This strategic plan sets out our vision and goals followed by some of the context that shapes our commissioning decisions, including local needs assessments and the potential impact of three financial scenarios. It then outlines the core programmes of work which will deliver our vision and finally how we will monitor progress and measures of success.

The plan should be read in conjunction with our Finance Plan and Organisational Development Plan, and the North West London Integrated Strategic Plan.

The strategic plan is refreshed annually. This document supersedes the November 2008 Commissioning Strategy Plan and April 2009 addendum.
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1. Chair’s and Chief Executive’s foreword

This updated strategic plan describes NHS Hammersmith and Fulham’s priorities for the next five years. These priorities firmly reflect the framework set down by Lord Darzi in his July 2007 report, *Healthcare for London (HfL) - A Framework for Action*.

**Top priorities**

Our over-riding priority in the years ahead is the creation of polysystems. These are groupings of health and care professionals capable of providing a wide range of high quality healthcare services within the community, cutting out unnecessary hospital visits for patients. Creating polysystems will transform the NHS, with new services for residents and new buildings to provide them from. But they are not simply about caring for people when they are ill – providing advice and support to residents about keeping healthy is central to their work.

The projects set out in the plan are priorities that must be delivered in order to create effective local polysystems. The work will see hospital services shifted to provide residents with more care in their homes and at convenient community settings including GP surgeries, children’s centres and schools. Hence some projects address changes in hospital care and others focus on improvements to primary and community services so GPs and their community colleagues have the skills and equipment they need to take on the new roles within polysystems.

Resources are of course limited and the prioritisation process we used to identify projects is explained later in the document. Engagement with local residents and clinicians has shaped the direction of the strategy and played a fundamental role in designing projects. In addition we explain the specific prioritisation criteria used by the Board to ensure the strategy is ambitious yet at the same time realistic and achievable.

**Solid foundations**

We have already made significant progress in putting HfL into action. In 2009, we opened London’s first Accident & Emergency (A&E) based polyclinics. Our polyclinics have shown that primary care doctors and nurses can more effectively help 65% of the people who walk into A&E departments.

We have also developed with local GPs our unique ‘Quality and Outcomes Framework Plus’ (QOF+) programme to target GP support to patients with some of the most life-limiting or life-threatening conditions. QOF+ has already brought many benefits (e.g. 1,500 extra residents have had their high-blood pressure controlled, significantly reducing their risk of having a stroke or heart attack).

This is just a start, and the challenges are not to be underestimated. To transform frontline services we must develop our skills as commissioners, redesign services and work even more closely with other NHS bodies and the council. Again, progress has been strong. We have created London’s first shared management team across a primary care trust (PCT) and local authority. With a single senior team, we are better placed to tackle local health inequalities and help residents improve their health. Our objective is to achieve fully integrated commissioning with the council; leading to integration of frontline services which can make the most of every contact residents have with public services to promote health and wellbeing.

We have also been instrumental in creating the North West London Commissioning Partnership, eight PCTs working together to gain the benefits of size by jointly commissioning large contracts for hospital services. The partnership will drive essential improvements in hospital care across North West London and will help the eight PCTs to be more efficient and focus their own work on strengthening primary and community care.
Quality, Innovation, Productivity and Prevention

The projects throughout this plan address quality, innovation, productivity and prevention. These are cornerstones of our plans to implement effective local polysystems. Local innovations such as primary care frontends at A&E departments and the Quality and Outcomes Framework Plus scheme are driving up quality in primary care and improving productivity of the whole local NHS by delivering more from primary care teams.

QOF+ in particular focuses on preventing ill health and minimising the impact of long-term conditions on residents through early detection and intervention. In addition we have projects across the maternity, children’s and staying healthy programmes that provide preventive services such as immunisations, stop smoking, weight management, cancer screening, and cardiovascular checks.

With our local hospital trust (Imperial) designated as the country’s first Academic Health Science Centre and strong ties to Imperial College through our Medical Directorate we are committed to developing innovative services that drive up quality, improve productivity and where ever possible help residents to avoid becoming ill.

Equally our integration with the council is an innovative step for a Primary Care Trust, and one we are convinced will allow us to improve quality alongside productivity improvements and to reach more residents with health and wellbeing support that prevents ill health.

We are also working with a number of national partners to pilot new services and ways of engaging and empowering residents including:

- A Connected Care project in White City to ensure public services are designed by residents for residents.
- One of 20 PCTs piloting personal health budgets (learning from similar systems in social care) to give patients greater control to choose the services that suit them best.
- One of three PCTs working with Diabetes UK to improve how local services are tailored to patients’ needs

Financial challenges

The economic climate has become tougher since Lord Darzi drafted his vision. NHS Hammersmith and Fulham’s strong financial position allows us to invest in strengthening primary care and community services. But these challenging financial times mean that it is even more important for us to focus investment on those changes that provide high quality and financially sustainable services, and which represent the best value for taxpayers’ money. We have shown with Healthcare for London has attracted wide support from the public and from clinicians. To deliver this vision, we are delighted to be working closely with the Local Involvement Network (LINKs), with GPs and other health professionals, and with our colleagues in the Hammersmith & Fulham Council. Together, we can make the NHS deliver even more.

Geoff Alltimes            Jeff Zitron
Chief Executive           Chairman
2. Vision, Goals and Values

2.1 VISION & GOALS

Our overall corporate vision is simple. We want to improve the health of the local population.

We have four strategic goals against which we plan and prioritise initiatives to deliver improvements in local people’s health and wellbeing.

- Enable and support health, independence and well-being
- Give people more control of their own health and healthcare
- Offer timely and convenient access to quality, cost effective care
- Proactively tackle health inequalities

These are broad goals which have been shaped by several years of engagement with local residents, clinicians, and other partners. They reflect national priorities such as patient choice, timely access to care, a shift to provide more care in convenient settings and a greater focus on supporting people to live healthy lives.

The goals also address specific local needs identified in our Joint Strategic Needs Assessment. In particular the vital work to remove the unacceptable variation in quality and availability of services related to who you are and where you live within the borough.

2.1.1 Measuring success

Our success in delivering against the vision and goals is measured by performance against:

- The world class commissioning outcomes
- NHS key performance indicators
- Initiative specific targets and milestones

Details, including the ten World Class Commissioning outcomes we have chosen and the rationale behind the choice, are set out in section 5.2.

2.1.2 Ambition

We want to see significant improvements in both the quality of local health services and the health of our residents over the period of this strategic plan.

A great deal has been achieved over the last decade with a transformation in both quality and availability of services. But there will never be a time where we say local NHS services are ‘good enough’. Advances in medical treatments and technology constantly raise the standard of care local people can expect. Equally, the changing needs of a changing population means we must constantly review the care available.

In the past year we have commissioned a range of new services that are already delivering better quality services at better value for money. They have laid the foundation for the local polysystems which will transform the quality of local NHS services through the use of innovative treatment, innovative approaches to how and where care is delivered and improved productivity.

There will always be a case for change. It will evolve as we address key issues and move on to the next challenge. Our current case for change is set out in section 3.2.
2.2 VALUES
NHS Hammersmith and Fulham has five corporate values based on the overall values of the NHS:

- Commitment to quality
- Respect and dignity
- Everybody counts
- Working together
- Improving lives

These values shape how we work with our partners, residents and internally; and are reflected in the commissioning decisions we make. We expect the providers that we commission to deliver services which reflect these values.

In 2009/10 we worked hard to embed our vision and values across all levels of the organisation linking them to a new induction programme and using a range of internal communications channels to promote them. To ensure our values are meaningful and real we have developed a set of behaviours that define how our values are exhibited in the work we do. Further work on embedding our values is outlined within our organisational development plan.

2.3 MAKING THE LINKS
The diagram below gives an overview of the programmes and projects outlined in this plan together with our vision, goals, and values; and the key enabling strategies that support our plan.

The following section sets the context for our strategic plan looking at local needs and our case for change, some of the progress we’ve made and the wider issues that impact on our plans >>>
3. Context

3.1 A PICTURE OF HAMMERSMITH AND FULHAM
This section gives a summary of key characteristics of our population. Our case for change in the following section takes facts about current health in the borough and articulates it into a rationale for why improvements must be made.

The detailed analysis of local needs which this plan addresses is available in our:

- **Joint Strategic Needs Assessment** - this combines local intelligence available from NHS and council sources to create a detailed picture of health and social issues in the borough.

- **Public Health Annual Reports** - our 2009 Public Health report looks specifically at which groups of the population are missing out on important preventive services.

In summary Hammersmith and Fulham is a relatively small inner London borough with a population of 178,600.

---

**The people**

- **Young population** 45% in their 20s and 30s, compared to London average of 35%

- **Highly mobile** 7th highest mobility rate England. 1 in 5 people move address each year.

- **Small households** 40% are one person households, 30% couples, 10% lone parents, 20% families with one or more dependent children

- **Ethnicity** 22% from non-white background, lower than the London average of 33%. Many small minority ethnic communities

- **Extremes of wealth** Half the population classed as well off, but 10,000 (37%) children living in low income homes.

---

**The place**

- **Small densely populated area with limited green space** (6.4 square miles and seventh most densely populated area in England)

- **North generally more deprived** though pockets of deprivation across the patch. (ranked 59th most deprived local authority in England and 13th out of 33 in London)

- **16,000 new homes planned in next decade** (with a focus on family sized units)

- **Wormwood scrubs prison** 1,200 adult male prisoners, many with more than one health problem.

---

3.1.1 Population growth
The population increased by 4.5% between 2001 and 2009. It is projected to increase by 4.6% between 2009 and 2015 and 11.6% by 2025. Whilst we expect an increase in all age groups, the main projected growth occurs in age groups between 45 and 59 years, with an expected increase of 49% during 2009-2025 (12,300 people).

Population growth is in part driven by a higher number of births (2,800 annually) than deaths (800 annually), although inward international migration is also a factor. Plans to build 10,000 new family homes in the borough over the next 10 years will also have a major impact although this will not impact on the five year timescale of this plan.
3.1.2 The health of our residents

Overall, life expectancy in the borough has been increasing in line with national trends. Mortality rates are also in line with the decreases seen nationally.

However, the figures for the whole borough mask an increasing gap between the best and worst off wards. On average men living in the most deprived areas die nearly eight years earlier than men in the most affluent areas. Our priority is to design polsystem services in ways which will reduce these inequalities whilst improving the overall health and quality of services for all.

Health problems that are more common in Hammersmith and Fulham

Compared to national averages we have high rates of:
- childhood obesity
- child tooth decay
- alcohol & drug misuse
- poor mental health
- HIV
- tuberculosis
- excess winter deaths
- emergency hospital admissions for older people

Prevention and detection too low

Uptake of preventive services such as immunisation, screening, and smoking cessation is improving but is still below national averages. Early diagnosis and treatment of long-term conditions in primary care is below expected levels and varies between individual practices.

<table>
<thead>
<tr>
<th>Deaths</th>
<th>(3 year period 2006 - 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>All deaths</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>954 (34%)</td>
</tr>
<tr>
<td>Cancer</td>
<td>782 (28%)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>354 (12%)</td>
</tr>
<tr>
<td>Other</td>
<td>748 (26%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,838 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-term conditions</th>
<th>(based on 08/09 QOF data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>Recorded on GP disease registers</td>
</tr>
<tr>
<td>Hypertension</td>
<td>17,046</td>
</tr>
<tr>
<td>Asthma</td>
<td>8,598</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5,803</td>
</tr>
<tr>
<td>CHD</td>
<td>3,397</td>
</tr>
<tr>
<td>COPD</td>
<td>1,899</td>
</tr>
</tbody>
</table>

Our Joint Strategic Needs Assessment (JSNA) concludes that the key risk factors for our residents are smoking, alcohol misuse and obesity. The prevalence of these risk factors is also higher in Hammersmith and Fulham than other parts of the country. Our Annual Public Health Report for 2009 looks at preventive services and in particular which groups of the community are missing out on these vital services – giving us good data on inequality and groups to target resources on.

The risk factors above together with under use of preventive services all contribute to the borough’s biggest killers and most prevalent long-term conditions shown opposite.

CHD – Coronary Heart Disease
COPD – Chronic Obstructive Pulmonary Disease
Who is most vulnerable?
Deprivation is one of the strongest factors in determining vulnerability to ill-health and its causes.

We use the Council’s population segmentation (based on Mosaic/Experian segmentation) overlaid with additional health data to support local planning.

The maps opposite show the clear correlation of poor health with deprivation. Map 1 highlights the concentration of deprived families in public housing (red) and poorer minority families (purple) in the north of the borough. Map 2 shows higher mortality rates for circulatory disease (dark green) also concentrated in the north.

Helping deprived families in public housing is a priority for the PCT and the Council. The burden of ill health and its root causes are carried disproportionately by deprived areas. These areas have:

- higher unemployment
- poorer educational attainment
- poorer fluency in English
- lower life expectancy
- higher prevalence of long term conditions
- higher use of emergency and unscheduled care
- poorer access to services

Our 2009 Annual Public Health Report looked at who misses out on important preventive services such as smoking cessation, cancer screening, and support to reduce alcohol misuse. It confirmed that people from deprived areas were making less use of preventive services than those from more affluent areas. This is despite the prevalence of behaviours such as smoking and alcohol misuse being higher in deprived areas.

Addressing the inequalities identified in the JSNA and public health report is fundamental to developing polysystems designed to meet the needs of their local population. Reducing health inequalities is one of our four strategic goals and is articulated in our case for change that follows >>>
3.2 LOCAL CASE FOR CHANGE

*Healthcare for London – A Framework for Action* (HfL) sets out why and how London’s NHS needs to improve. It gives a compelling case for significant improvement and has Londoners’ support following a public consultation in 2008.

Our local case for change takes the eight key reasons identified in *Healthcare for London* and applies them to the specific needs of Hammersmith and Fulham’s residents.

It translates the quantitative and qualitative data from our Joint Strategic Needs Assessment, residents’ feedback and provider performance information into a clear rationale for why NHS services in the borough must improve. Delivering against these challenges will significantly improve the health of local people.

### 3.2.1 The need to improve residents’ health

Hammersmith and Fulham residents face similar health challenges as other Londoners. However, particular problems we need to tackle include smoking, obesity, alcohol misuse and undiagnosed illness.

**Smoking** – 28% of residents smoke. Every year 54 residents die from lung cancer (10% higher than the London average) and a total of 210 deaths are linked to smoking.

**Obesity** – By the age of five 12% of our children are obese. By the age of 11 that jumps to 23%. Obesity can lead to diabetes, cancers and heart disease. Childhood obesity is a first class ticket to a life of ill health and an early death. We must help local families to understand the dangers of obesity and to adopt healthy behaviours. There are also 20,000 obese adults in the borough who could benefit from better services.

**Alcohol** – There are nearly 5,500 dependent drinkers in Hammersmith and Fulham, 10,000 more residents are considered high risk drinkers. Alcohol misuse is both a cause and a consequence of health problems; causing physical damage to a person’s body and often a response to mental health problems like depression. The deprived and elderly are worst affected.

**Undiagnosed disease** – Modelling suggests there are tens of thousands of local residents living with undiagnosed diseases: 19,000 with high blood pressure, 1,500 with diabetes, 300 with HIV and as many as one in ten sexually active young people with Chlamydia. Identifying and treating these conditions can be simple e.g. the use of medicines to control high blood pressure, and reduce the risk of heart attacks and strokes. Every year 110 local people die prematurely from these and other circulatory diseases.

**Screening** – Cancers kill 130 local people prematurely each year; yet many cancers can be prevented or treated. With better services to help people adopt healthy lifestyles and better uptake of screening we could prevent many of these illnesses or treat them earlier when the chances of a full recovery are highest – saving lives and helping people live longer.
3.2.2 The NHS is not meeting residents’ expectations

There have been significant improvements in local services in the past five years. Patient surveys show that the majority of people who use the local NHS are satisfied. However, there are important areas where we are not meeting residents’ expectations.

We know from formal consultation and informal engagement with local people that they want convenient, high quality services that are accessible regardless of who you are or where you live.

Local people are particularly keen to see improvements in primary care in terms of location and opening hours. Parts of the borough, notably the north, feel left out due to a lack of services or poorer performance in the services that are available.

3.2.3 One borough, but big inequalities in health and healthcare

Within a borough of just over six square miles there are massive inequalities in health and healthcare. This is closely linked to poverty, with the burden of ill health carried disproportionately by the more deprived communities. Mortality rates from common diseases like cancer, heart attacks and stroke are significantly higher in the poorer wards. On average people in the most affluent wards live over 5 years longer than those in the most deprived areas.

There are indefensible variations in the quality and availability of care across the borough, particularly in primary and community services. These variations compound the local inequalities with deprived wards poorly served in comparison to affluent areas.

Social inequalities are at the heart of many health inequalities. Education, housing and employment all have a direct impact on people’s health. We must seize the opportunity of integration with the Council to drive improvements across all the social causes of ill health – working in partnership to give local people the best chances to live healthy productive lives.

3.2.4 The hospital is not always the answer

People do not want to go to hospital unless it is absolutely necessary.

The leading causes of illness, disability and death are now linked to long-term conditions. General practice is uniquely placed to provide the care needed to support people with long-term conditions; and medical advances mean more care can be provided safely and effectively outside hospitals.

Yet general practice has increasingly become a gateway to treatment rather than a point of treatment. We must address local issues of capacity, capability and perception to develop primary and community care services which are (and are seen to be) uniformly high quality.

As one of London's two early implementers for polysystems we must grasp the opportunity to deliver more high quality primary and community care. Equally, we must use our integration with the Council to maximise every opportunity to support health and wellbeing and prevent unnecessary admissions to hospitals and care homes.
3.2.5 The need for more specialised care

Although most people can be cared for in community settings the most seriously ill need more specialised care. We are fortunate that our local hospitals already provide world class care in many fields, but there are still improvements needed.

We must accept that individual hospitals cannot deliver the highest possible standards of care if they try to do everything. The quality of care patients receive can be radically improved by developing centres of excellence. Hammersmith and Fulham must support North West London sector and London-wide work to improve specialised services where there is clear evidence that this will improve care for local residents.

3.2.6 Residents should benefit from cutting edge medicine

Hammersmith and Fulham residents are fortunate to have world renowned hospitals and medical research institutions on their doorstep. Imperial College Healthcare NHS Trust is the country’s first Academic Health Science Centre and one of the first Biomedical Research Centres. They aim to speed up how new medical treatments move from theory into practice. We must support the trust to deliver these goals so that local residents have the opportunity to be at the front of the queue to benefit from cost-effective improvements developed at local hospitals.

Innovation is not just about hospital care. We must make maximum use of our close ties to Imperial College’s Primary Care Directorate to ensure that innovation and the implementation of best practice is also at the heart of local general practice and community health services.

3.2.7 Using our workforce and buildings more effectively

The NHS’ greatest asset is its staff. We must make sure they are supported to do their job and that their abilities are being used to maximum effect. We must embrace alliances and partnerships across the NHS and with our local Council to increase capacity and reduce duplication to maximise the benefit for Hammersmith and Fulham residents.

A number of NHS sites across the borough, particularly GP surgeries, are old and not fit for modern medical services. This has a direct impact on the clinical quality of the care that can be provided. We must maximise opportunities to improve NHS buildings to make productive use of all the space available and provide the environment patients and staff deserve. We must also make the most of opportunities through integration with the council to deliver more health services from other locations such as children’s centres and schools.

3.2.8 Making the best use of taxpayers’ money

NHS Hammersmith and Fulham is responsible for an annual budget of around £350 million (2010/11). This is taxpayers’ money and we must constantly review how and where we invest to bring the maximum health benefits for local residents for the money we have.

We must shift more resources into preventive care that keeps people healthy, and community services that keep people out of hospital. The more we can do to prevent ill health the better it is for local residents, the NHS and the taxpayer.

We must also use the opportunities of council integration to deliver co-ordinated public services that offer best value and maximum benefit to local residents from our combined resources.

Improving services and getting better value do not need to be in conflict with each other. Many of the changes needed to improve local health services will make better use of our money.
3.3 ENGAGEMENT – DEVELOPING OUR PLANS IN PARTNERSHIP

3.3.1 Shaping our case for change and strategic plan
Our strategic plan is focused on addressing the challenges set out by Lord Darzi’s report *Healthcare for London – a Framework for Action (HfL)*. Lord Darzi’s proposals to improve the capital’s health services were developed through extensive discussions with clinicians and patients and give us a solid foundation of engagement.

In localising the HfL case for change we have built in further clinical leadership and used feedback from local residents to shape our plans.

- **Clinically led** - Our local case for change was drafted by our Medical Director and Public Health Director, both doctors and members of our executive team and Board. The draft was then shared with our Professional Executive Committee, Practice Based Commissioning Consortium and all local GPs.

- **Refined by partners and residents** - The case for change was refined through discussions with our non-executive board members, a joint meeting with the council’s Cabinet, the Overview and Scrutiny Committee, Borough Partnership, Local Involvement Network, our Patient and Public Involvement Network (a formal sub-committee of our Board which includes members from local patient and community groups and the sector), and internally with all our staff.

We have discussed the case for change and initial drafts of the strategic plan at 11 stakeholder events between October and December 2009 and through existing voluntary and community networks established by our community engagement team. More than 85% of people who completed a questionnaire agreed with the overall direction of the plan. There was also strong support for the proposals to make more cardiology, diabetes and respiratory care available from community settings.

Our annual general meeting in September 2009, attended by more than 80 residents, staff and community group representatives, also discussed the challenging financial future and the need to improve primary care through developing polysystems.

3.3.2 Incorporating the views of local residents
Our case for change and the projects which will deliver it incorporate our response to feedback from residents collected during engagement work since 2007. Feedback was collected through: national patient surveys; public polling (commissioned by NHS London); London-wide consultations on *Healthcare for London*; and the broad range of engagement we have conducted with the support of voluntary and community partners, the Local Involvement Network and its predecessor the Patient and Public Involvement Forum. We have distilled the feedback into the following key themes.

- **Improved access to**
  - preventive services
  - GP services
  - mental health services for BME communities
  - interpreting services across different health and social care settings.

- **Stronger links between health and social care, housing and education services** so people can have easy access to co-ordinated support for all their needs and they don’t get bounced around or need multiple appointments with different teams.

- **Improved communication & information** so people know what is available and how to get involved.
Independent public polling by MORI identified **improving access to GP services** as the top priority for Hammersmith and Fulham residents. We’ve already opened new practices and extended the hours of existing surgeries; and our overarching priority to implement polysystems is dependent on improving the quality and availability of GPs and their teams.

### 3.3.3 Engagement in shaping specific projects

We are committed to meaningful engagement with both clinicians and residents in order to plan and design local healthcare. Their involvement in shaping our strategic case for change and initial support for the draft plan is just the first step. This is being followed by systematic engagement in developing specific projects in this plan and the supporting strategies.

We have strong links with local 3rd sector organisations and patient groups including a positive relationship with our Local Involvement Network (LINK). Executives from the PCT attend a range of meetings to present and discuss local health topics.

In 2009/10 we redesigned our approach to programme management to ensure all the individual projects that contribute to delivering our vision and goals include appropriate public engagement and have clinical approval.

- **Proper engagement**
  
  All projects follow a standardised project management framework which requires documented plans for public engagement and an Equality Impact Assessment (EQIA) to be carried out before final business cases are approved. The documentation is reviewed by our Head of Engagement and support to carry out public and patient involvement (PPI) is available from our PPI team. A PPI toolkit has been created to support commissioning managers and project leads to carry out effective and meaningful engagement.

  EQIA’s ensure the needs of vulnerable/marginalised/hard-to-reach groups are considered and that all projects seek to reduce inequalities and avoid any negative impact on particular people due to race, sex, age, faith, sexual orientation, disabilities, or other factors. Independent external advice on EQIAs is available to all project leads.

- **Clinical approval**
  
  Our Professional Executive Committee (which includes three local GPs, Practice Based Commissioning lead, two nurse members and our Public Health Director, Medical Director and Chief Pharmacist) now review the business cases for all investment proposals greater than £50,000. Proposals do not go for final approval until our clinical leadership is satisfied that local needs are being addressed in an appropriate way.
3.3.4 Making the most of clinical involvement

To commission high quality cost effective care we need the frontline clinicians who work directly with patients to play an active part in our planning and decision making, both at a strategic and an operational level. Our clinical engagement strategy (included as part of our communications and engagement strategy) sets out the principles of effective engagement and identifies key actions to further improve clinical involvement.

The direct impact of clinical engagement on developing our plans includes:

- **Emphasis on quality** – Our work with Imperial College Healthcare NHS Trust to develop quality metrics for the acute contract led the way in London for the introduction of CQUINS. Our work was used as an example of key metrics to be used to monitor the quality of healthcare available to local people.

- **Clinically led service design** – We have convened working groups to redesign a number of services in the last two years, including for diabetes, musculoskeletal care and respiratory disease. The working groups report their key findings to the Professional Executive Committee for clinically led decision making. In addition, local forums for engaging secondary care clinicians have facilitated discussions on design and funding of maternity, cytology and respiratory services (leading to a respiratory consultant jointly appointed by the PCT and Imperial Healthcare NHS Trust).

3.3.5 The growing need for clinical engagement

Delivering on our plans to develop polysystems and shift more care into primary and community settings will require strong clinical leadership and engagement of doctors and nurses from primary, community and secondary services.

New engagement channels have been set up to enable this, including a monthly session for all local GPs led by our Professional Executive Committee Chairman. A number of local clinicians are also involved in the London and sector clinical reference groups supporting implementation of Healthcare for London.

Given the challenging financial future we face and the breadth of change being proposed as part of our local polysystems and the wider London and North West Sector implementation of Healthcare for London we are also creating a local prioritisation panel. The panel will include clinicians from across secondary and primary care alongside patient and public representatives. It will be used to discuss and debate how local investment is prioritised to meet the needs of local residents and ensure value for money through evidence based cost effective interventions.
3.4 PROGRESS SINCE NOVEMBER 2008

Considerable progress has been made since our previous strategic plan was prepared in late 2008. We have taken substantial steps to strengthen our commissioning arrangements and implemented or enhanced key projects which are improving the health of local people and laying the foundations for effective polysystems. Four of our most significant developments are:

3.4.1 Strengthening Commissioning

**Borough Integration** – The creation of a joint executive management team across the Primary Care Trust and local Council in April 2009 represents a major step forward in our ability to collaboratively commission services that improve the health of local residents. An early success is the move of all children’s service commissioning to be managed by the Primary Care Trust. This brings a combined budget of £14million under the responsibility of the PCT and is a vital area in which significant improvements can be made against all of our strategic goals. Our objective is to fully integrate the commissioning functions of the PCT and council. In turn, we will create more integrated frontline services that can provide the full range of support residents need in the most co-ordinated, effective and efficient way. This will be an important part of building effective polysystems and delivering the productivity gains needed in community health services. More detail on integration and its impact is given in the following section (p17).

**North West London Commissioning Partnership** – We have jointly established a new commissioning function to deal with the challenges of hospital reconfiguration and all acute contracts across the North West London sector. Through the partnership we will deliver the Healthcare for London ambitions for improved specialised hospital services including major trauma, stroke and paediatrics.

Originally developed as a tri-PCT arrangement with NHS Westminster and NHS Kensington and Chelsea, the partnership was extended to cover all eight PCTs in the sector. It is hosted by NHS Westminster and went live in September 2009.

We played a key role in establishing the partnership and will continue to play an active role to support and monitor its effectiveness through the Joint Committee of PCTs and regular collaboration with the sector executive. The partnership is also helping the eight PCTs in the sector to address management costs. The centralisation of specialist acute commissioning functions is more efficient than eight PCTs committing individual resources, and as a sector the partnership will review other options for management savings to support the target of 30% reductions.

3.4.2 Implementing & enhancing key projects

**Unscheduled care** – Following a successful tender, polyclinics have been opened as frontends to both A&E departments in the borough (Hammersmith in April 2009 and Charing Cross in Sept 2009). Both have proven successful with more than 65% of patients attending A&E now treated by primary care clinicians with no further need for hospital care. The impact on hospital admissions from A&E has also been significant with a 10% reduction (based on Hammersmith data) – bucking the national trend of rising A&E admissions.

The polyclinics give us an excellent foundation to develop our polysystems and are already showing that primary care led services and the settings they are delivered from can be transformed to offer people more support to deal with both emergencies and routine health problems.
**QOF Plus** – In 2008 we developed a local enhancement of the national Quality and Outcomes Framework (QOF) for General Practitioners. QOF+ gives local GPs extra support and resources to achieve greater performance in QOF areas where local need is highest. Working with Imperial College and local clinicians we have designed stretch targets in existing QOF indicators and added a number of local indicators.

The focus is on prevention and management of long-term conditions; and the transformation of local performance has been significant with our national ranking in some areas jumping from below 100th to the top 5 (see p55 for more details). QOF+ is a key driver for improving quality in primary care and reducing inequalities across the borough; as such it is a fundamental part of delivering effective polysystems.

Both our polyclinics and the QOF+ scheme are cited as examples of best practice in the North West London Integrated Strategic Plan; with the intention of rolling out similar unscheduled care models across the sector.

### 3.4.3 Existing national and local health priorities

<table>
<thead>
<tr>
<th>National targets</th>
<th>Performance (Q2 09/10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong performance</strong></td>
<td></td>
</tr>
<tr>
<td>Smoking quitters</td>
<td>GREEN</td>
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<tr>
<td>Timely access to secondary care: 18 week target</td>
<td>GREEN</td>
</tr>
<tr>
<td>Timely access to cancer treatment</td>
<td>GREEN</td>
</tr>
<tr>
<td><strong>Disappointing performance</strong></td>
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<tr>
<td>Maternity 12 week access</td>
<td>RED</td>
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<tr>
<td>Cervical Screening</td>
<td>RED</td>
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<tr>
<td><strong>Mitigating actions</strong></td>
<td></td>
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<tr>
<td>Additional investment in 2008/09 led to extra midwives recruited at local maternity units. Core project developed to address 12 week maternity issue (see page 35). Focus groups with local women to understand screening uptake and plan social marketing campaign/service improvements.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Local targets</th>
<th>Performance (Q2 09/10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong performance</strong></td>
<td></td>
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<tr>
<td>Tackling obesity among children</td>
<td>GREEN</td>
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<tr>
<td>Number of drug users in effective treatment</td>
<td>GREEN</td>
</tr>
<tr>
<td>Rate of hospital admissions for alcohol related harm</td>
<td>GREEN</td>
</tr>
<tr>
<td><strong>Disappointing performance</strong></td>
<td></td>
</tr>
<tr>
<td>Utilisation of the Choose and Book system</td>
<td>RED</td>
</tr>
<tr>
<td>Premature mortality in the most deprived areas</td>
<td>RED</td>
</tr>
<tr>
<td><strong>Mitigating actions</strong></td>
<td></td>
</tr>
<tr>
<td>Working with poor performing practices to encourage higher uptake of Choose and Book including a Locally Enhanced Service (LES) and publicity campaign to raise patient awareness. QOF+ aims to reduce mortality rates and focuses on reducing inequalities across primary care.</td>
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</tr>
</tbody>
</table>

Our current rating from the Care Quality Commission is ‘fair’ on quality of services commissioned and ‘good’ on use of resources.

Overall we are performing well against existing commitments and targets with some key exceptions in 2008/09 that had a significant impact on our Care Quality Commission rating. We have put actions in place to address these and are forecasting a year-end assessment of ‘good’.

Opposite is a summary of key national and local targets closely linked to our strategic objectives.
3.5 BOROUGH INTEGRATION
In March 2009 the local Council and NHS Hammersmith and Fulham approved plans for an executive integration - designed to bring significant improvements to the health and wellbeing of our residents. The integration embeds the PCT vision to improve the health of the local population alongside the Council’s vision of a ‘Borough of Opportunity’.

3.5.1 Why integrate?
Many factors that affect the health and wellbeing of local people can benefit from greater collaboration between the local authority and the NHS. As our Joint Strategic Needs Assessment concludes ‘shared problems require joint solutions’, for example:

- Availability of leisure services and town planning that considers the need for open spaces supports people to be physically active; obesity being a key local health inequality issue.
- Addressing healthy lifestyle issues such as nutrition and alcohol misuse through schools and children’s services can equip children with the knowledge and skills to make healthy choices throughout their lives.
- Better educational achievement and stable employment is linked closely to better health over people’s lifetimes.
- Improving the quality of housing and reducing overcrowding can combat a range of health problems such as asthma and the spread of diseases like TB.

The new economic climate also adds to the rationale for integration. Sharing of corporate functions offers opportunities to reduce duplication and improve the quality of local services whilst also delivering the improvements in management costs required by PCTs.

3.5.2 The integrated structure
The integration was formally established with the appointment of a joint Chief Executive and a Managing Director for Health in April 2009.

The executive management team (direct reports of the Chief Executive) are now jointly accountable for delivery against both PCT and Council targets.

3.5.3 Building on solid foundations
We already have a strong history of joint working with the council since the PCT was established in 2002, and this has been maintained across a change in the political administration.

The number of joint posts with commissioning portfolios spanning council and NHS services has increased over several years and a joint Director of Public Health was introduced in 2008.

Results of our Comprehensive Area Assessment have given Hammersmith and Fulham a ‘green flag’ for driving improvement through partnerships – meaning the local joint working across public services is considered best practice and others are encouraged to adopt similar models.
3.5.4 Delivering success

We need to ‘make every contact count’ - using every opportunity where residents use NHS or council services to promote health and wellbeing and increase people’s understanding of the services available.

Equally we need to ensure that frontline and behind the scenes services are designed to be as efficient and effective as they can be with a productive workforce that can deliver our ambitious plans for improvement.

Initial achievements include:

- The council’s children’s commissioning team has moved to report to the Managing Director, bringing a total of £14million across the two budgets under PCT responsibility.
- Staff in the council’s housing advice centre have been trained as stop smoking advisors.
- A children’s oral health programme is being implemented within schools and children’s centres across the borough.
- A GP search and registration function has been created on the council’s public website.
- Corporate services across the two organisations are being reviewed to establish the best level of integration. The PCT’s small HR and emergency planning teams have been moved into the council’s larger departments to benefit from added capacity, capability and resilience.
- Regular joint meetings of the PCT Board and Council Cabinet have been established and a joint forum for senior managers is in place.
- The PCT’s healthy living programme for staff has been rolled out to council employees.

3.5.5 Next steps

Our vision for taking integration forward is full integration of our commissioning activities across the two organisations; with the aim of commissioning more integrated frontline services that improve both quality and productivity in primary and community services.

To improve the quality of commissioning across all areas the council is adopting the NHS world class commissioning framework to promote best practice and improved services for residents.

The reviews of 24 corporate services used by both organisations will be completed over the next 12 months to identify where further integration can strengthen capacity and capability or deliver better value for money for both organisations.
3.6 PROVIDER LANDSCAPE

This section provides a brief overview of the main healthcare providers we currently commission services from, together with details of some new providers we have brought into the local market and areas for development during the course of this five year plan. There is additional provider analysis in each of the main programmes within the strategy section of this plan and in our commercial strategy.

3.6.1 Acute hospitals
Two NHS trusts provide the majority of hospital services for local residents - both are high performing trusts with national and global reputations for the care they provide. Although Patient Choice now allows people to use any hospital they wish the overwhelming majority of our residents choose to use these two trusts:

- **Imperial College Healthcare NHS Trust** runs the Hammersmith, Charing Cross, and Queen Charlotte's hospitals in the borough plus St Mary's and the Western Eye Hospital. They are currently applying for Foundation Trust status and are the country's first Academic Health Science Centre (combining academic medical research with everyday healthcare).

- **Chelsea and Westminster Healthcare NHS Foundation Trust** is based just outside our borders and is used by many residents in the south of the borough as their local hospital.

3.6.2 Primary care
There are 32 general practices in the borough, ranging in size from single-handed doctors to teams of 20+ GPs in our new polyclinics. Our polyclinic based practices register patients from anywhere in the borough and all local lists are open giving residents a choice of practices to register with. The quality and range of services varies considerably across practices and the current geographical spread means our more deprived areas are under-served. 26 practices are part of our enhanced service scheme Quality and Outcomes Framework Plus designed to improve performance in specific types of care where there is high local need.

Continued investment in dentistry means there is ample provision of NHS dentistry in the borough with 26 dental practices with NHS contracts of varying sizes, offering residents a wide choice of services. New child friendly services have been commissioned in seven practices in 2009. A new practice is being opened in the north in January 2010 to provide extra access in an area of high need.

There are 40 community pharmacies in the borough. In recent years local pharmacies have shown a strong desire to expand the care they provide and the majority now provide extended services including stop smoking support and Chlamydia screening. We are also developing pharmacies as additional providers for vascular screening.

3.6.3 Community healthcare
Central London Community Healthcare (an alliance of the community services of three primary care trusts) are the main provider of community nursing and therapy services; they are also responsible for the healthcare service provided in Wormwood Scrubs Prison. We are working with CLCH to ensure value for money and are reviewing which community services need to be market tested to ensure the most cost effective provider is in place. In the past year we have introduced new providers through tenders for specific elements of community services including the Family Nurse Partnership to help vulnerable teenage mothers and a new musculoskeletal service.

3.6.4 Mental health
The majority of mental health services are provided by West London Mental Health NHS Trust. The trust has a number of quality issues to address and as the only viable provider for many services we are working closely with them to improve standards. A range of services are also commissioned from voluntary organisations and there is increasing potential to develop the 3rd sector as providers of mental health support.
3.6.5 Voluntary and community organisations
We commission a range of local organisations to provide health and wellbeing services. There is a strong local 3rd sector with good engagement in NHS issues through our Patient and Public Involvement Network, the local LINk and other forums. We are expanding our use of the 3rd sector particularly in relation to self-care, health promotion programmes and community engagement work. In 2009 a number of new providers have been commissioned to deliver Expert Patients Programme, Health Trainers, Health Champions and Community Researchers.

3.6.6 Private providers
A relatively small number of health services are commissioned from private providers. Clinicaenta (day case and out-of-hospital services) and InHealth (community diagnostics) both supply care to local residents as part of London-wide contracts managed by the NHS London. Services are quality assured through NHS London.

In 2009 we re-commissioned our stop smoking services and awarded the contract to a new independent organisation established by experienced stop smoking advisors. The early results have been very good with performance above trajectory (mid Dec 2009 4-week quitters at 721 compared to trajectory of 640) for an important target that the PCT missed last year.

3.6.7 Developing the market & introducing new providers
A number of tenders completed in 2008 and 2009 show that there are a range of new and existing providers keen to bid for contracts. This is a positive sign as we begin work to establish polysystems which will be developing an extended range of primary and community services with a growing emphasis on prevention and support to address the wider determinants of ill health.

Contracts have been awarded to a range of new providers including newly established organisations (stop smoking), Primary Care Trusts from outside London (Family Nurse Partnership), and voluntary organisations (Expert Patient Programme). We are also working to establish an existing in-house service for HIV support (Living Well) as a social enterprise – proposals approved by our Board in November 2009.

The response to our unscheduled care tender demonstrated that local NHS providers are willing and able to create new partnerships that break down traditional organisational boundaries across acute, community and primary care in order to deliver services designed around patients' needs - an essential requirement for us in commissioning the new services that will cross polysystems, local and specialist hospitals.

We are also keen to develop new local providers for preventive services and long-term condition support - areas where there are considerable health inequalities due to the higher prevalence in minority and deprived communities. Small community groups often have direct access to the people most in need of this help, so they offer us an opportunity to commission targeted improvements where they are most needed. However, the tendering and contracting processes of the NHS can be a significant barrier for these potential providers to overcome. To address this we are proactively working with local organisations and establishing a ‘training academy’ to help them develop the business skills needed to effectively bid for the services we tender.

3.6.8 Ensuring Patient Experience is a quality metric
We now formally require all new and reviewed contracts to include a requirement for providers to collect and report back on patient experience data. This is established in the new contract with our community provider and the unscheduled care contract which provides our polyclinics and out-of-hours GP services.
3.7 ACTIVITY COMMISSIONED

In 2009/10 NHS Hammersmith and Fulham commissioned approximately £350 million worth of healthcare for local residents.

The chart opposite shows how our 2009/10 budget is split (percentage) across the different areas of healthcare.

Predicted activity growth & shifts

Changes in activity are modelled based on projections including: population growth; demand increase (based on preceding years' profile; capacity needed to meet national and local targets; impact of service redesign through implementing Healthcare for London).

Modelling for activity shows that there will be growth in all sectors over the course of this plan. However, through the implementation of polysystems and the associated redesign of services there will be a proportional shift away from activity in hospitals, with primary and community services delivering more of the care residents need.

The graph opposite shows the expected growth in spend on hospital activity (elective and non-elective spells) under the two scenarios of continuing as normal (no polysystems) or implementing polysystems.

As shown in the financial scenario section, continuing as normal is not a sustainable approach given the economic conditions. It will be essential to improve productivity across all sectors and to shift activity where appropriate into primary and community services; whilst simultaneously reducing demand for health services through effective prevention and early intervention.
3.8 FINANCIAL POSITION

NHS Hammersmith and Fulham has an annual budget of around £350m and is in a strong financial position; with annual surpluses generated since 2004/05 (ranging from £1m – 18.5m). We are forecasting a £10.5m surplus for 2009/10. The financial growth which the NHS has benefited from over the past decade has enabled us to implement many improvements in services at the same time as maintaining strong, sustainable finances. However, the three financial scenarios (section 5.3) provided by NHS London show that future growth will be limited at best.

We have a window of opportunity over the next two to three years to use our surplus and funds lodged with NHS London to make strategic investments to establish effective polysystems and ensure delivery against our goals and the challenges set out in our case for change; alongside ensuring sustainable finances.

The key investments outlined in this plan are designed to increase capacity in primary and community care and redesign clinical pathways to shift activity from hospitals into polysystem settings. The focus on a relatively small portion of our total investment is essential in order to put the polysystem infrastructure in place and begin the clinical pathway redesign work (outlined in section 4.2) that will ensure the most effective long-term use of the total investment made across acute, community and primary care.

Our plan has been modelled under three funding scenarios provided by NHS London: a base case with low growth; scenario 1 with no growth; and scenario 2 with moderate growth.

Using the NHS London affordability assumptions and additional local work with McKinsey to refine the modelling the work within this plan will ensure an affordable local healthcare system under the most challenging of the financial scenarios (scenario 1).

Section 5.3 gives more detail on each of the potential scenarios.
Overview of investments outlined in this plan

The chart below shows the spread of investment and disinvestment identified in our priority programmes. It shows how activity (and spend) will shift out of hospital services through projects such as developing community rehabilitation, offsetting increased investment in primary and community services as part of developing polysystems.

The impact of these changes is set out in detail in the sections on each programme. But first the plan sets out how we arrived at this set of programmes and projects through our prioritisation process.
4. Strategy

This section covers the core programmes that will deliver our vision and goals and the prioritisation process we used to identify key projects. The overarching priority is the implementation of local polysystems. Following a detailed description of our polysystem proposals we cover projects within each of the Healthcare for London care pathways. In addition we have a local programme for offender health (due to Wormwood Scrubs Prison being in the borough) >>>

4.1 Prioritisation

4.1.1 Refining our 2009-2014 strategic plan

The new economic climate and our own capacity to deliver a large number of projects effectively has led us to review the 90 plus projects linked to our previous strategic plan to prioritise those that should go ahead from 2010 onwards.

Projects in this plan were prioritised after consideration of:

- Healthcare for London, notably our ambition to develop effective and efficient polysystems
- Likely impact on health and wellbeing outcomes and reduction of health inequalities as identified in JSNA (including the views of local residents)
- Available evidence base supporting project/investment
- Sustainability, value for money and their potential to deliver or facilitate future efficiencies, in light of the financial environment
- Deliverability, in light of our management capacity
- A need to address identified quality or safety issues
- Impact on sector/partners of not continuing with a project

The evidence base was augmented by programme budgeting information (we lead an ONS cluster Programme Budgeting Forum and have particularly used programme budgeting around mental health care provision).

This approach comprises level 1 of our prioritisation framework.

What’s in?
An example of how one of the key projects in this plan meets a number of these criteria is the long-term condition programme on page 47. Redesign of care pathways for long-term conditions is in line with Healthcare for London and will improve the health of patients through among other things better disease management and more convenient access. A shift from providing services in hospitals to primary/community care is part of developing effective polysystems and delivering financial sustainability.

Quality improvements are being addressed within programmes for planned care, mental health and offender health.

What’s out for now?
Examples of projects developed in our last strategic plan which have been deferred (and the rationale) include:

- Lymphoedema service redesign (modelling concluded this was not a cost-effective to continue as an individual PCT, now discussing a sector approach with other PCTs)
- School health project for private schools (need to focus resources on most vulnerable children & families)
**Level 2** of our prioritisation framework is to prioritise specific projects/interventions.

The basic ranking is by cost-effectiveness (where possible cost per quality adjusted life year) with the potential for a number of specified factors to modify the ranking.

‘Need’ is a prerequisite for getting on the list of things to be considered.

Nationally set ‘must dos’ are outside prioritisation.

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**4.1.2 Establishing a Prioritisation Panel**

Effective commissioning needs strong clinical and public representation in the strategic prioritisation process. We have listened to and involved both clinicians and residents in drafting our case for change and developing this strategic plan. However, in 2010 we are taking a further step to formalise systematic engagement in our prioritisation process. We will establish an local priority setting panel including: local clinical experts; representatives of all the major clinical groups; and patient and public representatives. The lay-members of the group will be given training and support to ensure they can play an active role in debate about how the NHS in Hammersmith and Fulham should prioritise investments to meet local needs and make the most appropriate use of our finite resources.

**4.2 PROGRAMMES**

As outlined above we have revised our strategic plan initiatives in 2009 to include projects addressing the eight *Healthcare for London* care pathways. In addition, due to having Wormwood Scrubs prison in the borough, we have an important additional responsibility for the health of inmates and have added offender health as a specific programme.

*Healthcare for London* requires actions at a borough, sector and pan-London level – with the work across these three levels co-ordinated to ensure an optimal and consistent approach. Our plan addresses actions being taken in Hammersmith and Fulham. It supports and should be read in conjunction with the North West London Integrated Strategic Plan.

The following section gives details of the core programmes we are investing in over the next five years in order to deliver our vision and goals; and to implement *Healthcare for London*. 
4.3 DEVELOPING POLYSYSTEMS

Effective polysystems will provide the platform for NHSHF to deliver the improvements in health and local services set out in our case for change.

4.3.1 Polysystems vision

Our polysystems will improve the health of the local population, by increasing capacity and capability in primary and community care; and redesigning services to provide the right care, in the right place, at the right time. Higher quality care and better value for money will be achieved together.

4.3.2 Impact on health outcomes

Creating polysystems will:

- **Improve prevention and early detection for those most at risk** – more resources will be put into preventing ill-health (keeping people disease free and supporting those with long-term condition to keep symptoms under control). For those most at risk services will be responsive to individual needs and prevent conditions reaching crisis point. Our QOF+ scheme (section 4.4) shows how effective early detection and treatment can be. In line with sector plans Expert Patient Programmes will be extended, with existing multi-condition sessions supported by condition specific courses where appropriate.

- **Redesign clinical services** – clinicians across secondary, primary and community care together with partners from social care will design the optimal pathways to support their patients. Services will be based around the needs of the patient, providing the support or treatment they need from the most appropriate locations.

- **Increase capacity and capability in primary and community care to extend the services available outside hospital** – more doctors, nurses and therapists will be employed across primary and community services meaning an extended range of care available to patients without having to be referred to hospital.

- **Create integrated teams offering patients a simple holistic service** – integration will occur between secondary and community health services and across health and social care boundaries. Integrated commissioning across the Council and PCT is increasing opportunities for integrated provision, with services for children and families a core focus – helping children to grow into healthy adults and ensuring the most vulnerable are protected and enabled to thrive.

- **Provide greater efficiency and better use of resources** – More efficiently designed services will reduce the administrative burden on clinicians, allowing them to spend more time with patients. Reducing the duplication that currently exists across primary and secondary care will release resources to be reinvested elsewhere. Developing modern energy efficient buildings supporting larger clinical teams will also allow the sharing of management and back office functions.

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**What is a polysystem?**

A network of primary and community clinicians providing an extended range of care; including many treatments and tests currently carried out in hospitals.

Supported by a polyclinic hub, housing the latest diagnostic equipment, care will be provided from GP surgeries, health centres, pharmacies, and in patient’s homes – with community sites such as schools, children’s centres and leisure centres used where appropriate.

Polysystems will be designed around populations of at least 60,000 with services tailored to meet the specific needs of communities they serve.

They will transform the quality of primary and community care, helping people to stay healthy and reducing the need for hospital treatment – whilst delivering best value for taxpayers.
4.3.4 Progress to date
Since 2008 we have laid a number of the key foundations which our polysystems will be built upon:

- **Polyclinics open** - In 2009/10 we opened two polyclinics as front-ends to our local A&E departments. Both centres are showing that on a daily basis 65% of people walking into A&E can be seen by a primary care clinician. Admission rates from A&E are down more than 10% despite increasing attendances – bucking the national trend of increasing admissions. Our centres were the first in London to adopt the A&E front-end model and are now cited as examples of best practice in the NWL Integrated Strategic Plan with the intention that the same model is rolled out across the sector. Healthcare for London now uses our urgent care tender as an exemplar for others across London to follow.

- **Pathways redesigned** - Clinically led redesign of care pathways is fundamental to delivering an effective polysystem. Respiratory, diabetes and musculoskeletal care have already been redesigned and a programme of work set out for further specialties over the next 18 months (see page 31)

- **Primary care quality improvements** - Our Quality and Outcomes Framework Plus (QOF+) scheme, developed through a close partnership with Imperial College and local GPs, has shown significant improvements in the level and quality of care being provided in general practice. This innovative scheme to provide GPs with additional support and resources underpins our aims to deliver more for local patients from primary care (see page 58). Strong performance management is also important in driving up quality in primary care. To address this we have a performance management framework for general practice. Where possible we support practice to improve areas of underperformance. Where necessary we will remove contracts from poor performing services.
4.3.4 Putting the infrastructure in place

Building a local healthcare infrastructure capable of delivering expanded primary and community services is an essential first step.

Primary and community care services are currently too fragmented with a number of buildings underutilised and a significant number below minimum Disability Discrimination Act (DDA) and NHS standards.

By 2013, two polyclinics (Centres for Health) plus four other developments will provide appropriate high quality primary care environment to replace our current 13 non-compliant GP premises and provide a cost effective solution to expanding primary care capacity to support the polysystem service shifts.

4.3.5 Key building and refurbishment projects

- **Wandsworth Bridge Road**
  Business case – Dec 2009
  Completion – Dec 2010

- **White City Health and Care Centre**
  Business case – Jan 2010
  Completion – Dec 2011

- **Current White City and Stamford Brook**
  Disposal – Jan 2012

- **North End Road**
  Business case – Jan 2010
  Completion – Dec 2010

- **Fulham Centre for Health**
  Phase 2 completion – Jun 2010
  Phase 3 completion – Dec 2011

- **Shepherds Bush**
  Options appraisal – Mar 2010

- **Parsons Green**
  Development start – Jan 2012

- **Richford Gate**
  Refurbishment – Oct 2010

Capital requirements for these plans are set out in the finance section on page 75.
4.3.6 Alignment with other polysystems in the sector
For our integrated strategic plan to deliver the planned improvements in hospital based care it is essential that each PCT provides a consistent minimum standard of polysystem that will allow the shifts in care from hospitals to take place.

In line with the NWL sector plans for polysystems each local system will include:
- Pre referral and pre operative diagnostic workups (not duplicated in hospitals)
- Children’s Centres used as locations to provide care / support services
- End of Life partnership to work with nursing homes
- 55% of outpatient appointments
- Integrated mental health services

As part of our original urgent care tender, which set up our first polyclinics, a Single Point of Access (SPA) phone line is also being established (integrating with the existing inner north west London service cited as best practice in the sector). This will be a 24hour advice line to direct patients seeking care and supporting clinicians to make appropriate referrals to other services.

4.3.7 Localising polysystem design to meet residents’ needs
Over and above the minimum standards for the sector we will design our polysystems to meet specific local needs. The large inequalities in health and healthcare provision between the north and south of the borough require two distinct polysystems. Each will be supported by a polyclinic hub (using the community based model in the north and the hospital based model in the south).

For the north, as the more deprived area, there will be a polysystem serving a smaller population of 75,000. Particular issues it will address include a wide variation in quality and accessibility of existing primary care, high levels (relative to the rest of the borough and national averages) of smoking, heart disease, respiratory disease, teenage pregnancy, depression and diabetes.

The polysystem hub will be the new White City Health and Care Centre (polyclinic) which will be completed in early 2012. A temporary service opened in January 2010 located on the grounds of a local school. The polysystem will include approx 13 practices with 45 GPs. Between three and seven existing general practices will relocate to the polyclinic and the remainder based in normal GP surgeries supported by the hub.

A Connected Care project in partnership with the national charity Turning Point is being used to ensure a high degree of community engagement in designing the final polyclinic service model. Core services will include:
- urgent and planned care polyclinic services currently delivered at Hammersmith Hospital
- diagnostics including x-ray and ultrasound
- primary medical services for up to 50,000 patients
- extended primary care services delivered from the temporary facility at Canberra school
- community, specialist and general dentistry
- a Local Pharmaceutical Service enhanced community pharmacy
- newly redesigned clinical pathways e.g. community diabetic service, respiratory service, musculoskeletal, cardiology, ear nose and throat
- two community mental health teams & Improving Access to Psychological Therapies service
- adult integrated learning & physical disabilities services and 3rd sector disabilities services
- integrated health and social care teams for adult support
- integrated teams for vulnerable children

In order to meet our ambitious plans all these services will be redesigned over the next 18 months. The polysystem will be further supported by a new development at Shepherd’s Bush that will replace at least three current practices and provide enhanced primary care for residents which will be moving into new housing planned for the area.
For central and south, a polysystem will serve 110,000 residents. Characteristics of the population include a relatively healthy population and good standard of primary care with easy access (which attracts patients from the north and those who work locally but live further away).

The polyclinic at Charing Cross Hospital (Fulham Centre for Health) will be the hub; linked to three smaller developments which will recycle existing health buildings at Parson’s Green and Wandsworth Bridge Rd and a new development scheduled for late 2010 on the North End Rd, as well as existing high quality primary care premises. The polysystem will include approximately 18 GP practices with 85 GPs.

Fulham Centre for Health currently provides 65% of former A&E activity through a primary care front-end and GP practice with capacity for 15,000 patients. The service will be expanded in two further phases with the next phase to complete in June 2010 providing:

- a Local Pharmaceutical Service enhanced community pharmacy
- one-stop shop, integrated community diabetes service
- Tier 1 and 2 alcohol service
- Improving Access to Psychological Therapies (IAPT) services
- breathlessness clinic and rapid access respiratory service
- cardiology diagnostics, outpatients and rehabilitation services
- full range of enhanced primary care services
- new services to accommodate the service redesign of outpatient and intermediate care as a result of the Polysystems Programme including access to multi-disciplinary musculoskeletal and pain management services.

Through the transfer of care to home and community based services we plan to decommission 27 rehabilitation beds, to facilitate the closure of inpatient rehabilitation services. The space being freed up will be able to support the plans for providing further primary care services in the polyclinic.

4.3.8 Community services and homecare
Enhanced community nursing and therapy services will support primary care to provide more care for residents without the need for hospital visits. Community teams will be based at the two polyclinic hubs with clinics also run from GP surgeries and health centres linked to the polyclinic.

Clinical pathway redesign will, where safe and effective, aim to provide more care in patients’ homes; either through clinicians visiting patients or equipment being provided to allow people to self-manage long-term conditions.
4.3.9 Clinical Pathway redesign

Applying NHS London modelling and additional local analysis with McKinsey has created a hierarchy of opportunity based on improving clinical quality, improved efficiency and use of resources and likely deliverability.

Each clinical pathway has its own service redesign programme team, clinical leads from both primary and secondary care and is supported by detailed analytical and modelling support. This mirrors the completed redesign work around Unscheduled Care which is already delivering to target (65% attendances in primary care) and Musculoskeletal which goes live in March 2010. The full programme is set out below. This may be subject to change as we attempt to rationalise and coordinate timescales with partner PCTs commissioning services from the same providers.

Initial analysis indicates that implementing these service shifts (coupled with decommissioning of ineffective interventions and reductions in unit cost of out of hospital care) will result in £19m of savings per year by 2014. We plan to reduce outpatient attendances by 30% which will include reducing new to follow-up ratios. 55% of this activity will be re-provided in the polysystems. This work will closely dovetail with the sector-wide work as the analysis predicts that our need for acute sector beds is likely to reduce by 161 over the same period.
4.3.10 Delivering the vision

In order to deliver the ambitious vision in a timescale commensurate with our status as an exemplar site we have developed a polysystem programme board, chaired by the Managing Director to oversee the core work programme. The programme includes five separate transformation workstreams supported by four cross-cutting enabling workstreams. Consultant support has been procured to map out the full programme, ensure programme controls are built in place from the outset and ensure the interdependencies and interfaces are managed.

The Council is fully engaged in the transformation programme and council directors are leading the workstreams for out of hospital care and integrated children’s services. The creation of integrated commissioning and provision for these services will enable us to make “every contact count” and provide more responsive services whilst increasing efficiency.

This transformational programme is supported by Central London Community Healthcare, which now covers three PCTs, and provides the bulk of our community services. It is not anticipated that given the scale and pace of the transformational workstream that we will separately market test existing services, before optimal services models have been determined.

<table>
<thead>
<tr>
<th>Work streams</th>
<th>Key goals</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary care</td>
<td>Contract for high quality universal primary care – commission new GP practice frontends for A&amp;E</td>
<td>Sept 09</td>
</tr>
<tr>
<td></td>
<td>Develop new interim provision for White City</td>
<td>Jan 2010</td>
</tr>
<tr>
<td></td>
<td>Commission new provision for central Fulham</td>
<td>Jun 2010</td>
</tr>
<tr>
<td></td>
<td>Current Primary Care Performance Management Framework to deliver change in provider performance or change of provision.</td>
<td>Ongoing</td>
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<tr>
<td></td>
<td>Develop a commissioning model for enhanced primary care across localities.</td>
<td>Sept 2010</td>
</tr>
<tr>
<td></td>
<td>Review the requirements from primary care to develop effective polysystems. To contract with eligible providers for outcomes based contracts for localities.</td>
<td>Sept 2010</td>
</tr>
<tr>
<td></td>
<td>Current balanced scorecard reviewed and new quality indicators developed. High quality practices to be accredited as providers of enhanced primary care (development of QOF Plus model)</td>
<td>Dec 2010</td>
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<tr>
<td></td>
<td>Appraise polyclinic / polysystem management options including potential for an Integrated Care Organisation in White City.</td>
<td>Dec 2010</td>
</tr>
<tr>
<td>out of hospital care</td>
<td>Re-engineer rehabilitation services to reduce bed usage at Charing Cross by 27 beds.</td>
<td>Jan 2010</td>
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<tr>
<td></td>
<td>Develop and implement population risk stratification tool.</td>
<td>Feb 2010</td>
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<tr>
<td></td>
<td>Map funding flows in primary / community / social care based on aggressive implementation of polysystem development</td>
<td>Feb 2010</td>
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<tr>
<td></td>
<td>Develop optimal model of Out of Hospital support across health, local authority, voluntary and private sector and commission / implement.</td>
<td>Mar 2010 to implement by Sept 2010</td>
</tr>
<tr>
<td>clinical pathway redesign</td>
<td>Prioritise clinical pathways for redesign based on financial opportunity, improved clinical quality and deliverability.</td>
<td>Dec 2009</td>
</tr>
<tr>
<td></td>
<td>Implement new models of care for clinical pathways</td>
<td>See page 31</td>
</tr>
<tr>
<td>Integrated children’s services</td>
<td>Integrate children’s commissioning across health, social care and education.</td>
<td>Dec 2009</td>
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<tr>
<td></td>
<td>Develop and implement new model for integrated support for disabled children moving community paediatrics out of acute setting.</td>
<td>Jun 2010 / Dec 2010</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Develop options for reconfiguration of services across three PCTs to increase productivity.</td>
<td>Feb 2010</td>
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<tr>
<td></td>
<td>Develop costed optimal model of service provision to promote recovery model and agree implementation timeline.</td>
<td>Apr 2010</td>
</tr>
<tr>
<td><strong>Enablers</strong></td>
<td>Restructure PCT to align to commissioning cycle and implement polysystem - procure additional support for information analysis &amp; programme management</td>
<td>Dec 09</td>
</tr>
<tr>
<td>Organisational development and stakeholder engagement</td>
<td>Align council support for polysystem development</td>
<td>Oct 09</td>
</tr>
<tr>
<td></td>
<td>Engage primary care in polysystem development</td>
<td>Sept 09</td>
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<tr>
<td></td>
<td>Develop detailed stakeholder engagement strategy</td>
<td>Jan 2010</td>
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<tr>
<td>Finance and Information</td>
<td>Procure support for full polysystem modelling and complete task</td>
<td>Dec 09 / Feb 10</td>
</tr>
<tr>
<td>Management</td>
<td>Develop specification for Business Information Unit to support transformational change and implement</td>
<td>Feb 10</td>
</tr>
<tr>
<td></td>
<td>Model financial impacts of service changes</td>
<td>Ongoing</td>
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<tr>
<td>Clinical Commissioning</td>
<td>Create Referral Information Service to support redesigned care pathways</td>
<td>Mar 2010</td>
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<tr>
<td></td>
<td>Agree development funding for PBC consortium</td>
<td>Jan 2010</td>
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<tr>
<td></td>
<td>Agree new model of clinical commissioning including new incentives for engaging in polysystem redesign, new governance framework, sub-PCT structure and redesign role of PEC.</td>
<td>Feb 2010</td>
</tr>
<tr>
<td>Estates</td>
<td>Building and refurbishment projects for polysystem sites</td>
<td>See page 28</td>
</tr>
</tbody>
</table>
4.3.11 Improving productivity in primary and community care

The structure of our polysystems will support increased productivity in primary and community services allowing clinicians to spend a greater proportion of their time with patients or on clinical leadership work to pass on their skills and experience to others.

Practice clusters and larger practices based in polyclinics will enable sharing of more efficient practice management/administration functions and integration of IT systems – reducing the time clinicians spend on administrative work.

The integration of frontline community services with the council will also support improved productivity with streamlined processes, enhanced skill mix within teams and less duplication.

Redesigning care pathways around integrated services will also happen across the NHS and we are working with the rest of the North West London sector on workforce development. The Health Innovation and Education Cluster led by Chelsea and Westminster Hospital Foundation Trust and the Northwest London Collaboration for Leadership in Applied Health Research and Care (CLAHRC) also offer opportunities to redesign care pathways around integrated services.

We are also working with Central London Community Healthcare to improve patient-facing time of community nurses and therapists. Health visiting and district nursing are particular services where improvements are needed. CLCH has piloted mobile technology to reduce travel time spent between the service base and patient homes. Other initiatives are also being developed and the PCT Board received regular reports on productivity measures.

4.3.12 Revenue funding

We have budgeted £5million over two years to establish our polysystem. This will fund the additional set up cost of extra capacity in primary and community care services and a period of double running while services are moved from hospital settings.

Capacity will need to be increased over and above that currently provided within the acute sector as our experience of improved case finding and population risk stratification through QOF+ (and the current gap between our expected and actual prevalence levels for some chronic diseases, see page 7) indicates that current provision is insufficient to manage chronic disease to the highest possible standards.

Once the new primary and community services are established we will decommission the hospital based capacity to release funding to cover the recurrent running cost of the polysystem. Increased productivity and capabilities within the polysystem will also reduce the need for some elective procedures, releasing further savings.

Capital funding requirements for buildings and IT infrastructure to establish our polysystems are given in the finance section (page 75).

4.3.13 Links to sector wide polysystem planning

We are working closely with the North West London Commissioning Partnership to ensure our polysystems deliver the minimum standards needed to support the sector wide hospital reconfiguration programme set out in the Integrated Strategic Plan.

To ensure the whole sector has a sustainable financial future it will be essential that all eight PCTs develop polysystems that enable the required level of shift in hospital care to primary and community settings. We are confident that our polysystem plan will deliver over and above what is required and as an early implementer we will share our learning across North West London and London as a whole to support polysystem implementation.

*The focus of our 2009-14 strategic plan is implementation of polysystems. The projects in the eight Healthcare for London programmes that follow cover the work needed to create our polysystems infrastructure and some of the initial service improvements made possible by polysystems*
4.4 MATERNITY AND NEWBORN

4.4.1 Overview
Local women already benefit from two high quality maternity units at Queen Charlotte’s Hospital and Chelsea and Westminster Hospital. They are offered a choice, depending on their circumstances, of three place of birth options (home birth, midwifery led care or hospital birth supported by a medical team).

However there are still areas that need developing to give a better service during pregnancy and labour, and to improve the immediate and longer-term health of mothers and their children. A key issue which cuts across several elements in the case for change is midwifery workforce capacity. In 2008/09 extra investment allowed Imperial College Healthcare to recruit ten more midwives, leading to significant improvements in the number of women assessed by a midwife within 12 weeks (up from 33 to 72% - National target for 2009/10 is 84%, 2010/11 is 90%). There has been an increase in the ratio of midwives to women (up from 1:37 to 1:34 – London target is 1:30). The increased ratio has developed the capacity to achieve 1:1 care during labour.

We are working with the seven other PCTs in the sector through the North West London Integrated Strategic Plan to address; the provision of maternity units and related workforce requirements; reductions in caesarean sections; increased provision of home birth; increase patient satisfaction and to ensure NICE standards are met.

4.4.2 Core projects

1. Twelve week maternity assessment – further investment for providers to recruit more midwives; rollout of North West London standardised GP ante-natal referral forms; online and telephone self referral for Imperial College Healthcare Trust; midwifery support provided in local children’s centres; and targeted community engagement to publicise benefits of early booking and ante-natal care

2. One to one midwifery care during labour – further investment for providers to recruit more midwives.

3. Convenient support before and after birth – A range of targeted integrated services including the Family Nurse Partnership service launching in January 2010; named health visitors and midwives linked to each of the boroughs 15 children’s centres; ante-natal and post-natal elements added to QOF+; borough wide parenting programme; and improved peri-natal mental health services and care pathways.

Five year programme investment

<table>
<thead>
<tr>
<th>Year</th>
<th>£000s</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>2010/11</td>
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<tr>
<td>2012/13</td>
<td>1108</td>
</tr>
<tr>
<td>2013/14</td>
<td>1108</td>
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</tbody>
</table>
4.4.3 Impact on health outcomes

- **Twelve week maternity assessment** – by March 2011 90% of all pregnant women to receive an assessment from a maternity professional within the first 12 weeks of pregnancy. More women accessing maternity services in early pregnancy will identify vulnerable mothers and those with more complex needs. Addressing these needs early and effectively will improve pregnancy outcomes for women and their children.

- **One to one midwifery care during labour** - Safer childbirth, better maternal and infant health outcomes, improved patient experience

- **Convenient support before and after birth** - Family Nurse Partnership helping 50-70 teenage women and their children and families each year (contributing to reduced infant mortality and fewer low birth weight babies). More women quitting smoking during pregnancy (current rates low at 3%). Increase in immunisation uptake (target of 90%) and rates of breast feeding at 6-8 weeks (2009/10 target 80%).

- **Perinatal mental health**: Equitable provision & access to perinatal mental health services in line with NICE guidelines

4.4.4 Impact on inequalities

Improved access to early midwifery assessment will improve the identification of vulnerable women and offer the support they need. The Family Nurse Partnership programme is specifically aimed at increasing support for the most vulnerable young parents.

4.4.5 Potential efficiency savings

We are not predicting any direct efficiency savings within this programme although improved care and support particularly for women who are vulnerable or have complex needs should help reduce higher cost treatments such as caesarean sections, and will prevent mothers and their children needing additional support later in life.

An increase in breastfeeding will have a long-term impact on obesity and related chronic conditions e.g. diabetes. The Family Nurse Partnership will provide long-term savings through health promotion and increased uptake of preventive services. Self referral systems will improve access whilst reducing bureaucracy.

Karen is 16, she lives in Wormholt Park and is 11 weeks pregnant – her bump isn’t showing so she hasn’t told her mum yet, but she’s convinced she wants to keep the baby. She smokes and is overweight.

**How it might have been in the past:**
Karen confides in her school nurse who offers advice, but she keeps putting off telling her mum until the bump shows. Being overweight she hides it until her 16th week and is a month late for her first scan.

She continues smoking and together with a poor diet this affects the development of her child who is born below the ideal weight.

Putting off telling her mum also caused problems at home and means there are regular arguments. Both Karen and the child’s grandmother continue smoking around the house and the baby misses his first immunisation appointment.

The stress of the baby and arguments with mum make concentrating at school impossible and Karen flunks all her GCSEs.

**How it can be in the future:**
Karen confides in her school nurse and is told about the new Family Nurse Partnership project. Karen meets with the team and is given specialist advice and support. She gets booked in for a 12 week scan and is convinced that telling her mum is best.

Karen’s support nurse meets with her and her mum to talk about the pregnancy, labour and the future. Now well informed about what to expect Karen quits smoking and pays more attention to eating a diet that will help her child develop.

Her mum and boyfriend have come to terms with the pregnancy. Mum is at the birth and encourages Karen to breastfeed the baby.

The support team are in regular touch with Karen and make sure she remembers all the baby’s immunisations and knows all about the support from local Children’s Centres.

With granny’s help Karen keeps on top of school work and gets through her exams with a decent set of Cs and the odd B. Inspired by the support she’s received Karen’s ambition is to train to become a midwife.
4.4.6 Implementation timeline

- Maternity elements introduced to QOF+ (Apr)
- Health visitor in children centre (09/10)
- Launch of Family Nurse Partnership (Jan)
- Perinatal mental health services reviewed (Jun)
- Health visitors in social work teams (Dec)
- Community engagement for targeted ante-natal care in place (Apr)

2009 2010 2011

4.4.7 Provider landscape / market assessment

- High quality hospital providers in place. Popularity causing some problems with local women not always able to book.
- New NHS provider successful in Family Nurse Partnership tender
- Integration of local community providers across three PCTs supports sharing of best practice, economies of scale and work towards a level playing field of quality services.
4.5 CHILDREN AND YOUNG PEOPLE

4.5.1 Overview
Improving services for children is a key part of our polysystem work. We have integrated children’s commissioning across the PCT and council to ensure strong community-based services. Children’s Centres will be polysystem locations.

Childhood obesity is higher than average (23% of children are obese by the final year of primary school). We have invested substantial sums in NHS dentistry to ensure easy access but tooth decay is still a big problem for local children. Increased efforts to promote childhood immunisations saw rates creeping up over several years but they remain too low for population immunity.

The new primary care services at local A&E departments increase the local availability of urgent care for children. Improvements to hospital-based care for children, including the appropriate provision of inpatient paediatrics, are being developed across the North West London sector and are addressed in the Integrated Strategic Plan.

Services will be developed further to take full advantage of the new polysystem developmental programme. The PCT is already working in close collaboration with the Council and NW London Commissioning Partnership, as has a multidisciplinary and multiagency approach to all aspects of children’s services, involving local Trusts, the voluntary sector, schools and Children’s Centres. Initiatives will address the full lifecycle of health and wellbeing, including health literacy, education, prevention, early detection, child-friendly access, care closer to home, support for families and carers, high-quality specialised care, rehabilitation, transitional and long-term support.

Particular priority for pathway redesign will be given to universal child health and care for those with complex needs. A key priority is to address issues early in childhood and prevent illness later on, recognising that most successful programmes must engage the whole family. We will exploit the wide range of existing mechanisms to talk to children, young people and parents and carers about the redesigning of services.

4.5.2 Core projects

1. Childhood obesity – a range of prevention and treatment programmes (Boost 0-5 years, MEND 7-13 years [family support services for overweight children], Bike-it, free swimming, QPR and Chelsea football club supported activities); programmes such as Cook and Eat as part of extended schools and others delivered through children’s centres and community groups; and the Healthy Schools and school meals standards.

Programme case for change
- Childhood obesity rates are too high
- The oral health of local children is poor despite ready access to NHS dentistry
- Immunisation rates are too low
- Children need better support and advice in primary care
- Children with complex needs need a more accessible community service

Five year programme investment

![Five year programme investment chart](chart.png)
2. **Child oral health** – a range of prevention and treatment activities including accreditation of local dentists as child friendly; school and family based health promotion programmes.

3. **Childhood immunisations** – implement new Failsafe team to follow up on missed immunisation appointments and strengthen work with primary and community clinicians.

4. **Children’s support in primary and community care** – Integration of frontline children’s services with community based provision for universal, services, vulnerable children and those with complex needs. Strengthening community services with school health model and health visitors working in Safeguarding teams.

4.5.3 Impact on health outcomes

- Prevent further increase in childhood obesity rates. Increase percentage of children taking part in two hours of sport each week. Increase percentage of local schools with ‘healthy school status’ (currently 89% primary, 50% secondary, 80% special).

- Reduce percentage of five-year-olds with tooth decay (currently 53%). Increase the percentage of children visiting a dentist by age five by 10%, from an established baseline.

- Increasing the current rate of 70% to the target of 90% (by 2011/12) of children aged two who complete immunisation for MMR; 90% of eligible girls receive HPV; 90% of babies receive BCG by 12 months of age.

- Safeguarding children: Continued commitment to safeguarding children, specifically increasing the percentage of all eligible staff trained to the Care Quality Commission target of 80% in the various care settings (acute, mental health and community).

- Common Assessment Frameworks: Increase number of Common Assessment Frameworks (CAF) by 50% which identifies children with emerging vulnerability requiring additional services.

- Reducing risky behaviours: Reduction in health related risk taking behaviour by young people e.g. teenage pregnancy and substance misuse.

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James is three years old, he lives with his parents in White City. He’s got a sweet tooth, is getting a bit plump and his milk teeth are showing signs of decay.

How it might have been in the past:
James has been a fussy eater since he turned two and his mum, Katy, has found it easier to give into sweets and snacks.

Katy never really thought about the effect on James’ teeth until he complained about toothache. And she’s avoided dentists due to her own poor experience as a youngster.

Reluctantly she drags James to a dentist but her own anxiety rubs off and the trip is a miserable experience that neither wants to repeat.

James and his new baby sister grow up on a poor high sugar diet. James’ adult teeth begin to show signs of decay soon after coming through but he painfully avoids dentists throughout his childhood until an infected abscess needs major emergency treatment.

How it can be in the future:
Katy takes James along to the Randolph Beresford Early Years Centre to find out what’s on offer at local children’s centres.

The Health Visitor at the centre gives James a quick development check and talks about his weight. Katy mentions his toothache and is told about the new NHS dentists around the corner offering child friendly services.

Booked in quickly, James has the immediate problems with his teeth fixed and Katy gets more advice about foods to avoid and brushing James’ teeth regularly.

Back at the Children’s Centre Katy and James sign up for cooking and nutrition courses and the new Boost programme to support overweight children under 5. Parenting classes also give advice on coping with toddlers without sweet rewards.

An improved diet and regular dental appointments means James grows taller without getting wider and his milk teeth are replaced by strong adult teeth.

His newly arrived little sister benefits from mum’s better understanding of healthy eating and new confidence in dental services so avoids the early problems James had.
4.5.4 Implementation timeline

4.5.4 Impact on inequalities

Many of the borough’s children live in deprived families and obesity and tooth decay are more common within deprived groups. Improvements in Safeguarding services will support the most vulnerable local children. Children’s centres are distributed across the borough and increased health services at the centres will support all local families. Education and services for children are a valuable way to spread health literacy to their families and, more generally, to incoming communities that are initially unfamiliar with how best to access services.

4.5.6 Provider landscape / market assessment

- High quality hospital provider for children’s service in place.
- Opportunity to use council children’s centres and schools to help deliver co-ordinated polysystem projects.
- Integration of local community providers across three PCTs supports sharing of best practice, economies of scale and work towards a level playing field of quality services.
- Improved access to primary care as part of polysystem work.
4.6 STAYING HEALTHY

4.6.1 Overview

Our JSNA highlights that potentially tens of thousands of residents have undiagnosed diseases. If diagnosed many of these diseases could be controlled to prevent or delay further problems. Under-diagnosis is in part due to poor uptake of screening.

Polysystems, together with our integration with the council, offers a unique opportunity to address public health issues at an individual and environmental level.

We are expanding health promotion work into council services that see large numbers of local residents and using our QOF+ scheme to increase early identification and intervention for long-term conditions with more treatment available in general practice.

Strong partnerships with the local voluntary and community sector are also allowing us to expand health promotion and preventive services beyond the traditional reaches of the NHS.

4.6.2 Core projects

1. Preventing disease – Newly tendered stop smoking service in place. Working with the council to address tobacco control activities including smoke free homes initiative and stop smoking support targeted for young people. Combating alcohol abuse through new ‘tier 2’ alcohol support service, alcohol related hospital admission data profiling; review of 2009/10 older people’s alcohol project; and training council staff in shelters for rough sleepers. Linked closely to the early detection project and focused on addressing the inequality in uptake identified by our 2009 Public Health Report. Obesity and immunisation issues are addressed in the children and young people programme – p38.

2. Early detection of disease – Increasing uptake of cancer screening (cervical and breast as priority) through social marketing work with services users to identify improvements that will change behaviour. QOF+ is also a key enabler for primary care detection addressing cardiovascular disease and diabetes. In addition we are developing pharmacy based vascular risk assessment and community projects for Chlamydia screening.

3. Self care – Commissioning third sector providers to expand existing Expert Patients Programme. Expand health champions’ delivery of health promotion and service sign-posting. Develop a community information centre to provide advice and support for managing long-term conditions.

Programme case for change

- Thousands of local residents live with undiagnosed disease
- Too few people use the preventive services available
- We must coordinate whole population initiatives with individual support
- Health improvement must be everyone’s business and reach beyond the NHS

Five year programme investment

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<thead>
<tr>
<th>Year</th>
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<td>534</td>
</tr>
<tr>
<td>2013/14</td>
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4.6.3 Impact on health outcomes

- Over 1,000 local smokers a year quitting with help from NHS funded stop smoking support.
- Slowing the growth of alcohol related hospital admissions.
- More cancers (pre-cancerous conditions) detected early leading to successful treatment.
- 200 people with long-term conditions completing the Expert Patients Programme and better able to manage their condition; leading to reduced emergency admissions.
- Increasing life expectancy for the population to 79.5 for men and 85.5 for women by 2015.
- Targeting work on our vulnerable communities will reduced local health inequalities - measured by a reduction in the gap between life expectancy of the best and worst off wards.

4.6.4 Impact on inequalities

As identified in our JSNA and Annual Public Health Report 2009 the burden of poor health is carried disproportionately by deprived communities. Projects such as our Expert Patient Programme, Health Champions and Health Trainers actively target communities that suffer the greatest inequality. In additional general services such as stop smoking have been given specific targets for helping smokers from manual occupations and minority ethnic backgrounds.

4.6.5 Potential efficiency savings

Preventive services outlined in this programme will have a long-term cost benefit to the NHS by reducing the numbers needing complex treatment for disease.

In 2009 under our QOF+ scheme local GPs helped another 1,500 residents to bring their high blood pressure down to safer levels. This will prevent heart attacks and strokes, reducing premature deaths and saving NHS resources.

Self care programmes including our established Expert Patients Programme successfully prevent emergency admissions by giving residents with long-term conditions the skills to manage their own symptoms.

Patrick is a plumber from Shepherds Bush. He’s 41, smokes and enjoys a few drinks after work and on the weekend. His diet isn’t great but an active job and weekend footy games keep him fairly trim.

How it might have been in the past:
Patrick is registered with a local GP but can’t remember the last time he saw a doctor. He knows he should quit smoking but feeling pretty fit he doesn’t really worry about his health.

He has no idea that his cholesterol levels and blood pressure are high.

He carries on smoking and drinking too much for several years until he collapses with chest pains during a Saturday kick around on the Scrubs with his mates.

Patrick is rushed to hospital and treated for a serious heart attack. After surgery he spends a two weeks in hospital during which he contracts MRSA.

Following more treatment and a month in hospital Patrick returns home. The heart attack has left him seriously breathless; which he’s on medication to control but a game of football is out of the question now.

How it can be in the future:
Patrick gets a letter from his GP telling him about the new NHS Health Check being offered to everyone over 40. His wife convinces him it’s worth doing and he makes the appointment.

The quick health check involves a blood test and measures Patrick’s height, weight and blood pressure. The appointment also asks Patrick about his drinking and spots that he’s well over the recommended levels.

The results put Patrick in the high risk group and his GP refers him to their in-house stop smoking advisor and prescribes tablets to lower his blood pressure and cholesterol together with advice on diet. He also gets advice about cutting down on the booze.

Patrick manages to quit smoking and cuts back on take-aways and mid-week drinking sessions.

Saturday morning matches on the Scrubs come and go without the dreaded collapse and Patrick’s new found fag-free fitness means footy is more fun than ever.
Chlamydia screening is identifying young people with the disease and, with a single dose of antibiotic, preventing potentially serious and costly health problems such as infertility later in life.

Effective competitive tendering of new services provided by 3rd sector/independent providers will ensure value for money from new contracts.

4.6.6 Implementation timeline

4.6.7 Provider landscape / market assessment

This programme is rooted in developing the local market for preventive, self-care and health promotion services. All the core projects above will take advantage of our integration with the local authority and close partnerships with voluntary and community groups and pharmacists to develop greater capacity and expand the local market.

We have had considerable success in the past year including the retendering of our stop smoking services with award of the contract to a newly established independent provider.

We have also made good use of a strong voluntary and community sector to commission additional Expert Patient Programme capacity, health trainers and health champions – with further expansion planned.

In addition we have developed a number of effective partnerships with national charities for common long-term conditions including Diabetes UK and Asthma UK. With these partners we have piloted new programmes which bring immediate benefits to local residents and allow the charities to develop and evaluate new programmes to be rolled out nationally.
4.7 MENTAL HEALTH

4.7.1 Overview

People with all types of mental health problems need access to high quality support.

Those with mild to moderate problems such as anxiety and depression need better access to community based services; and the economic climate means more are likely to need help.

We need to work with West London Mental Health NHS Trust (WLMHT) to improve services so that people with severe mental illness have access to high quality care.

There is under-diagnosis of dementia locally meaning vulnerable older people and their carers are not receiving the help they need.

4.7.2 Core projects

- **Talking therapies expansion** – Implementation of a local Improving Access to Psychological Therapies (IAPT) programme offering more talking therapy and helping people with mild to moderate problems to recover and return to/remain in work.

- **Dementia services** – Commissioning of services in line with Healthcare for London pathway. Increased identification of people with dementia through the new one-stop memory clinic. Taking advantage of Borough integration and council contacts with older people to raise awareness of dementia and improve support.

- **Quality framework for West London Mental Health Trust** – Develop performance management of provider to support significant improvement against key indicators.

4.7.3 Impact on health outcomes

- **Talking therapies expansion** – 1688 people with depression or anxiety moving to recovery every year. 94 people with mild or moderate mental illness moving off sick pay and benefits each year.

- **Dementia** – increase in number of diagnosed people on GP dementia registers as proportion of expected prevalence from 28% to 50% by 2012/13 (current London average is 37%). Improved patient experience of receiving a diagnosis and treatment of dementia to be measured through the Royal College of Psychiatry’s patient survey for memory clinics.

- **Quality framework for WLMHT** – improved patient safety measured by a reduction in serious untoward incidents, improved audit results on compliance with NICE guidance, improved performance in Care Quality Commission annual rating (currently WEAK on quality of services). WLMHT to move from bottom 20% of Mental Health Trusts in terms of patients’ overall rating of their care into the top 20% by 2012/13.
4.7.4 Impact on inequalities

The burden of mental health problems is carried disproportionately by people from more deprived communities and ethnic minorities. As a result improvements in this area will help to improve the health and wellbeing of the most vulnerable.

4.7.5 Provider landscape / market assessment

Several factors combine to limit the ability of the PCT to seek alternative providers; including joint contracting. Also, WLMHT provides core national service framework services, all of which constitute a pathway which is at risk of breakdown if services are split. There has also not been a competitive market for historical reasons.

Given the above, we are developing a framework for monitoring improvements in the quality of services, moving away from the more activity based monitoring that has taken place historically. In particular, the framework will secure improvements in patient safety, patient experience and outcomes indicating a recovery-based approach. At the same time, the PCT is preparing for Payment by Results which will support increased choice for service users and consequently incentivise improved performance.

4.7.6 Implementation timeline

Grace is 74, she lives in Fulham and her family has noticed she’s become more forgetful in the last year. She puts it down to growing old and ignores it.

How it might have been in the past: Grace’s forgetfulness develops over time but otherwise she’s pretty healthy so she and her family just put up with the muddles. It becomes an increasing burden on Grace’s husband as she can no longer go out or do things around the house without him. A forgotten chip pan left on the hob narrowly misses setting fire to the house. Her children visit less as it upsets the grandchildren when Granny doesn’t remember them.

How it could be in future: Grace’s husband spots an article about the new memory clinic in the local NHS magazine. He speaks to their GP and is referred to the clinic. After an initial home visit by the triage nurse Grace comes into the clinic for a range of tests including a brain scan, blood tests and memory check with a psychologist. Within six weeks the results are in and a second appointment with the team explains that Grace has Alzheimer’s Dementia. They discuss her support needs and Grace starts on medication to help with her memory problems. Her GP is told about the results and adds Grace to the practice’s dementia register to make sure she gets regular check-ups and support.
4.8 ACUTE CARE

4.8.1 Overview
Stoke and major trauma services have been redesigned across London and Imperial College Healthcare NHS Trust will open a new Hyper Acute Stroke Unit in 2010 and a Major Trauma Unit in 2012. Further specialist services will be redesigned across London and the North West London Sector.

We are working with the other seven PCTs in NWL through the Commissioning Partnership and the Integrated Strategic Plan to develop specialist hospital care and redesign of the acute provider landscape. This work will ensure the appropriate provision of emergency surgery in line with Healthcare for London and clinical reference group recommendations. We will also work with the sector to maximise the use of designated local hospitals for elective treatment.

Our local plans in this programme focus on creating the community based support services which, as part of the polysystem, will allow hospital patients to return home quickly and receive the majority of their rehabilitation from community clinics or in their own homes. Developing high quality community services offers a significant opportunity to release savings from current hospital based rehabilitation.

4.8.2 Core project
Improving out of hospital care
- Evaluation of the Hospital at Home model of care established in 2009. Potential mainstreaming to support faster discharge.
- Integration of NHS and social care rehabilitation services to streamline access to appropriate rehabilitation. This will include rehabilitation for stroke patients.
- Enhanced discharge planning arrangements to deliver gold standard discharge planning

4.8.3 Impact on health outcomes
- Patients will benefit from faster discharge from hospital with improved community based rehabilitation services.
- Over 7 years, we expect to reduce reliance on hospital based care by the equivalent of 161 beds. (Achieving this is dependent on both the out of hospital project and other programmes for long-term conditions management, implementation of thresholds for elective referrals and better preventive healthcare.)
- Delayed discharges will reduce from 18/100,000 to the national target of 15/100,000.

4.8.4 Implementation timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2009</td>
<td>Charing Cross Stroke Unit open (Jan)</td>
</tr>
<tr>
<td>2010</td>
<td>Hospital at home evaluation (10/11)</td>
</tr>
<tr>
<td></td>
<td>Charing Cross Hyper Acute Stroke Unit open (Jan)</td>
</tr>
<tr>
<td>2011</td>
<td>Delayed discharges down to national target (Mar)</td>
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4.8.5 Efficiency savings
Initial investment to create an integrated community rehabilitation services will create an alternative to the current hospital based rehabilitation. Using McKinsey modelling applied to local data we plan to provide sufficient community and home based care to replace (over a period of seven years) the equivalent of 161 hospital beds.

The transfer of care from hospital to community based services represents significant savings (as shown above) with an estimated saving of £11.2million by 2013/14 compared to continuing with a hospital based service.

4.8.6 Provider landscape / market assessment
Community based rehabilitation services are currently provided by Central London Community Healthcare (CLCH) and the council. Hospital at Home is a relatively new service provided by CLCH which needs evaluation but has the potential for expansion.

Additional capacity for acute home care is commissioned from Clinictenta on a London basis. Again this is a new service which requires monitoring and development to ensure quality.

There is potential to develop the market with third sector providers able to deliver more home-based care to support faster discharge and help re-establish and maintain people’s independence following hospital treatment.

Nitin is 57 and lives in College Park, it's a Friday evening and he’s just had a stroke.

How it might have been in the past:
Nitin’s wife calls the ambulance and they get to the local A&E quickly, but Nitin needs a brain scan to check if the stroke is due to a burst or clotted blood vessel before doctors can give the right treatment.

Unfortunately the hospital’s scanner is only manned during the week and whilst the doctors and nurse do their best to look after Nitin it’s Monday morning before he gets a scan. More than 48 hours after his stroke with more brain damage occurring all that time.

Nitin eventually gets the treatment he needs and survives, but is left with serious physical disabilities. He spends nearly two months in hospital waiting for nursing and social care support to be arranged before he can go home.

His severe disabilities force early retirement and mean he needs constant care for the rest of his life.

How it can be in the future:
The ambulance team know Nitin’s symptoms mean it’s almost certainly a stroke so they by-pass the local A&E and head straight for the 24hour specialist stroke unit.

As soon as Nitin arrives he’s sent for a scan and the doctors are able to confirm the type of stroke and take him straight into surgery.

A couple of days later Nitin is transferred back to his local stroke unit, where family and friends can visit more easily.

The quick action by the specialist team means the effects of the stroke were limited and Nitin is left with some minor weakness in his left side and a slight speech problem.

While in hospital he has a review from the rehabilitation team and initial help starts straight away. A series of visits from physiotherapists, occupational therapists and speech therapists are also booked for when Nitin returns home.

Over the next 12 months Nitin makes a steady recovery and after a year off is able to return to work with no visible after effects of the stroke.
4.9 PLANNED CARE

4.9.1 Overview

Our local programme on planned care covers the improved quality and capacity needed in primary care to deliver effective polysystems.

By offering a greater range of care from GPs and their teams people will only be referred to hospital when it is absolutely necessary.

Progress has already been made to improve quality and access to general practice services in Hammersmith and Fulham.

- GP practices based at both local A&E departments now seeing 65% of patients
- 28 of our 32 practices offer extended hours services for patients
- Over 90% of practices are signed up to deliver the local QOF+ scheme
- A general practice performance management framework has been developed and implemented with support from the LMC and has enabled a systematic response to performance which falls below minimum standards.
- A programme of commissioning and decommissioning is underway to improve the quality of care and to establish polysystem leadership in key localities.
- Appointment of a Practice Nurse Development Manager to lead a programme to improve the capacity and capability of practice nurses and HCAs and support optimum delivery of emerging care pathways

Our local programme of planned care builds on these achievements and will define a set of quality and capacity benchmarks required by primary care providers to deliver extended primary care services within the polysystem. These quality standards support delivery of care pathways to ensure that patients will only be referred to hospital when it is absolutely necessary.

A key focus is on reducing the unacceptable variations in quality and access to primary care within the borough. This will contribute significantly to reducing the health inequalities identified in the Joint Strategic Needs Assessment. Improvements in primary care will bring all practices up to at least a minimum standard to be agreed across the North West London sector. Our QOF+ scheme is cited as a best practice incentive model in the NWL ISP.

4.9.2 Core projects

1. Improving quality – the focus of all planned care quality improvement work is to increase primary care productivity and reduce the need for secondary care referral. A range of activities including: the production of a clinically defined set of general practice quality standards which will be used to pre-qualify practices under an ‘any willing provider’ (AWP) model for commissioning new services. Early adoption of Map of Medicine across all general practices will impact on referral rates by ensuring completion of all primary care elements of a care pathway before referral to hospital and will act as a signpost for locally developed pathways. Real-time feedback systems in all general practice premises will support collection of better data on patient experience and enable practices to make changes when needed; and further development of our Quality and Outcomes Framework Plus (QOF+) scheme (page 58). General practice will be supported to work more collaboratively in virtual provider units to enable optimum use of resources, skills and
expertise needed to deliver high quality cost effective patient care. Locality working will be supported by a general practice business intelligence function and dedicated support teams at locality level to ensure PCT expertise and resources are fully directed to support delivery of high quality care. Infection control is being improved with the appointment of an Infection Prevention Nurse in January 2010 to work with GPs, dentists, pharmacies & optometrists.

2. **Improving access** – extended hours will be made available for all H&F patients by 2011, establishing a single point of access (SPA) phone line for health information in the borough to support clinicians as well as patients (integrated with inner north west London best practice model), opening of Canberra Centre for Health. The AWP commissioning process will provide a cost effective and timely process for commissioning a wide range of extended primary care. These extended services will be available to all patients based on need rather than postcode and will be priced to reflect optimum use of general practice skill mix in their delivery.

3. **Improving premises** – capital improvement activities to ensure all general practice care is provided from compliant premises.

**4.9.3 Impact on health outcomes**

- **Improving quality** – referral rates standardized across practices, 100% of practices achieving >90% against QOF+ indicators by 2011/12, all practices achieving minimum standards against the proposed practice accreditation scheme by December 2010.

- **Improving access** – more patients able to get the care they need in the right place at the right time, first time through; a 24/7 single point of access (SPA) phone line phased in from 2010; new Canberra Centre for Health open in December 2009 and White City Health and Care Centre in December 2011; extended services at Fulham Centre for Health; and extended opening hours available for 100% of patients by 2011 (currently 80%)

- **Improving premises** – within three years all GP services will be provided from buildings that are fully compliant with Disability Discrimination Act standards and other NHS standards for healthcare premises; currently 1/3 of local practices are below minimum standards and a further 7 cannot offer expanded services without refurbishment or relocation.

**4.9.4 Potential efficiency savings**

Improving the quality and range of treatments provided in primary care requires a significant initial investment. However, in the medium / long-term this programme will move activity out of hospitals and bring an overall improvement in efficiency. This will support the sector wide plans to drive productivity metrics to the top quartile within trusts and primary/community care, ensuring that polysystems are operating at an effective scale.

In the short term a primary care patient list validation process in 2010 is anticipated to save £450k.
4.9.5 Implementation timeline

4.9.6 Provider landscape / market assessment

The Practice Based Commissioning (PBC) consortium has developed during 2009/10 and the next stage is to support the consortium to establish itself as a separate legal entity. In future the consortium will enter into a contractual agreement with the PCT to take forward key projects, including setting up a referral management service, clinical leadership for the practice accreditation process and development of locality working.

The primary care commissioning strategy is to deliver more general practice through the use of flexible, time limited contractual arrangements linked to specified service standards and outcomes. In the short term the PCT has taken on direct management of two local practices; the new practice within the Canberra Centre for Health and one where quality issues meant the existing contract had to be withdrawn. Both these contracts will be tendered out to providers who will be required to take on polyclinic management and play a lead role in amalgamating services to deliver the polysystem.
4.10 LONG-TERM CONDITIONS

4.10.1 Overview

We know that currently services for some key conditions (diabetes, respiratory and heart disease) are disjointed and not providing patients with a convenient co-ordinated service across primary, community and secondary care.

Our polysystems will provide new diagnostic services from polyclinics and integrated teams of consultants and nurse practitioners to give people with long term conditions the best possible care. A new tool for population risk stratification will also help identify those most likely to develop long-term conditions.

Respiratory and cardiovascular disease and diabetes have been identified (through the sector ISP) as the conditions most amenable to service redesign and delivery through polysystems in order to improve quality for patients and release efficiency savings. This programme focuses on the implementation of new pathways for respiratory and diabetes – redesigned using Healthcare for London guidance and best practice from within the NWL sector to ensure consistency with other PCTs in the sector. The schedule for further care pathway redesign is given on page 31 within the polysystem section.

Our QOF plus scheme (page 58) and the staying healthy programme (page 41) also address a number of issues related to detection and support for long-term conditions.

4.10.2 Core projects

- **Respiratory** - the project focuses on implementing the integrated care pathway for Chronic Obstructive Pulmonary Disease (COPD) and is made up of six key activities:
  1. Spirometry clinics to facilitate early intervention
  2. Training primary care staff
  3. Community based pulmonary rehabilitation
  4. Early discharge support programme
  5. Polysystem based multidisciplinary elective and non-elective service, including psychological support
  6. IT and administrative support

- **Diabetes** - the project focuses on implementing the integrated care pathway for diabetes care agreed in 2009/10. Specific activities include:
  1. Recruiting a community consultant diabetologist and two paediatric diabetes nurse specialists
  2. Increased GP referrals of people with diabetes to self management programmes (via QOF+)
  3. Review of current skills and capacity in primary and secondary care
  4. Providing out-patient services in community settings

- **Cardiology** – initial phase of service redesign programme to develop cardiology pathway will complete in March 2010 followed by procurement phase with implementation in October 2010.
4.10.3 Impact on health outcomes

- **Respiratory** – this project will have a significant impact on improving the health and wellbeing of local people with chronic respiratory problems:

  - Diagnose people currently living with undiagnosed COPD (increase GP registers to 90% of expected prevalence in 25% of practices in year one, then 50% and 75% in years two and three)
  - Reduce hospital admissions and outpatient follow up activity by providing new community based alternatives (100% of follow up activity transferred to community services)
  - Shorter lengths of stay for those needing hospital treatment (50% reduction within three years)

- **Diabetes** – this project will have a significant impact on improving the health and well-being of local people with diabetes:

  - 1065 patients with uncontrolled blood sugar referred to self management programmes between Dec 2009 and Nov 2011
  - By March 2012 a 20% increase in people with diabetes whose blood sugar is under control (HbA1c reading less than 7)
  - By March 2012 a 50% reduction in emergency admissions for diabetes related care
  - Service improvements will show through in patient experience with key indicators in the Care Quality Commission’s patient survey 3% above the national average.
  - By March 2012 100% of hospital outpatient and follow up care will be provided in the community and primary care.

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Kahid is 64 and lives on the Clem Atlee estate with his wife. He’s smoked for many years but has recently become worried about feeling short of breath.

**How it might have been in the past:**
Kahid talks to his GP about the breathlessness, but given there are no significant clinical signs the doctor suggests he cuts down on cigarettes and calls back if it gets worse.

It does, and Kahid returns to the GP a few months later. The doctor decides Kahid needs some tests but is unsure if it’s related to a heart or lung problem. Given the normal chest sound the doctor plumps for a cardiology referral.

Several weeks later Kahid has a hospital appointment with a range of tests that only confirm it’s not a heart problem and lead to another referral to another specialist.

More weeks go by before eventually Kahid gets a diagnosis of Chronic Obstructive Pulmonary Disease and is offered help from the community respiratory team.

As time goes on Kahid struggles to control his symptoms and frequently heads for A&E to get help.

**How it could be in the future:**
Kahid’s first visit to the GP results in an immediate referral to the new breathlessness clinic in the nearby polyclinic. He also agrees to let the practice stop smoking advisor give him a call to discuss ways to quit.

Kahid is able to call the breathlessness clinic himself to book an evening appointment that fits around his work.

At the clinic a detailed medical history is taken and a range of heart and lung tests are carried out. The results are reviewed by a team including consultants, physiotherapists, nurses and technicians.

Kahid has a follow up with the team within two weeks of the tests. A treatment plan including a range of medication and lifestyle advice is offered.

If he experiences severe symptoms Kahid knows that advice and help is close to hand through an instant access telephone helpline.
4.10.4 Impact on inequalities

We know from our joint strategic needs assessments, public health reports and national data that the burden of long-term condition related ill-health is carried disproportionately by people from deprived and minority ethnic backgrounds - prevalence is higher while uptake of support services and effective management is lower. The improved access and quality of services for long-term conditions will help address these inequalities with services designed around particular groups to address the specific equality issues they face.

4.10.5 Potential savings

Service redesign of long-term condition care pathways will release savings from the acute sector. Initial modelling of the diabetes pathway shows savings of £230,000 in 2011/12 and £339,000 in 2012/13.

4.10.6 Implementation timeline

4.10.7 Provider landscape / market assessment

The majority of current services are based in the acute sector. Community respiratory and diabetes services are provided by Central London Community Healthcare with close links to Imperial. The capacity and quality of long-term condition support in primary care varies across the borough. A combination of training, incentives and introduction of new primary care services will ensure consistent quality sufficient to shift activity out of hospitals.
4.11 END OF LIFE CARE

4.11.1 Overview
The NWL Integrated Strategic Plan requires all PCTs to implement a number of End of Life (EOL) initiatives to ensure polysystems across the sector are delivering consistent care and support.

In addition, local work on the End of Life agenda needs to focus on developing a better understanding of residents’ needs before specific projects are developed. Approximately 800 people die in Hammersmith and Fulham each year, mainly from illnesses or injuries which allow for effective end of life planning and a choice of where the person would prefer to die. Currently 60% of people die in hospital, whilst patient surveys suggest just 4% want to.

Links need to be made across mental health services and end-of-life in relation to supporting dementia patients.

4.11.2 Potential impact on health outcomes
Further modelling and evaluation of options needs to be carried out, however, potential improvements linked to better end of life care include:

- Better support for patients and their families during the end of life period
- Better palliative care support in the community
- Fewer inappropriate emergency hospital admissions prior to death
- Greater choice for patients on where they die and more people dying where they wish to

4.11.3 Core work areas identified

- Develop a EOL partnership model within the polysystems programme. An end of life care clinical pathway will be developed as part of the polysystem modelling ensuring that people choosing to die at home and their families are supported by community based palliative care packages.

- Deliver on choice by reducing the number of people who die in hospital from 60% to the NHSL target of 50% by 2012.

- Improve access to Psychological support for patients and their families pre and post death (meeting NICE Improving Outcomes Guidance).

- Build the Healthcare for London Quality Markers for End of Life Care into all service specifications to ensure high quality commissioning of all EOL services from hospital trusts, hospices, GPs and nursing homes.

- Support business development opportunities within the charitable sector hospice provision and strengthen voluntary sector palliative care provision in community settings.

- Further local implementation of national best practice tools, including universal application of Gold Standard Framework by GPs.
• Extend the role of a Consultant in Elderly Care across all three local Nursing Homes.

• Reduce inequities by increasing the number of patients with a non-cancer diagnosis having improved access to both specialist and generalist palliative care.

• Raise public awareness around planning for end of life.

4.11.4 Potential efficiency savings

Some people who die in local hospitals are there for long periods before their actual death (from 50 days to more than 200 days). Improved community/home based care allowing people to return home to die could reduce these lengths of stay considerably. Initial modelling suggests a 10 % reduction in lengths of stay could release approximately £900,000 over three years.

4.11.5 Provider landscape / market assessment

End of life care requires specialist and generalist staff and current providers include NHS trusts as well as statutory and third sector providers. The third sector is well positioned to respond to the end of life agenda with expertise that spans primary, secondary and nursing care settings.

End of life skills and expertise are in high demand given the national priority of this pathway, leading to a skill shortage of both specialist and generalist clinicians. Providers are in direct competition with each other in order to attract the best staff.
4.12 OFFENDER HEALTH

4.12.1 Overview
To address the challenges of having a prison within the borough and respond to the recommendations of the Bradley Report we have included an additional programme beyond the eight HfL care pathways.

Prison populations have a higher prevalence (compared to the general population) of alcohol and drug misuse, mental health problems and poorly controlled long-term conditions.

4.12.2 Core projects

1. **Improving healthcare in prison** - develop and enhance the health services within HMP Wormwood Scrubs. The aim will be services of the same quality that is available outside prison and to respond specifically to inequalities identified through the recently completed prison health needs assessment. Staff recruitment is the key element of delivering this project.

2. **Supporting offenders in the community** – To improve the health outcomes for offenders outside prison living, or registered with a GP, in the borough. In particular, to respond to the recommendations from recent government reviews including the Bradley Report* published in April 2009.

4.12.3 Impact on health outcomes

- Increased screening and treatment for sexually transmitted diseases
- Prisoners with long-term conditions provided with self-management support
- TB screening and treatment
- GP registration and medical handover for prisoners being released
- Improved mental health and substance misuse support to reduce risk of reoffending
- Increased access to health services for those in the criminal justice system (i.e. police custody suites and courts)

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* The Bradley Report, Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system. April 2009
4.12.4 Impact on inequalities
The proportion of people from black and minority ethnic groups or deprived backgrounds is higher in the prison population than in the general population. Improving the health of offenders and services available to them will reduce inequalities.

4.12.5 Implementation timeline

- 65% of performance indicators green by March 2010 (currently 6%)
- Vacancy rate in prison health service down to 11% by March 2011 (currently over 30%). Recruitment drive commences April 2010.
- Commence tender process (jointly with NHS K&C) for the Criminal Justice team to extend from courts into police custody suites in response to the Bradley report. April 2010
- Commence new Criminal Justice team service April 2011.

4.12.6 Provider landscape / market assessment
Prison healthcare service currently provided by Central London Community Healthcare (inherited from PCT commissioning / provider split). CLCH now covers three boroughs with Wormwood Scrubs being the only prison within its patch.

Prison healthcare is a high risk service that requires a range of community, primary and mental health expertise. A review of potential alternative providers would be beneficial. There is a need to work with other London PCTs commissioning prison services to undertake joint evaluations and market testing to help understand the capability and capacity of providers.

Support for offenders outside prison has potential for third sector market development.
4.13 QUALITY AND OUTCOMES FRAMEWORK PLUS

Implementing effective polysystems can only happen if primary care clinicians are given the resources and support they need expand their range of services and take on more of the work currently done in hospitals. Launched in December 2008, this innovative local scheme has been developed by our PEC Chair/Medical Director in partnership with local clinicians and Imperial College London’s Department of Primary Care and Social Medicine. QOF+ is addressing specific local needs identified through our Joint Strategic Needs Assessment and other local intelligence.

QOF+ aims to improve the quality of care across all general practice by:

- raising the bar for achievement against existing QOF major chronic disease targets
- introducing new clinical targets focused around health promotion and disease prevention
- opening new avenues for support and engagement with general practice.

It has already led to significant improvement across a range of performance indicators and is a vital crosscutting programme which supports the delivery of a number of the projects listed in this plan.

**Success in 2009**

Below are a few of the QOF+ improvements that are directly improving the health of local residents (more detail of progress is provided in our mid-year review):

**Ethnicity status** - In the campaign to reduce health inequalities for our patients, gaining better insight into our patient population is a key goal. Through QOF+ the percentage of patients on GP chronic disease registers with their ethnicity recorded increased from 23% to 74% between January 2009 and October 2009.

**Hypertension** - Between March and September 2009 there was an 11% increase in patients who had adequate blood pressure control (up from 78% to 89%). This means 1,542 more local residents now have their blood pressure under control. It takes NHS Hammersmith from 114th to 1st in the national ranking.

**Diabetes** - Prior to 2009, NHS Hammersmith and Fulham had seen a slow year-on-year decline in three important areas of diabetes control. QOF+ has reversed this, and in the case of cholesterol control improved NHS Hammersmith’s national ranking from 124th to 4th.

**Alcohol** - Since December 2008, 11,600 patients have been screened for hazardous or harmful drinking; with 1579 identified as at-risk from their alcohol consumption. 75% of these have since been offered advice or referral for assistance with controlling their alcohol consumption.

**Next steps**

QOF+ is one of our most important tools to commission better care for local residents from general practice. We are investing £11.3million over the five years of this plan. However, the scheme remains flexible with the indicators reviewed each year and local clinicians able to influence its future direction. As general practice improves and more traditionally hospital based services are provided from primary care investment in QOF+ may increase further.
5. Delivery

This section covers enablers that need to be in place to support delivery of our strategy; how we will measure the success of implementing our strategic plan; the potential impact of different financial scenarios; and the key risks to delivering the plan.

5.1 ENABLERS

Creating effective polysystems requires a number of enablers to be in place both within the Primary Care Trust and to support the providers who will deliver the healthcare services that make up the polysystems.

5.1.1 Organisational development

We have an ongoing programme of organisational development (OD) activities to support the delivery of our strategic plan. Our OD plan addresses the needs of the whole health economy, not just the PCT. Key areas are summarised below.

- **Developing a commissioning focused flexible organisation**
  Separation of our provider arm; creation of the NWL Commissioning Partnership and integration with the Council have all strengthened our ability to focus on the local commissioning needs for Hammersmith and Fulham and delivering the organisation’s top priority – implementing polysystems.

  The development of shared services with the council and neighbouring PCTs is improving efficiencies and providing a broader pool of skills and experience to all the partners involved. Council integration has led to integrated teams for children’s commissioning and human resources and further joint service reviews underway. IT services are being shared with NHS Westminster and NHS Kensington and Chelsea.

  Following the provider separation and development of new commissioning partnerships we have restructured the organisation around the commissioning cycle framework. The Public Health Directorate lead on needs assessment and community engagement, the Medical Directorate provides clinical leadership, engagement and clinical innovation; the Commissioning Directorate leads on service redesign, market development and contract monitoring; the Finance and Resource Directorate provide procurement, project management, performance management and evaluation skills; and the Strategy Directorate maintain an overall strategic co-ordination role to ensure effective matrix working across the different phases of the commissioning cycle.

  We are creating the capacity we need to deliver our goals and the projects within the strategic plan through a mix of permanent recruitment and strategic use of short term consultancy for time limited projects needing additional/specialist skills. The creation of Commissioning Support for London is also adding capacity.

- **Strengthening our Board**
  Three new Non-Executive Directors have joined the PCT; Peter Worthington, Trish Longdon, and Sandy Jones. Together they add skills in strategic planning, governance, audit and commercial negotiations to the range of expertise within our non-executive team. Two new executive directors (Geoff Alltimes, Chief Executive and Jill Robinson, Director of Finance and Resources) and a new PEC Chair (David Wingfield) also add skills and experience from local authority, private sector and clinical backgrounds.

  A governance review has been completed, led by the Chairman, to ensure that the Board and its committees are focused on the right things in the most effective way. We have clarified the roles of Board committees and the new structure was approved by the Board in January 2010. It reduces the number of committees and focuses work on assurance activities.
• **Strengthening clinical leadership**
A number of doctors have been recruited to commissioning posts within the Medical Directorate and Public Health Directorate. Separating the Medical Director and Professional Executive Committee Chair roles combined with new appointments means there are now more clinicians on our PEC. The role of PEC in designing and approving the projects within our strategic plan is also now stronger with the committee being a formal part of the programme management process to ensure clinical review and challenge on all projects.

The new PEC chair is reviewing the committee’s membership with a view to adding frontline representatives from the council’s services for adults and children.

The Medical Directorate is improving clinical leadership and engagement across primary, community and secondary care – vital to delivering effective polysystems and shifting activity out of hospitals.

• **Formalising the executive team**
Following the internal restructure permanent appointments have been made to the joint chief executive, Managing Director, Commissioning Director and Medical Director. in early 2010.

• **Developing our staff**
We are committed to the development of staff across all levels of the organisation. In the past year we have provided a range of internal and external training courses focused on the skills needed within a world class commissioning organisation. Details provided in our OD plan.

• **Embedding our vision and values**
We have revisited our vision, goals and values, responding to comments from staff, stakeholders and the 2008/09 WCC Panel feedback. They are now simpler, more focused and easier to articulate. All available internal communication channels have been used to promote and embed our vision and values. A new induction & mandatory training programme for staff is focused on the commissioning cycle, people’s role within it, the skills required, and the links to our vision and values.

5.1.1a Next steps for internal development
The Board led a review of our organisational development needs in 2009. Two broad categories of OD work recognise progress made in 2008/09 that needs to be embedded further and the outstanding challenges which still need to be addressed: (details of the actions in each area are in our Organisational Development Plan)

1. **Fill outstanding capacity, capability and process gaps**
   a) Develop workforce strategy for recruitment and development required
   b) Develop systematic data collection and analysis processes
   c) Develop systematic patient experience and public engagement systems
   d) Develop systematic prioritisation framework

2. **Embed recent improvements in**
   a) Clinical leadership
   b) Equality and engagement
   c) Vision, values and competencies
   d) Project management and procurement
   e) Performance / contract management of providers

A key addition to the capacity and capability of the primary care trust will be the Business Intelligence Unit that is currently being scoped with support from McKinsey. The unit will pool existing data analytical skills spread across public health and performance management teams and identify gaps in our skills base. Improved analysis of local need and provider performance will strengthen how we design and commission services on behalf of our residents and support the PCT to achieve higher levels in a number of the world class commissioning competencies.
5.1.1b Supporting development of our providers

- **Central London Community Healthcare**
  We have worked closely with our provider side services and the neighbouring PCTs involved in the creation of Central London Community Healthcare. Two non-executives from each PCT have supported executives in planning the separation (with an NHSHF non-exec chairing the shadow Board). Key support around IT, finance and human resources have also been provided with a number of staff from our corporate services transferring to the new organisation.

- **West London Mental Health Trust**
  We have continued to work closely with the Trust to improve its performance. This has included agreeing an improvement plan which was jointly refined following the Care Quality Commission report issued during the year. We meet regularly with the new Chief Executive to ensure we have a shared understanding of the priority areas and that we are supporting them in success.

- **Imperial College Healthcare Trust**
  Is a strong trust with high quality management and clinical leadership. We continue to work with their senior managers and clinicians to ensure engagement with the changes happening through hospital reconfiguration and development of polysystems. Where appropriate we will support the trust through these changes, for example identifying the resources required for periods of double running during the establishment of polysystems and new out of hospital services.

- **General Practitioners & Practice Based Commissioning**
  A large practice based commissioning consortium covering c.140000 patients (2/3 of the Borough) has been established for several years. Its Chair sits on the PEC and on the polysystem programme board emphasising the key role that it plays in clinical leadership. Clinical leads are being drawn from PBC for each of the clinical service redesign projects; with leads for demand management, diabetes, respiratory and cardiovascular already in place.

  The PBC Chair works closely with the PEC Chair on the development of General Practice to meet the challenge of delivering care through the new polysystem model and has contributed strongly to the regular cycle of PEC led GP polysystems forum meetings that is under way.

  Through the ongoing development of our innovative QOF+ programme we are supporting local GPs to provide services above and beyond the nationally set standards. Through our improved performance management framework we are also supporting poor performing practices where possible (and removing contracts if necessary).

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*Through continued development of our own organisation and those we commission services from we can increase capacity and capability to deliver our plans. The next section summarises the impact of implementing this plan on our provider workforce requirements...*
5.1.2 Provider workforce planning

The McKinsey polysystem workforce model is being used to forecast the integrated workforce requirements and identify key gaps and barriers to implementation. The following three key drivers for workforce shift and change have been used:

1. **Transition of care from acute to community settings**
   Requiring an increase in the existing roles within primary and community care, plus additional community based consultants, diagnostic technicians and rehabilitation staff. Linked to decreasing need for hospital based roles for services transferring to community settings.

2. **Increase in productivity of clinical staff and enhanced skill mix**
   Clinicians' need to be supported to increase the time they spend with patients – through better use of IT, smart working programmes and integrated records. Co-location of services and use of shared administration functions in polyclinics and other large primary care sites. Up-skilling and diversification of specialist skills within and across GP practices.

3. **Better management of long-term conditions to delay / reduce complications and unplanned care needs**

The PCT's workforce strategy addresses these and our internal workforce issues in more detail.

5.1.3 Using information and IT

Information Management and Technology (IM&T) has been identified as a key enabler to support the delivery of the strategic plan. Special emphasis is being placed on the structure of services to ensure that IM&T is business rather than technology led. This is being achieved by re-structuring the current service and creating an IM&T Intelligent Customer and a shared service across NHS Hammersmith and Fulham, NHS Kensington and Chelsea and NHS Westminster.

**The Intelligent Customer service will:**
- Produce the organisation's IM&T strategy
- Achieve business alignment
- Performance manage the delivery and execution of IM&T systems, services and projects which are delivered by the shared service or other external providers.

The service will be a highly specialised team of IM&T experts that will have a comprehensive understanding of all organisational systems, data and processes. This team will act as the technology expert for the PCTs and will develop a deep understanding of the PCTs commissioning strategies in order to facilitate the delivery of technology related systems and solutions driven by commissioning requirements.
**IM&T strategic investments**

There are a number of key strategic areas where investment in technology can play a significant part in improving care for patients. These diverse areas can be summarised as follows:

- Development of clinical and business systems to support the delivery of polysystems
- Adopting eHealth solutions to assist with the redesign of service delivery
- Implementing new technology in general practice to support Health MOTs
- Providing our general practitioners with electronic discharge summaries
- Preparation for the implementation of the Electronic Prescription Service (Release 2)
- Preparation for the implementation of the Summary Care Record
- Protecting the confidentiality and security of patient identifiable information by investing more resource in information governance and security
- Identifying opportunities for implementing interoperability between systems to support patient care
- Building a common, enterprise level infrastructure, to support the delivery and maintenance of the above systems - standardising where possible across our partner PCTs.

IT is a key enabler for delivery of this strategic plan and in particular for the polysystem model. Polysystems will require secure data sharing to improve communication between health and social care staff (including staff working in schools). There are also potential benefits from use of patient monitoring technologies and deployment of telemetry to manage patients’ conditions more effectively, improve outcomes, reduce use of hospitals and facilitate earlier discharge.

**Business Intelligence Unit**

As part of our organisational development we identified the need to bring together various sources of data and analytical capacity within the organisation. We are currently working with McKinsey to develop a model for a Business Intelligence Unit that will complement and work in conjunction with CSL and the NW London Commissioning Partnership.

**eHealth**

eHealth is a maturing set of technologies which encompasses telemedicine and telecare. These will play an important part in supporting the delivery of healthcare in the out of hospital setting and will be used to promote and encourage self-care.

The use of touch-screen devices with vital signs-gathering peripherals that interface with clinical systems will enable patient self-service in a wide range of locations within GP surgeries and polyclinics. We plan to use such devices to facilitate new patient checks and regular monitoring of people with depression, hypertension and obesity.

By eliminating the basic data gathering and recording done by professionals, this both increases clinicians’ time to care, and reduces costs. In addition, the device can be used to deliver personalised information back to the patient to encourage improved self-care and prevention of subsequent health problems.

The opportunities to implement more sophisticated devices into GP surgeries and pharmacies, to enable immediate testing will help deliver a full NHS Health Check in one sitting as well as providing other preventive services.

Devices can also be used in the home for those suffering from long term conditions that are overseen by community services, where treatment benefits from regular monitoring. These gather responses to long term condition related questions and vital signs information which are then sent back to an assessment, monitoring and response service.

Our Medical Director is Director of the eHealth unit in Imperial College’s Primary Care Directorate.
5.1.4 Market management, provider requirements and plurality of provision

We have developed a commercial strategy which gives greater detail on our plans for developing the local healthcare market to ensure high quality services, value for money and ensure residents have appropriate choice.

The implications of the strategy on our key providers:

- **Acute (Imperial and Chelsea and Westminster)**
  As described elsewhere in the Strategic Plan, we intend to move activity out of hospitals and into community care settings. We plan to remove £14m from acute settings by 2013/14. The impact on beds will be to remove 161 inpatient beds by 2016/17. This will be delivered through Healthcare for London and polysystems. The main impact will be at Imperial. The impact on Chelsea and Westminster will be less; however, polysystems in Kensington and Chelsea PCT and Westminster PCT will also have an impact. These are described in more detail in the North West London Integrated Strategic Plan.

- **Mental Health (WLMHT)**
  The Strategic Plan is not likely to impact on the number of beds or on the income of West London Mental Health Trust. However, a key project is to improve WLMHT’s quality of services rating from ‘weak’ to ‘good’ over the next four years. This will mean significant changes to the way care is provided by the Trust and may necessitate infrastructure changes. In addition, mental health services are a key feature of our Commercial Strategy and we will be testing the market over the next five years. The impact of market testing is not yet known. The aim is to improve the quality of services to patients.

- **GPs**
  We have articulated how we intend to improve: access to GP services; the quality of GP services; and the quality of GP premises. By working with the GPs in Hammersmith and Fulham we will together understand where changes need to be made to meet the needs of patients, including links to the polysystem model. We envisage higher quality GP practices and fewer locations from which they will be delivered.

- **Community Care (CLCH)**
  Central London Community Healthcare is a new organisation currently hosted by Kensington and Chelsea PCT. It is important that, prior to becoming a legal entity in its own right, it is in a sound financial position. As polysystems develop, we envisage removing £9m from CLCH by 2016/17. These savings are likely to be made through increased efficiencies gained through consolidation of services across the three local PCTs.

- **North West London dimension.**
  The North West London Integrated Strategic Plan sets out cross-borough issues and implications for patients and providers.
5.2 MEASURING SUCCESS
– PERFORMANCE AND PROJECT MANAGEMENT

Progress against our vision and goals will be measured using a range of metrics that include:

- World Class Commissioning outcomes
- NHS key performance indicators
- Initiative specific targets and milestones

We have set the trajectories for our world class commissioning health outcomes and the targets for individual projects to be challenging yet achievable. As we implement the improvements needed to deliver against our vision and goals we will review progress and stretch our targets in areas showing strong performance.

5.2.1 WCC outcome measures
The ten World Class Commissioning outcomes we will use to measure success in achieving our vision and goals are listed below (with our trajectory for improvement in each outcome).

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Improvement Aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>09/10</td>
</tr>
<tr>
<td>Health inequalities (Males)</td>
<td></td>
</tr>
<tr>
<td>Slope index of inequality for life expectancy at birth</td>
<td>4.20</td>
</tr>
<tr>
<td>Life expectancy (Males)</td>
<td>78.0</td>
</tr>
<tr>
<td>Life expectancy (Females)</td>
<td>84.0</td>
</tr>
<tr>
<td>Proportion of children who complete MMR immunisation by 2nd birthday</td>
<td>85%</td>
</tr>
<tr>
<td>Prevalence of obesity in Year 6 children</td>
<td>23%</td>
</tr>
<tr>
<td>Smoking quitters Rate per 100,000 aged 16 and over</td>
<td>1,031</td>
</tr>
<tr>
<td>Self reported experience of patients &amp; users</td>
<td>77.6%</td>
</tr>
<tr>
<td>Hospital admissions for alcohol related harm Rate per 100,000</td>
<td>2,052</td>
</tr>
<tr>
<td>Number of people using Improving Access to Psychological Therapy (IAPT) services assessed as moving to recovery (Proportion of those completing a course)</td>
<td>1670 (49.5%)</td>
</tr>
<tr>
<td>Premature cardiovascular mortality * Standardised rates per 100,000 for all CVD mortality [Premature mortality defined as death under 75 yrs]</td>
<td>91 (71)</td>
</tr>
<tr>
<td>Diabetes controlled blood sugar Percentage of diabetes patients with an HbA1c of 7.5 or less</td>
<td>68%</td>
</tr>
</tbody>
</table>

* At the time of writing, the CVD mortality trajectory is under negotiation with NHS London. Figures in brackets for 2009/10 and 2010/11 are existing Vital Signs targets.

The PCT has a “fair to good” improvement plan agreed with NHS London addressing key targets which underperformed in 2008/09. This plan includes actions to address a number of underperforming areas which it was not possible to include within the 8 locally selected outcomes for world class commissioning.
5.2.2 Choosing outcome measures for 2009-2014
The eight locally defined World Class Commissioning outcomes have been chosen following discussion by the full Board of Directors. They have been chosen because they measure important local issues highlighted in our case for change; notably ‘the need to improve residents health’ which is essentially our overall corporate vision.

Childhood obesity, smoking, alcohol misuse and poor control of long-term conditions are all problems that affect significant numbers of local residents. Improvements to NHS services in these areas will have an immediate benefit for the residents affected. Equally, with their focus on prevention, improvements in these areas support the financial sustainability of the NHS by limiting the need for high-cost specialist hospital treatments. The patient experience measure for primary care services will be an important measure of the success of our top priority in the years ahead i.e. implementing effective polysystems.

5.2.3 Enriching the national measures
To provide advanced monitoring of key local inequalities we are enriching a number of the outcome measures with additional local data:

- **Smoking quitters** – enrich outcome measure with locally available data by occupation and BME group with the aim to especially increase access and quit rates in these groups.

- **Cardiovascular disease mortality** – enrich outcome measure with intra-borough inequality in early CVD deaths.

- **Diabetes controlled blood sugar** – enrich outcome measure to include finding the undiagnosed and reducing variation in practice.

We have changed two outcomes in the 2009 refresh of our strategic plan. The new indicators measure improvement in the same fields (children’s health and mental health) but focus on new priorities within those fields. The changes were made following a series of Board level discussions to reassure ourselves that the moves were warranted.

- **Children’s health** – switching from breastfeeding to MMR immunisation

  Previous low levels of breastfeeding have been addressed and we have seen an increase in performance. We are now confident that women are getting the support they need so we want to focus on addressing other areas of improving and protecting the health of local children. Levels of childhood immunisations have improved year on year but they remain below the recommended 90% level to prevent epidemics of potentially fatal childhood diseases – reaching this ‘herd immunity’ level is a significant challenge. In 2009/10 we commissioned a new *Failsafe* team to deliver the improvements needed, so it is important for us to include a measure of success within world class commissioning.

- **Mental health** – switching from ‘service users in employment’ to ‘people moving to recovery with support from psychological services’

  With the development of a local Improving Access to Psychological Therapies (IAPT) programme we believe the new outcome is a better measure of both improvements in health and PCT performance. The original measure was only survey based and covered small numbers, whereas the IAPT service will target over 1600 people each year. We will also enrich the national measure with local data on the percentage of people recovered in employment and carry out subgroup analysis for inequality monitoring e.g. prisoners / offenders. An additional reason to switch this outcome is the economic climate and rising unemployment, making it difficult to use employment data as a main measure of mental health service quality.
5.2.4 SMART measures for our strategic goals

We have used a blend of WCC outcomes, existing commitments, vital signs (tiers 1-3) and locally defined targets to measure the success of our four strategic goals over the next 5 years. These have been agreed with our Director of Public Health and have been cross-referenced back to the health inequalities framework. The tables below show the trajectories for improvement we aim to deliver by 2013/14 (shaded targets are our 10 WCC outcome measures).

There is some overlap where a target supports more than one goal especially with WCC outcomes. For simplification we have not duplicated targets but created a blend of targets that, together, provide a picture of our progress.

<table>
<thead>
<tr>
<th>Goal 1: Enable and support health, independence and well-being</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of children who complete MMR immunisation by 2nd Birthday</td>
<td>85%</td>
<td>85%</td>
<td>90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Prevalence of obesity in Year 6 children</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Diabetes controlled Blood Sugar</td>
<td>68%</td>
<td>70%</td>
<td>74%</td>
<td>77%</td>
<td>79%</td>
</tr>
<tr>
<td>100 per cent of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy.</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Implementation of the Stroke Strategy (number of people spending 90%+ of their time on a stroke unit)</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Number of drug users recorded as being in effective treatment</td>
<td>873</td>
<td>899</td>
<td>899</td>
<td>899</td>
<td>899</td>
</tr>
<tr>
<td>Increase in numbers of people with dementia being reviewed in primary care as a proportion of those on the register (local)</td>
<td>81%</td>
<td>83%</td>
<td>85%</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td>Number of local schools with enhanced healthy school status</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2: Give people more control of their health and healthcare</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of hospital admissions per 100,000 for alcohol related harm (2010/1 :against a LAA/VSC26 target of 2329)</td>
<td>2052</td>
<td>2127</td>
<td>2207</td>
<td>2280</td>
<td>2347</td>
</tr>
<tr>
<td>Smoking quitters</td>
<td>1031</td>
<td>1039</td>
<td>1041</td>
<td>1051</td>
<td>1061</td>
</tr>
<tr>
<td>All patients who need them have access to crisis services, with delivery of 100,000 new crisis resolution home treatment episodes each year</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
</tr>
<tr>
<td>Proportion of men and women aged 70 - 75 taking part in bowel screening programme</td>
<td>30%</td>
<td>30%</td>
<td>32%</td>
<td>33%</td>
<td>34%</td>
</tr>
<tr>
<td>Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices, by 12 completed weeks of pregnancy</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)</td>
<td>11%</td>
<td>36%</td>
<td>36%</td>
<td>36%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Goal 3: Improve patient experience by offering timely and convenient access to quality cost effective care

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self reported experience of patients &amp; users</td>
<td>77.6%</td>
<td>81.2%</td>
<td>83%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>For IAPT services the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment</td>
<td>1670</td>
<td>1670</td>
<td>1688</td>
<td>1688</td>
<td>1688</td>
</tr>
<tr>
<td>A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Patient experience of access to primary care. Supporting measures: Extended opening hours for GP practices, increased capacity in primary care, Patient reported access to out-of-hours care (indicator to be developed)</td>
<td>53%</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Public confidence in local NHS</td>
<td>72</td>
<td>74</td>
<td>75</td>
<td>76</td>
<td>77</td>
</tr>
<tr>
<td>Number of delayed transfers of care per 100,000 population (aged 18 and over)</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Percentage of GP’s achieving &gt;90% against QOF+ indicators</td>
<td>93%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Goal 4: Positively tackle health inequalities

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Inequalities (male)</td>
<td>7.8</td>
<td>7.72</td>
<td>7.64</td>
<td>7.57</td>
<td>7.49</td>
</tr>
<tr>
<td>Health Inequalities (female)</td>
<td>4.2</td>
<td>4.16</td>
<td>4.12</td>
<td>4.08</td>
<td>4.03</td>
</tr>
<tr>
<td>Life Expectancy (male)</td>
<td>78</td>
<td>78.3</td>
<td>78.6</td>
<td>78.9</td>
<td>79.2</td>
</tr>
<tr>
<td>Life Expectancy (female)</td>
<td>84</td>
<td>84.3</td>
<td>84.6</td>
<td>84.9</td>
<td>85.2</td>
</tr>
<tr>
<td>CVD Mortality</td>
<td>91</td>
<td>85</td>
<td>79</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>All patients who need it to have access to a comprehensive child and adolescent mental health service, including 24-hour cover and appropriate services for 16- and 17-year-olds and appropriate services for children and young people with learning disabilities.</td>
<td>PCT self-assess 4 positive responses required</td>
<td>PCT self-assess 4 positive responses required</td>
<td>PCT self-assess 4 positive responses required</td>
<td>PCT self-assess 4 positive responses required</td>
<td>PCT self-assess 4 positive responses required</td>
</tr>
<tr>
<td>Proportion of women receiving cervical cancer screening test results within two weeks</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>Number of drug users recorded as being in effective treatment</td>
<td>856</td>
<td>899</td>
<td>899</td>
<td>899</td>
<td>899</td>
</tr>
</tbody>
</table>

NB. Our Health Inequalities Framework provides a detailed analysis of health inequalities and corresponding metrics to assess progress. The above provides a useful set of metrics to monitor progress against this goal and does not replace the framework.
5.2.5 In-year monitoring of progress

To ensure that all programmes run to their planned timescale the PCT has a systematic programme management approach co-ordinated by a dedicated Programme Management Office (PMO). The PMO supports the successful delivery of programmes through four dimensions of: governance, planning, programme management expertise, and visibility.

The PMO governance framework provides quality thresholds and assurance for projects before they commence. Project managers complete consistent and robust business cases and project initiation documents, which must address key project success factors in order to secure approval, including:

- clinical and public engagement plans
- equality impact assessments
- financial planning
- milestones
- benefits in terms of health outcomes, productivity improvements, reduced inequalities etc
- success measures & evaluation plans.

By crystallising the expected costs, outcomes and timescales, the process enables the Commissioning Executive Team to assess the quality of individual proposals before they are initiated.

The PMO supports and challenges projects during the planning stage, using programme management expertise to drive up quality. It also offers bespoke support and regular workshops to disseminate good practice.

The PMO also helps commissioners to make connections between related projects and programmes. Regular PMO reviews of active projects track progress and provide early indication of problems with individual projects. The PMO reporting processes collate this intelligence, and provide visibility for delivery of the overall strategic plan.

The PMO process requires all projects to identify success measures and evaluation plans to ensure the PCT can monitor the outcome of our investments/disinvestments and report on the relative success of different projects.

5.2.6 Programme interdependencies

<table>
<thead>
<tr>
<th>Programme</th>
<th>Interdependency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and newborn</td>
<td>QOF+ through improved GP referrals</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Planned Care supporting improvements to primary care provision to children</td>
</tr>
<tr>
<td>Staying healthy</td>
<td>QOF+ supporting the identification of people with long-term conditions</td>
</tr>
<tr>
<td>Mental health</td>
<td>Offender Health through multi-agency criminal justice mental health team</td>
</tr>
<tr>
<td>Acute care</td>
<td>Polysystems enabling change of activity settings</td>
</tr>
<tr>
<td>Planned care</td>
<td>QOF+ to help improve performance in primary care</td>
</tr>
<tr>
<td>Long-term conditions</td>
<td>Staying Healthy and QOF+ to identify and improve management of people with long-term conditions</td>
</tr>
<tr>
<td>End of life care</td>
<td>Communications and engagement through the development of the expert patient programme.</td>
</tr>
<tr>
<td>Offender health</td>
<td>Mental Health programme.</td>
</tr>
</tbody>
</table>
5.3 STRATEGY UNDER MULTIPLE FINANCIAL SCENARIOS

5.3.1 General Assumptions
We have considered the three funding scenarios provided by NHS London and their impact on our ability to deliver improvements to local health services. The core assumptions for each scenario are:

- **Base Case**: Moderate growth in funding (+2.5%), equating to flat growth in real terms
- **Scenario 1**: No growth in funding, equating to negative growth in real terms (-2.3%)
- **Scenario 2**: Growth in funding (+3.25%), equating to minimal growth in real terms (+0.75%)

In addition to these assumptions, we have tailored the following assumptions to more accurately reflect the underlying trends within Hammersmith and Fulham:

- **Population growth (0.7%)**: We have based this on Greater London Authority (GLA) population figures. We are aware of planned housing developments in the borough but as all significant developments are scheduled beyond the scope of this planning period we have not included the impact at this stage.
  
  This population growth rate has been applied to Primary Care to reflect activity growth in these areas. Based on our analysis of historical trends and the nature of the existing contracts, we believe this to be an accurate representation of the expected growth on baseline spend.

- **Community Care Services**: We have reflected activity growth at 3.9% in line with Healthcare for London assumptions

- **Acute growth (2.9%)**: The general guidance from NHS London indicates an overall annual growth rate of 4% over the period, which is based on the total growth rate indicated in the McKinsey model as applied to North West London Sector. As part of the development of our polysystem we have broken down acute spend by major point of delivery and applied the specific growth rates provided in the McKinsey upper end sensitivity model for the sector. We then compared this result to our historical trends in this area, which confirmed that the revised average rate of 2.9% is a more accurate forecast for NHS Hammersmith and Fulham. It should be noted that with the implementation of polyclinics at Hammersmith Hospital and Charing Cross in 2009/10 our A&E activity is now decreasing significantly. We have modelled this activity going forward and consequently the overall Acute Growth for 2010/11 is a net 0.6% increase.

- **Corporate efficiencies**: In line with NHS London planning assumptions we have applied the pay awards uplift to the relevant elements of our corporate overheads. Additionally, we are looking to achieve 3% efficiency per annum in these areas. Opportunities from integration with the local council and shared management/administration functions within polysystems being key ways to reduce overheads.

- **Baseline activity**: In preparation for refreshing the strategic plan, we reviewed all expenditure areas with the relevant commissioners to identify specific cost pressures and savings emerging in the current financial year. The results of this review were used as the baseline for 2010/11 activity.

- **Operating Framework**: We have included the impact of key elements of the recently published Operating Framework. The impact of cost improvement programmes (CIPs) related to management and agency costs, which require savings of 30% over the next four years. We have reflected a saving of 22% in 2010/11 with the balance being achieved over the rest of the period. We have also included £1.7m per annum to reflect the impact of the changes to Central Budgets in accordance with NHS London Guidance. Finally, we have identified a minimum of 2% of expenditure which is non-recurrent in nature.

The details of these assumptions are included in the finance templates accompanying this plan.
5.3.2 Delivering efficiency savings through greater productivity

To ensure that we have sufficient funds to invest behind these initiatives, we have identified a number of areas where cost savings and efficiencies can be achieved – both within the PCT and more significantly within key provider services.

Better designed services that reduce duplication across different providers, together with increased productivity, will generate significant efficiency savings without reducing the quality of care available to patients.

Using the assumptions within the NHS London affordability modelling we expect effective polysystems to generate approximately £20 million in savings through more productive use of the frontline primary and community care staff. Our own work with our community providers shows district nurses and health visitors only spend a small fraction of their total working hours with patients (21% and 15% respectively) – this must be improved through better designed services, reduced administration burdens on clinicians and better use of IT and smart working systems. The creation of a three-borough alliance for community healthcare will also deliver efficiencies from management and overhead costs.

Efficiency savings must not threaten the quality of care for residents. There are areas of the affordability assumptions which need more in-depth local review. For example, whilst we agree there is a need to improve productivity within primary care we believe that the assumption of shortening GP appointment slots may be counter-productive given the polysystem objective of delivering more comprehensive support for long-term conditions within primary care. It is also possible that shortened GP appointments would drive up hospital referrals.

<table>
<thead>
<tr>
<th>£ million</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Cumulative Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate efficiencies</td>
<td>3.0</td>
<td>3.7</td>
<td>4.1</td>
<td>4.7</td>
<td>15.5</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>0</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Community care services</td>
<td>3.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3.0</td>
</tr>
<tr>
<td>CLCH productivity gains</td>
<td>0.9</td>
<td>1.8</td>
<td>2.7</td>
<td>3.6</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>Total savings plan</strong></td>
<td><strong>6.9</strong></td>
<td><strong>6.0</strong></td>
<td><strong>7.8</strong></td>
<td><strong>9.8</strong></td>
<td><strong>30.5</strong></td>
</tr>
</tbody>
</table>

**Corporate efficiencies:** during the current financial year we have restructured the organisation to reflect the requirements of a commissioning organisation and to enable us to deliver the strategic goals and key outcomes. This has resulted in the creation of an enhanced Medical Directorate and a Strategy Directorate encompassing World Class Commissioning, Organisational Development and a Business Intelligence Unit. At the same time we have also realised opportunities to integrate with the council, integrating our transactional HR and payroll service with their existing services and working in close cooperation with their procurement team. Additionally we are developing a shared IM&T service with Westminster and Kensington & Chelsea PCTs.

As a result of the above, we expect 2010/11 to be a year of consolidation of new structures and ways of working, but will also continue the integration project with the council and neighbouring PCTs and are targeting increased efficiencies in future years. We have established a savings programme to release 30% reduction in these costs over the period and will be reporting as part of our CIPs.
**Community care services:** As part of our baseline review, we incorporated a number of initiatives into the individual service areas. We are also working with our new provider organisation, CLCH, to achieve economies of scale from the integration and are developing a joint plan to achieve savings of 3% pa on existing services.

**Prescribing costs:** Primary care drug costs have historically grown year on year due to a combination of an increased number of prescriptions and use of new patented drugs. Over the next 5 years we will focus intensively on drug expenditure to blunt the expenditure growth. Downward pressure on drug expenditure will be a combination of:

- work with prescribers by our Pharmacy Team and doctors (e.g. switching to less expensive medicines recommended by NICE)
- savings when high expenditure drugs come off patent (the average current price of a basket of drugs that have come off patent over the last few years is 22% of the price of the branded drug)
- price reductions (e.g. as a result of the Pharmaceutical Price Regulation Scheme).

We will also work to manage our expenditure on high cost hospital drugs (e.g. by funding medicine use in line with relevant guidance from NICE).

**5.3.3 Scenario 1 – negative growth in real terms**

Given the current economic environment we have assumed that Scenario 1 is the most likely funding reality. This means that significant service redesign is required to ensure the quality of care for local residents can improve alongside achieving greater efficiency.

This scenario is affordable provided effective polysystems are implemented and the predicted shifts in acute activity and efficiency savings are realised.
Our investment plan over the five year period is linked to our strategic goals as shown opposite.

Delivering the programmes outlined in this plan will reduce our acute hospital spend by £35m over the period - through a combination of shifting activity to community settings and improved preventive services reducing the number of residents needing treatment.

When polysystems are fully implemented they will release annualised savings of between £20-25m through the lower cost of community based provision.

5.3.4 Base Case

The key difference in the Base Case is the underlying assumption in funding. As noted above, NHS London have indicated that we should consider a moderate growth in funding over the period (+2.5%), which equates to flat growth in real terms. This would equate to an increase in funding versus Scenario 1 as follows:

<table>
<thead>
<tr>
<th>£ million</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Increase</td>
<td>8.6</td>
<td>17.4</td>
<td>26.4</td>
</tr>
</tbody>
</table>

Increased funding to improve quality of primary care: the QOF+ initiative commenced in October 2008 for a period of three years. At the end of this trial we will evaluate its success against the agreed outcomes to ascertain whether we should continue the programme. Initial evaluations at the end of the first year indicate that we have been very successful in meeting, and even exceeding, our initial expectations and we are currently in the process of completing a value for money review. Given these initial findings, we have included the continuation of QOF+ in Scenario 1. However, should we receive increased funding we would look at extending the current programme or implementing similar initiatives within Primary Care and have included an increased investment in the Base Case to £5m per annum from 2011/12.

Investment in technology: as part of our work on polysystems, we have given consideration to the underlying technology requirements and have allocated some funding. However, given the developments in telemetry over the last twenty years and its increased use in on-ward systems, we believe that there are also significant opportunities to explore how telemetry could be used in community settings to manage patient conditions more effectively, improve outcomes, reduce admissions to hospital and facilitate earlier discharge. Increased funding would enable us to evaluate this option and implement in the medium term.

We have estimated an incremental annual operating cost of £1m from 2011/12 as well as an increase in capital requirements, included in Section 5.3.6 below.
**Staying healthy:** in this area we would look to extend our work with the council to increase access to opportunities for physical activities, information and advice on healthier lifestyles. We would extend our work with targeted groups to the wider population and review extension of the range of services to tackle obesity. We would look at extending the expert patient programme to every patient with long term conditions, including training patients in self management.

**Other projects:** we have a number of smaller projects across the range of programmes which we have not been able to prioritise in Scenario 1. The annual impact of these is estimated to be approximately £1m, commencing in 2010/11.

Other considerations, which have not been factored into the Base Case currently are:

**Investment in estates:** an increase in funding would give us an opportunity to explore further opportunities to optimise utilisation of our estates. We are currently incurring annual costs of approximately £1.5m in relation to 1 Hammersmith Broadway and we would look at the opportunity to relocate to a more flexible location, potentially in conjunction with the council and incorporating health, community and social care facilities. We would consider both revenue and capital options in this situation.

**Maternity Matters:** our current plans include an ongoing investment in Maternity Matters with our acute providers. However, given the significance of midwifery workforce capacity to achieve one to one midwife care during labour, we would consider increasing our investment in this area. This is dependent on the ability to recruit, which has proven problematic in past years and is not necessarily resolved by increased funding.

**5.3.5 Scenario 2**

In Scenario 2, NHS London have indicated that we should consider a more significant growth in funding over the period (+3.25%), which equates to growth in real terms of +0.75%. This would equate to an increase in funding versus Scenario 1 as follows:

<table>
<thead>
<tr>
<th>£ million</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Increase</td>
<td>11.2</td>
<td>22.7</td>
<td>34.6</td>
</tr>
</tbody>
</table>

Although this scenario is thought to be unlikely, we have given some consideration to additional opportunities that this would afford.

As well as the opportunities noted in section 3.3, this increase in funding would allow a broader scope to the overall polysystem implementation. From our work with NWL Sector, we are aware of the development plans in neighbouring PCTs (specifically Hounslow, Ealing and Kensington & Chelsea) and which will inevitably offer opportunities for improved care for some of our residents. In this situation we would look at the possibility of cross sector initiatives to accelerate these plans.
5.3.6 Capital requirements
A key enabler for this strategic plan is our ability to maximise use of our current estate, keeping new build requirements to an absolute minimum. Additionally, as a result of our close integration with the council we are in a unique position to ensure we maximise the potential to deliver health services from other locations such as children’s centres and schools.

The core of our strategy is to facilitate Healthcare for London through the implementation of a borough polysystem. The key capital components of this are:

- **Polyclinics**: two sites located in White City (North) and Charing Cross (South Central). The White City Health & Care Centre is a new build, but will be combined with relocation and closure of a number of existing locations, including Local Authority and Voluntary Sector premises. The polyclinic at Charing Cross will be an expansion of our current Unscheduled Care Centre (UCC) and will use existing space on the hospital grounds.

- **Health centres**: we anticipate creating 5 – 7 large centres to supplement the services provided in the polyclinics and ensure equality of provision throughout the borough. Sites will primarily be refurbishments of existing buildings.

- **GP surgeries**: the intention is to rationalise the existing network of premises and relocate practices to either the polyclinics or health centres where appropriate. Within 3 years we intend to only commission primary care from fit-for-purpose estate. We estimate that currently approximately 45% of existing sites would not meet this standard. Only those premises that currently meet standards (or could be brought up to standard with minimal investment) and are considered to be an integral part of the polysystem will be maintained.

- **Technology innovation**: will be a key enabler to facilitate easier and secure data sharing to improve communication between different healthcare teams and to identify and realise operational efficiencies.

Financing White City
We are looking at alternative options for White City to the Local Investment Finance Trust proposal included in our previous strategic plan. Our initial financial evaluation indicates that we would save approximately £6m if we were to purchase rather than proceed with a pure LIFT scheme. Additionally the property would have a residual value which we have not taken into consideration in this calculation. Initial discussions with NHS London have supported this proposal and a business case is being prepared to gain formal approval.

Releasing capital
We have identified a number of existing PCT owned sites that will not be needed as part of the polysystem. Sale of these will release £4million.

<table>
<thead>
<tr>
<th>£'000s</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>New build</td>
<td>8,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refurbishment</td>
<td>4,560</td>
<td>4,250</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Technology Innovation</td>
<td>500</td>
<td>1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance - Estates</td>
<td>500</td>
<td>650</td>
<td>650</td>
<td>650</td>
</tr>
<tr>
<td>Maintenance - Technology</td>
<td>540</td>
<td>640</td>
<td>640</td>
<td>640</td>
</tr>
<tr>
<td>Disposals</td>
<td>(4,000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAPITAL REQUIRED</td>
<td>6,100</td>
<td>11,040</td>
<td>2,290</td>
<td>1,290</td>
</tr>
</tbody>
</table>
5.3.6a Capital requirements under different financial scenarios

Given the financial situation and the low probability of receiving significant capital funding in future years we will need to transfer part of our revenue surplus to capital. The amount varies under different financial scenarios:

Scenario 1:
Revenue to capital transfer to cover:
- capital requirement for new build
- refurbishment
- technology innovation

net of proceeds from disposals in 2011/12. We will require annual capital funding of £1m - £1.3m per annum to cover ongoing maintenance of current estates and technology.

Base Case and Scenario 2:
Revenue to capital transfer to cover:
- all capital requirements, net of proceeds from disposals in 2011/12. This would also cover increased investment in technology innovation in both scenarios, estimated as an additional £1m in 2011/12 and £2m in 2012/13.

5.4 RISK ASSESSMENT

5.4.1 Financial risks and opportunities

As part of the development of this plan we have assessed the following major risks:

- The acute costs have primarily been modelled using NHS London guidelines. However we are aware of the work currently being undertaken by Imperial (ICHT) in assessing the profitability of their non-PbR activity. As part of the 2009/10 contract negotiations we agreed to a review of these prices. The review led by the PCTs was inconclusive and ICHT have now commissioned a more detailed piece of work. They are convinced that the conclusion from this work will lead to a significant increase in non-PbR costs in 2010/11. This increase has not been considered in these plans and we estimate the annual impact to be in the range £1.5m - £3.5m.

- Our current funding levels are significantly above capitation (+16.6%), which would result in a reduction of our funding by approximately £46m. We have modelled a financial scenario looking at the impact of reducing funding levels to capitation over a 5 year period, and although we could ensure the financial viability of the PCT in the short term, it would not be a long term sustainable position.

- Many of the assumptions underpinning this plan are based on the HfL affordability work carried out by McKinsey. Although we have worked with McKinsey to understand the detail of these assumptions and are comfortable that they are not unreasonable, they are as yet unproven and consequently there is a risk of not achieving the extent of savings, activity shifts and decommissioning anticipated.
To balance these risks there are some opportunities that we have also not been able to evaluate and which are therefore not included in our detailed plans:

- We continue to have a very close working relationship with ICHT and have already started discussions with their executive team on how we can co-operate in achieving the significant efficiencies and changes required by both sides in the coming years. We intend to work closely with them in developing comprehensive care pathway designs and assessing the end to end economics. Our expectation is that this will improve the overall efficiency and efficacy of service changes and benefit all parties.

- As we continue the integration with the council we are confident of identifying increased opportunities for joint working. Specifically with the appointment of a joint Children’s Services Commissioner we anticipate that we will realise additional shared efficiencies in provision of service which have not yet been identified or evaluated.

- We have already commenced discussion with our Mental Health provider involving both Hounslow and Ealing PCTs to investigate the possibilities of integrated service provision. These discussions are at an early stage, but we are confident that they will result in increased efficiencies for both provider and commissioners.

5.4.2 Sensitivity Analysis

Our ability to deliver this strategic plan whilst generating a minimum 1% surplus - around £3.8million - is dependent on both the funding and expenditure assumptions underpinning the financial modelling and planning being realised between 2009/10 and 2013/14.

Funding sensitivity

The sensitivity of this plan to the three funding scenarios outlined above is analysed in the main financial templates. We have assumed that the worst case Scenario 1 (flat cash being received from 2011/12 onwards) is the most likely funding that we will receive and therefore have focused our strategic plan to deliver a £4million surplus against this assumption. To assess the sensitivity of the plan to the funding assumptions we have modelled the cost impact of the same service plan for all three funding scenarios. However, an additional range of projects to further improve healthcare in Hammersmith and Fulham has been identified which we will deliver if we receive improved funding than is forecast under Scenario 1, i.e. tending towards either Base Case or Scenario 2 funding.

Expenditure

There is a low likelihood (explained in sheet “Risks and Opportunities” of the Financial Plan) that four assumptions underpinning the delivery of the £4million surplus under funding Scenario 1 may not be realised. These assumptions and the associated likelihood levels are:

1. Acute activity growth of 4.0% not 2.9% (Likelihood at 10%)
2. Zero saving delivered by ACV – Scenario 1 assumes £2.3 million recurrently by 2013/14 (Likelihood at 20%)
3. 50% higher costs for delivering care in polysystems – Scenario 1 assumes £4.4million recurrently by 2013/14 (Likelihood at 10%)
4. Department of Health centralised prescribing cost reduction, Scenario 1 assumes £1.5million recurrently by 2013/14 not under control of NHSHF (Likelihood at 50%)
The graph below shows the impact on our annual surplus should all the above materialise at:

1) full magnitude
2) possible (after applying likelihood factor)

### Mitigating actions

The deliverability of these assumptions and the magnitude of the impact of any variation will be monitored and assessed on an ongoing basis. To mitigate the impact of these risks, we will ensure compensating savings are delivered through extending the CIPs being generated through our integration with the council and through driving down costs on existing contracts as a result of the ongoing market review and retendering of existing contracts as articulated in our Commercial Strategy and monitored by the Competition Board.
### 5.4.3 Key corporate risks linked to strategic plan

The high level risks identified in our corporate risk register and linked to delivery of the Strategic Plan are set out below. (Likelihood and consequence are rated on a scale of 1-5 where 1 is low/minor and 5 is high/catastrophic)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Risk Ref</th>
<th>Risk Description</th>
<th>Likelihood Score</th>
<th>Consequence Score</th>
<th>Financial Impact</th>
<th>Mitigations</th>
<th>Contingencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>G1 R1</td>
<td>Risk of not achieving immunisation targets leading to preventable diseases.</td>
<td>5</td>
<td>4</td>
<td>Opportunity of saving if vaccination rates increase to prevent disease.</td>
<td>Failsafe Team in place to follow-up children who have not been immunised.</td>
<td>No financial contingency. Initiative costs to be supported from savings.</td>
</tr>
<tr>
<td>G2</td>
<td>G2 R2</td>
<td>Risk of inadequate healthcare provision for prisoners leading to poor health outcomes including avoidable death.</td>
<td>5</td>
<td>4</td>
<td>Cost implication in terms of litigation. From Sept 2008 to Sept 2009 there were 6 reviews costing £18k with estimated legal costs of £7.8k</td>
<td>Investment in additional healthcare staff made during 2009/10.</td>
<td>£626k set aside for the next five years to maintain increased staff provision.</td>
</tr>
<tr>
<td>G3</td>
<td>G3 R3</td>
<td>Risk that we are unable to respond to the economic climate and deliver changes at required pace.</td>
<td>4</td>
<td>5</td>
<td>Service redesigns will release £14m from acute sector &amp; £3.6m from community settings by 2013/14.</td>
<td>Financial modelling based on various scenarios.</td>
<td>Planning rapid implementation of Healthcare for London.</td>
</tr>
<tr>
<td>G4</td>
<td>G4 R4</td>
<td>Risk of not achieving infection control standards leading to risk of infection, management costs and costs of litigation.</td>
<td>4</td>
<td>4</td>
<td>Savings opportunity if risk is well managed.</td>
<td>Working with providers to understand the root cause of infections that do occur and responding accordingly.</td>
<td>Resources remain within budgets to review infections on a case by case basis next year and beyond.</td>
</tr>
<tr>
<td>G5</td>
<td>G5 R5</td>
<td>Risk that the Mental Health Provider does not improve leading to increased demand on other parts of the health service.</td>
<td>4</td>
<td>4</td>
<td>Opportunity for savings from baseline budgets.</td>
<td>Enhanced Performance Management Panel and Service Level Agreement meetings set up at Chief Executive level.</td>
<td>Mental Health is area in 2010/11. The strategic plan describes the projects that are planned and corresponding resource.</td>
</tr>
<tr>
<td>G6</td>
<td>G6 R6</td>
<td>Risk of non-PbR price increases in acute of between £1.5m to £3m annually.</td>
<td>4</td>
<td>4</td>
<td>Between £1.5m and £3m annually</td>
<td>Financial planning to cater for multiple scenarios</td>
<td>Financial modelling in-year to respond to changes and prioritisation framework</td>
</tr>
<tr>
<td>G7</td>
<td>G7 R7</td>
<td>Risk of increased costs from pandemic flu: costs of managing the pandemic, consequences of deferred healthcare.</td>
<td>5</td>
<td>3</td>
<td>Estimated additional costs in 2009/10 of £1,500k</td>
<td>Comprehensive business continuity plans encompassing flu resilience and winter planning.</td>
<td>Covered by £1,500k contingency in 2009/10.</td>
</tr>
<tr>
<td>G8</td>
<td>G8 R8</td>
<td>Risk of poorer health outcomes of those in the north of the borough compared to the south of the borough.</td>
<td>5</td>
<td>3</td>
<td>Results in increased costs from poor health and increased demand on health services in the north.</td>
<td>White City Project underway monitored by the Capital and Estates Committee. Canberra Practice opens in Jan 2010 which will increase primary care capacity.</td>
<td>Continue to monitor health inequalities and modify the Strategic Plan initiatives accordingly.</td>
</tr>
<tr>
<td>Scenario</td>
<td>Risk</td>
<td>Probability</td>
<td>Potential</td>
<td>Description</td>
<td>Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
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<td>-------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G2 R9</td>
<td>Risk of: a) poor case finding of people with disease; b) people with diagnosed disease not being placed on relevant GP disease registers. Consequences: avoidable morbidity, suboptimal disease management, avoidable expenditure.</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>Opportunities for increasing cost effectiveness. The QOF+ programme is incentivising case finding and appropriate use of disease registers. The Strategic Plan describes initiatives and resources for increased screening to be delivered through QOF+ and long term conditions programmes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R10</td>
<td>Risk that acute spend is not monitored effectively in the early stages of the Commissioning Partnership (ACV).</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Increased staff costs for dual running of performance monitoring. Risk that validation queries at Imperial are not identified (c. £100k per month at risk). Dual running of some performance management activities. Working closely through the JCPCT to ensure the Commissioning Partnership is appropriately resourced.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R11</td>
<td>Our current funding levels are significantly above capitation (+16.6%)</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Potential reduction in funding of £46m. Modelled a financial scenario of reducing funding levels to capitation over 5 years. Financial viability in the short-term, but not it sustainable long-term.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R12</td>
<td>Risk that the McKinsey Healthcare for London modelling does not hold true.</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Significant. Degree will depend on difference between assumptions and what is achievable. We have worked with McKinsey to understand the detail of these assumptions. Financial contingency is covered in the financial modelling of different financial scenarios.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R13</td>
<td>Risk that our assumptions on acute growth (demand management) are too conservative.</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Applied 2.9% for growth in acute activity (compared to NHS London assumption of 4%). Risk is £6.7m per annum by 2013/14. Financial modelling based on scenario 1 (which is more severe than base case). Contingency is the leeway between scenario 1 and base case.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>Risk that we do not have the required capacity and capability to deliver the Strategic Plan.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Not be able to respond to the changing economic climate quickly enough. Organisational Development Plan. Finances have been set aside in directorate training budgets to support delivery of OD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R15</td>
<td>Risk that the ACV does not deliver planned savings.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Scenario 1 assumes £2.3m recurrent saving by 2013/14. Dual running of some performance management activities. Working closely through the JCPCT to ensure the Commissioning Partnership succeeds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R16</td>
<td>Risk that the financial modelling of changes in care setting for activity doesn’t hold true</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Maximum of £4.4m at risk by 2013/14. Modelling of activity and finances with external support. Extending existing CIPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3 R17</td>
<td>significant prescribing cost savings already made, but risk that unable to make further savings in line with HfL assumptions.</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>£1.5m recurrent savings to be found by 2013/14. Further work with prescribers to identify and realise efficiencies. Extending the CIPs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Board

6.1 DECLARATION OF BOARD APPROVAL

The Trust Board approved this Strategic Plan at its meeting on 25th November 2009 subject to some minor amendments. Authority was delegated to the Chairman to approve final amendments prior to submission.

The Trust Board has been engaged in shaping, challenging and managing the strategy through a number of Board Seminars. Seminars are informal meetings covering 3 hours where topics are discussed in detail in draft form as a way to challenge assumptions and develop ideas prior to presentation to the Trust Board for consideration. The key topics have been:

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 May 2009</td>
<td>Maternity Matters</td>
</tr>
<tr>
<td></td>
<td>Health visiting</td>
</tr>
<tr>
<td></td>
<td>Commissioning Partnership</td>
</tr>
<tr>
<td>10 June 2009</td>
<td>Improving quality of primary care</td>
</tr>
<tr>
<td></td>
<td>Risk management and objective setting</td>
</tr>
<tr>
<td>9 July 2009</td>
<td>Medium Term Financial Strategy</td>
</tr>
<tr>
<td></td>
<td>CSP Refresh: vision, goals and prioritisation</td>
</tr>
<tr>
<td>29 July 2009</td>
<td>North West London acute provider landscape</td>
</tr>
<tr>
<td></td>
<td>Imperial College Healthcare future service strategy</td>
</tr>
<tr>
<td>21 September 2009</td>
<td>CSP Refresh</td>
</tr>
<tr>
<td>14 October 2009</td>
<td>CSP initiatives and priorities</td>
</tr>
<tr>
<td></td>
<td>Medium Term Financial Plan update</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Area Assessment</td>
</tr>
<tr>
<td>16 November 2009</td>
<td>Review of prioritised initiatives and prioritisation framework</td>
</tr>
</tbody>
</table>

The Trust Board has also considered the following strategic issues at formal Board meetings:

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 March 2009</td>
<td>Borough integration</td>
</tr>
<tr>
<td></td>
<td>North West London Commissioning Partnership</td>
</tr>
<tr>
<td></td>
<td>Central London Community Healthcare transfer</td>
</tr>
<tr>
<td>20 May 2009</td>
<td>Sexual health strategy</td>
</tr>
<tr>
<td>8 July 2009</td>
<td>Commissioning Support for London</td>
</tr>
<tr>
<td></td>
<td>Stroke and major trauma consultation</td>
</tr>
<tr>
<td></td>
<td>Risk management</td>
</tr>
<tr>
<td></td>
<td>Board development</td>
</tr>
<tr>
<td>23 September 2009</td>
<td>Care Quality Commission report into West London Mental Health Trust</td>
</tr>
<tr>
<td>25 November 2009</td>
<td>Strategic Plan refresh</td>
</tr>
<tr>
<td></td>
<td>Medium Term Financial Strategy</td>
</tr>
<tr>
<td></td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td></td>
<td>Integrating children’s commissioning</td>
</tr>
</tbody>
</table>

Responsibility for the strategic plan rests with the Accountable Officer. Day-to-day responsibility for the development of the plan rests with the Director of Strategy through the Managing Director. The Trust Board has overall responsibility for consideration and approval of the strategic plan.

The Trust Board has led quality and productivity improvements through defining and overseeing major projects such as the urgent care tender leading to polyclinics at both Hammersmith Hospital and Charing Cross Hospital.

The Trust Board receives a programme report at each meeting with progress against the strategic plan. During the year, the monthly performance report has been developed to cross-reference with the programme report. Board meetings take place bi-monthly.
# Appendix 1 – reference to North West London Integrated Strategic Plan

<table>
<thead>
<tr>
<th>NWL ISP Goal No.</th>
<th>NHSHF Goal No.</th>
<th>Initiative</th>
<th>Page in NHSHF strategic plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>Planned Care</td>
<td>29</td>
</tr>
<tr>
<td>1,2,3</td>
<td>3</td>
<td>Pre referral and pre operative diagnostic workups should take place in the polysystem, and not be duplicated in the hospital.</td>
<td>31</td>
</tr>
<tr>
<td>3</td>
<td>1,3</td>
<td>30% of outpatient attendances should be decommissioned, (e.g. by reduction of new to follow up, determining services which do not require follow up), and 55% reprovided in polysystems. To be standardised as far as possible through sector workshops.</td>
<td>46</td>
</tr>
<tr>
<td>1,2</td>
<td>1,3</td>
<td>Maximise use of designated local hospitals as elective centres</td>
<td>49</td>
</tr>
<tr>
<td>1,2</td>
<td>3</td>
<td>Drive productivity metrics to the top quartile within Trusts and primary/ community care, ensuring that poly systems are operating at an effective scale.</td>
<td>31</td>
</tr>
<tr>
<td>1,7,8</td>
<td>1,2,3</td>
<td>Long Term Conditions (LTCs)</td>
<td>31, 51</td>
</tr>
<tr>
<td>7,8</td>
<td>1,2</td>
<td>Apply consistent care pathways across the PCTs and Trusts, initially for diabetes and COPD then expanding the range of LTCs covered over the planning period.</td>
<td>26</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>End of Life Care</td>
<td>29/54</td>
</tr>
<tr>
<td>9</td>
<td>3</td>
<td>Each polysystem to include an end of life partnership, working with nursing homes to manage end of life care</td>
<td>54</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Ensure that GPs universally apply the Gold standard framework for end of life care.</td>
<td>54</td>
</tr>
<tr>
<td>2,3</td>
<td>2,3</td>
<td>Commission for high quality end of life care- in acute Trusts, hospices, nursing homes community and GP contracts.</td>
<td>54</td>
</tr>
<tr>
<td>6</td>
<td>1,4</td>
<td>Staying Healthy</td>
<td>39 - 41</td>
</tr>
<tr>
<td>8</td>
<td>1,4</td>
<td>PCT plans to achieve immunisation and screening targets. Sector to share best practice examples</td>
<td>38, 41</td>
</tr>
<tr>
<td>7, 8</td>
<td>1,4</td>
<td>PCT plans to combat obesity and alcohol abuse</td>
<td>41, 58</td>
</tr>
<tr>
<td>3, 8</td>
<td>3</td>
<td>Acute Care</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>2,3</td>
<td>Implementation of HfL stroke and trauma service reconfiguration</td>
<td>29/49</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Develop a single point of access system for urgent care – inner NWL best practice model</td>
<td>27</td>
</tr>
<tr>
<td>1, 3</td>
<td>3</td>
<td>Primary care front end at each A&amp;E and Urgent care centre</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Rationalise urgent care, including emergency surgery provision, in line with HfL and CWG/ CRG recommendations, subject to business case and consultation</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Levelling up of the quality and accessibility of primary care to a pan sector standard, using appropriate incentives</td>
<td>48</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Maternity</td>
<td>35</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Configuration of maternity units in line with HfL/ CWG/CRG recommendation subject to business case and consultation</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Implement team midwifery to support choice of home birth</td>
<td>35</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Children and Young people</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>A strong community service, including acute nursing in the community, must be in place to support the changes in settings of care</td>
<td>38</td>
</tr>
<tr>
<td>2, 6</td>
<td>1,4</td>
<td>Rationalise inpatient paediatric services and implement Paediatric Assessment units at all urgent care centres</td>
<td>38</td>
</tr>
<tr>
<td>6</td>
<td>1,4</td>
<td>Children’s centres to be a spoke of polysystems</td>
<td>38</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>PCTs to ensure that immunisation and breastfeeding targets are met, and to put plans in place to reduce child obesity</td>
<td>38</td>
</tr>
<tr>
<td>2</td>
<td>1,3</td>
<td>Mental Health</td>
<td>44/54</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>PCTs to commission dementia services per the HfL pathway, as both a long term and an end of life condition</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>1,3</td>
<td>Integration of mental health services into polysystems</td>
<td>29</td>
</tr>
</tbody>
</table>