers such as shared analytics, joint governance (commissioner-commissioner, commissioner-provider, provider-provider) and the testing of new approaches to payment and risk/reward sharing.

Therefore the focus for WSIC in 16/17 is to:

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- Roll out, review and refine new models of care that reflect the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities;
- Embed new ways of working, culture and behaviours to underpin the system changes required;
- Support and engage with shadow ACP boards as they develop;
- Shape an approach to assurance that will ensure WSIC provides the best quality and best value care for the population of NWL;
- Monitor the new models of care against a shadow population-level capitated budget;
- Introduce a ring-fenced element of real risk share where appropriate;
- Continue to embed co-production throughout ways of working;
- Share learning and best practice across and beyond NWL.

Mental Health Transformation: *Improving mental and physical health through integrated services.*

NWL is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value.

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

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

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

- Implementation of new urgent care pathways and compliance with national target waiting times;

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

Further details are provided in Appendix 1.

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Strategic objectives

Central London CCG has been undertaking process of establishing its annual objectives for 2015/16. At the Public meeting of the Governing Body on 3rd June 2015, the CWHHE strategic objectives were presented and accepted as the CCG's long term goals. These objectives are outlined in below.
These are:

1. Enabling people to take more control of their health and wellbeing through information and ill-health prevention.
2. Securing high quality services for patients and reducing the inequality gap.
3. Strengthen the organisation's infrastructure to help us deliver high quality commissioning.
4. Working with stakeholders to develop strategies and plans.
5. Delivering strategic change programmes in the areas of primary care, mental health, integrated care, and hospital reconfiguration.
6. Empowering staff to deliver our statutory and organisational duties.

Priority areas

The CCG agreed its priority areas should focus on having clarity of purpose and outcomes to be achieved, leading to sustainable change with measurable results, supported by well-established processes.
Our three transformational objectives for the year are:

1) Confirm clear, aligned models of care for key areas by Establishing clear, shared models of care and supporting incentive approaches for:
   - Integrated care (link to BC)
   - Primary care (link to OOH and co-comm)
   - Unscheduled care (link to Vanguard)
   - Mental Health (link to borough redesign and current review)
   - Planned Care (offer definition)

2) Address Westminster's priority inequalities by, working with the LA, developing a clear plan to address key areas of focus arising from the JSNA
3) Establish priorities for contracting by, developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs

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Figure 1– Central London CCG's objectives

Central London CCG buys services for Westminster's patients which are…

CCG transformational objectives 2015/16

BASED ON A DETAILED UNDERSTANDING OF NEEDS

homelessness, childhood obesity, mental health prevalence, falls, HIV, TB, liver disease, suicide, vaccinations coverage

CCG annual objective:
Address Westminster's priority inequalities by developing a clear plan to address key areas of focus arising from the Joint Strategic Needs Assessment

PART OF A COHERENT STATED APPROACH BY DELIVERY PROGRAMME

Working with GP Practices
Supporting the GP federation
OOH Services, LIS
Co-commissioning
EPP, Patient information
PRIMARY CARE

In emergencies
Community Independence Service
UCC/A&E sustainability
NHS 111 and GP Out of Hours
Intermediate Care beds
UNSCHEDULED CARE

To join up care
Test villages
IC Business Case
Children's services
Homeless service redesign
INTEGRATED CARE

For good mental health
Community services review,
IAPT, CNWL Urgent SPA,
Perinatal, Dementia,
Suicide training
MENTAL HEALTH

To improve health
Embed redesigned services
Cardio/Resp; Dermatology;
MSK; Ophthalmology
Gynaecology/Urology
PLANNED CARE

CCG annual objective:
Confirm models of care for key areas by establishing clear, shared delivery models and supporting incentive approaches

ALIGNED TO STRATEGIC PRINCIPLES

Personalised
Localised
Integrated
Centralised

BUILT ON SOLID FOUNDATIONS

Patient and public involvement, GP member engagement, honest contracting, robust financial control, clear governance

CCG annual objective:
Establish priorities for contracting by developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs,

UNDERPINNED BY

Clear, visible leadership	Local system focus and collaboration	Quality and safety culture

Smart Priorities

To deliver the strategic objectives, in 2016/17 we will do a number of projects, as outlined below.

[to be updated when final projects and numbering are in place]

Project Name	Programme area	QIPP /BAU/ Enablers	Personalised	Localised	Integrated	Centralised
Project 1	Primary Care	QIPP	✓			
Project 2	Integrated Care	BAU		✓		
Project 3	Mental Health	Enabler		✓	✓	

The full list of projects in included Appendix 2 below.

Provider impacts of QIPP related initiatives are included in Appendix 3 below.

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Appendix 1 Strategic programmes shared across North West London

Programme	Project	Outputs/Outcomes	Expected Completion
Acute reconfiguration	Paediatrics	Peadiatrics transition from Ealing Hospital completed	Jun-16
	Business Case Development	Development of Implementation Business Case Development of business case for: ChelWest, Middlesex, NWP, Hillingdon, St Mary's, Ealing, Charing Cross, CMH	Feb -16 to Dec -18
	Capital Works Programmes	Build programme complete for: ChelWest, Middlesex, NWP, Hillingdon, St Mary's, Ealing, Charing Cross, CMH	Sep -18 to Dec – 25
	Out of Hospital	Out of Hospital delivery rebased Establish tracking of out of hospital delivery	Nov – 15
	Ealing Transitions	Transition of Ealing Hospital in line with the proposed local hospital model of care	Sep -18 to Sep -20
	Charing Cross Transitions	Transition of Charing Cross hospital in line with the proposed local hospital model of care	Sep -18 to Sep -20
	CMH Transformation	CMH developed in line with the proposed local hospital model of care	TBC
Primary Care Transformation	New Model of Primary Care	New model of primary care providing improved outcomes for patients while ensuring the sustainability of general practice and focused on a proactive and preventative approach, including non-medical services, to be implemented	Dec-16
	GP Network Readiness	Providing greater flexibility for patients in scheduling appointments, e.g. advance booking am-8pm GP appointments available Monday – Friday, and Saturday and Sunday services.	Apr-15
	Primary Care Estates	Clear strategy for investing in primary care and community/OOH estates, making them fit-for-purpose	Jun-16
	Primary Care Co-Commissioning	Providers working to deliver shared outcomes, jointly commissioned for a whole population segment	Sep -15
Whole Systems Integrated Care	Informatics	Population level information available and used for resource planning and patients records available online that are clear and concise	Dec-15
	Outcomes & Metrics	Developing and syndicating a single set of Outcomes & Metrics for the Whole Systems programme	Jan-16
	Change Academy	Developing New team-based ways of working support integration and continuity	Jun-16
	Early Adopters	Transitioning out of hospital managed consistently 7 days a week Pharmacy making greater contributions to care, providing advice and support Care Plans provided to patients to manage their care Diagnostics available in community settings	Apr-17
	Early Adopters Mental Health	Working across West London CCG the WSIC Early Adopter for Long Term Mental Health Needs (LTMHN) aims to develop a new model of care - based on co-production to date this will be on the basis of a 'Community Living Well' Model.	Apr-17
Mental Health and Wellbeing	MH & Wellbeing Strategy	Bring together local commissioners, providers, users and carers and other local stakeholders to identify, test and refine the optimal approach to delivering mental health and wellbeing services across NWL and to transition to implementation of this solution.	Apr-17
	Urgent Care Redesign	Improving the entire acute mental health pathway, including access to support, advice and assessment services, through prevention and self-help, to the role of primary and secondary care in providing a high quality, timely and effective crisis service	Apr-16
	Learning Disabilities	Learning Disabilities and Mental Health teams working jointly to ensure patients receive the care and treatment they need locally	Apr-16
	Long Term Mental Health Needs	Ensure the 8 borough based Early Adopters looking at over 65s/75s/LTCs include the requirement for the right mental health involvement in their development and their models of care	Aug-15
	Perinatal	Models of care and best practice examples researched to inform pathway development and generic NWL Perinatal service specification developed	Apr-16
	System Resilience Programme	Ensuring services users are empowered in-line with recovery principles and drive change with paid professionals and Focusing on Crisis Care and Early Intervention in Primary Care, preventing unnecessary referrals and improving access to services	Apr-16

Appendix 2 List of projects/programmes

QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Service Redesign	Integrated gynaecology and urology service	Introduction of community dermatology service	Planned care	Service aims: Delivery of the right care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention and self-care; Improved clinical management of continence conditions Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities, Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access. Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	The new provider will have responsibility for safe and effective mobilisation and operation of service.	Dr Sheila Neogi Dr David Spiro
Service Redesign	Integrated Cardio Respiratory Service	Introduction of integrated cardiology and respiratory service covering diagnosis, treatment and rehabilitation services.	Planned care	Service aims: Delivery of the right cardiology and respiratory care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention; Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities, Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (especially diagnostics/rehabilitation)/ MDT approach. Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	ICHT, subcontracting part of the service to Chelsea and Westminster hospital identified as the providers and responsibility for safe and effective mobilisation and operation of service.	Dr Maroof Harghindawal and Dr Neville Pursell
Service Redesign	Community Dermatology service	Introduction of community dermatology service	Planned care	Service aims: Delivery of the right care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention and self care; Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities; Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	ICHT, identified as the provider and responsibility for safe and effective mobilisation and operation of service.	Dr Kasheef
QIPP	Community Independence Service (ex BCF08)	Continue implementation and further development of the Community Independence Service, forging stronger integration between health and social care.	Urgent Care / Intermediate Care	Following on from the design and implementation of the new Community Independence Service last year, we will further develop this service, strengthening the links to intermediate bedded care, neuro-rehab, mental health support and whole systems integrated care. We will also work with the providers to consolidate benefits achieved to date and evolve the service to improve its efficiency and effectiveness	We expect to achieve better value for money from this service by improving the links and pathways between this service and other health and care services, including intermediate bedded care, NHS 111 and Out of Ours GP services and Neuro-Rehabilitation to further reduce the need for non-elective admission to hospital, A&E attendances, and residential care and also Length of Stay (LoS) reductions in acute settings,	Lead providers for the service will need to review their pathways with a wider range of services and improve linkages. They will also need to continue to improve coordination with social care and ensure that staff levels are built up and maintained at a level necessary to deliver desired activity	Dr Afsana Safa
Enabler	IAPT	Review of talking therapy services for patients with common mental illness, aiming to increase compliance with national standards for increasing access to psychological therapies (IAPT) key activities include working closely with all providers to promote the service and increase access; to review case complexity and fidelity to the NICE model to improve recovery rates to consider contracting options to increase the diversity of service provision. Mental health services with the purpose of strengthening access to psychological therapies, in line with national IAPT model.	Mental Health	To achieve nationally set KPI's for access (15% of CMI prevalence), recovery (50% of those entering treatment should move to recovery) and waiting times (75% of patients entering treatment should be seen within 6 weeks and 95% within 19 weeks.	Ensuring patients with anxiety and/or depression receive talking therapies this is a preventative measure that reduced the likelihood of developing a long term mental health conditions, helping people to return to work and supporting people to manage their issues when required.	To promote the service and engage with under-served groups such as those with long term conditions, BME communities and older adults. All providers to maintain compliance with the NICE model to be managed through IAPT working group and LES counsellors forum.	Paul O'Reilly
Enabler	Community and Primary Care Mental Health Service Review	To review all community and primary care mental health services.	Mental Health	To highlight any gaps and issues in the provision of mental health service currently provided across CL CCG including dementia and perinatal services.	To ensure commissioned services for mental health offer the right care in the right place at the right time for patients across CLCCG.	To support the review, by providing relevant data and information to enable a transparent and representative outcome.	-
Enabler	Suicide Intervention and Prevention Training	To provide suicide intervention and prevention training to GP Practice staff, secondary care staff and the voluntary sector.	Mental Health	To provide training for a range of organisational staff that may come in to contact with suicidal people.	To increase awareness and create possible interventions for those people who are suicidal across Westminster, Kensington and Chelsea and Hammersmith and Fulham	To engage with relevant organisations, provide all organisational aspects of training including administration, and to provide regular reports on the topic.	-

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
QIPP/BAU	Medicines Management	To provide our patients with adequate medicines and medicine management services that contribute to improving their health outcomes.	Prescribing	The programme has a number of aims, including: Improve cost effective prescribing; Reduce incidences of unintended harm from prescribed medicine; Reduce incidences of errors with prescribed medicines following discharge from hospital; Address problematic poly-pharmacy to improve health outcomes and quality of life.	Achieve better value and improve health outcomes from the monies spent on prescribed medicines. Reduce unplanned hospital admissions resulting from adverse effects of medicines.	GPs need to engage with programme to improve cost effective prescribing and implement agreed action plans. GPs to agree to dedicate sufficient time to implement actions resulting from delivery of projects aimed at reducing medicines related harm.	Dr Sheila Neogi
QIPP	Improving children and young peoples' services in villages	Joint Primary Care/Paediatrician hubs	Integrated Care	1) o move paediatric first and follow up appointments from the hospital setting into GP practice, clinically appropriate 2) to up-skill primary care clinicians. 3) to build parent/carer confidence in accessing the most appropriate and timely care for their children	More convenient access for patients, with shorter waits for an appointment. Skills and knowledge of primary care clinicians will be improved. Communication between all professionals who care for children will be enhanced resulting in better overall outcomes for children. Patient confidence in accessing high quality care will be increased	GP Providers will need to: 1) Ensure that all paediatric referrals are directed into the GP/Village clinic, unless requiring other specialist paediatric input 2) Ensure that referrals into the GP practice clinic are appropriate (and would otherwise have been referred into secondary care). 3) Bring cases for 4/Disseminate learning. Acute providers will need to:1) Ensure consistent availability of a paediatrician 2) Ensure that paediatric referral waiting list in acutes do not increase 3) Consider any referrals with view to re-directing these into the GP practice clinic where appropriate.	Niamh McLaughlin
QIPP	Homelessness	Intermediate Care	Integrated Care	Improve care of homeless patients by having a better co-ordinated community offering and beds in hostels for homeless patients to be discharged to where they can recuperate / be stepped up to when they need additional input to keep them out of hospital. MH and Physical health beds	Better overall, co-ordinated management of homeless patients with better long-term outcomes for patients and reduced time in hospital. Provide better support to mainstream GPs and acutes through education and training.	To work closely together, under the homeless GP management, to deliver a more co-ordinated service from patient identification to timely delivery of care and development of a move-on plan.	Paul O'Reilly
QIPP	Hepatitis C	Hep C clinics at 2 locations aimed at high risk, homeless population	Integrated Care		Increased completion of successful treatment / increased life expectancy of population /reduced public health risk	Report on referral/treatment as per specification document. Provide clinic space & consultant and 2 nurses to run the service/ use the clinical systems required	Paul O'Reilly
Enabler	Groundswell	Advocacy and Targeted Advocacy for Homeless patients	Integrated Care		Peer advocates provide support to homeless, working with them to get them to engage with health issues, help them get to appointments and understand the implications/options open to them	Practices to refer patients and include Groundswell in MDTs Groundswell to target patients for assistance as directed by the Practices	Paul O'Reilly
QIPP	Integrated NHS 111 / GP Out of Hours	Commissioning a new integrated NHS 111 / GP Out of Hours service.	Urgent Care	To work with partners across North West London to develop an integrated NHS 111 / GP OOHs service which aligns to a national framework and provides people with urgent but not life threatening needs a highly responsive, effective and personalised services outside of hospital.	We expect to achieve better value for money from this service by helping people access the right care at the right time and improving the pathway and linkages between the urgent care, intermediate care, primary care and social care systems which will help to reduce A&E attendances and non-elective admissions, increase self-care.	To be confirmed	To be confirmed
QIPP	St Mary's UCC	Either: Operating St Mary's UCC from at a new tariff; or Reviewing and re-procuring St Mary's UCC	Urgent Care	If new tariff: To develop and negotiate a new tariff for the St Mary's UCC with the new provider that increases the value for money of the service. If reprocuring the service: To procure an improved primary care-led Urgent Care Centre at St Mary's Hospital that optimises the throughput of the UCC and maximises its effectiveness as a service through well-developed pathways, improved streaming with the ED, closer alignment with the rest of the urgent care system and improved partnership working with the acute hospital provide.	We expect to achieve better value for money both by securing a better price for the CCG for this service and improving the service so that it sees a higher percentage of urgent care system activity, reducing A&E attendances and non-elective admission.	Develop partnership arrangements and joint clinical governance to ensure the UCC and ED work well together and that streaming into the UCC and ED maximise the opportunities to ensure the correct acuity is dealt with at the appropriate location	Dr Afsana Safa
QIPP	Neuro-Rehab	The procurement of Neuro-Rehab care provision	Intermediate Care	To procure a neuro-rehab service, building on the NHSE Service Specification and national definition that provides rehabilitation for patients with complex needs in order to assist them to achieve their maximum potential for physical, cognitive, social and psychological function, enhance their participation in society and improve their quality of life.	Effective specialist neuro-rehabilitation for people with traumatic brain, spinal injury and stroke will reduce: Length of stay in hospital; Longer-term dependency Longer-term (continuing care) costs.	To work in an integrated and partnership-centred way with acute. Intermediate and community care providers.	Dr Alan Haikin

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Transformational	Urgent Care System development	To develop a system-wide collaborative approach to urgent care that further aligns and integrates urgent care provision to ensure that no matter where a patient accesses the system, they have the same easy access to the appropriate care pathways. To support and enable this, the project will also aims to develop a strong governance framework within which urgent care will operate that encourages effective system leadership of plans to develop, integrate and deliver sustainability within the urgent care system.	Urgent Care	To develop an integrated vision and a five year plan for the development of the urgent care system in central London. To improve the effectiveness of the Tri-borough SRG and ensure it provides leadership over the development of the urgent care system in central London and beyond. To develop with partners the NWL Urgent and Emergency Care Network, ensuring that its roles and responsibilities are clearly defined and that the local governance structure surrounding the urgent care system is clear	We expect this to deliver improved leadership, held by providers, commissioners and clinicians, over the urgent care system. This should enable to system, over the longer term, to develop in a way which delivers improved sustainability (including in times of pressure) and improved outcomes for patients	To play an active role in system development and to work in partnerships with other providers, commissioners and clinicians to take a systems approach	Dr Alan Haikin
Transformatioal	CAMHS services	Local implementation of Future in Mind – transformation of CAMHS services. These include: Establishing a community Eating Disorder Service; Improving CAMHS Learning Disabilities ('LD') services.Improved access to consultation and advice service and efficient access to CAMHS. Improved 24/7 crisis response service Out of Hours Co-ordinated training and public education programme with Public Health.Improve NHS England ('NHSE') pathway in and out of CAMHS Tier 4. Explore home treatment options. CAMHS Improving Access to Psychological Therapies ('IAPT'): training on outcomes to be concluded	Children's Services	Submit a NW London Transformation Plan to access additional funding: approx. 3/400K per CCG, to provide the above services.	The aim of the programme is far-reaching and includes: Development of a cost-effective community Eating Disorder Service created. Promoting resilience, prevention and early intervention. Improving access to effective support. Care for the most vulnerable. Accountability and transparency. Development and modernisation of workforce.	Service redesign and modernisation expectations: flexible hours, improved crisis response, transparency and outcomes focus [pending to link with specific deadlines and risk mitigation in previous section]	Niamh McLaughlin for CL CCG
BAU	Children's and Families Act 2014 (including personal health budgets)	Implement changes required as a consequence of the Act.	Children's Services	Co-ordinated assessment: 0-25 Education, Health and Care for children and young people with Special Educational Needs and Disabilities Signposting families to the LA/CCG 'local offer' - website which includes summaries of Health services available for young people with SEN and disabilties. Continue to commissioning local child development services to provide timely health assessments for EHC Plans. Focus on preparing for adulthood – young people can have a plan beyond 19 years if required to support access to employment or independence. LAs and health expected to jointly commission services based on JSNAs. Involvement and co-production of children, young people and families Collaborating with our LA partners to deliver 'personal budgets' and 'personal health budgets'.	Reform the system of support across Education, Health and Social Care to ensure that services are organised with the needs and preferences of the child and their family firmly at the centre, from birth to the transition to adulthood.	Providing advice for EHC needs assessments and transfers from Statements within statutory timescales. Attending multi agency meetings and tribunals.Working with LA colleagues.Supporting and working with families and children and young people in the process.	Niamh McLaughlin
BAU	Children's Continuing Care	Ensuring efficient, up to date and value for money packages of care for children meeting the criteria for continuing care.	Children's Services	Adhering to the National Framework for Children and Young People's Continuing Care. The Framework sets out a children and young people's continuing care process that should: adhere to a set of core values, key principles and timetables; make the child or young person and their family the focus of the continuing care process and facilitate the provision of personalised packages of care; be developed and owned locally by a multi-agency team; cross organisational and inter-agency boundaries, thus reducing the possibility of fragmented care; and include measurement of outcomes and promote continuous quality improvement.	Children, young people and their families are actively engaged in the continuing care process; The continuing care process is co-ordinated and consistent between organisations; Health and social care practitioners, including those working in the independent and third sectors, and the public understand the continuing care process.	Delivering care packages as commissioned within contractual arrangements and local safeguarding guidelines.	Niamh McLaughlin
Transformational	Speech and Language Therapy (SALT) re-commissioning and re-procurement	Jointly Commissioning and Tendering the Paediatric Speech and Language Therapy (SALT) Service	Children's Services	Jointly commissioned across the three LAs and the three Clinical Commissioning Groups (CCGs) in Central London, Hammersmith and Fulham and West London. Review of current delivery model and re-specification of the service – opportunity to change the delivery model Undertake an open market tender exercise in line with procurement requirements, with a view to awarding the new contract by October 2016.	New more integrated jointly commissioned service. Maximised value for money. Flexible response to nee EHC plans. Capability to meet the18 to 25 challenge.	Engagement of current provider in the process. Potential providers engage in the commissioning opportunity.	Niamh McLaughlin

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Transformational	Early Support Key Working services	Early Support (Key Working) Services for children with complex needs and disabilities and their families	Children's Services	To ensure a consistent approach in working with parents to be and parents with children 0 – 5 years, the Government expects all services to work from a shared set of key principles.	Co-ordinate, streamline and add value to existing services for children with disabilities. Involve parents, grandparents and other carers in ways that build on their existing strengths; Ensure lasting support by linking activities to services for older children; be culturally appropriate and sensitive to particular needs.	Report quarterly to commissioners on the KPIs and produce an annual report that includes 2 case studies and a summary of parent/carer feedback	Niamh McLaughlin.
Enabler	Equalities Objectives 2017-2020	The CCG will be setting new Equality objectives for 2017 that reflect the diversity of our population. This is directly related to our Statutory Public Sector Equality Duty (PSED).	Engagement	The CCG understands that drawing on the expertise of patients, carers, members of the public, service providers and voluntary or community organisations is of critical importance when shaping services. This insight enables us to ensure services are of a high quality, value for money and reflect the needs of our diverse population.	If we identify the needs of our population at an early stage in the design and development of services, it will ultimately allow us to provide effective solutions to local health challenges and ensure our services are accessible to all.	Patients and the public should not be discriminated against or have their needs impacted adversely by our commissioning. Patients, the public and staff have the right to equality of opportunity.	Paul O'Reilly
Enabler	Patient & Public Involvement Policy	This policy aims to provide a more democratic approach to involvement. It was clear that with the growing number of Patient & Public Involvement opportunities, we needed a new way forward that proactively broke down some of the barriers to involvement.	Engagement	The CCG is introducing letters of engagement that include clarity over the opportunity, expectation and the support offered by CLCCG; remuneration for this active engagement with clear outcomes attached; and 1-2-1 support for patients and staff. By ensuring the roles are remunerated fairly and that patients are offered additional support, we can enable more equity to involvement.	This will allows us to formally acknowledge the great work our patients do to ensure we effectively commission services to improve the health and wellbeing of the population in Westminster. The end of year review will allow us to measure how effective the approach has been and make an informed decision as to next steps.	Patients need to be involved across the commissioning process. This approach directly relates to statutory obligation duty for participation.	Paul O'Reilly
Enabler	Patient & Public Engagement	This includes developing or implementing the CCG PPE strategy, which sets out our approach to achieving meaningful engagement with patients, carers and the public. This directly relates to our statutory participation duties set out in the NHS Act 2006 and the Health and Social Care Act 2012.	Engagement	To shape a strategic approach to patient and public engagement, which ensures we commission effectively for the entirety of our population. The document and subsequent implementation also provides the CCG officers and public with a defined work plan for engagement, this enables the CCG to be transparent and accountable.	By actively engaging with the entirety of our population the CCG ensures it delivers services that respond to our patients' needs, offering an improved patient experience. This help the CCG to proactively reduce health inequalities and improve outcomes.	Key stakeholders should have the opportunity to collaborate with the CCG as equal partners, to ensure the successful and effective commissioning of health services.	Paul O'Reilly
Enabler	Quality strategy implementation	Implementation of the strategic overview of strategy within the CCG	Quality	Work together with patients, carers and our partners to achieve the best quality healthcare outcomes by using the best clinical evidence and patient feedback to commission care that is: Effective; Safeguards patients and prevents all avoidable harm ; consistently shows improvements in positive experience and satisfaction of all patients and carers and staff	Commission high quality services; Identify improvements to secure the quality of services commissioned; The commissioning process drives continuous quality improvement	To deliver the quality the quality of care commissioned by the CCG within resources	Lizzie Wallman
Enabler	Homelessness	Hepatitis C	Integrated Care	Hep C clinics at 2 locations aimed at high risk, homeless population.	Increased completion of successful treatment / increased life expectancy of population /reduced public health risk	Report on referral/treatment as per spec Provide clinic space & consultant and 2 nurses to run the service/ use the clinical systems required	Paul O'Reilly
Enabler	Locality Scheme	The Locality Scheme is an enabler for enhancing quality and safety, promoting financial efficiency and improving patient experience and outcomes for patients. The purpose of the Locality Scheme is to implement change in primary care for improved quality outcomes for patients and increased financial efficiency across the system. The Locality Scheme is aligned to and reinforces other programmes and areas of work, including: Shaping a Healthier Future for North West London; North West London Out of Hospital Strategy; Whole Systems Integrated Care; CL CCG Operating Plan. CL CCG QIPP.	Primary Care	The objectives of the Locality Scheme are to: Invest in and assist the development of primary care; Support the delivery of redesigned care pathways to achieve improved service quality; Recognise the value of partnership working and the sharing of best practice by facilitating collaboration between member practices, and between practices and commissioners; Implement change that leads to improved quality outcomes for patients, supporting CL CCG's strategic objectives and improving financial efficiency in line with QIPP. Specific targets and priorities are identified annually and therefore the 2016/17 scheme will be shaped by engagement expected to commence in November 2015.	Better care and experience for patients; Increased member engagement with the CCG; Increased collaboration between practices: Better achievement of QIPP schemes e.g. through encouraging engagement with new services: Better access and improved outcomes for perceived vulnerable groups: Improved data quality: Improved engagement with the rollout of IT projects e.g. Referral Wizard.	Meet deadlines for submissions outlined in the Locality Scheme: Provide updates through 1:1 meetings with Locality Support Managers: Work collaboratively, participating in locality meetings and share learning.	Primary Care Governing Body Lead
Enabler	DVT Pilot	The Deep Vein Thrombosis (DVT) pilot commenced in January 2015 at eleven GP practices in the North and South localities. The pilot will run until the end of December after which point it will be reviewed to consider future commissioning recommendations and whether the service may be a candidate for an Out of Hospital Service.	Primary Care	The pilot aims to improve the clinical pathway and experience of adult patients with a suspected DVT by providing high quality diagnostic testing as close to patients' homes as possible.	Greater patient choice; More convenient care where DVT is suspected Swifter care and less pressure on acute services	To deliver the service in line with the specification. To share learning and participate in an evaluation	Krishan Aggarwal

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Enabler	Beat the Street – Childhood Obesity	A high proportion of population in the area do not meet the national guidelines for physical activity. Beat the Street will encourage people to walk and cycle around their area, to school, to work or to the shops as part of a challenge. Focused at children, this will lead to reduction in childhood obesity over a period of time and will support the local physical activity goals. This is a Central London CCG led project drawing on from similar successful programmes from other parts of the country. The project aims to take a population wide approach within Westminster including areas of Queen's park and Paddington (West London CCG). Other significant stakeholder will be Westminster City Council.	Public Health	To increase physical activity levels amongst participants to get people out of their cars for short journeys and to enhance levels of well-being and community cohesion. Beat the Street is designed to 'nudge' people to try walking and cycling for a period of six weeks, at the end of which it is anticipated that a significant proportion of the population will continue with the behaviour change, incorporating regular walks and bicycle rides into their daily lives, either as part of an active commute, or as a family activity.	For the **whole** community:increase physical activity levels; decrease health inequalities; support sustainable travel; increase community cohesion.	Deliver the project as per the specification. e.g. Frequent project reports/updates. Dedicated CCG dashboard to monitor. Rollout of equipment i.e. beat boxes. Timely delivery of beat the street smart cards. End of the project evaluation report including further recommendations.	Niamh McLaughlin
Enabler	Care Leavers	Engagement within a national Department of Health funded initiative for 10 CCGs across the country. To improve the health of adults and young people who were in the care of the state as children by utilising the user voice to develop guides and resources to better inform the commissioning and delivery of services. This will result in health professionals being more aware and informed of the heath issues facing care leavers and how to combat them. This will lead to better services and better outcomes for care leavers.	Inequalities (hosted in Primary Care)		Increased awareness of the health needs of care leavers. A range of resources to support commissioners. Improved commissioning of services in relation to care leaver health. Increased user voice participation in health services for care leavers. Improved long term health outcomes for care leavers		TBC

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