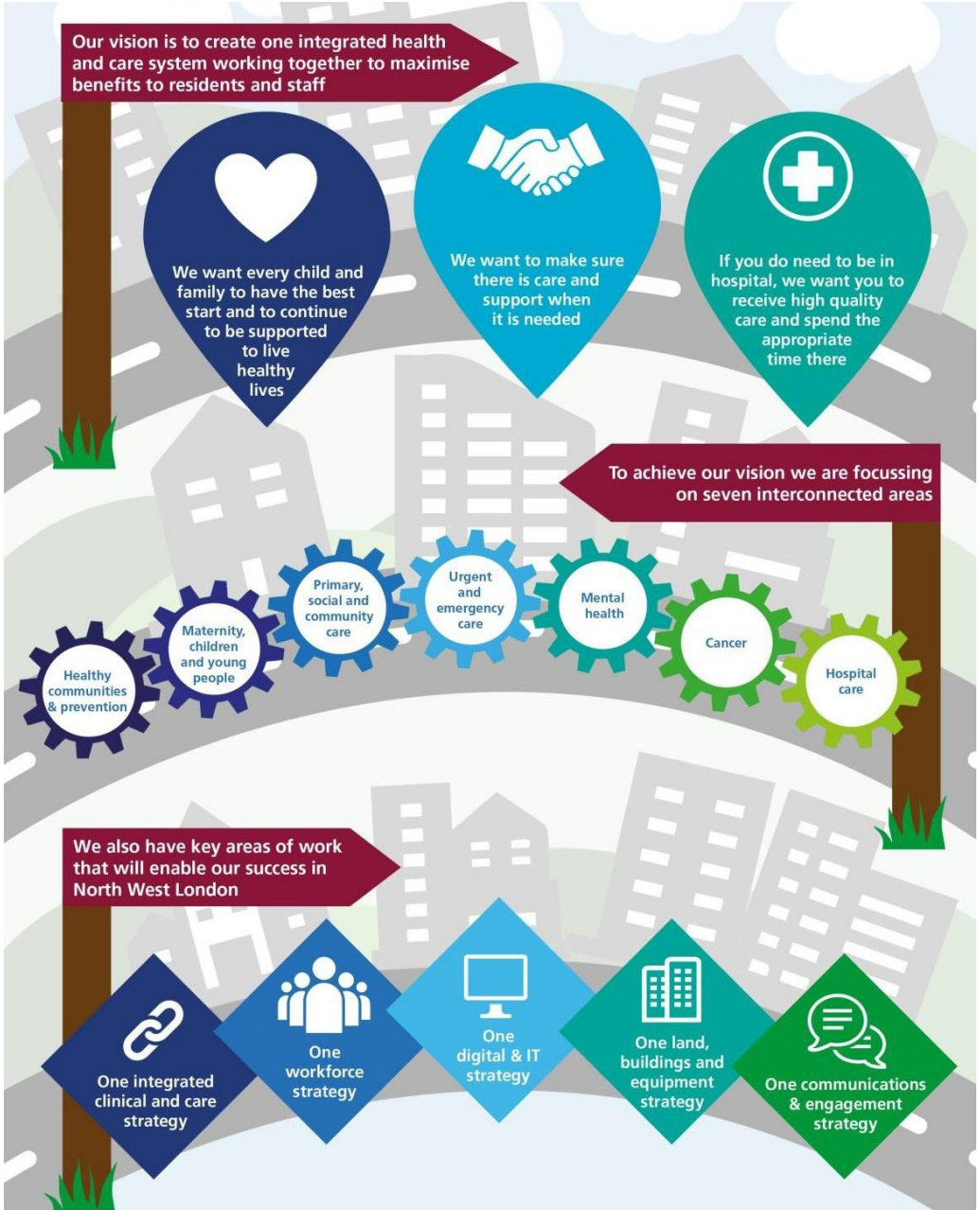
Improving care across North West London



The North West London
health and care partnership

An update - NW London Health & Care Partnership progress 7 March 2019

Introduction

This report provides a summary of progress up to January 2019, towards achieving the transformation objectives of the Health and Care Partnership and the progress made on the NW London governance.

General Updates

Governance review of our Partnership

The process of transitioning to our new Health & Care partnership arrangements continues to make good progress. The first Partnership Operations Group is scheduled for 14th March and the first Health and Care Partnership Board for 23rd May.

Meanwhile the Clinical and Quality Leadership Group have held a workshop to debate and agree what outcomes we should measure our success as a health and care partnership - which are the outcomes by which we should hold ourselves to account and measure our improvement. We also have held a workshop for all provider CEOs and CCG chairs where we collectively developed principles for how we should be working differently as a system rather than a set of leaders of single organisations. These will be agreed through the Health and Care Partnership Board and brought back to a future Joint Committee. We are in the process of developing the outcomes dashboard that will enable us to have good visibility of these.

We are in the process of identifying SROs, clinical leads and project leads for each of our seven interconnected portfolio areas, as well as working with all CCGs and our other stakeholder organisations to identify who should site on the programme boards and how these will best work with local governance arrangements.

National & local alignment

We have undertaken an initial review of how our refreshed partnership plan aligns with the intentions of the NHS long term plan. This has previously been shared with Joint Committee members through other meetings and members will recall that there is close alignment. Over the coming months we will work through our programme boards and other forums to further develop our thinking and crystallise this into NW London's 5 year strategy in light of the national plan. Public and staff engagement will form a significant part in developing this and we are working with our lay partners to develop our approach to facilitate meaningful public input.

Transformation progress

The following section outlines key progress in our 7 interconnected portfolio & enabler areas

1) Healthy Communities & Prevention

Our aim: *to support people to support themselves and others, to live full and active lives in their community*

The shadow Healthy Communities and Prevention Board met on 31st January. As part of the refresh a new lay member and third sector representative joined the Board. This further reiterates our commitment to ensuring a stronger voice is heard from the third sector & patients/residents of NW London.

1.1) Promoting Self Care

Digital SelfCare solutions to long term condition management

myCOPD (Chronic Obstructive Pulmonary Disease) - The NHS long term plan has indicated that the myCOPD app can be provided to patients via GPs. In NW London we believe this will really help to support patients to be increasingly 'active' in their self-care. Plans are being developed to support the roll-out of the myCOPD app and the NW London '*myCOPD ''sharing the learning' event'* which was held early February, helped to support shared learning.

myHeart - Similarly the roll-out of the myHeart health app has commenced through the Cardiac Health and Rehabilitation services at Imperial College Healthcare NHS Trust. So far, 25 patients have enrolled.

Diabetes - An additional 2500 '*Diabetes Health App*' licenses have been procured for our eight CCGs. These are targeted to general practices where the need is most, 64 practices have signed up. To date, over 450 patients have enrolled and a plan is in place to rapidly expand this, with over 7,000 patients being offered the use of this app via email or text message.

Patient Activation Measure (PAM) Assessment - So far 34,744 patients across NW London have completed a PAM assessment including 4,265 re-assessments which will help support the management of their healthcare. In addition, PAM will be included within the Health Help Now app from February 2019 for West London CCG.

Social Prescribing - The scoping of Social Prescribing provision across NW London has now been completed. It includes a Digital Social Prescribing pilot within West London which is progressing with 10 practices identified to participate.

We contributed to the London Mayor's vision which is currently out for consultation, and the NHS Long Term Plan has announced that there will be funding for Social Prescribing link workers through the Primary Care Network funds for 2019/20. NW London will of course be ensuring we align and maximise any opportunities.

1.2) Promoting Healthy Lifestyles

The shadow programme group agreed that the workstream priorities for 2019/20 would continue to be alcohol misuse and childhood obesity. Outcome indicators which will help monitor progress were agreed by the board and will be formally signed off at the next meeting in March.

2) Maternity & Children & Young People

Our aims: *to develop our Health and Care System offer for Children and Young People which looks beyond illness and to improve safety, continuity and personalisation of maternity care*

2.1) Children & Young people (CYP)

Children and Young People is being proposed as a new programme within the Health & Care Partnership's plan, although it already has existing structures. We are currently working with system colleagues to appoint to the senior clinical and managerial roles which will oversee the programme or work. Additionally we are exploring the option for the existing NW London Children and Young People Network to also fulfil the function of the programme board.

The initial projects have been agreed as:

1) Asthma - adopting best care across NW London
2) Complex Care needs – improving what matters to children & young people
3) Dental - improving dental care
4) Starting well & staying well – jointly with the Maternity Programme

2.2) Ma terni ty 'Bette r Bir ths ' (our Local Maternity System)

December 2018 marked the closure of the maternity early adopters programme. These pathways are being trialled with women using the birth centre at Imperial, and women booked for elective Cesarian sections at Northwick Park.. The next phase of the Maternity Transformation Programme includes aims to decrease stillbirths, neonatal deaths and intrapartum brain injuries between now and March 2021. However we are awaiting confirmation of funding by NHSe for this important programme; we have received positive reassurance that this will be forthcoming and the programme will commence once this is confirmed.

Continuity of Carer

Women experiencing care from the same midwife throughout their journey increased last month following the launch of new models to increase the continuity of carer rate. This includes a birth centre model at Imperial and an elective C-section caseload at Northwick

Park. Further models are being launched in February and March to ensure we reach a 20% target of women booked onto a continuity of carer pathway.

Safer Carer

A new 'Safer care project' is in development focusing on sharing learning from clinical incidents, standardising pathways and collaborating on safety initiatives. This aims to launch in April 2019.

3) Primary, Social & Community *NB: there are many interdependencies between this portfolio area and the Urgent & Emergency Care portfolio area. Please ensure the 2 areas are taken as a 'whole'.*

Our aim: *to improve community based care so as to support people closer to home and prevent deterioration in their health and wellbeing*

3.1) Supporting Primary Care at scale

The national investment & evolution five year financial framework has been released which includes a Primary Care Network directed enhanced service (DES) for commencement from the 01 July. This national steer was anticipated and we are actively working to understand the impact to us here in NW London.

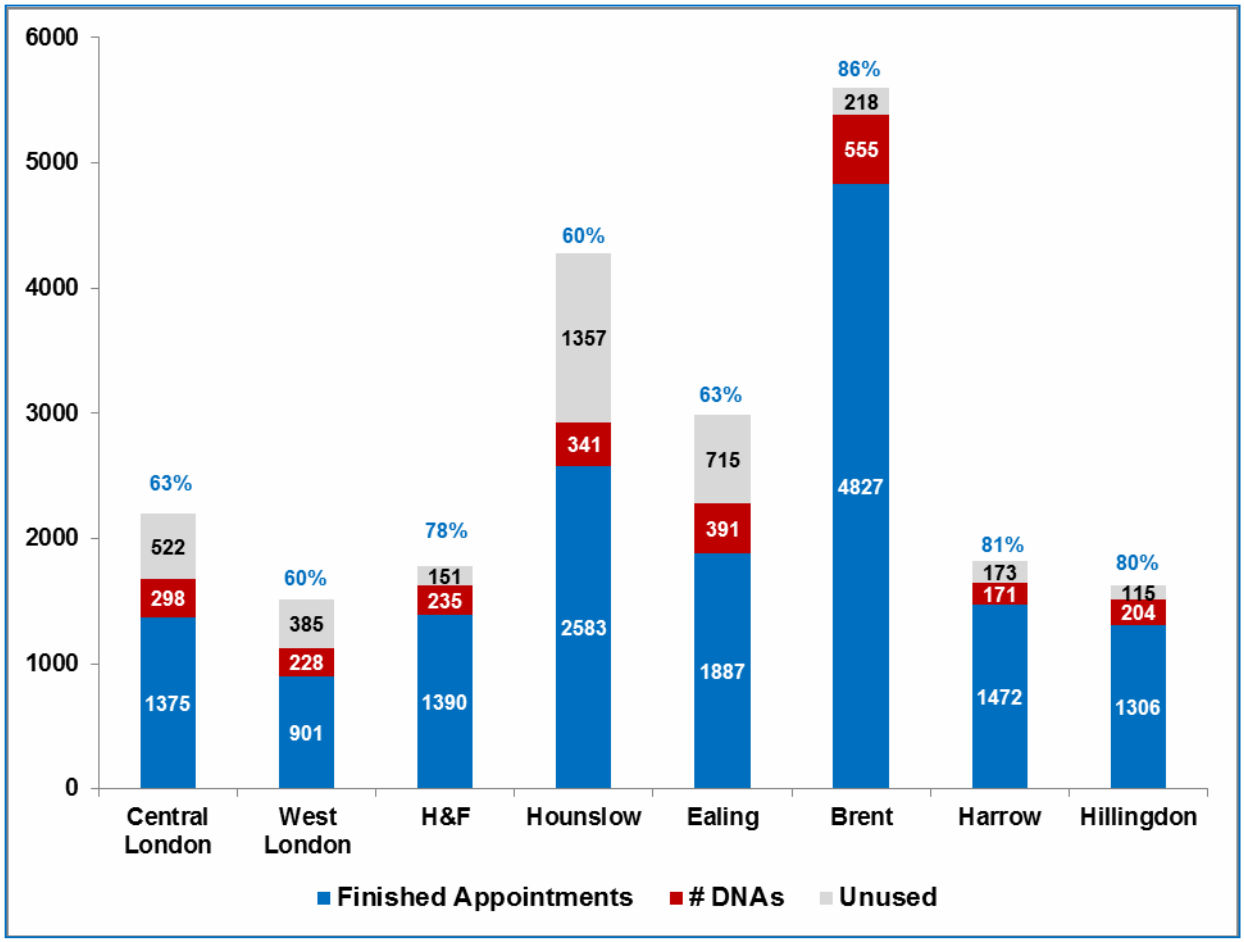
Another national steer which we are actively participating in is the NHS Digital App. Work has commenced with Brent to support its development as a Digital Accelerator site.

Further funding which will offer resilience support to practices in NW London has also been confirmed. Team working with commissioning partners has resulted in the identification of a number of practices which would benefit from this type of support and we are working to tailor the support required. However one such initiative which has been designed to develop and support clinical and managerial leaders of our Federations (ie the '*Confident Leader Programme*') is imminent with the contract being signed by the provider. The programme will run throughout the year.

GP extended access

GP extended access – work continues to ensure that there are appointments available & being utilised from 08:00 to 20:00 across NW London. In January, there were over 21,000 appointments available for patients within the extended access hubs where 72% (up by 5% from December) appointments were used. Figure 1.1 offers a graphical representation of this by CCG.

Figure 1.1: Appointment Utilisation by CCG



In addition, '*In-hours booking'* is now live within Hammersmith & Fulham and Central London. Ealing, Brent, Harrow and Hillingdon are expected to go live in February. This means patients can book an appointment with their GP practices through 111 at all hours of the day.

Recently a patient survey was completed in Ealing where 100% of the patients that used the Extended Access service were highly impressed with their appointment times with 90% of patients able to meet face-to-face with a GP. Also, when asked to rate their quality of care, 100% of patients said they experienced an excellent or good quality of care and all said they would recommend the service.

Patient Feedback:

'The NHS was really listening to patients and were being responsive to working people and parents with children'.

'Great idea, this may put less stress on NHS A&E in hospitals'

Online consultations

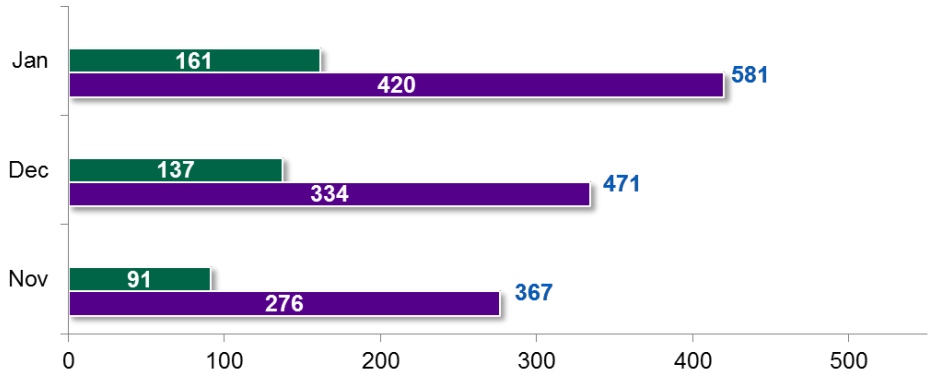
Online consultations is now live across 16 practices in Brent with another 6 expected to go live in February which will include another network (Kilburn) joining the pilot. There are also another 7 practices live in Central London.

Since the service commenced in November last year, across two networks in Brent and one Primary Care Home in Central London, patients have been steadily submitting e-consultations to GPs.

To date there have been over 2200 patients (1419 in Brent & 832 in Central London) who have submitted e-consults. Further fact and figures include;

- approx. 150 have booked an appointment with a GP in the Extended Access hub or their home practice
- 43 patients were issued with a prescription
- 101 patients have had telephone consultations
- 168 patients have been sent an e-consult message
- 100% of the e-consults that have been submitted have been responded to within 48 hours.

Figure 1.2 : Online consultations by Clinical and Administration consults for Brent Nov 2018 to Jan 2019



Key green = Admin purple = Clinical

The above chart shows the number of online consultations submitted in Brent from November to January. These are split into administrative and clinical queries. All 'eConsult' queries submitted by patients are received at their registered practice and filtered by the lead administrator. All administrative queries (i.e. repeat prescriptions, request for medical notes, reports or letters) are dealt with by the practice administrators. Clinical queries (i.e.

general medical advice, pains and illnesses covering a range of conditions), are submitted to the clinicians in the eHub and are dealt with accordingly, resulting in remote closure via telephone call, direct message to patient, prescriptions or a booked face-to-face appointment at patient's practice or extended access hub as appropriate.

Patient feedback:

- *'The service was a much quicker and more efficient way to request assistance from the GP practice than calling or going in person, and the whole process worked smoothly from start to finish'.*
- *'I was contacted within the time frame and offered good advice and an appointment was made quickly for the next day to see a GP. All went very smoothly as it should be if I were able to get through to the surgery and not have to wait forever to get an appointment. I am very pleased with this new service and recommend it to others'.*
- *'I was pleasantly surprised at the speed of receiving a reply. The service is amazing and if it eases the workload of the GPs and nurses it's a winner in my opinion'.*

Primary Care Workforce

A key element of the national investment & evolution five year financial framework is the funding of five alternative primary care roles (e.g. Clinical Pharmacist and Social Prescribing link workers) for primary care networks.

Two Primary Care Homes in NW London have now commenced the use of the workforce workload modelling tool. This will support practices in mapping out their workload.

In addition, further funding to aid innovative recruitment and retention support has been confirmed for NW London in the following 2 areas:

- a pilot a programme that will retain GPs in areas of deprivation and support GPs through Quality Improvement methodology and workshops
- work to support the recruitment and retention of Nurses in general practice.

3.2) Supporting people with Frailty

NW London frailty teams in Northwick Park Hospital and The Hillingdon Hospitals' continue to work in A&Es throughout December and January and we await activity and impact data. Their support is helping to ensure people are supported to receive ongoing care at home rather than being admitted into hospital.

Health Education England has allocated funding for the development of an advanced frailty practitioner role working between Chiswick Nursing Centre, their local GP Practice and Charing Cross Hospital. The role will provide expert support, advice and liaison to staff in these organisations as well as wider system partners to try and reduce the number of

ambulance conveyances and admissions to hospital. The role will deliver training and education to teams in all of the organisations to improve care. In order to help quantify impact we are working to devise metrics to help evidence whether the change is successful including impact on the well-being of residents.

***3.3/4) <u>Supporting people with Dementia & in the Last phase of life</u>** (telemedicine)*

Enhanced care in care homes - '*Is my resident well*?' training empowers care home staff to identify deterioration earlier resulting in residents receiving more timely care within their home. The locally commissioned care home training provides both cross cutting and bespoke training with targeted training linked to local priority clinical competencies, including dementia and end of life care. As of 31 January, 853 participants have been trained in 84 care homes across NW London, with an increase of 215 participants in January. The increased numbers of care home staff receiving training will encourage better care, improved communication and raised understanding around key pathways between hospitals and other NHS care teams with the care home workforce.

Our Health and Care Partnership is implementing the NHSe's '*medicines optimisation in care homes programme*'. Pharmacists working in care homes improve care and quality, reduce risk of harm from medicines and release staff resources. NW London has secured some funding which has been used to recruit and train four new pharmacists and a pharmacy technician who have now started work. To support the pharmacy teams in their roles, NHS England is delivering a development programme which began on 30 January 2019.

The '*hospital transfer protocol',* which is designed to improve communication and relationships between hospitals and care homes when care home residents are admitted to hospital, has been rolled out across NW London and work continues with hospitals to ensure care home residents are recognised during admission, treatment and discharge. A patient-level case review of the hospital experience of care home residents is underway at Chelsea & Westminster Hospital. The review will analyse the journey of care home residents through hospital up until discharge back to their care homes. The review will examine how the current protocol is working and help providing insight on how we can support and expedite discharge from hospital for care home residents.

The specialist telephone advice line for care homes continues to run Monday to Sunday, 08:00 to 02:00, staffed by nurses with specialist skills in supporting people at the end of their life. There were 307 calls from 73 care homes in January 2019, with over 3000 calls to the service from April 2018 to January 2019. Call numbers have increased from last year. The top five reasons of calls included lower respiratory tract infection, urinary tract infection, falls, cough and vomiting.

The first wave of the roll out of video consultation technology to care homes is now live in eight care homes. The care homes have a portable tablet and are able to access face-to-face advice and support by dialling the 111*6 service. As well as connecting care homes to the 111*6 telemedicine service, we have connected a GP practice to one of their local care

homes to help provide more primary care support to those care home residents and to understand how technology can help deliver better care to care home residents.

3.5) Supporting People with Diabetes

NW London has been working both locally (in borough/CCG footprints) and collectively across the entirety of NW London, together we have delivered the outcomes below.

a) Drop in annual growth of acute diabetes admissions (8.3% (2017/18) to 4.9%(2018/19)
b) Cost growth has slowed to 7.9% in 2018/19 for diabetes in-patients from 11% annually for the past four years.
c) In five of our CCGs (Central, West London, Hammersmith & Fulham, Hounslow and Ealing) for the first time since 2005, the number of people with diabetes newly diagnosed each year has reduced. (This coincides with the Out of Hospital contract which includes screening, annual review and offer of referral into the National Diabetes Prevention Programme).
d) Some CCGs, e.g. Hounslow, have improved the three treatment targets of HbA1c, blood pressure and cholesterol so effectively that they are seeing a reduction in acute activity and QIPP savings

The following infographics offer additional insight into challenges for our population here in NW London, the positive impact we are having and key messages from the NHS Long Term plan – all of which is being taken into account as colleagues work to identify key priority areas for 2019/20

North West London Diabetes Transformation Programme

The challenge:

£22m predicted rise in cost of diabetes in-patient activity in 2019/20 if we do nothing

Over **148,000** people in NWL with diabetes

Over **90,000** people in NWL with diagnosed non-diabetic hyperglycaemia

Over **1 in 10** people in NWL have diabetes or NDH (likely to be nearer 1 in 7)

of all hospital admissions have diabetes

of all bed occupancy is for people with diabetes

Over **£140m** annual cost of complications

£84m cardiovascular
£32m foot
£11m renal (excluding transplant and dialysis)

Over **£37m** annual cost of diabetes medication alone (excluding other medicines)

The programme:

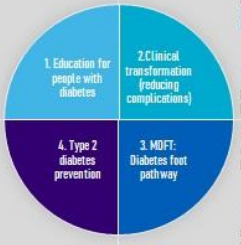
4 project areas and **2** key enablers spanning **8** CCGs

Structured education
More patients receiving self-management support

10,146
received structured education since April 2017 (4666 since April this year)

664
patients received digital structured education

Prevention
6958
Patients referred to National Diabetes Prevention Programme since April 2018



Clinical transformation
Integrated outcomes based contract developed

639
healthcare professionals have received PITstop, PrePITstop or Cambridge Diabetes Education Programme training to date

876
hospital, care home and mental health team care professionals trained using diabetes 10 point training

Diabetes foot pathway
additional podiatrists supporting improved footcare pathway including weekend cover

8%
reduction in in-patient footcare activity compared with last 4 years

Digital
EMISweb diabetes template rolled out to primary care
WSIC diabetes benchmarking, population health and care radar complete and rolled out
Information governance complete, supporting more robust data extraction and integration
KnowDiabetes website refresh nearly complete
Know Diabetes contact centre to pilot Q4 18/19
At scale **digital behaviour change content and campaigns** near completion

Mental Health
Mental health indicators included in NWL integrated service spec

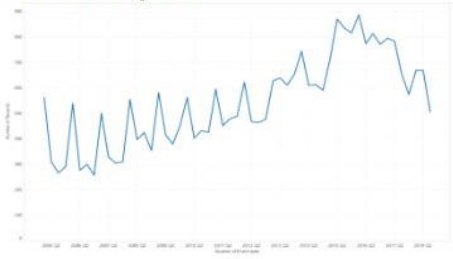
Mental health nurses supporting primary care training

The impact:

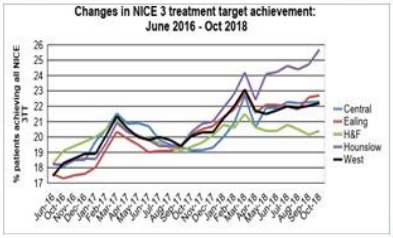
Achieving improvements in key areas

Reducing new diabetes diagnoses

Graph showing reduction in new diabetes diagnoses since introduction of the Non-Diabetes Hyperglycaemia primary care contract and National Diabetes Prevention Programme in 2016



Improving treatment targets, achieving QIPP savings

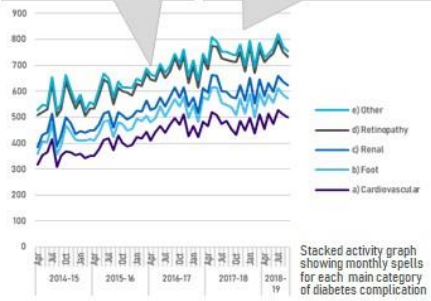


Hounslow CCG
5.3%
improvement in 3 treatment target achievement this year, now achieving QIPP savings from reductions in acute activity

Reducing hospital activity and cost

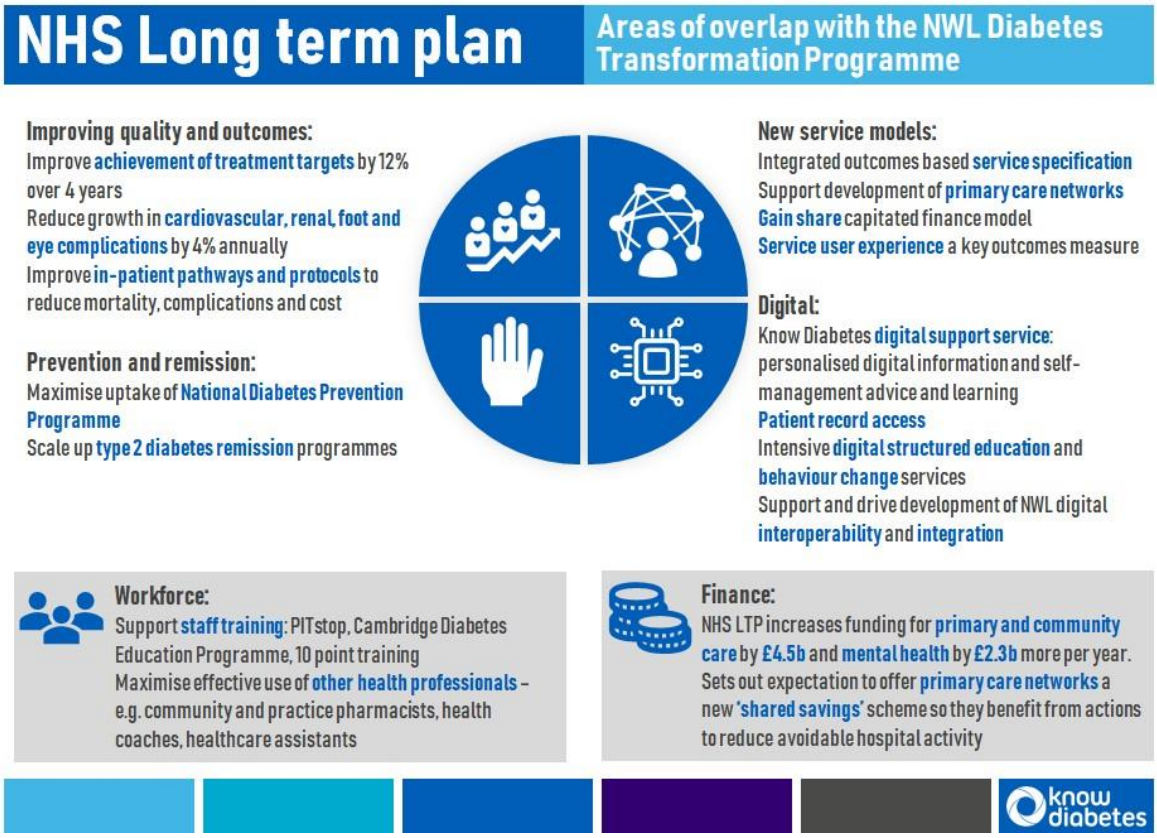
8.3%
Average annual growth in inpatient spells with diabetes complications from 2014-2018

4.9%
FOT growth in inpatient spells (M1-7 2018/19) for diabetes complications



Stacked activity graph showing monthly spells for each main category of diabetes complication

Cost growth for diabetes inpatients has averaged over **11%** annually for the past 4 years and has slowed to **7.3%** in 18/19



4) Urgent & Emergency Care

Our aim: *to ensure Urgent and Emergency care is delivering the right care in the right place (ie home, community or hospital) first time.*

Whilst Urgent and Emergency care has been proposed as a new portfolio area within the Health & Care Partnership's plan, there are already existing structures to align with. We are currently working with system colleagues to appoint to the senior clinical and managerial roles for this interconnected portfolio area as well as ensure 'fit' to the four existing A&E Boards.

There is however significant focus on helping patients to go home as soon as they are fit to leave - through our Home First programme.

Home First

As of December 2018, over 4100 patients were supported using Home First pathway principles. This project has contributed to a reduction in the time older people have spent in hospital by over 5,900 days since April 2018.

The significant impact for people aged 75+ with regard to time spent in hospital after an emergency admission is demonstrated in data on hospital length of stay across NW London and this is illustrated in the graphs below at Figure 1.3

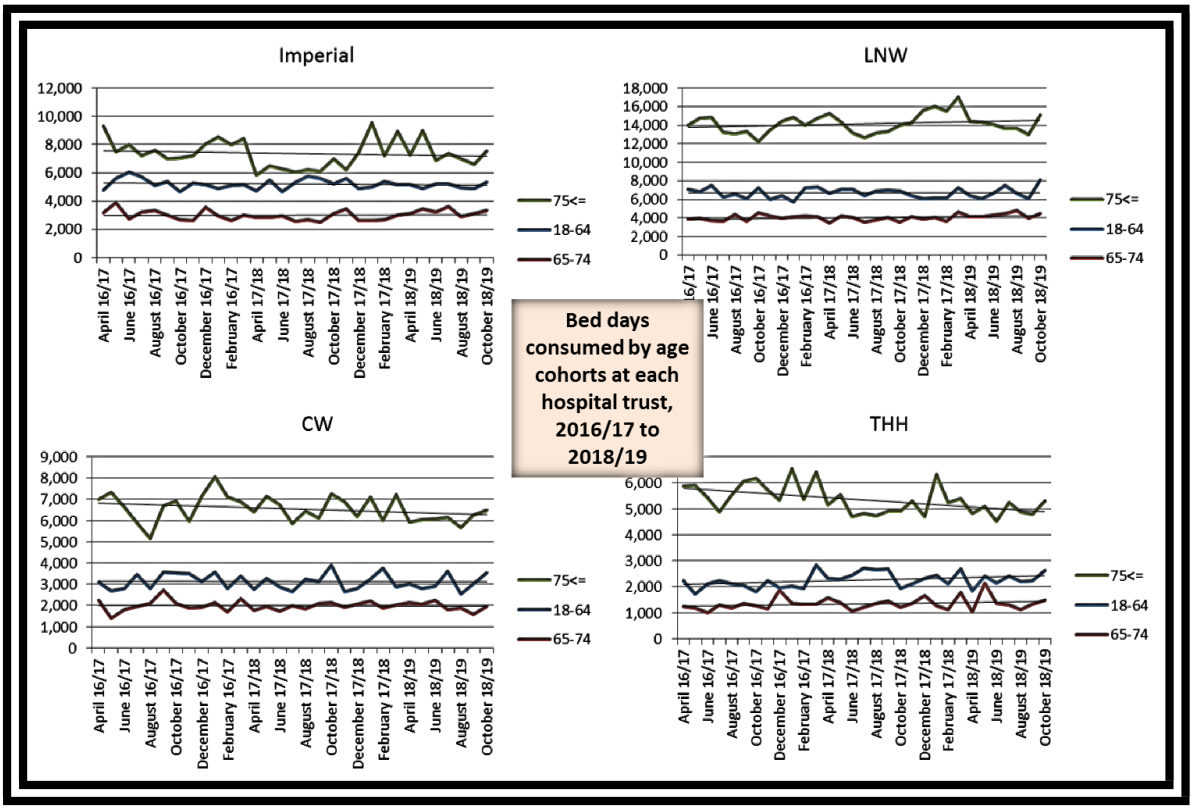


Figure 1.3: Bed days used by 75+ year cohort in NW London

The new streamlined process from six pilot wards in January 2019 saw 19 patients discharged from hospital to community rehabilitation beds. Further intelligence suggests;

- 9 patients were accepted on the same day, the majority within 1 hr of receipt
- 3 patients were discharged to the community based rehabilitation unit within 24 hrs
- 6 were discharged outside of 24 hrs.

Another patient was discharged home for a continuing healthcare assessment. As numbers are low, a review of the continuing healthcare assessment pathway has been held at Chelsea and Westminster Hospital. There will be a renewed focus and drive behind identifying and discharging patients on this pathway for the remainder of the trial period.

5) Mental Health

Our aim: *to improve outcomes for children and adults with mental health, learning disability and autism needs, and enable them to live well through timely access to community based and high quality of care no matter where they live.*

However we recognise that resources within mental health transformation are currently limited and we are therefore continuing to focus on our key areas. In particular for this update 'Transforming Care Partnership' has been highlighted

5.2) ***Focused interventions for targeted populations***

Transforming Care Partnership

The Transforming Care Partnership programme aims to reduce reliance on inpatient care and improve the quality of community-based support for people with learning disabilities and / or autism who have a mental health need and/or challenging or offending behaviour.

NW London has high number of adult patients (40) who are in non-secure inpatient beds and there is a national, but challenging ask, to discharge these patients back into communities. The 'challenge' is due to complex needs and legal circumstances of the individual patients. An integrated model of care and support emphasising the need for early intervention, proactive and reactive support to avoid admissions, including the use of dynamic risk registers and Care and Treatment Reviews have been developed. CCGs and Local Authorities are working in collaboration to implement these tools to manage complex needs in communities to minimise inpatient admissions. Funding has been secured to increase investment in the local community teams to support discharge planning, develop peer-led training programmes for families and interventions to minimise future admissions.

6) Improving Cancer Care

Our Aim *to improve cancer care by early identification, rapid treatment and living well with or beyond cancer. (Earlier diagnosis through strengthened interventions and informed choice, supported by timely and effective multi-disciplinary care which enables people to live as independently as possible with, and beyond a cancer diagnosis)*

Whilst '*Improving Cancer Care*' is being proposed as a new portfolio area within the Health & Care Partnership's plan, there are already existing structures and programmes of work to align with. We are currently working with system colleagues to appoint to the senior clinical and managerial roles for this interconnected portfolio area as well as ensure 'fit' to existing forums.

7) Hospital Care

Our aims: *to implement good quality, sustainable acute care in the most appropriate places as close to people's home as possible and for NHS Providers to work together to improve value and patient experience whilst increasing quality and reducing costs*

7.1)***Implementing in and out of hospital reconfiguration***

Capital business cases to support clinical improvements

A number of provider capital schemes have been approved. These include; improving theatres at Northwick Park and Imperial, and for improvement of patient dormitories and facilities at Central North West London Trust. These schemes will progress to Outline and Full business case development. The acute care transformation team is preparing to support the development and commissioner assurance of these business cases and we are also working to develop a proposal for a NW London acute activity modelling tool. A Technical Group has been meeting regularly to agree assumptions underpinning the model.

Also to note we are continuing with the development & role out of plans for the GP community hubs. This will provide our population here in NW London with the means of obtaining appropriate care in a community setting rather than needing to go to hospital. Task and finish meetings are being held with each CCG to aid their review of hub implementation plans and value for money.

7.2) NHS Providers working together

Outpatients Transformation

The NW London Outpatients Transformation programme is progressing well. During January / February the programme launched 'soft triage' against the first wave of clinical specialties. Initial feedback from the batches of referrals which have been reviewed, has confirmed that there is significant opportunity to improve the quality of referrals. Updates to Gynaecology and Gatroenterology referrals have also been published, reflecting feedback from GPs and the Local Medical Council.

The second wave of specialities (ophthalmology, neurology, respiratory and urology) have commenced with collaborative workshops held during January and February for Respiratory and Urology, and planning for the second Neurology workshop is progressing.

Additionally a suite of outcomes and indicators are in the process of development across all CCGs and Providers. These will track the impact upon outpatient activity and will include evaluation of the impact on non-routine pathways (e.g. suspected cancer pathways) and broader quality related metrics. The details of the indicators are being developed at the moment, but will include:

- Total referrals made into a service from across NW London
- Number of referrals returned to GPs without an appointment being made
- Total number of first and follow up appointments
- Waiting time from referral to first appointment

Enabler - Workforce

Highlights of work underway includes the following;

- **Change Management Facilitators** modules for primary care networks have concluded. Action learning sets are now underway. Two project sites in Westminster are preparing to use the Workforce Modelling Toolkit. An evaluation will be finalised at end of Q4 18/19.
- **Primary Care Retention and Recruitment funding** totalling £330,000 has been distributed to CCG's for local initiatives. A further £50,000 was awarded by NHSe to support a pilot project in NW London to retaining GPs working in areas of high deprivation and further work in recruiting GPs with long-absence back into General Practice.
- **General Practice Nursing (GPN) 10 point plan** – Health Education England have match-funded an additional £34k to support the Legacy mentorship scheme.
- **Community services leadership programme** – A provider has been selected to deliver a leadership development programme to support nurses and therapists working in community provision in leading transformational change.
- **Care Home and Home Care Leadership programme**; Care Home and Home Care managers across CCG and Local Authority commissioned care have been invited to participate in the My Home Life leadership programme targeted at direct care provision. The programme funded by Health Education England will commence delivery in March.
- **Mental Health Workforce**. Health Education England has rated NW London as amber on progress against mental health projects. NW London's mental health workforce plan is being developed with key stakeholders to focus on one service area at a time, commencing with a Children and Young Peoples Mental Health Workforce workshop in February.
- **Apprenticeship Programme**; two approaches are being taken forward by the Staffing Programme Board;

  1) accelerating implementation of standard pay across apprenticeships and a collaborative and consistent approach procuring and managing the providers of apprenticeship programme and

  2) Partnering with local colleges to attract college leavers into non clinical roles in the NHS, with a view to joining apprenticeship programmes in the future. There is the opportunity for a partnership bid against the Mayor of London's European Social Fund allocation to support Londoners into health and care employment.
- **Systems Leadership** - £40k secured from London Leadership Academy. Project Group established with Imperial College Healthcare Partners (ICHP) to lead on procurement of systems leadership, clinical leaders and wider OD programme offers.

Enabler - Digital

Funding bids across NW London were submitted and are being reviewed by NHSe/NHSi, for:

- Health-System Led Investment (HSLI - provider capital for Digital Maturity)
- Electronic Prescribing and Meds Admin (EPMA - two Acute/one Mental Health Trust)
- One London Local Health and Care Records Exemplar (LHCRE)

NW London Health and Care Information Exchange (HCIE) is a key project, to enable better integrated care through shared records, and support NW London's Health Care Partnership transformation such as the Outpatient Programme which will require increased digital interaction with patients.

A NW London Digital Strategy needs to be developed, to support our Health and Care Partnership's Clinical Strategy when it has been fully agreed and ensure we align and deliver to the digital principles set out in the Long Term NHS Plan.

Development of the Whole Systems Integrated Care (WSIC) Data Warehouse has progressed well during the period; Primary Care digital projects have also progressed well, although there is no funding for 2019/20 from the Estates and Technology Transformation Fund (ETTF) which will result in cutting back the digital programme from April 2019.

Conclusion

This paper has provided a summary of progress for the latest reporting period as well introduced the full suite of 7 Portfolio Areas in our Health and Care Partnership Plan.