NHS
Waltham Forest
Clinical Commissioning Group

NHS Waltham Forest CCG Commissioning Strategic Plan A Three Year Plan 2016/17 – 2019/20

Transforming Services Together LOCAL

FINAL November 2016

Contents

1 Foreword

We are delighted to set out our strategic plan which describes the CCG's undertaking to ensure continual improvement in the quality of health services, prevent illness and promote health, drive greater efficiency and productivity in services and look for innovative solutions to ensure the very best healthcare is available to patients.

NHS Commissioners are required to have clear and credible strategic commissioning plans that best meet the needs of their local population within the resources available to them. These must then be actively managed to ensure the plans deliver safe and high quality care for patients and the public.

Waltham Forest Clinical Commissioning Group's (CCG) Strategic Commissioning Plan is a comprehensive plan to describe what healthcare services will be commissioned over the next three years to ensure local residents have access to the best possible health and health care services that deliver the best outcomes.

Our plans sit within the wider context of the national and North East London health care strategy and describe what we are doing locally in Waltham Forest. The overall theme of our plans and work programmes is integration of care across the health and care system working with our providers to develop one accountable care system.

The national vision for the NHS, described in the Five Year Forward View, is clear in its message that there needs to be change and challenge to current arrangements which are unsustainable to continue into the future. Although we are building on a successful starting point by being well placed and with a strong foundation to meet the challenges posed, further consideration and planning is needed.

We have been working with our partners across health and social care to change the way care is delivered to patients to make it more personalised and responsive, such as the integrated care and care management transformation programme. We intend to continue to work in close partnership to explore solutions to challenges faced and this paper will highlight that there is considerable work ahead and a journey of change and transformation.

Signed by:

Dr Anwar Khan

Chair, NHS Waltham Forest

NHS Waltham Forest Clinical Commissioning Group

Mr Terry Huff

Accountable Officer,

2 Executive Summary

This commissioning strategy (CSP) refreshes and updates the previous Waltham Forest Commissioning Strategic Plan (CSP) 2014 – 17. It sets out the national strategic framework within which the CCG operates and the local context with specific reference to the Transforming Services Together programme and the North East London Sustainability and Transformation Plan. It describes the demography of the borough and how its demographics are expected to shift in various important ways over the coming years.

Through a series of Governing Body and all staff dedicated sessions, the business priorities of the organisation and priority work programmes were agreed, taken forward through a programme board approach, led by a CCG officer and clinical director. These plans are the local delivery plans to implement the wider strategic plans across North East London.

The main content of the CSP describes the achievements and ambitions of the ten programmes: Long Term Conditions, Urgent Care and Surge Management, Planned Care, Cancer, Integrated Care and Care Management, Learning Disabilities, End of Life Care, Primary Care, Maternity and Mental Health.

All the programmes adopt integration as a general approach. Integrated care is one of the high impact transformational change programmes and a key part of the Better Care Together Programme. For example for diabetes the ambition is to commission a seamless care pathway and improve the variation of care across primary care. A key element of the urgent care programme is the re-procurement of an integrated urgent and emergency care service covering 111 and GP Out-of-Hours. The new service would include much stronger links with proposed “clinical hubs”, as well as better integration with primary care services, that would help to resolve urgent care needs without attendance at A&E.

There is a section on quality and governance that describes the CCG’s objective to shape the quality of commissioned services to better support the needs of residents, whilst ensuring services are subject to the rigorous checks and balances expected from contracted services. When we talk about quality we mean patient safety, effectiveness of care and patient experience. Assuring these three elements of quality for patients will be central to our work with providers in secondary and primary care.

The final sections look at the enablers required to deliver the programmes of work including IT, organisational development, estates, workforce, communications and engagement and procurement.

The CSP serves to signpost for further information and throughout the document there are hyperlinks to use to obtain further detail.

3 Who we are

NHS Waltham Forest Clinical Commissioning Group (CCG) was established on 1 April 2013. It is a clinically-led statutory NHS body responsible for the planning and commissioning of health care services for the local area. We are responsible for the health of Waltham Forest, and are measured by how much we improve the health outcomes for the population.

Commissioning is about getting the best possible health outcomes, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospital and community services. It is an ongoing process, and we must constantly respond and adapt to changing local circumstances

There are 44 GP practices in the borough, all of which are members of the CCG. These practices are divided into three localities – Leyton and Leytonstone, Walthamstow and Chingford. Being a member of the CCG means these practices can influence what the CCG is doing. The members also nominate the eight clinical directors who sit on the Governing Body and provide clinical leadership to the organisation .

For further information click here http://www.walthamforestccg.nhs.uk/

We also work closely with the local authority and have pooled funding as part of the Better Care Fund. Integration is a key theme of the CSP as we move towards implementing new models of care including an accountable care organisation (see Section 7.5). We also anticipate further integration with the local authority over time.

3.1 The Provider Landscape

The North and East London provider landscape is characterised by a wide mix of organisational types, ranging from very large specialist teaching hospitals, specialist hospitals and integrated care organisations through to smaller acute units, there is also a significant private provider market in the area. The nature of healthcare in London means that there are good levels of competition within the sector.

We commission services through a range of NHS and Non-NHS providers with the contract monitoring and negotiation process being led by clinical commissioners.

Services are commissioned from the following providers

Acute (Hospital Services): Whipps Cross Hospital Barts Health

Mental Health: North East London NHS Foundation Trust

Community: North East London NHS Foundation Trust

Primary Care:

44 GP practices

60 pharmacies

34 NHS dental practices and 43 optician practices

4 Demography

The health challenges faced by Waltham Forest are evolving and complex. The Joint Strategic Needs Assessment (JSNA) is led by the Health and Wellbeing Board - a multi-community committee with membership drawn from the CCG, local authority, the voluntary sector and the local patient representative organisation.

The JSNA (currently being refreshed) shows that the borough's demographics are expected to shift in various important ways over the coming years. While our overall population is likely to continue to expand, the scale of the increase is forecast to be highest in children of school age (5-19yrs) and oldest (80+) sections of society. The population aged 65+ is estimated to increase by 22% over just the next 10 years to 2025, an increase of over 6,000; over the next 20 years, the estimated increase is 61% (increase of more than 16,500)

At the same time, Waltham Forest is continuing to become more ethnically diverse. We therefore need to ensure that services commissioned are adequately tailored to meet the specific needs of all population groups and are sustainable enough to address the continuing population growth.

The 2015 GLA population projects estimate a population of 273,934 persons living in the borough in nearly 100,000 households. The borough has a similar age structure to London as a whole with a larger percentage of children and people aged 20-39 than the England and Wales average. The 2011 Census data show that Waltham Forest's BAME (Black Asian and Minority Ethnic) population is 123,450. This is the 8th highest rate in London, when expressed as a percentage of total population (47.8%).

According to the recently released 2015 IMD scores, Waltham Forest is the 7th most deprived borough in London, and 35th across England. This represents a slight improvement compared to the previous figures from 2011. However, the borough still contains many areas facing very high levels of deprivation, and the attendant problems for health and wellbeing.

We have identified and collated evidence on the areas where there are major opportunities both to improve health outcomes for Waltham Forest based on the key findings emerging from the Waltham Forest Joint Strategic Needs Assessment (JSNA), and in the Public Health Outcomes Framework (PHOF).

- Waltham Forest has average rates of hospital admission for alcohol related conditions (broad measure) following a downward trend in recent years. Admissions for men are slightly higher than London and England. Rates of admissions for women are slightly higher than the London average and almost identical to the England average.
- Around 20% of the population smoke. Smoking attributable hospital admissions are well below both London and national averages. Use of stop smoking services has been steady in 2015/16, despite the growing challenge of e-cigarettes, but there is still large room for improvement. An estimated 18% of deaths in Waltham Forest are smoking related (about 268 a year).
- The number of cases of TB is high, currently at 41 cases per 100,000 compared to a London wide rate of 35 cases per 100,000. Diagnosis in A&E indicates that TB is being diagnosed at a late stage. This is an important and urgent local issue
- Recorded Diabetes prevalence in Waltham Forest has been increasing and is at an estimated 6.6% of the adult population. While there has been an increasing trend in prevalence nationally, the rate of

increase in WF is slightly lower, and slightly below that seen in London. Prevalence is predicted to rise to over 11% of the population by 2030 as a result of changing demographics, creating the risk that more people with diabetes will have diabetic complications in the near future

- Cardiovascular disease remains the biggest killer of those aged 75 and under, and there are significantly higher rates in the poorer wards compared to more affluent areas. In addition, cardiovascular mortality is significantly above both the London and National average in Waltham Forest.
- The main causes of death are cancer, cardiovascular disease and lung disease (COPD), similarly to most areas within England.
- Tuberculosis (TB) and HIV are the two communicable diseases of greatest concern. Incidence of TB had been increasing in the Borough; however the latest data shows the first fall in three years.
- There is significant variation in life expectancy in the borough with a difference of 5.3 years for men between the wealthiest and poorest parts of the borough and 5.5 years for women.
- For 2013, prostate cancer incidence is above that found nationally, but lung, bowel and breast cancer are either lower than England rates or similar. However, despite overall lower incidence of cancer, mortality rates are average. One year cancer survival, at 68.7% is lower than the national average of 70.2%; however, large improvements relative to the national rate have been seen over the last 10 years. Uptake of screening is in line with London rates, although similarly to the rest of London, lower than national targets
- The association between deprivation and prevalence of coronary heart disease in London remains strong, with Waltham Forest having a higher prevalence of CHD at all ages, comparable to other boroughs with high IMD scores (high relative deprivation)
- The increase in Waltham Forest's elderly population clearly has major implications for both the NHS and social care within the borough. Again, there is a significant role for prevention here, particularly in areas affecting the elderly such as falls. For older people who have developed long-term conditions, sustained joint work between Social Care, the NHS and Public Health will be needed to strengthen the focus on improving quality of life
- As reported in the PHOF, Health related quality of life for older people is equal to the London average but below the national average, and excess winter deaths are above average.
- There are poor outcomes for falls patients. Hospital admissions for falls and falls injuries in Waltham Forest are significantly higher than its comparators and there is a significantly higher mortality from fracture of femur for 65 to 84 years age group than its comparators
- Childhood obesity is a growing problem – 22.9% of Reception class children in the borough have excess weight, this is slightly higher than the national average. 35.8% of Year 6 children have excess weight, significantly above the national average.
- We are an outlier in the incidence of sickle cell disease
- Self-harm incidence in children and younger adults has decreased. Self-harm related emergency hospital admission rates amongst 10-24 year olds are lower than the London and England averages (2014/15). Admissions for mental health for 0-17 year olds are also relatively low, with the local rate in 2014/15 below both the London and national rate

- Smoking and obesity are serious problems that impact on the health outcomes of the population. Smoking rates are reducing but obesity is increasing, particularly amongst children.

For more information click here

https://www.walthamforest.gov.uk/content/joint-strategic-needs-assessment-jsna

http://www.walthamforestccg.nhs.uk/news-items/waltham-forest-joint-health-and-wellbeing-strategy-published/19342

NHS England and Public England have complied Commissioning for Value packs support commissioners to identify priority programmes which offer the best opportunities to improve healthcare for the local populations. Commissioning for Value is a programme of work within NHS RightCare and is about:

1. Identifying priority areas which offer the best opportunities to improve healthcare for populations
2. Improving the value that patients receive from their healthcare
3. Improving the value that populations receive from investment in their local health system.

We have reviewed the latest 2016 data packs which inform our planning and decision making.

5 Our Vision, Values and Strategic Goals

Our vision and values have been given a renewed focus by membership practices and CCG staff to create a strong sense of purpose and direction.

Successful organisations not only ensure that all objectives and priorities are aligned to their corporate vision, but they also have a clear and single set of values that define how things are done and how they behave. Values underpin the culture of the organisation. They are demonstrated in our behaviours and the way we do things in the organisation

Our vision is the organisation's statement of intent and by defining our values which shape the direction of our strategic planning which underpins all that we do. Our Vision, Values and Goals are set out below;

VISION	"We will put patients at the heart of everything that we do and use our joint experience to improve the delivery of local health care and ensure value for money."
VALUES	• We will act with integrity, treating everyone with respect and equity • We will actively listen to enable everyone to maximise their potential and fully contribute to the organisation • We will work in close participation with our partners across health and social care
STRATEGIC GOALS	• To meet our statutory requirements • To be clinically led • To commission good organisational development for individuals, teams and the organisation • To strengthen our collaboration with *WEL and **WELC • To involve patients, communities and hard to reach groups

*WEL Waltham Forest, Newham and Tower Hamlets CCGs

**WELC Waltham Forest, Newham, Tower Hamlets and City & Hackney CCGs

6 Strategic Fit

6.1 National Strategy

Nationally the NHS is facing a multi-billion financial shortfall by 2020-21 if no action is taken. It is recognised that major change for the NHS is required to respond to the challenges of an ageing population, to failures in the quality of services such as those seen at Mid Staffordshire and Winterbourne View, and to make that sure that the population get the best value when the public finances are under pressure.

The national NHS strategy, set out in the Five Year Forward View (23 October 2014), outlined the case for change and gives a clear vision for the future of the NHS. It expresses the view that current models for health and care services will be unsustainable in the context of reducing social care budgets and no real increase in NHS budgets, at a time when demand for services and costs are increasing. The NHS faces a potential funding gap of around £30bn by 2020/21 if nothing were to change.

It heralds new ways of working and describes different models how the NHS and its partners can choose to work with each other in a different way and has started the move towards a different health service, recognising the challenges and outlining potential solutions to the big questions facing health and care.

The vision for the NHS which we, as leaders of the local system, respond to in our strategic plans, includes:

- The relationship the NHS as a whole has with patients and communities particularly relating to supporting prevention, empowering patients and engaging with communities

- New models of care across services including learning from emerging models of care across the country, recognising that local needs and delivery mean that one size does not fit all and looking at new models of care that can support primary care delivery and integration. This includes (multispecialty community providers (MCPs) / primary and acute care systems (PACS) and responses to urgent care demand such as urgent and emergency care networks

- Descriptions about how to achieve the vision including supporting local solutions and leadership, building a modern workforce, using information technology to revolutionise care and supporting health innovation and learning.

For more information on the Five Year Forward View click here

https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The Strengthening Financial Performance and Accountability in 2016/17 (21 July 2016) sets out a series of actions designed to support the NHS to achieve financial sustainability and improve operational performance. This regime referred to as the “reset” sets out a seven-point plan to stabilise NHS finances during 2016/17, provided further detail on access to the Sustainability and Transformation Fund (STF) in 2016/17, outlines the proposed basis for assessing the financial performance of provider organisations and introduces new programmes of financial special measures for providers and commissioners that are unable to ensure sufficient financial discipline.

The 'reset' sets out the agreed legal responsibilities of individual NHS bodies to live within the funding Parliament has decided should be available to the NHS this year. These individual accountabilities will be supplemented by the sustainability and transformation plans now being developed in communities across England, which will set out the wider, shared action they will take together to unleash broader improvement on health, care, and financial sustainability to 2020.

For more information on the Strengthening Financial Performance and Accountability in 2016/17 click here

https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/

The delivery of these national ambitions drives and shapes our local CSP, as well as our wider five-year strategic plan Transforming Services Together across Waltham Forest, Tower Hamlets and Newham CCGs and the North East London system wide Sustainability and Transformation plans.

6.2 Better Health for London

Across London NHS England, Public Health England, London Councils and the 32 London CCGs have come together to outline how, individually and collaboratively, they will work towards London becoming the world's healthiest major city.

The critical role of local government in shaping health and care services is recognised in both the London Health Commission's report and the NHS Five Year Forward View. We are keen to strengthen that role further, and work with all our partners to achieve the aspirations set out in the Next Steps Plan, which builds on both pieces of work.

The new partnership has been established in response to the challenges set out in the London Health Commission's Better Health for London report and the NHS Five Year Forward View. The aim is to work together at all levels to make the best use of resources and build on best practice to improve the health and well-being of all Londoners, wherever they live in the capital. In the long term the plan a platform basis to explore how London could benefit from more autonomy to improve the future of the capital's health.

Better Health for London: Next Steps sets out shared ambitions towards the following shared goals which strongly align to our strategic plans and the ambitions of the Waltham Forest Health and Wellbeing Strategy 2016 – 20:

- Give all London's children a healthy, happy start to life
- Get London fitter with better food, more exercise and healthier living
- Make work a healthy place to be in London
- Help Londoners to kick unhealthy habits
- Improve care for the most mentally ill in London so they live longer, healthier lives
- Enable Londoners to do more to look after themselves
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them
- Create the best health and care services of any world city, throughout London and on every day
- Fully engage and involve Londoners in the future health of their city
- Put London at the centre of the global revolution in digital health

For more information click here

https://www.england.nhs.uk/london/2015/10/30/better-health-for-london/

6.3 North East London Sustainability and Transformation Footprint

In December 2015, NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form 44 STP 'footprints' across England. The health and care organisations within these geographic footprints STPs will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

The footprints are locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, along with how they best fit with other footprints.

STPs footprints are not statutory bodies, but collective discussion forums which aim to bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations. They do not replace existing local bodies, or change local accountabilities.

The local footprint is North East London (NEL). Over the past six months, 20 organisations across NEL have worked together to develop a Sustainability and Transformation plan (STP). The STP is North East London's response to the challenge of adding pace and change to implement the Five Year Forward View and articulate one overarching STP plan across the North East London CCGs that brings together local organisations – CCGs, local authorities and provider trusts to work together to make changes to how local people live, access care, and how care is delivered.

This builds on previous positive experiences of collaboration in NEL but also protects and promotes autonomy for all the organisations involved. Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. On this basis, all parties recognise that they must work together to address this, as this offers the best opportunity to make the health economy sustainable by 2021 and beyond and is the route to access transformational funding opportunities.

There is one single vision that has been adopted across NE London:

1. To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.

2. To develop new models of care to achieve better outcomes for all, focused on prevention and out of hospital care.

3. To work in partnership to commission, contract and deliver services efficiently and safely.

North East London is an area with significant health and wellbeing challenges. The population is set to grow by 18% in the next five years, and five out of the eight boroughs are in the lowest quintile for deprivation in the UK. Health inequality is high, with prevalence of ill health driven by factors such as

smoking and childhood obesity. People frequently move and are highly dependent on secondary care. This makes the challenges unique and places significant pressure on local services.

By bringing together work from the three health economies (WEL: Newham, Tower Hamlets and Waltham Forest, BHR: Barking and Dagenham, Havering and Redbridge and CH: City and Hackney), a NE London level framework has been developed that will ensure every patient receives the same level of high quality care.

Whilst each of three economies has a different starting point, six priorities have been identified which need to be addressed collectively to ensure that residents receive quality services, consistent outcomes, and equity.

1. How can we ensure that we channel demand with appropriate capacity in NEL?
2. How do we transform our delivery models to support self-care, deliver better care close to home and high quality secondary care?
3. How can we ensure that our health and social care providers remain sustainable?
4. How do we transform specialised services through collaborative working?
5. How can we create a system-wide decision making model that enables placed based care and clearly involves key partner agencies?
6. How do we maximise the use of our infrastructure so that it supports our vision (and plans owned at a NEL level)?

The enablers that will support delivery of the plan are:

Workforce: retention of existing staff; workforce transformation to support new models, primary care, caring for the workforce, reduction on use of bank / agency. NEL As a destination where people want to live and work

Informatics: shared care record and access to care records

Estates: clear plans to support the emerging care models across the system, including investment and disposals in line with local authority plans

Finance: access and use of non-recurrent funds to support delivery of the plan, delivering financial sustainability across NEL

For more information click here (To add when strategy is published)

6.4 Waltham Forest, Tower Hamlets and Newham (WEL) System

TST is a core component of the STP and is the delivery plan for the WEL strategic planning system. It is fully aligned with the STP described above.

Transforming Services Together (TST) is a programme that brings together the CCGs of Newham, Tower Hamlets and Waltham Forest, as well as Barts Health NHS Trust, the main hospital services provider in these boroughs, to deliver high quality, safe and sustainable services for the population of East London.
The transformation and partnership working involved in TST is focussed on a number of clinical work streams, and this work informs and shapes the NEL STP. This CSP describes the local delivery and Waltham Forest specific plans for transformation.
For more information click here
www.transformingservices.org.uk

As well as a strategic fit within the wider NEL system described above, the CSP sits alongside and complements the Waltham Forest Better Care Fund and the Health and Wellbeing strategy.

6.5 Better Care Together

The joint vision of the CCG and Local Authority is to create a simplified and easy to access system of care and support for Waltham Forest residents where care is personalised and individuals are supported to be as independent as possible. Integrating health and social care and working together is paramount to this. To make this happen local health and social care systems are being brought together to work in a seamless way so that people get coordinated support close to home, only going into hospital when they really need to and staying no longer than necessary.

Both organisations have pooled 'health money' and 'social care money' into a single fund, called the Better Care Fund (BCF). This enables the organisations to get best value for the money collectively spent. The Council and the CCG jointly lead the health and social care integration agenda and this includes a pooled budget of £18,218,000 for 2016/17.

The Better Care Together Programme coordinates and supports a wide range of integration projects across the borough. It works closely with other change management programmes such as 'Transforming Services Together' and 'Redefining Waltham Forest' to share resources and plan strategically for the future. The local partnership brings together all parts of the NHS, Council, Healthwatch, voluntary sector and residents and their families, to integrate health and social care delivery and to test the benefits of joint working.

The 2016 /17 plan aims to transition the Better Care Together Programme into business as usual as quickly as possible. We think this will be achieved by March 2018, with the full integration of health and social care occurring by 2020 in line with the requirements of the NHS Five Year Forward View.

A further ambition of the Better Care Together Programme is to support the development of provider networks and an Accountable Care System. These new 'system models' enable partners to share risks and deliver well-coordinated, integrated care across the system for specific client groups such as vulnerable adults, children, people with learning disabilities and those with mental health issues.

For more information about the Better Care Together Programme, click on the link below.

http://welccc.nhs.sitekit.net/

6.6 Health and Wellbeing Strategy

The Health and Wellbeing Board (HWB) brings together partners from across the local authority, CCG, Healthwatch, and others. The goal of the HWB is to improve the health and wellbeing of the people in their area, reduce health inequalities, and promote the integration of services. The HWB is required to produce a Joint Health and Wellbeing Strategy, (referred to as 'The Strategy') which sets out priorities and guides the plans and decisions of the local authority, the CCG and NHS England. The Strategy addresses three main areas of action:

- From conception to age 18
- 'Working age' adult life
- Older people and protecting our communities.

The Strategy for 2016-20 was agreed by the HWB, Health Scrutiny, Cabinet and Full Council.

For more information on the Health and Wellbeing Strategy click here
http://democracy.walthamforest.gov.uk/documents/s50622/Appendix%201%20-%20Joint%20Health%20and%20Wellbeing%20Strategy%202016-20.pdf

7 Transformation in Waltham Forest – TST Local

TST Local is the CCG's specific response to the WEL TST delivery programme. The CCG has established priority work programmes to deliver the CCG's and ultimately the NE London STP strategic vision and goals. The local programmes are described more fully in the following section which describes the CCG priority programmes which are fully aligned to the TST delivery programme and support the ambition of the Five Year Forward View, described in section 6.1.

The two themes of TST are Primary Health Services and Sustainable Hospitals which are closed related and aligned. The majority of the CCG's priority local delivery programmes sit under the first theme.

Through a series of Governing Body and all staff dedicated sessions, the business priorities of the organisation were agreed. Each priority work programme is taken forward through a programme board approach led by CCG officer and clinical director and supported by clinical leads.

7.1 Long Term Conditions

DIABETES

Diabetes is one of the most significant long-term conditions that can lead to a number of other serious conditions such as heart disease, stroke and chronic kidney disease. It is expected to continue to be a significant health issue in Waltham Forest as the local population ages and risk factors continue to increase. People of South Asian origin are at the highest risk of developing diabetes with black ethnic groups also having a higher risk compared their white counterparts. However, these risks can be reduced with early diagnosis, high control of blood sugar in the first 10 years after diagnosis and healthy life style choices.

Prevalence

As described in section 4 there is a high prevalence of diabetes estimated at 6.6% of the Waltham Forest population. Estimates indicate that there is also 6,550 adults with undiagnosed diabetes.

Ambitions

Our ambition is to commission a seamless care pathway and improve the variation of care across primary care. In partnership with London Borough of Waltham Forest and in collaboration with Newham, Tower Hamlets and City & Hackney, we have been successful for wave 1 of the NHS Diabetes Prevention Programme and will commence this service 1 April 2017.

Diabetes Improvement Plan

Diabetes UK were commissioned in 2015/16 to support the development of a comprehensive diabetes programme improvement plan which will include pathway redesign, quality improvement for diabetes care in primary care and improving communication and partnership working across the system. The strategic framework and action plan will be finished by October 2016. We are working closely with key stakeholders including patients. This plan will set out the timeframe for these development areas over the next three years. Once the draft strategic framework is available we will engage more widely with patients about the services and pathway in more detail.

A one year diabetes triage and MDT pilot that tests if the pathway can improve patient care has been completed. The evaluation will inform the developing strategy and pathway.

Diabetes is now also part of the NELFT Shadow Year for outcome based commissioning and this will strengthen partnership working across the pathway and specifically enable improvements in tier 3 services and diabetes patient education in 2017.

CORONARY VASCULAR DISEASE (CVD)

CVD is the biggest killer in the London Borough of Waltham Forest and causes 24% of premature deaths (75 years and under). It is the main contributor for health inequalities between Waltham Forest and England.

The borough has a higher burden of lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity. Up to 19 in every 100 deaths from Coronary Heart Disease (CHD) are associated with smoking. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. There are significantly higher death rates in the most deprived wards compared to other parts of the borough. The premature (under 75 years) death rate for women in Waltham Forest is 56% higher than the national rate for CHD, and is fourth highest out of all London boroughs. As the local population ages, increasing demands will be made on health and social care needs. It is predicted that the highest increase in population over the next 20 years will be for men and women over the age of 50 with an estimated increase of 34% from 57,900 to 79,100 people.

The two most important causes of CVD death are CHD and stroke, the main risk factors for CHD and stroke are high blood lipid levels, smoking, obesity, hypertension, diabetes, physical inactivity and high alcohol intake. Some ethnic groups such as South Asians and the Black African and Black Caribbean groups have a higher risk due to a genetic predisposition towards some of the key risk factors such as diabetes and hypertension.

Our aim is to improve the quality of advice, self-management opportunities, care and outcomes for patients and to deliver care closer to home. We are currently undertaking the ground work to develop a strategic framework that maps out the associated CVD pathways and a phased, integrated, improvement programme and timeline for the next three years. There is a strong correlation between cardiac conditions, diabetes and renal disease and these areas will need to be linked to the strategic framework.

ANTICOAGULATION SERVICES

We are committed to improving community services, and has developed an innovative model for providing community oral anticoagulation therapy to prevent the formation of blood clots and strokes. This was implemented in April 2016 and incorporates national best practice and a streamlined patient pathway allowing patients being treated with warfarin to visit a GP practices/ community clinic or Pharmacist for monitoring and dosing close to their home. The new model also pilots initiation of anticoagulants to patients with Atrial Fibrillation (AF) in a community setting rather than the acute. This will support the national driver in regard to improving diagnosis of AF and will also ensure that AF patients are treated with anticoagulants instead of aspirin for the prevention of stroke which will improve clinical outcomes and patient experience.

HEART FAILURE (HF)

Heart failure (HF) is a significant health challenge in Waltham Forest. There is evidence to show that it is one of the most common discharge diagnoses for elderly patients. The British Heart Foundation suggests that there is a large undiagnosed population with HF conditions. Reflecting this unmet need, at present 50% of all patients are diagnosed as an emergency admission and there is a high rate of readmissions within 28 days of discharge. Almost 90% of HF admissions are emergency admissions and it accounts for 5% of overall medical admissions with readmission rates among the highest for any common condition in the UK (as high as 50% over 3 months) (Healthcare Commission 2007).

In Waltham Forest the prevalence of HF is higher than the average for England with a related higher admissions rate for patients.

We are working with the Bart's Health team to review the HF pathway and develop an integrated approach to patient prevention and condition management across the borough.

This includes;

- Developing clear pathways with consultant-led GP support for CVD conditions
- Improving prevention activities across the borough for those who are likely to suffer from Heart Failure
- Developing clear pathways to reduce repeat attendance at A&E for patients with Heart Failure and to support those who are discharged from Hospital with an effective and timely community support care plan.
- Improving the knowledge of Heart Failure across the GP community, providing easy access to expert knowledge, advice and guidance for the treatment of Heart Failure

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

We commission Bart's Health (Whipps Cross Hospital site) to provide a COPD pathway which includes the 'COPD discharge bundle.' This facilitates supported hospital discharge. It includes smoking cessation advice, checking inhaler technique, reissue of a medicines rescue pack and booking a follow-up community appointment within 2 weeks.

Over the next 3 years we plan to;

- 2016/17
    - Strategic Framework Development (including patient engagement).
    - Anticoagulation Pilot and evaluation
    - Redesign of Heart Failure pathway
- 2017-2020
    - Anticoagulation procurement
    - Phased improvement plan implementation including pathway redesign

Some key outcomes from these plans are;

- Improve clinical outcomes
- Deliver care closer to home for patients
- Speed up the diagnostic process via outpatient services for patients with suspected cardiac conditions
- Reduce the number of unnecessary appointments

7.2 Urgent Care and Surge Management

Strategic Aims and Objectives

1. Ensure that Whipps Cross meet the 4hr A&E waiting time standard on a sustained and sustainable basis

2. Reduce the number of people that attend A&E that could have been seen in alternative services including the Urgent Care Centre as well as primary and community health services

3. Reduce the number of people that are conveyed by ambulance to A&E that could have been managed in alternative settings including within their own homes

4. Reduce the number of people that are admitted to hospital by ensuring alternative services are utilised and by establishing Ambulatory Care Services at Whipps Cross

5. Create a streamlined set of urgent care services which provide clear access points and consistent treatment for patients

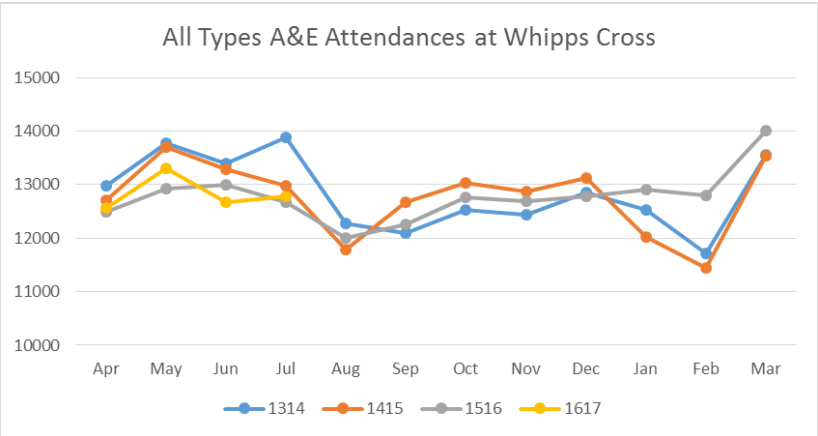
6. Ensure that the Urgent Care Centre has access to diagnostics

7. Ensure that IT systems are connected in order to share patient records so that care plans are visible to clinicians operating within unscheduled care settings

8. Reduce the number of high intensity users of urgent care services

Background

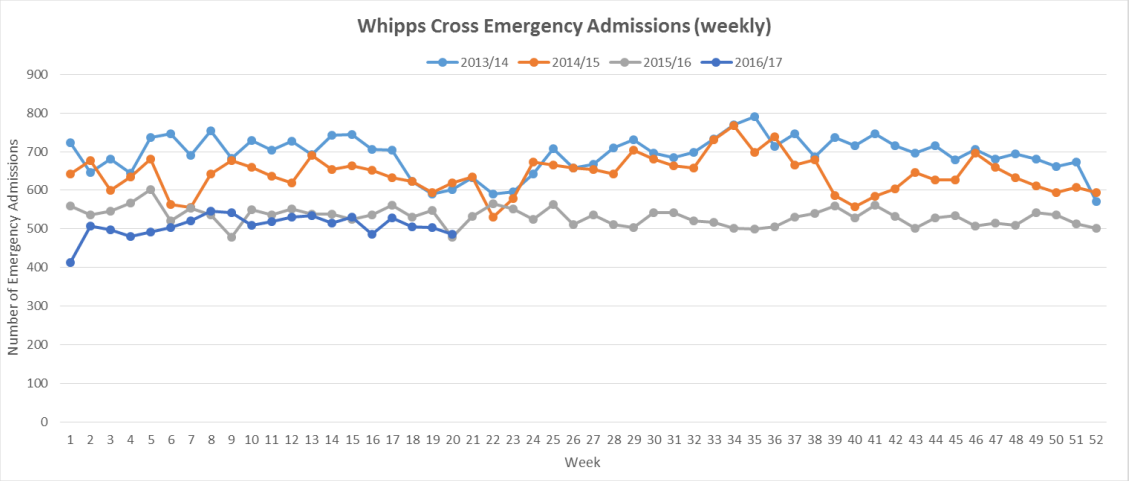
The chart below shows the number of A&E attendances at Whipps Cross Hospital.



Total A&E attendances at Whipps Cross were 154837 in 2015/16. This was a 0.1% increase on the previous year and a 0.3% decrease over a two year period. Overall the number of attendances has remained relatively unchanged. Despite these overall reductions, activity within the Emergency Department has increased due to reduced utilisation of the Urgent Care Centre. WFCCG activity at

Whipps Cross Emergency Department increased by 1% in 2015/16. Activity has increased more rapidly for children (by 8% in 2014/15).

The chart below shows the number of Emergency Admissions at Whipps Cross Hospital.



Total emergency admissions at Whipps Cross were 27,663 in 2015/16. This was a 17% decrease in activity compare to 2014/15 and a 23% decrease over a two year period. Part of this reduction reflects changes in the way activity has been counted at Whipps Cross but a large proportion of the change can be attributed to reduced attendances from high risk patients that have been managed through the integrated care programme, the impact of the Rapid Response service and the expansion of Ambulatory Care at Whipps Cross.

Plans to Improve Urgent Care

We are undertaking a transformational programme to deliver sustainable and clinically safe urgent care services which will involve system wide engagement across WELC and BHR health and social care economies, providers including SEPT, LAS, Barts Health, NELFT, PELC and Waltham Forest Community Health services providers. The CCG's strategy for urgent care services is to reduce unnecessary hospital attendance and admission. Key element of this programme is the re-procurement of an integrated urgent and emergency care service covering 111 and GP Out-of-Hours. Waltham Forest CCG is working with the seven other CCGs in North East London to plan this procurement. The new service would include much stronger links with proposed "clinical hubs", as well as better integration with primary care services, that would help to resolve urgent care needs without attendance at A&E.

- **Urgent Care Centre Procurement**: The service has been transferred to South Essex Partnership Trust from 19 September and plans have been developed in increase activity seen in the UCC. The CCG has developed a new service specification and plans to go out to procurement in Q3 2016/17. The new specification includes access to diagnostics and this will be piloted over winter 2016/17.

- **Integrated Urgent Care/ NHS111**: The CCG is working with the seven North East London CCGs to re-procure the NHS111 service. The key aims of this work are to increase the ability of patients to access clinical advice as part of the assessment. The NHS 111 service will become a key part of the urgent care front door and part of the re-design involved improving the connection between NHS111 and other services so that patients can be directly booked into downstream services.

- **Ambulatory Care** - Development of the ambulatory care service. In 2015 this is service became operational 9:00-21:00, 5 days a week. The aim is that this service would help to avoid seven breaches per day and avoid eight admissions per day. In 2015/16 admissions with a zero or one day length of stay reduced by 50% and have continued to reduce in 2016/17. The development of the service to see more than 30 patients per day has been supported by a CQUIN in 2016/17. Plans for a seven day service are being developed for 2017/18.

- **GP Extended Access Pilot** - since June 2015 the CCG has commissioned weekend GP and nurse appointments at three locations across the borough. By July 2016 the service is seeing in the region of 1000 patients per month.

- **Whipps Cross Improvement Plan**: This action plans followed a further analysis of the problems and proposed a series of actions focusing on non-admitted breaches and delays in bed availability. Elements of this plan include establishing a Paediatric Short Stay Assessment Unit (PASSU) and Clinical Decision Unit (CDU), establishing a "patient flow centre" and improving discharges for simple and complex patients.

- **Collaboration between London Ambulance Service and Rapid Response**. There are a high number of patients that are currently conveyed to hospital that could be managed in the community with rapid treatment and referral to the appropriate services. The CCG plans to rationalise the current services which include the LAS service, the Rapid Response service and the GP OOHs home visiting service. Plans will focus on the needs of patients rather than the historical configuration of services. A specific service that would focus on complex patients that call 999 is being developed based on similar services in BHR and City and Hackney CCGs.

- **Frequent Hospital Attenders -** Together with Whipps Cross the CCG has established a Frequent Attenders Group to pick up issues and risks related to individual patients and help develop system wide solutions. Over winter 2016/17 the CCG will invest in a care coordinator to ensure that these patients have a management plan and are linked into the appropriate services.

- **DVT service in the Community -** The CCG has developed plans for a DVT service in the community and these will be piloted in 2016/17. This will enable patients with suspected DVT to receive point of care testing in the community that is able to rule out the risk of DVT and thereby prevent hospital attendances. The pilot will establish the possibility of establishing a more substantive service that includes ultrasound and the initiation of anti-coagulants for positive cases.

- **DOS Development -** The CCG will be developing the Directory of Service and the ability of local urgent care services and patients to access the DOS in order to promote alternatives to A&E attendance. This will include greater promotion of pharmacy services and the GP extended access Hubs.

- **Integrated Care and Rapid Response -** The CCG is considering additional investment in service to reduce alcohol related admissions and also to provide additional support to nursing and care homes within the borough to support patients in these locations. Both these target groups characterised by high numbers of frequent attenders.

7.3 Planned Care

Strategic Aims and Objectives

The increased demands across health and social care services means that planned care services need to be strengthened over the next 3 years to support shifts in activity as well as the delivery of the planned improvements to integrated, primary care, urgent care and other pathways.

The implementation of the range of planned care programmes should result in measurable reductions in activity in hospital both in new and follow up appointments.

Our strategic aims over the next few years is to ensure an effective planned care programme which results in earlier assessment and treatment which avoids duplications, more capacity and services in the community and clearer pathways which support better outcomes and experience for patients. This patient outcome improvement focus will be at the heart of the work we do in regard to planned care services with the underpinning principle of ensuring that patients are seen in the right place, at the right time by the right person.

Achievements to date

Some initial work has already started we have undertaken a peer review scheme which involved GP to GP discussion of referral management systems and processes. The programme encouraged the sharing of best practice, use of clinical audit and review. Work has also been undertaken to develop clinical pathways examples of which include children's respiratory, back pain and gynaecology. All clinical pathways and referrals forms will be stored in the newly launched GP practice intranet which is a portal of information for the primary care workforce.

We have also commissioned GP education sessions which have had a clinical focus to strengthen GP knowledge in a range of clinical areas. All of this work has supported GP practices to manage patient care and referral into clinically appropriate services.

A new diagnostic service has been commissioned, stabilised and reviewed a number of community services and pathways which has provided a good foundation for the planned reconfigurations over the next few years.

The scope of planned care is broad and a Planned Care Framework is being developed to create a programme of work for the next few years. This will link into wider work that is being undertaken across TST and will aim to work closely where appropriate with other CCGs. The planned care framework will focus to deliver changes in a number of key areas;

STRATEGIC PATHWAY REDESIGN

GP referrals

There are plans to continue to support GP education and build and develop clinical pathways to support effective management and referral. We are admirably one of the highest users of the NHSE referral system, which is the IT system by which GP's make patient referrals. The aim is to build on this to increase referrals by this method and this will be done by a reviewing the existing system to identify areas for improvement. This review and follow up work will include ensuring information is up to date, supports the most effective pathways and putting in place any necessary support to practices. The

increased use of hospital and community e mail and telephone referral advice services will be built into existing and new contracts. This will allow for GP's to discuss any queries and work with other clinicians to manage patient care more effectively.

Planned Care Clinical Pathway

A key part of the changes to planned care is to ensure that the patient journey is a positive as possible and that the services are able to deliver high quality patient outcomes. As part of this work we will be reviewing and redesigning a number of key planned care pathways. These include the following;

Muscular Skeletal (MSK) services pathway

There is currently a fragmented patient pathway with long waiting times. There are plans to put in place an integrated MSK service in the community which will allow patients to be assessed and seen more quickly by experienced clinicians. This will result in increased community capacity with better patient outcomes and less activity in hospital.

Ophthalmology pathway

We undertook a review of ophthalmology services in 2015 across all eye care service providers. This identified key opportunities to improve patient services including increasing capacity in the community, moving some care from hospitals and creating a more streamlined patient journey which removes unnecessary duplication. The intention is to have in place more integrated pathways and services by 2016/17. This will ensure that there is capacity to meet increased demand and that more people are diagnosed and treated earlier in a closer to home setting.

Dermatology, colorectal and gynaecology pathway

The review of these services identified a number of changes that can be made including **improvements** to the range of services we already offer. These services will be procured in 2016 with the intention of new services being in place by 2017. This will allow for a strengthened community capacity in these areas which will allow for more people to be seen in the community rather than in hospital.

Chronic Kidney disease (CKD) pathway

We have identified a gap in the renal replacement therapy for end-stage kidney disease (ESKD), we are planning to introduce a collaborative virtual CKD clinic and Referral Management System between Waltham Forest Primary Care and Bart's Health NHS Trust, providing a more responsive service to CKD patients. This service will support patients to have better health outcomes, to be supported closer to home and avoid hospital admissions.

Anti-coagulation pathway

We are piloting a new service which started in April 2016 which will provide a more integrated pathway for patients which is more equitable and will in the long term shift activity from the hospital to the community. The pathway development will ensure that there is a service which matches the trends in demand. It will also result in more patients being identified, referred appropriately and seen closer to home rather than in the hospital.

Elective Care

Elective care is care that is planned in advance following referral from a GP. An elective care treatment centre has been commissioned which allows patients to have a number of clinical procedures and treatments more quickly and within the community. Over the next year we will be promoting this service to GP's and patients to improve increased use of this service. This will support reduced waiting times for patients and the improved earlier treatment will support better outcomes in care and reduce pressures on hospital services.

7.4 Cancer

The cancer work programme consists of four key areas:

1. Local delivery of the ambitions outlined in the 5 Year Forward View
2. Delivery of CCG responsibilities outlined in the Five Year Cancer Commissioning Strategy for London
3. Implement Cancer Commissioning Intentions developed by the London Transforming Cancer Services Team, with partner CCGs
4. Work with the WELC Collaborative to monitor waiting times performance and recovery action plans at Barts Health in key challenged pathways

Strategic Aims and Objectives

The strategic aims and objectives reflect those outlined in the 5 Year Forward View and Five Year Cancer Commissioning Strategy for London. Aspects which relate to healthy living and early detection have their focus in primary care and public health, while commissioning intentions and waiting time performance focus on Barts Health and other acute providers.

- Better prevention, especially supporting public health smoking cessation and obesity reduction programmes
- Faster diagnosis: reduce the proportion of patients diagnosed through A&E, currently about 25% of diagnoses, support GPs in spotting the symptoms of cancer, particularly suspicious combinations of symptoms, expanding access to screening
- Better treatment and care for all: tackling current variation in treatment and outcomes
- Make supporting care closer to people's homes, working in partnership with patient organisations to support the provision of the Cancer Recovery Package

We will also adopt as our objectives the implementation of CCG responsibilities as outlined in the 5 Year London Cancer Strategy. In particular the focus will be on:

- Preventing residents of the borough from developing cancers amenable to changes in lifestyle by commissioning well-evidenced primary prevention programmes focussed on the key risk factors linked to London's biggest diseases
- Work with NHS England screening commissioners to facilitate the pathway from screening to treatment and achieve the 62 day pathway
- Include screening in their educational activities for primary care
- Nominate screening leads to champion and facilitate messaging

- Work with local community groups (facilitated through links with local authority public health teams) to deliver messages about screening
- Investing in GP cancer leads who provide local leadership and co-ordination for early detection activities
- Commission additional endoscopy capacity for lower gastrointestinal cancers and to only commission from JAG accredited providers
- Commission locally-developed awareness campaigns to improve earlier detection of cancer

A recent CCG review showed that one year survival outcomes for breast, bowel and lung cancers in Waltham Forest are average for London. However, London as a whole has outcomes which are below the national average (England). Figures extracted from the National Cancer Intelligence Network (NCIN) in 2016 show that Waltham Forest had 130 deaths per 100,000 of population aged under 75 in 2013, against an England average of 142. The causes of these survival rates are related to a lack of awareness of cancer symptoms by the general population, delay in diagnosis and advanced stage at the point of diagnosis, often due to late presentation.

Cancer is one of four top priorities for outcome improvement across London and represents one of the top three causes for premature mortality across WELC CCGs. The review showed that we have challenges in five year survival rates. Getting patients to be more aware of potential cancer symptoms and to present at a much earlier stage to their GP was identified as being fundamental to improving long-term outcomes in the borough. This requires GPs to be expert at picking up signs and symptoms of early stage cancer and for effective pathways to be in place for patients being referred.

A work programme will be developed to develop relationships with practices, providing peer support to help practices, implement models of care and problem solve issues at practice level that are a barrier to improvement and address identified learning and training needs using Macmillan training and education resources e.g. the cancer in Primary Care Communication Toolkit.

Achievements to date

- The All Party Parliamentary Group on Cancer released a report on 1 July 2015 citing Waltham Forest as one of the top 10 areas with the most improved one year survival rates in 2012 compared to 2011 (66.6%, up from 65%).
- One Year Colorectal Cancer Survival Rates: Office of National Statistics analysis shows Waltham Forest as the most improved CCG in north and east London for age standardised one year-net survival for adults with colorectal cancer rising from 69.3 per cent (one of the lowest) in 2008 to 80.2% in 2012. Latest data on one year survival for colorectal cancer shows that the rate in Waltham Forest remained steady in 2013 (most recent available) at 80.3%, against a national average of 77.7%.
- Public Health Outreach: The London Borough of Waltham Forest have appointed a community outreach organisation to deliver a public awareness service which aims to increasing public awareness of cancer through community engagement, the project will target men and women at higher risk of late diagnosis of cancer.
- Straight-to-Test (STT) is a colorectal diagnostic pathway developed following advances in endoscopy. It was established at Whipps Cross Hospital in 2014 with an aim to reducing waiting times and follow-up ratios. A nurse telephone triage system is used following referral which

allows patients requiring investigation to receive a colonoscopy in 2—3 weeks. The early data showed the impact is to increase numbers of patients being seen in 2—6 weeks. It is anticipated that this pathway will contribute to improving the detection of colorectal cancer.

- Breast Triple assessment unit opened at Whipps Cross in May 2016

Over the next 3 years, we plan to

- Develop an implementation plan for Cancer based on the London Cancer Strategy
- Extensive and sustained Macmillan GP engagement with primary care, GPs to improve their skills in diagnosing the symptoms of cancer and to enable timely access to treatment through innovative diagnostic tools (e.g. the electronic Cancer Decision Support Tool)
- Continued improvements in one year survival rates for cervical cancer ,colorectal cancer, bringing Waltham Forest in line with England's average
- Improvements in cervical, lung and breast one year survival rates, which reflect a similar level of improvement in colorectal cancer
- Improvements in 5 year survival rates for bowel, breast and lung cancers, bringing Waltham Forest closer to the England average
- Improved local uptake in screening programmes that will increase the detection rate of stage I & II cancers
- The Macmillan Recovery Package provided for people living with cancer, delivered through acute care providers
- A Joint Advisory Group (JAG) accredited endoscopy service and Straight-to-Test model for bowel cancer pathways
- A developed CCG and local authority partnership on cancer public awareness campaigns

7.5 Integrated Care and Care Management

[1]

> "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".

Integrated Care is one of our high impact transformational change programmes and a key part of our Better Care Together Programme. Waltham Forest and East London (WEL) is a national "Pioneer" for integrated Care and is leading the development and thinking on how to embed effective joined up services in order to inform national policy development.

Context

Waltham Forest has a deprived population; significant health inequalities and high number of people with one or more long term conditions.

- Too many people (42%) are in a hospital bed when they could be more comfortably and effectively supported in the community [2]

[1] National Voice "I Statements
[2] Utilisation Management Points of Care review 2015

- Older people can become more frail while in hospital e.g. lose 5% percent of muscle strength per day [3]
- 1.15 million bed days are lost nationally to reported delayed transfers of care in acute hospitals during 2015 (up 31% since 2013)[4]
- We face a financial challenge due to growing demand and an expanding and aging population. If we do nothing different, we'll need an extra 550 inpatient beds in East London by 2025 (costing about £450 million to build and £250 million a year to run). Overall our organisations will be in deficit by almost £400 million by 2021/22[5]
- We won't be able to recruit the workforce to staff these beds, and we know that hospital is not the right place for many people
- Our IT systems are not interoperable "they don't yet talk to each other".

Strategic Aims and Objectives

In order to meet these challenges, through the development of Integrated Care the CCG is working to:

- Improve patient experience
- Improve quality of care
- Reduce unnecessary, unplanned ED attendance and hospital admissions at Whipps Cross and associated costs
- Support early intervention and self-care.

Approach

The CCG, working with Health, Local Authority and 3rd sector partners is using a whole systems approach to deliver integrated care. The Integrated Care Programme is scaling up to put in place a "managed network of care and support" for residents of Waltham Forest and to embed this into "business as usual". Figure 1 demonstrates the risk based approach to the population which continues to underpin the WF approach to integrated care.

Figure 1 – Risk based approach to integrated care

[3] National Audit Office 2015
[4] National Audit Office 2015
[5] TST Strategic investment case 2016

The delivery of the managed network of care and support is through a range of planned and unplanned/urgent care interventions as follows:

Planned Care:

- Systematic "case finding" top 5% of population at risk of an unplanned hospital admission and "case management" for people with complex requirements
- "Care coordination" with a named coordinator for people who require care and support including health and social care
- Enabled "self -management" approach including health coaching to help people take control of their own health
- 3rd sector support to enable people to stay well and safe at home including use of their local community network

Unplanned/ Urgent Care:

- Rapid Response to people in urgent need or crisis to help prevent unplanned admission
- Coordinated approach across the urgent care system including NHS 111, Out of Hours; Ambulance Service; Community rapid response service to ensure people access the right service which may include hospital i.e. "right service; right place right time".

The CCG is working with its providers to develop an accountable care system and is moving a population based approach to commissioning services. It is also cognisant that payment reform mechanisms which will need to support this.

The managed network of care and support considers the whole person – their physical health, mental health and social care needs. The focus is on empowering individuals by providing responsive, coordinated and proactive planned care and unplanned/urgent care if needed. The objective is for people to live well for longer; leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.

There are a common set of principles which underpin the approach to integrated care:

- Systematic, regular risk stratification of the whole population to support case finding for those most at risk of unplanned hospitalisation.
- Care that is centred on an individual's needs to enable individuals to live independently and remain socially active.
- Care that is evidence based and cost-effective.
- Preventing admission to hospital wherever possible by supporting care at home or in the community.
- Avoiding duplicated effort in situations where a patient has many people involved in their care.
- Actively developing local providers and supporting collaboration in the way we contract. Evaluating what we do as we do it and revising our approach as we learn about what we are achieving.
- Learning from each other, learning from national and international integration programmes and sharing our learning outside the programme.

Enablers

There are many enablers to a successfully integrated system; a critical enabler is the use of IT and appropriate sharing of information. The CCG and its partners are continuing to work to improve the interoperability (joined up) of IT systems and is working towards an integrated patient care record. The CCG is supporting the implementation of the London Digital Roadmap.

Achievements

The Integrated Care Programme has demonstrated many achievements which include:

- Overall good patient experience
- Case management to those in the top 5% of people most at risk of unplanned admission
- Over 15,000 individualised care plans for patients
- 19% reduction in unplanned hospital admissions 2015/16
- Achieved £2.4 M savings 2015/16 which supports further funding community services

Over the next 3 years we will develop an accountable care system where commissioners and providers will jointly collaborate to develop services

- To deliver integrated care for the population of Waltham Forest; encourage a focus on ever closer cooperation and collaboration between health and social care providers, the use of different contracting mechanisms and the role of the CCG as a systems leader
- Embed a managed network of care for those that would benefit in Waltham Forest

- Support people in the medium and low risk cohorts with a range of interventions to help them keep well and feel more empowered to manage their own care at home; this will include self-management programmes and the use of telehealth; social prescribing and also health and social care navigation
- Continue to provide care coordination and specialist help to people identified as being most at risk of unplanned hospital admission
- Provide an "enhanced" integrated care model to people living in care homes who currently have a higher risk of unplanned hospital admission
- Develop out of hospital pathways to ensure people receive the level of support they need to enable them to return home from hospital as soon as they are medically fit and to ensure they are not admitted to hospital if they don't need to be; "right care; right place; right time"
- Further improve the interconnectivity of IT systems and sharing of information across providers and the development of a shared care record for patients; patient portal to their care
- Support the development of the workforce including new roles.

Falls Prevention

We have invested in a falls procurement for a community falls prevention and bone health service for people 65 years and over who have had a fall or are at risk of a fall. The service will provide risk identification, specialist, patient-centred multidisciplinary assessment and appropriate intervention to ensure optimal management of falls, and where possible reduce the risks of further falling. A formal procurement process for a community falls service provider was completed with a service in place from October 2015.

7.6 Learning Disabilities

Transforming Care Partnership Work

Within Waltham Forest the support and care provided to people with a learning disability and/or autism and their carers is a key priority for the CCG and identified as an area where significant improvement is required. During late 2015/16 Waltham Forest CCG has been collaborating with the three other London boroughs – City and Hackney, Newham and Tower Hamlets on the development of a joint Transforming Care Partnership action plan, with the aim of improving services and support in the community for people who are currently in an inpatient facility or are at risk of future admission. The programme has involved all the partner local authorities and CCGs in devising a shared plan. The plan is focussed on fewer people being inappropriately cared for in Assessment and Treatment Units and better support that enables people with behaviour sometimes described as challenging to live well in their communities.

Waltham Forest has led the consultation and engagement strand of the local Transforming Care Partnership, seeing engagement with both local residents across the boroughs but also an understanding of the experience for people and their carers who have been inpatients in the current system. Engagement has taken place with a number of stakeholders - local parents, local providers of Positive Behaviour Support (PBS) training and local providers. Feedback has been instrumental in the plan's development.

The plan has been NHSE assured and has been agreed through the Health and Wellbeing Board

Work still to do

During 2016/17 and 2017/18 the CCG intends to embed the actions recently published in the Joint Market Position Statement for the Registered Care Market and subsequent engagement that we create a market that is robust, resilient and capable of supporting people with complex needs and behaviours to live well in their local communities.

Embed PBS so that it is practised widely throughout the system which will ensure that there is less reliance on inpatient facilities

Review current structure of TCPLD- make sure it is fit for the future

From April 2017 the CCG and London Borough of Waltham Forest will have a new Section 75 agreement for Learning Disabilities, which is currently in development, as part of this programme work is being undertaken to ensure that the current Integrated Service is fit for the future; and in particular has the capacity to support people with complex needs/ behaviour that can be described as challenging- the cohort that are likely to emerge as a more substantial group as a result of the Transforming Care work stream to deliver support that enables people with very complex and challenging needs to live well at home.

In parallel to this process the development of the Shadow Year pilot in community and mental health services also covers services supporting people with a learning disability, the expectation is that improved support will be available to front line services to support people in a mainstream setting with specialist services being provided for the most at need.

Work is also ongoing to devise the outcome measures and an evaluation methodology for Learning Disability services within Waltham Forest.

Health Checks and Health Action Planning

A review of 2015-16 Health Check information has revealed that Waltham Forest is lower than London average for completion.

A quality improvement action plan has been devised to ensure that the 2016-17 uptake is improved. Some issues around coding have been established and work is being undertaken to rectify any irregularities in reporting. This programme will continue into 2017/18 ensuring that appropriate training and support is available to primary care to ensure that uptake and the health needs of people with a learning disability are met.

Personal Health Budgets (PHBs)

Since October 2014, Waltham Forest CCG have successfully delivered the mandate from the Secretary of State to meet the legal requirements of a ‘right to ask’ for, and a ‘right to have’ a Personal Health Budget (PHB) for children and adults meeting the criteria for NHS Continuing Healthcare (CHC).

The Waltham Forest PHB programme supports the CCG to:

- Meet our statutory requirements;
- Improve the patient experience across all services;
- Involve patients, communities and hard-to-reach groups.

PHBs also support wider cross-cutting themes of prevention, early intervention, personalisation and promoting independence, and integrating the CCG strategy for self-care.

To meet the requirements of the Five Year Forward View we are running a range of micro-pilots to gauge the effectiveness and benefits of Personal Health Budgets across Waltham Forest, and to test what might work on a larger scale. These will be run across a range of care groups and will be based on areas of best practice as well as local need. The intention is to fund these through a range of different sources including existing budgets/DH grants/CCG business cases.

The CCG's vision for Personal Health Budgets is:

By March 2017, Waltham Forest CCG will have piloted Personal Health Budgets (PHB) across a range of care groups, to support those in receipt of a PHB to improve health and wellbeing outcomes, achieve a better quality of life, and to develop on-going strategies in self-management of the care they receive.

This offer will include delivery of integrated budgets across health and social care for those with a learning disability, and integrated budgets across education, health and social care (as part of SEND reforms) for children and young people.

In the summer of 2016, Waltham Forest CCG successfully launched two of its pilot schemes:

- Supporting Vulnerable women in Maternity / Perinatal Mental Health
- Supporting full time carers for family members

These further cohorts identified for a PHB pilot are proposed for launch in 2017/18 – 2019/20

- Cancer Screening for Carers
- Adults with Learning Disabilities
- Children and Young People with Special Educational Needs and Disabilities (SEND)
- Adults with two or more Long Term Conditions, e.g. Type 2 Diabetes and Depression

7.7 End of Life Care

Patients are generally defined as 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent and expected within a few hours or days); and those with advanced, progressive, incurable conditions, general frailty and co-existing conditions. (General Medical Council 2010).

Around half a million people die in England each year, of which almost two thirds are aged over 75 years. The large majority of deaths follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere. (EOL Strategy 2008).

On average there are 1500 deaths in Waltham Forest each year (61% aged 75+ years). In 2007-09, circulatory diseases accounted for the greatest proportion of deaths (33.2%), followed by cancer (24.5%) and respiratory diseases (COPD & pneumonia) at 11.6%.

The current rate of home deaths in Waltham Forest stands at 18.8% (London average 22%) and the majority in hospital at 68%, which ranks Waltham Forest as having the highest hospital death rate in London (av 63.7%) and England (av 56.7%). However, this figure reduces to 49%, when the rate is adjusted to remove deaths at the Margaret Centre, which is Waltham Forest's palliative care ward based at Whipps Cross.

A recent survey on preferences for place of death found 63% of people in London would prefer to die and home and a further 29% would prefer to die in hospice. (National End of Life Care Intelligence Network 2010).

Ambitions for End of Life Care September 2015 states:

"Where people are cared for – whether that is in a hospital, a nursing home, in a hospice or in a person's own home – should not matter. What is important is that the person is able to access co-ordinated and individual care based on their needs, delivered with compassion and sensitivity by caring health and care professionals and that there is regular and effective communication between staff and the dying person and their family".

Strategic Aims and Objectives

Our vision for End of Life Care is to enable people to die in their preferred place in a supported, safe and appropriate environment that meets the needs they have identified in advance. This will be irrespective of their medical condition.

The delivery of comprehensive end of life care services in Waltham Forest will enable our vision to be achieved. This will ensure that we have support in the community to enable more people to die at home while they are safe supported and pain free. There will be a shift from people being admitted to hospital to die there because their end of life phase is not recognised until such a late stage that they cannot be allowed home or to a hospice bed.

Improving End of Life Care Planning

Planning for end of life care will need to take place within all community services as the majority of palliative care support is not delivered through specialist palliative care teams. We will provide specialist palliative care to support the delivery of palliative care in people's homes ensuring that there is cover 24/7 to take into account that any crisis at the end stages is more likely to occur out of hours than during 9.00 – 5.00pm Monday to Friday.

Access to advice and support 24/7 as well as psychological and spiritual support for patients their families and carers will ensure that people dying experience a good death. The London End of Life Care Clinical Network has described a good death as being one where it is the best death that can be achieved in the context of the individual's clinical diagnosis and symptoms, as well as the specific social,

cultural and spiritual circumstances, taking into consideration patient and carer wishes and professional expertise.

We will ensure provision takes into account the wishes of people who are dying and meets their cultural, clinical and spiritual needs.

Services that have previously not felt they can help patients who are approaching the end of life will need to be redefined as “End of Life Care” and must be provided for the whole journey not simply the end stages.

GPs will be enabled to use their palliative care register more effectively, identifying patients earlier who will die in the next twelve months, adding them to their registers and having the monthly reviews with their MDTs to ensure that their needs are being met. They will need to be the coordinators of community support ensuring referrals are made drugs are prescribed and authorised to prevent families feeling that hospital is their only option when the person is in their end stages. This will be underpinned by education and support to ensure that staff at all levels can have difficult conversations and document patient’s wishes particularly in respect of DNAR (Do Not Attempt Resuscitation).

Finally we need to ensure that medication is both available and accessible to ensure people at their end stages are symptom and pain free. We know that “Management of a loved one’s pain, not having access to 24/7 care and strains on finances are the top concerns UK people would have if faced with looking after a loved one with terminal illness.” Marie Curie/London School of Economics and Political Sciences April 2015

Education

There will need to be education and training across the whole system to ensure better identification, documentation and support for people who are approaching the end of their lives. This will need to extend from Community, Acute, Residential and Nursing Care Homes and in Primary Care. We will work very closely with the CEPN to deliver multi-disciplinary/ multi- professional training across a range of professionals.

Over the next 3 years we plan to:

In order to support a higher rate of deaths outside hospital, our community services must be robust and responsive to patient needs. Our End-of-Life clinical leads will use information ensure to palliative care planning is incorporated into the integrated care system, associated rapid response and integrated community teams through active engagement with key strategic and operational delivery forums.
Some people will choose to die in hospital and we will ensure our commissioned services from Barts Health to provide End of Life Care in line with Ambitions for End of Life Care September 2015, delivered with compassion and sensitivity by caring health and care professionals and that there is regular and effective communication between staff and the dying person and their family.

This will need to be supported by an adequately resourced and educated team of staff delivering care from a virtual palliative care across all wards. They will also need to ensure a rapid discharge process for patients nearing the end of life who wish to die at home, in their care home or in a hospice.

7.8 Primary Care

Primary Care Objectives

Waltham Forest CCG will build on the excellent work currently being delivered by primary care, harness local skills and experience to create one of the best primary care services in the country. The CCG will focus on the following objectives:

1. Improve primary care services to deliver better health outcomes for our local population
2. Improve patient access to and experience of primary care services
3. Ensure effective community engagement to help support the delivery of patient centred care
4. Maximise clinical engagement, ensuring strong leadership across all primary care services
5. Embrace technology and ensure that the primary care infrastructure is fit for purpose and supports patients to self-manage.
6. Enable practices to work collaboratively with other agencies to support the delivery of integrated care

Primary Care workforce

We will monitor and plan for capacity issues as well as carry out initiatives to help reduce or transfer demand to the best alternative services. We have undertaken a workforce audit and have used this to support us to develop recruitment and retention schemes, which will see the primary care workforce being expanded to include roles which are beyond traditional GP consultations, including the use of Physician Associates, Clinical Pharmacists in general practice settings, assistant practitioners and care navigators. We are also developing training and development programmes to further upskill and develop the workforce.

Premises

By taking leadership on estates and working with local CCGs where it is beneficial to, we have produced an estates strategy. This work is aligned to the Primary Care Strategy and acts as a key enabler to delivering and utilising fit for purpose premises which supports working via a multi-disciplinary approach, whilst making best use of public estate. The CCG is working closely to support practices to attract infrastructure funding to improve the capital estate and improve capacity.

Use of Technology

We will support practices to use technology differently, including enabling repeat prescriptions, online booking and access to records from home. In addition we have produced a digital health strategy. This helps to support patients to access primary care clinicians and information, to help them manage their conditions using digital technology such as video-conferencing and texting alerts. Utilising technology appropriately allows services to be developed that are truly seamless, with effective signposting, co-ordination of care and exchange of information supporting every patient's journey.

A range of technology options will be tested which will support the roll out of the new model of service delivery (for example, supporting self-management and telephone triage) along with consideration of how 111 can support and enhance delivery including the ability for them to directly book appointments.

Improving Quality

The CCG is developing a focussed Primary Care improvement programme which aims to support the delivery of consistently high quality primary care services, free from unexplained variation. We have developed a Primary Care Quality Dashboard with a range of metrics to monitor and address quality issues. Access and patient experience are both metrics which are included. This will be used together with various other sources of data to support practices to build their resilience and improve quality, which in turn will improve quality and outcomes for patients.

Improving Collaboration

It is an ambition for general practice to work collaboratively with other practices to support in particular economies of scale around infrastructure such as sharing resources and rethinking the skills mix and working innovatively to enable clinicians to see patients on the same day.

Transformation

Primary care is at the heart of the transformation of health and health services. Today 90 per cent of NHS activity takes place in primary care for 7.5 per cent of the cost. The model of general practice that has served us well in the past is now under unprecedented strain and there are significant challenges that must be addressed.

The transformation of primary care is central to delivering the five year vision of a sustainable NHS, high quality services and improved outcomes for local patients. The CCG is working closely with neighbouring boroughs to deliver local integrated service models in which high quality 'at-scale' primary care will play a leading role. We aim to deliver high quality, locally responsive primary care as the key platform for system sustainability and our work programme falls under three improvement areas, namely, proactive, accessible and co-ordinated care.

PROACTIVE CARE

The CCG is committed to developing a proactive and personalised programme of care tailored to support the health and wellness of patients in the borough. The balance of work will be shifted to early intervention and planned care. Patients and carers will be supported to manage their own health and wellbeing. Patients will experience joined up services and shared records, enhancing their confidence and reducing their reliance on GP's when other professionals can help them.

This will be achieved by the following actions:

- The CCG will use opportunities around co-commissioning to work with community pharmacy and review the current use of the minor aliments scheme, to see how this service benefits patients or can be used differently to empower patients to self-care.

- Support to self-manage both ailments and/or conditions working closely with community pharmacists and NHS England Local Area Team (LAT) to ensure the existing 'pharmacy first' service is utilised to its fullest potential.

- We will look at different ways of bringing together primary care providers, including general practice, community health services, pharmacy, dentistry, optometry, voluntary organisations and social care to improve health and wellbeing rather than working apart.

- The CCG will work jointly with public health to strengthen the links between healthcare providers, community and voluntary services to implement non-medical interventions often referred to as 'social prescribing'

- We will work with partner organisations to develop a communications programme designed to inform the public about primary care services available to the population and how to access them as easily as possible. This will be combined with self-care and healthy living advice and support on the social determinants of heath.

- We will develop new initiatives with vulnerable patients in mind. This will ensure that those that are more vulnerable in society including deaf, hard of hearing, the elderly, those with learning disabilities, homeless people, refugees, ex-offenders and carers looking after a vulnerable person will benefit from new initiatives and not be disadvantaged in any way. This will involve working closely with key partners who include NHS England, public health and the local authority to address the needs of these patients.

- The CCG has funded the Waltham Forest Carers Association to pilot a scheme focussed on identifying and supporting carers in Waltham Forest. The aim of this initiative is to support primary care colleagues (including GPs, practice nursing and administration) to identify, refer and support carers. This work is on-going and is in the process of being evaluated. The project aims to support and involve carers in their own health and the health of the people they care for.

ACCESSIBLE CARE

The CCG is committed to providing a responsive, timely and accessible service that responds to the boroughs different patient preferences and access needs. With this in mind we have worked closely to support the development of our GP federated network, which are formal alliances of practices working together as a single legal body, offering patients consistent effective and accessible seven day primary care offer, supported by technology.

The network is currently piloting delivery of extended hours' provision, which aims for people to have easier and more convenient access to GP services, with the option to book appointments seven days a week via three hubs, based within each locality. The pilot allows the CCG to test a new and innovative model of primary care access that will support the redesign of urgent and integrated care pathways, will have a positive impact upon A&E, urgent care centre and out of hours activity and will improve patient experience.

It aims to meet the London primary care standards where there are benefits for patients, for example:

- The availability of seven day access to GP services within each of the three localities
- The development and agreement an overarching model of primary care that sets out the offer for patients which includes:

  - Longer appointments where necessary
  - Continuity of clinician where this is preferred
  - A range of options for accessing advice and care at a time that is convenient and supports a busy lifestyle

- Ability to access a same day appointment with a GP when necessary and the ability to book in advance.
- Not having to wait on the telephone on hold for more than reasonably expected

The pilot will be subject to a full evaluation of outcomes in 2016/17 that will enable an informed decision to be made regarding longer term commissioning.

CO-ORDINATED CARE

The CCG is committed to providing care and support that is integrated across health and social care and is focussed and centred on patients' needs. The aim is for there to be a seamless delegation to the extended Primary Care team and collaboration with social care, freeing up space for GPs to spend time with patients with more complex conditions on person-centred, planned and preventative care.

To ensure we are delivering co-ordinated care there are 3 key enablers:

1) **Co-commissioning -** We see co-commissioning as a real opportunity for the CCG to have greater influence over the way NHS funding is invested locally. The WEL CCGs (Waltham Forest, Tower Hamlets and Newham) have a strong and proven track record of collaborative commissioning, and are using this opportunity as a key enabler to helping us deliver our respective CCG and Health and Well Being Board priorities and our joint Five Year Plan, the benefits include Improved access to primary care and wider out-of-hospital services, with more services available closer to home resulting in improved health outcomes, equity of access and reduced inequalities.

2) **Integrated Care -** Waltham Forest introduced Integrated Care Management as a key transformational programme in 2011 and is part of a national Pioneer Programme. Integrating care and improving patient experience is key to delivery of the CCG Strategic Objectives. The CCG has ambition to improve integrated care further. In 2016/17 and we have embarked on a "shadow year" for community and mental health services to further improve coordination of services. This means:

    - Wrapping delivery of services more closely around patients and primary care in localities
    - Differentiating planned from unplanned care; this will ensure people receive well-coordinated planned care to help them stay well at home and a rapidly responding (unplanned care) service if they need if and when they need it to help prevent unnecessary hospital admission
    - Aligning more closely the delivery of physical and mental health services
    - Ensuring all patients receiving care have a named coordinator of their care
    - Improving ease of access to primary care, community and mental health services
    - Further developing integrated care for children and young people and also harder to reach groups such as people with learning disabilities.

3) **Development of Provider Networks -** the CCG recognises that if we are going to meet the healthcare challenges of the borough then scaling up primary care is essential. The aim is that collaborative working will enable the development of an overarching model of primary care that means patients can receive services at a practice; network and borough level supported by a range of flexible service options that reflect the needs and preferences of the local population and meets agreed quality standards.

7.9 Maternity

Strategic Aims and Objectives

In Waltham Forest, our aim is that the maternity services we commission

- adopt a "life course approach" and support the transition from pregnancy to family life with services that are woman and family centred and reflect local needs and priorities
- are flexible, appropriate and accessible to all women
- improve the range of locations where women can give birth and choice of service provider
- are provided in accordance with the requirements of Royal College and NICE standards, national policy guidelines, evidence and best practice
- support providers to conduct audits and use the findings of these audits to improve clinical practice
- work with local women to understand their experiences and support improvements in quality of services.
- To ensure that the providers of the maternity services listen to the views and experiences of the women using those services and that these views are taken into account in all matters relating to maternity care

Achievements to date

Over the past year to help strengthen maternity commissioning in Waltham Forest and drive further improvement in the quality of services and patient experience, we have increased the capacity of the CCG's commissioning team for Maternity and Children's Services. This has enabled us to greatly improve the communication channels with our local providers. In addition to the Maternity Dashboard, which the CCG receives on a monthly basis (a regular report on quality and safety measures), we have formalised our quality meetings to include regular audits on indicators from our providers and broadened membership. In these meetings, we work together to tackle some of the challenges facing the health services and our population.

For example, delayed antenatal booking was highlighted in the Dashboard we receive and the CCG has been working closely with Barts Health Trust on a multi-pronged campaign to help improve the pathway and promote early uptake of antenatal booking. This campaign includes an education component (commissioned by the CCG) on the importance of early booking, increasing out of hour's appointments, GP education sessions, and access to translation services. We know it is often vulnerable groups who delay their first antenatal appointments, so we are also planning targeted outreach activities.

There has been a strong emphasis on "parity of esteem" and improved mental health provision for pregnant and post-partum women. We have facilitated training for midwives to recognise the signs and systems of mental ill health, improved the pathway and increased access to IAPT (Increase Access to Psychological Therapies).

Commissioning strategies around maternity services now better incorporate the views of patients. One way this has been achieved is through the establishment of our Maternity Services Liaison Committees (MSLC), which Social Action for Health has been commissioned to manage. In just a few months, 16 women have been trained as health guides to engage with women about their experiences of services and we have had our first MSLC meeting. MSLC's are an established model for involving the users of maternity services in monitoring and developing the quality of services provided.

Similar to other boroughs in North East London, there are significant cost pressures in maternity services. There are, however, numerous national and local policies and strategies which guide the

commissioning and provision of maternity services and which are designed to ensure women receive the highest quality care possible. The CCG is very enthusiastic about the government's recently announced ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50%.

The CCG continues to work alongside the Transforming Services Together Programme and the findings of the National Maternity Review to consider how services should be developed to meet the changing needs of women and babies.

Waltham Forest CCG is closely following ongoing research in maternity services so that we can continue to base our commissioning decisions on evidence based best practice. We are particularly fortunate to have innovative research underway locally. The REACH Pregnancy Programme [Research for Equitable Antenatal Care and Health] aims to improve access to and experiences of antenatal care for pregnant women living in areas with poverty and mixed ethnic groups. The research is conducted by Bart's Health NHS Trust/ University of East London and comprises a team of experienced researchers. A few of the areas being explored are the feasibility of group based antenatal care and increasing user involvement in maternity services. We are looking forward to the findings of this important research which we know reflects our local community.

Over the next 3 years, we plan to:

We will build on our achievements in 2014/15 to continue improving the quality of services and the experiences of women and their families in Waltham Forest. Our initiatives for 2015-16 include:

- **Increasing midwife led care** – The evidence indicates that midwife-led settings lead to better outcomes for women at low risk of developing intrapartum complications. We are working with our providers to ensure that midwife led birthing units (both in hospital and standalone) are reliably available to our population.

- **Helping to reduce stillbirth** – Aligned with the government's plan to reduce still births, the CCG is working alongside Bart's Trust on a campaign to increase pregnant women's awareness of the need for prompt reporting of decreased foetal movements.

- **Increasing choice for place of birth** – In addition to working with Barts Trust to encourage birthing in midwife led units, there are plans to pilot a homebirth pilot to enable low risk women who would like to birth at home, to do so.

- **Growing our Maternity Services Liaison Committee (MSLC)** – Support Social Action for Health to grow and manage our MSLC will ensure the views of women and their families continue to shape our services.

- **Improving the self-referral pathway for women in Waltham Forest** – We are working with Barts to help facilitate online "self-referral" improving the accessibility and efficiency of health services for our population.

- **Increasing continuity –** Evidence suggests that care provided by midwives in continuity of-care models contributes to high-quality and safe care in high-income countries. We are working with our providers to enable more women to be attended by a known midwife.

- **Better defining the pathway for perinatal mental health** – By embedding a perinatal mental health nurse (March 2016) to ensure there is an equitable, seamless and consistent pathway of care for all women.

- **Personalising care** – There are plans to pilot innovative personalised care through the use of Personal Health Budgets for women suffering from Post-Traumatic Stress Syndrome resulting from a previous traumatic birth.

- **Further embedding the reporting framework** – The CCG is working to embed our reporting framework into our performance management, so we can continually improve the quality of services provided. This includes supporting our providers to conduct clinical audits and using the findings to improve clinical practice.

- **GP education sessions** – In order to improve care across the pathway, the CCG will organise education sessions for General Practitioners in the borough on a variety of maternity topics.

7.10 Mental Health

Strategic Aims and Objectives

To ensure parity between mental health and physical health by:

- Improving the physical healthcare of people with mental health problems
- Improving the mental health care of people with long term conditions
- Develop services that are integrated and wrap around the person no matter what their physical, mental or social care needs are.

Over the next 3 years, our plans are:

1. Strengthening our primary care and wellness service by starting the new Mental Health wellness pilot, improving access, reducing stigma and improving early intervention and prevention services.
2. Building further on improving dementia services by effective use of support services to patients and carers, closer working with Whipps Cross hospital with new dementia and delirium team to make improvements in the pathway and service delivery.
3. Commissioning effective support and pathways of care for people with mental health needs at times of crisis in accordance with crisis care concordat plans and achieving the milestones set in the Waltham Forest concordat plan.
4. Ensuring people with mental health problems have access to appropriate evidence-based NHS assessment and treatment services that support recovery, in line with the access and waiting time standards (e.g. IAPT and EIP)
5. Supporting the delivery of training to enable the upskilling of the primary care workforce to support patients in the community by CCG education programme and locality meetings.
6. Commissioning effective support and pathways of care for eating disorder and perinatal mental health concerns and conditions

7. Commissioning effective support and pathways of care for Children and Young People with mental health concerns and conditions by implementing the CAMHS (Child and Adolescent Meant Health Services) transformation plan

How we will measure this success:

- Evaluate patient experience/satisfaction
- Measuring against performance:
- Improving access to psychological therapies - 75% of people referred will be treated within 6 weeks of referral, 95% will be treated within 18 weeks of referral, 50% of people completing treatment move onto recovery
- Early intervention in psychosis - over 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral
- Meeting access and NICE complaint packages for eating disorder services

7.11 Children and Young People

Over the past 12 months the CCG has focussed on developing services for children and young people in the community. This has included in the commissioning of a new community Tier 3 Specialist Continence Service, increasing capacity of the community epilepsy nursing provision in Waltham Forest and developed clinical pathways.

Significant planning for the development of the Better Care Fund for Children and Young People has also been taking place during the year, working closely with the London Borough of Waltham Forest on the joint priorities for Waltham Forest services and pathways.

Work has been undertaken to align the thinking from the day with our collective ambitions and vision in order to agree a work programme that will deliver the following success factors:

- Shifting the whole system to think about the family
- Improve cost, effectiveness and collaboration
- Right sizing systems and resources
- Improved synergy across the partnership
- Improved navigation and self-care pathways
- Early identification of need

Work stream	Outcome identified	Focus of work stream
Integrated Disability Service	Single integrated pathway 0-25 where appropriate	• Use the SEND reforms as a mechanism to drive a fully integrated programme. • Empower community IDS providers to deliver on enhanced service reach. • Explore integration across the 18-25 age group including secure transitions pathways.

Work stream	Outcome identified	Focus of work stream
		• Explore opportunities for co-location of services and estates. • Support the development of provider partnerships.
Cluster Hub Delivery for 0-18	Extend the children's centre operating model to include appropriate mainstream health services.	• To streamline pathways for children and families reducing the number of professional contacts and meetings. • To extend the co-delivery model across a range of services. • To explore how we extend the reach of the health messages for under-fives moving to a self-navigation and community approach. • Explore opportunities for co-location of services and estates.
Joint commissioning arrangements	To identify areas of spend that could potentially be pooled.	• To use the areas of speech and language to explore pooled commissioning • Modelling need and demand across systems • Managing pathways more effectively. • Exploration of resource allocation across the tiers of need. • Explore opportunities for co-location of services and estates.
Ease of access into the System A/B	To improve the pathways for Children and young people To explore the extended use of 92 LGR	• Use risk-stratification tools to map children and young people known across services. • SARC • Explore pathways for rapid interventions and follow up support. • Explore opportunities for co-location of services and estates.

Work stream	Outcome identified	Focus of work stream
Care co-ordinated pathways	Redesign of services to support delivery	• Use risk-stratification tools to map children and young people known across services. • Explore current pathways for rapid intervention • Identify cohort of children and young people who are known across all services of high level need.
CAMHS		• To better link the CAMHS transformational plan to the children's BCF.

Development of Primary Care

The CCG recognises the importance of primary care services and the significant role that GPs play in supporting children and young people in the management of their healthcare. One of our priorities over the next few years is to further develop the local training and development opportunities for primary care through running of education sessions on pathways and clinical practice. In line with recommendations of the Healthy London Partnership we are looking to develop stronger links between consultant paediatricians and localities.

Access to up to date clinical information, referral paperwork and pathways is important to ensure that patients are seen at the right time in the right place and constant work will be undertaken to update and maintain the GP Practice Portal with up to date information for practices.

Urgent Care

Urgent care for children and young people has two focuses, one around supporting children and families not to attend urgent care service unless needed and second on developing pathways so that where people attend urgent care services in Waltham Forest they receive the care and treatment that they need and require.

Later on we detail the work we are undertaking around information and self-care for children and young people to help them and their families self-care but we are also exploring the development of HOT clinics, where children need input from acute paediatricians but don't need to be seen the same day, the clinic would enable GPs to book patients in for an appointment within a two week window, rather than be sent to urgent care services.

Pathway Review

A key priority is to review and develop new clinical pathways which children and young people access, in particular a focus on pathways between acute and primary care services. The pathways being reviewed are:

- Asthma (TST)

- Diabetes (TST)

- Epilepsy (TST)

- Allergy (TST)

- Dermatology (QIPP)
- Vitamin D Deficiency
- Physio & COOP (QIPP)
- Lymphadenopathy
- Constipation & Abdominal Pain
- Neonatal Jaundice and Weight Loss
- ENT/ Audiology
- Squint Pathway

Self-Care /Early Help Programme

In 2014/15 the CCG launched the Child Health and Common Childhood Illness scheme which is a responses for parents of children aged between 0-5 and available through booklets, provided in red books when discharged from maternity services, and via a dedicated website and app.

The scheme has been running for a sufficient time, with nearly 10,000 booklets being distributed to local parents, the CCG plans to review the impact that the scheme has made and build in updates based on comments from local parents who have used the resource, the outcomes will be in place by April 2017.

8 Quality and Safety Improvement

Strategic Aims and Objectives

Our objective is to shape the quality of commissioned services to better support the needs of the people in Waltham Forest, whilst ensuring services are subject to the rigorous checks and balances expected from contracted services. When we talk about quality we mean patient safety, effectiveness of care and patient experience. Assuring these three elements of quality for patients will be central to our work with providers in secondary and primary care.

NHS WFCCG Commissioning Intentions for 2016/17 and approach to commissioning Quality standards in 2017/18 will supplement the NHS Outcomes Framework and include the local delivery of national outcome goals.

The underlying key priorities for the CCG are to see:

- Consistent delivery of the NHS Constitutional Standards
- Delivery of the CQC action plans and Improvement Plans
- Reduction in the recurrent level of financial deficit
- Transforming Services Together
- Integrated Care

Therefore the CCG will wish to agree a contractual agreement that supports the achievement of the above.

Delivery of NHS Outcomes Framework 2016/17

This national framework sets out 5 domains within which the NHS aims to achieve improvements. Each domain has a number of outcome indicators, which have been linked to the CCG's outcomes; a summary of the domains is shown in the table below:

Domain 1	**Preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long term conditions**
Domain 3	**Helping people to recover from episodes of ill health or following injury**
Domain 4	**Ensuring that people have a positive experience of care**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**

We monitor the safety and quality of the services that we commission through regular review at joint monthly meetings with Barts Health NHS Trust and North East London Mental Health Trust. Following the Care Quality Commission inspection of Barts Health and Whipps Cross November 2014, The NHS Trust Development Authority (TDA) now NHS Improvement placed Barts Health Trust in Special Measures. The trust is required to implement the requisite improvement to have the enforcement notices removed. WFCCG and NHS Improvement continue to review the implementation and achievement of the improvement action plan at a site specific Clinical Quality Review Oversight and Assurance meeting. Any areas of concern or risk to achievement of plan are further escalated.

WFCCG also reviews information from quality accounts, audits, external reviews, serious incidents, patient feedback, the Friends and Family Test (FFT) and complaints. We undertake Quality Assurance Visits and Peer Reviews with the Barts Health. This gives us the opportunity to meet with patients and staff and see exactly how services are being delivered. In addition, we have specified quality requirements in the contract with each trust, including Commissioning for Quality and Innovation (CQUIN) schemes for 2016/17. These requirements are also reviewed regularly at the meetings.

Promoting quality in Primary care

We are committed to working with our practices, both individually and through the locality arrangements, to promote quality in primary care and support improvements; ways in which we will do this include the following:

- Using data, and sharing information across practices and localities
- Having an open culture of peer review, constructive challenge and shared learning; specifically through the locality arrangements
- Implementing interventions which have the most beneficial impact on health outcomes and patient experience, including best practice pathways common across all our practices
- Developing services at a local level, and developing the ability to tackle variation in provision through inter practice referral systems
- Work to improve primary care access
- Promoting patient safety in primary care; and we will assess the feasibility of introducing a primary care 'never events' process
- Working with practices on managing demand, activity, and budgets
- Working with practices on medicines optimisation.
- Promoting patient experience feedback with the GP Friends and Family test survey.

We will work alongside NHS England (London region) who commission primary care and have been developing frameworks for quality improvement. Once the frameworks are in place we will be working with the information supplied, including any primary care dashboards, to promote quality and improvement with our practices.

Care Homes

We want to reduce the number of avoidable A&E Attendances and admissions from Care Homes and supported housing and gain an understanding of what gaps in services and other challenges impact the decision to refer care home and supported housing residents to hospital on an unplanned basis. Additionally we want to develop an enhanced model of care to support our care home residents in collaboration with our stakeholders and a sustainable training programme for care home staff with

specific emphasis on End of Life, Dying Well, Dementia, Tissue Viability, Continence, Intravenous Therapy and Falls Preventions. The intention is to provide a more pro-active approach to improving resident's healthcare by comprehensive medical assessment including residents' preferences, culture and decisions about end of life care.

Quality Assurance Processes

In addition to the contractual and operating performance related standards, there has been an ongoing focus on ensuring that providers of services to WFCCG communities are delivering quality services. Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally. A priority will be the development of a timely and comprehensive quality assurance system to prevent, identify and respond to quality failures, taking on board the recommendations of the Francis Report. The CCG will link to the local Quality Surveillance Group (London region) to share information and intelligence and receive assurance through its Performance and Quality Committee and Governing Body.

The CCG has in place a programme of Quality Assurance reviews across all of its provider organisations including Whipps Cross, North East London Foundation Trust, residential paediatric homes, paediatric footprint both in the hospital and community. In 2016/17 a full programme of quality assurance visits will be progressed in line with all other provider organisations.

National Legislation

The introduction of the statutory Duty of Candour October 2014 is requisite to implementing a key recommendation from the Francis Report. We continue to work with all of our providers to ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system.

Winterbourne View Hospital Review

In the light of 'Transforming Care: A National response to Winterbourne View Hospital', the aim will be to ensure a dramatic reduction in hospital placements for people with learning disabilities, mental health conditions, challenging behaviour or autism in NHS funded care. We are implementing a care pathway for people with learning disabilities, which includes pre-admission and discharge planning, risk assessment and use of a 'Patient Passport'.

The Care and Treatment Review process for all applicable patients in secure units was introduced in autumn 2014. The reviews are chaired by NHS England and ensure independent representation to enable a clinical oversight. The CCG are required to ensure that these reviews take place and we continue to work closely with all partners to support the care and treatment needs for all Winterbourne view patients.

Leading Change, Adding Value

Compassion in Practice 2013 - 2015, the national strategy for nurses, midwives and care has now been incorporated into the new framework "Leading Change, Adding Value". The framework is aligned to the Five Year Forward View and via 10 key commitments instils in all nursing, midwifery and care staff the belief that they can lead to deliver better outcomes, better experiences for all patients and staff and ensure appropriate use of resources. The framework retains the 6 C's highlighted in Compassionate Care and works to support the reduction in variation in health care. The CCG along with NHS England,

our providers and Health Education will take the opportunity to build on the successes of this work in contributing to the next national vision. This will ensure that compassion remains central to the services we commission.

Patient Experience

WFCCG's vision is to put patients at the centre of everything we do. We will do this by actively listening to our patients, communities and hard to reach groups and using their experiences to shape care.

We continue to make substantial investment in the patient experience agenda. Working with the Patients Association we have commissioned a project to support improved GP patient participation. The aim of this project is to ensure there are patient participation groups in all of our practices. These are key to ensuring that patients and carers are at the heart of primary care commissioning. The project is due for completion in September 2016.

A full time Patient Experience coordinator has been recruited. This role is key to supporting our local Patient Experience agenda both within the acute and primary care setting.
The Patient Reference Group was established in 2014 and is in place to support development of strategies and plans for local health services by involving members. In recognition of the importance of patient involvement and timely feedback to the Governing body in late 2015 the frequency for the patient reference group meetings was increased to monthly and aligned to provide timely information.

We work in partnership with Whipps Cross Hospital by supporting and attending patient panels. This forum is to allow patients opinions to be voiced, heard and action to be taken.
WFCCG works closely with voluntary sector organisations for example Social Action for Health (SAFH) and Healthwatch as local consumer champions to elicit the voice of children and young people.

Quality Incentives CQUIN

The CCG continues to work with providers to ensure that the CQUIN schemes both in the current and future contracts are delivering quality services. CQUIN's continue to allow providers to earn up to 2.5% of their annual contract outturn with one fifth available for achievement of national improvement goals.

The Five Year Forward View (FYFV) has set out the vision for promoting well-being and preventing ill health. A key element is to align incentives with the reform of payment approaches and contracts

The National CQUINS for 16/17 are as follows:

1. NHS staff health and wellbeing;
2. Identification and early treatment of Sepsis;
3. Improving the physical health for patients with severe mental illness (PSMI);
4. Cancer 62 day waits.
5. Antimicrobial resistance.

The 2016/17 national goals on Sepsis and PSMI continue the focus on priorities from 2015/16 and build in a higher level of ambition. Three new indicators have been introduced as below;

1. NHS Staff Health and Wellbeing. The aim is to improve the health and wellbeing of our NHS staff which is a priority for us all.
2. Cancer 62 day waits.

3. Antimicrobial resistance. The CQUIN aims to reduce antibiotic consumption and encourage a prescribing review within 72 hours of commencing an antibiotic.

The local CQUINS for WFCCG focus on;

- Reducing Delayed Transfers of Care, reducing delayed medically optimised patients.
- Improving End of Life Care
  Increasing Ambulatory Care to support flow

Safeguarding Children and Vulnerable Adults

WFCCG is statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes specific responsibilities for Looked After Children (LAC), Domestic Violence against Women and Girls (VAWG), Female Genital Mutilation, Child Sexual Exploitation (CSE) and for supporting the Child Death Overview Panel (CDOP) process.

In response to the guidance set out in the Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2013 revised in July 2015[6] WFCCG takes a cross generational approach to safeguarding children, young people and adults. This is delivered through a single integrated team that provides strategic leadership for safeguarding children, looked after children and vulnerable adults across the Waltham Forest health economy. The roles provide leadership, quality assurance, training, supervision and specialist clinical advice on safeguarding to the CCG and the provider organisations.

We have further invested in our safeguarding team to ensure we comply with the statutory guidance as set out in the Care Act 2014[7]. Our Designated Adult Safeguarding Manager will work closely with the London Borough of Waltham Forest, the Safeguarding Adult Board and provider organisations to ensure that our providers meet their responsibilities through our commissioning arrangements.

The CCG developed a single safeguarding strategy which will enable cross generational working across the organisation. The Safeguarding team will present progress against the strategy work plan to the Performance and Quality Committee on a Quarterly basis. The CCG has a high level of commitment to safeguarding children and adults and is an active member of the Local Safeguarding Children Board and the Safeguarding Adult Board.

Care Quality Commission Inspection

WFCCG commissions acute care from Whipps Cross Hospital (Barts Health). Whipps Cross was inspected by the Care Quality Commission in November 2014 with the report being published in March 2015. The report rated Whipps Cross as 'inadequate'. Finding that the following services were inadequate and significant improvements required.

1. Urgent and emergency care

[6] Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2015
[7] Care Act 2014, HMSO, June 2014

2. Medical care (including care for older people)
3. Surgery, services for children and young people
4. Outpatients and diagnostic imaging
5. Services for those patients requiring end of life

The report rated maternity and gynaecology and critical care as “requires improvement”.

Overall the hospital was rated as inadequate for safe, effective, responsive and well-led, the domain of caring requiring improvement.

We actively responded to the CQC notices and the four enforcement notices served to Whipps Cross. Following the inspection site level actions plans were developed by Barts Health Trust to address the quality issues and concerns. WFCCG have continued to work closely with NHS Improvement and Barts Health in the monitoring of the improvement plan via scrutiny at the site level Clinical Quality Review Oversight and Assurance meeting.

The CQC held a planned re-inspection of Whipps Cross Hospital in July 2016 and we will work to ensure that system wide support continues to be provided to deliver on any actions required to expedite recovery and ensure high levels of safe quality care and patient experience.

9 Governance

NHS Waltham Forest Clinical Commissioning Group (WFCCG) has put in place robust governance arrangements in order to support our Membership organisation. These are demonstrated through WFCCGs Constitution, Standards of Business Conduct, active management of our conflicts of interest, and clinical quality assurance arrangements through our approach to clinical procurements.

The CSP describes our approach to communicating with our Members, and our key objective in improving communication in this area. Good communication can support the governance function and how good governance can strengthen the communication function. Community participation is central to our approach and we have established a new community participation group: the CCG Reference Group. This group will help provide the structure by which the local community can influence every stage of the commissioning cycle.

Our Governing Body retains overall responsibility for delivery of our key objectives and is supported through a meeting structure that underpins all the necessary statutory and good practice governance disciplines. A range of policies and procedures have been developed and are refreshed regularly to provide information, guidance and direction to ensure such decisions are made within a safe and secure environment for both our staff and our local population.

Board Assurance Framework

The Board Assurance Framework is reviewed regularly by the Governing Body, to ensure that risks which may affect WF CCG meeting its corporate objectives are identified and mitigation to those risks are in place.

Clinical Quality Assurance

There are several processes in place to monitor the clinical quality and effectiveness of services provided to patients by our key providers. These include WF CCG led Clinical Quality Review Meetings, Oversight and Assurance Meetings, Task and Finish Groups and Clinical Forums. The outputs from these meeting are monitored through the Performance and Quality Committee.

WF CCG have full delegated co-commissioning responsibilities for 44 GP practices within the borough. The quality of these services is monitored through the Primary Care Subcommittee, while all decisions taken regarding primary care are taken through the Primary Care Committee.

There is a programme of Quality Assurance visits in progress with our key providers, including nursing homes in the borough.

WF CCG are developing a more collaborative approach to conducting these visits within nursing care and residential homes, with the local authority.

10 Financial Strategy

The overall purpose of the medium term financial strategy (MTFS) is to underpin the delivery of our strategy by establishing a robust, flexible and sustainable financial environment within which to operate. The strategy will enable the local system to develop as necessary within the context of the current and projected economic and political climate providing a financial framework for collaborative working.

The purpose of this financial strategy is as follows:

- to review the resources allocated to NHS WFCCG and promote the fair allocation of resources to meet the health needs of Waltham Forest residents
- Promotes robust financial control along with the implementation and maintenance of strong governance arrangements
- Aims to deliver a sustainable recurrent surplus
- Will meet the statutory requirements of the organisation
- Demonstrates the most appropriate use of resources for the population based on need.

The MTFS will be revisited annually in line with the operational and strategic planning and will be informed by any emerging NHS planning guidance.

The resource assumptions used in the MTFS are those issued by the NHS England within "Everyone Counts" which was published in December 2012. Overall in the NHS, annual uplifts have reduced in recent years after a prolonged period of substantial real term growth. Public sector finances will continue to be adversely affected as the Government seeks to balance the UK economy.

Technological developments in medical treatments and equipment as well as increases in the elderly population and the numbers with long term conditions are leading to pressures on healthcare budgets.

Legislation such as the Human Rights Act can broaden access to certain interventions or drugs which can also lead to pressure on healthcare budgets.

Projected CCG Allocations

The allocation in 2016/17 is £389.5 million inclusive of £6.2 million running cost budget and £34.9 million for delegated primary care. This includes £8.6 million carried forward surplus from 2014/15 which is non recurrent and a reduction of £0.8 million of non-recurrent income. In total, As such, at the time of writing this CSP the underlying recurrent CCG allocation is £375.4 million.

The following table shows how we expect our allocation to change over the life of this plan based on the latest available planning guidance issued to CCGs.

Projected CCG Allocation	2016/17 £M	2017/18 £M	2018/19 £M
Opening Baseline	338,723	346,651	355,251
Primary Care Co-Commissioning	36,678	38,723	40,204
Running Cost Allocation	6,235	6,267	6,300
Return of surplus	8,656	8,600	6,000
Other non-recurrent allocation	-748	0	0
Closing Baseline	389,544	400,241	407,755

Financial Allocations

The 2016/17 income allocated to CCGs and direct commissioning has been published alongside the 2016/17 NHSE planning guidance. The chosen approach to allocation of funding has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare. For CCGs, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation

Financial Planning Assumptions

Surpluses and deficits accumulated at 31 March 2017 and subsequent years will be carried forward into the following financial years. Commissioners are asked to include proposals for access to historical surpluses, if required, in their plans.

The prices within the National Tariff for 2016/17 are generally the 2015/16 prices rolled forward and adjusted for inflation and efficiency. The cost uplift for 2016/17 is 3.6% and the efficiency requirement is 2%, giving an overall adjustment to tariff prices of 1.6%

10.1 IM&T

Strategic Aims and Objectives

The IT and Digital Strategy has been developed to set the strategic direction, the overall objectives of the strategy for 2015/16 and how these will be implemented are set out below:

- Modern clinical systems - roll out a single clinical system, or multiple interoperable systems, in primary care to enable easier transition to a fully paperless local health and social care system Connectedness – enable integration of care across the local health system

- Self-managed care – provide access to electronic patient records, alerts and personalised analytics to enable the individuals to engage better with managing their own health and wellbeing leading to reduced burden on health services
- A vehicle to analyse, benchmark and report on activity and outcomes – enable improvements in primary care priorities to serve the local community in a more proactive manner through improved analysis of patient data (anonymized) across Waltham Forest
- A confident user community – putting in place training and other support services for clinical professionals to enable them to make better use of IT, resulting in better value from CCG investments
- Patient and public involvement – increase awareness amongst the local population about Digital services and seeking feedback to refine and prioritise the future roadmap of services. Involvement is needed to drive-up take-up of Digital services otherwise benefits will not be delivered (e.g. improved access and reduced administrative load on practices).

Achievements to date

Modern clinical systems - We have successfully migrated 22 GP practices to use the preferred clinical system in our area, EMIS Web (14 practices were already using this system prior to April 2014). We are also planning to complete the migration of a further one practice before December 2015. At this point, all Waltham Forest GP practices will be using the most modern GP systems available.

Connectedness

This covers three areas:

- Sharing patient data, with patient consent, between GP practices and local Barts hospitals. This sharing is now active for 34 GP practices and will be for at least 37 before December 2015. This electronic sharing means that clinicians at Barts and in GP practices will have a more complete picture of the patient, which should result in better care.
- Electronic pathology requesting. All Waltham Forest practices are enabled with tQuest, a system for making paperless requests for blood tests. This has reduced administrative work and improved accuracy of the overall process. There are also plans to extend this electronic requesting service to include radiology before December 2015.
- Electronic discharge summaries. Some of the providers provide all discharge summaries electronically, we are now looking for the end of March 2016 to extend to all the local health providers.

Self-managed care

All Waltham Forest practices have now enabled electronic access (either through the web or a smartphone app) for patients to view a summary of their care record. Under the auspicious of the WEL CCGs programme called Transforming Services Together (TST), new systems are being planned that will allow patients to receive alerts and personalised assessments to help them avoid or delay the onset of various conditions.

A vehicle to analyse, benchmark and report on activity and outcomes - Waltham Forest CCG are fortunate to have invested in a number of business analytics support systems. A recent study has been undertaken to better match the needs of commissioners and clinicians to the available analytics solutions. The fruits of this work are expected in the next six months.

A confident user community

The six monthly IT audits have been very successful in identifying training and support needs. As a result of this, with support from NELCSU, we have undertaken three major programmes of training and support:

- Helping practices to get ready for patient online services and ensuring that each practice is able to send patient Summary Care Records to the national NHS service (called the "spine") for sharing this patient data across all health providers.
- Providing additional training and support to use and operate Health Analytics, a key system that supports the high successful Integrated Care programme run with the support of Community Matrons from NELFT.
- Providing support and training to use tQuest and the system called MIG (for Medical Interoperability Gateway) for linking with Barts for sharing patient information.

Patient and public involvement

With regards to Digital services for the public, the main and major programme has been the rollout to all 44 practices of the iPlato SMS service. This service allows practices not only to remind patients of appointments but also allow patients to cancel using a SMS message, thus reducing the number of appointments that go unused. The iPlato SMS service will also be enhanced early next year with an iPlato smartphone app, which will allow access to all online GP services (booking appointments, ordering repeat prescriptions and viewing the patient record). The other major area of development is digital consultations to improve convenience for patients. To this end, four GP practices in Waltham Forest will be trialling the use of Skype for GP consultations. Finally, before the end of December 2015 we will have developed plans to improve and upgrade GP web sites to improve information for patients and access to online services.

10.2 Organisational Development

The CCG has a firm commitment to achieving its clinical priorities, corporate objectives and ensuring patients are at the centre of what we do. The Organisation Development (OD) Strategy and associated implementation plan is an enabler for this, describing how we will develop its people, processes and organisation so that it can be a world class commissioner of healthcare for the people of Waltham Forest.

We recognise that an engaged, motivated and skilled workforce, operating with the right culture is essential to the delivery of our aims and objectives. We recognise the impact of excellent leadership and strong effective teams. Therefore, creating a culture of innovation, learning and teamwork and engaging leadership is fundamental to the OD Plan.

The overarching aim of the OD strategy and plan is to support the delivery of corporate objectives and in particular the provision of consistent and high standards of quality, clinically driven care to the population of Waltham Forest.

The objectives of the organisational development plan are:

- deliver a direct improvement in individual and team performance
- development of a broader overview of our role and our stakeholders
- development of our staff and teams in terms of their skills and career
- improve the effectiveness and capability of the Governing Body

- ensure the Governing Body are equipped with enhanced knowledge and skills to fulfil roles
- embed a single culture and shared purpose throughout the organisation
- ensure we attract and retain the right people with the right skills
- develop new ways of working that meet the need of our patients

As a large local employer we support The London Healthy Workplace Charter. This is a self-assessment framework that recognises and rewards employers for investing in workplace health and wellbeing. It provides a series of standards for workplaces to meet in order to guide them to creating a health-enhancing workplace.

We want to work towards the three levels against each standard: commitment, achievement and excellence as we want to get the best out of our workforce, stand out as an exemplary employer, show commitment to our staff, access local support and advice and seek opportunities to learn from others.

10.3 Workforce

There is a real workforce challenge to address such as:

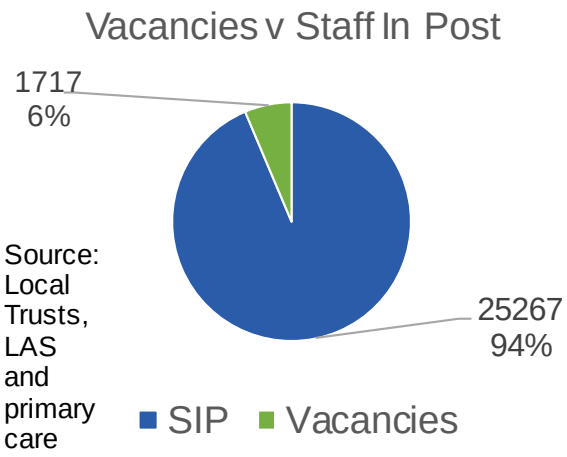
The population of east London is expected to rise by 270,000 over the next 10 years:

- 1 in 6 suffer a mental health difficulty at any one time - this will place additional demand on mental health services
- a growth of about 5,000 births with 1,200 of these births are likely to be within Barts Health maternity services within the next 5 years
- Approximately 48,000 additional A&E attendances;
- 16,000 more children and young people living across east London;
- 1.12m general practice appointments and 52,000 outpatient appointments per annum by 2025; and
- Increased demand for elective surgery, increased diagnostic procedures

Transport costs and the cost of affordable housing in the region is a major factor in recruiting and retaining staff. In addition the TST programme has highlighted how crucial it is to develop a workforce that is able to work across traditional acute and community boundaries.

Creating a flexible workforce that can care for patients across organisational boundaries is a crucial enabler. This involves designing new roles where there are recruitment and capacity challenges (emergency care staff, paediatric specialists, midwives, obstetricians, GPs and community care staff) and supporting our workforce to deliver seven day services. We see 24/7 care in primary care as a key enabler to reduce A&E demand and have entered into an early dialogue with Health Education North Central and East London (HENCEL), commissioners for education and training for the workforce of the future, about the change requirements that arise from the WEL strategy and will work with London Education and Training Boards to ensure the local workforce is trained with skills that meet the needs of the local health economy.

The local workforce across WEL collated from local Trust data looks like this –



Source: Local Trusts, LAS and primary care

There are known and longstanding gaps in certain workforce groups and specialisms e.g. certain nursing groups, emergency care, psychiatry, general practice.

Alternative roles therefore must be considered e.g. Physician Associates and Advanced Practitioners. Developing a sustainable supply of new roles will require the development of new partnership working, possibly across education, third sector and other health related and health deliverable organisations.

In addition we need to use existing skills within the region to compliment current healthcare delivery e.g. general and community pharmacists.

Cross-boundary partnerships must be developed with other healthcare providers who may be outside the region e.g. Defence medical practitioners, paramedics and the ambulance services.

New ways of working will require considerable organisational and cultural development, changing our mind-set as well as our practices. We need to consider for example

- Federating the clinical and non-clinical skills within General Practice to achieve greater efficiencies and scales of production
- The creation of cross-boundary working to enhance patient pathways e.g. across primary, secondary and social care
- The development of integrated and multi-disciplinary urgent care centres which make use of 24/7 community and primary care services

There are also the consequences of mass retirement within a short timeframe. Providers report retirement rates vary between 10% and 17%. For male GPs over 65 the rates are:

- 22% Newham
- 15% WF
- 5% TH

The CCG will be working with partners to address the challenges faces and identify creative solutions such as:

- Improve recruitment to establishment levels in new and existing models of care
- Improve rates of retention
- Improve efficiencies through new ways of working
- Consider the use of new roles or alternative roles
- Improve cross-site and cross-boundary collaboration
- identify incentives to work in our locality

- Upskill and train staff to be more aware of other healthcare conditions
- Continue building on our established links with HENCEL, the London Education and Training Boards and the local Community Provider Education Network to ensure the local workforce is trained with skills that meet the needs of the local health economy
- Conduct workforce baseline exercises to help us ensure that providers have the appropriate capacity of skilled staff to meet our growing demand
- Work with Local Authorities, the Mayor of London and housing associations to address the 'housing challenge' nurses face

10.4 Estates

The CCG has adopted a leadership position on estates and will complete our borough Strategy for consultation by December 2015. We will work with neighbouring CCGs to produce a regional estates strategy (using information from a local estate audit) as a leader rather than a contributor by April 2016. Local practices have successfully obtained £3m infrastructure funding to improve the capital estate and improve capacity. We will support practices to obtain future infrastructure monies and improvement grants through the assessments of our premises and priorities identified in our estate strategy. We will review how our estate is being used to ensure that we are obtaining value for money and providing a greater amount of capacity for services based in the community.

10.5 Communication and Engagement

Communications

Strategic Aims and Objectives

- Key stakeholders will know what we're doing, and we will be seen as the local healthcare leader
- Staff and GPs will have access to the information and communications and engagement support they need to do their jobs well
- Patient and public engagement will be innovative and delivered in line with the NHS Constitution
- We will have communications and engagement support to improve the health outcomes of our local population
- Communication and engagement projects will be delivered in line with our statutory responsibilities
- Work will be managed proactively and urgent issues will be dealt with effectively

Achievements to date

Good communication is at the heart of a well-functioning clinical commissioning group. First and foremost, we need to listen to and engage with our local community, the residents of Waltham Forest.

Communication is a 'two way street': it is not just about informing people of what we are doing, but also about listening to stakeholders and collaborating closely to improve the delivery of local health care services and ensure value for money. This will help avoid duplication or gaps in service provision and make sure that we focus on the areas of greatest need.

Key to successful communication is finding the most effective methods to keep everyone informed and to receive feedback. In the two years since the CCG was established we have established a wide range

of platforms that help us communicate and engage with different stakeholder groups on a regular basis. This includes:

- A recently redeveloped public website, which is highly engaging and was shortlisted for 'Best Website' in the Association for Healthcare Communications and Marketing awards
- Patient reference and rapid feedback groups, which were recruited through a robust interview process and provide feedback on our ideas and plans
- A series of awareness campaigns to highlight key services, such as Improving Access to Psychological Therapies. We saw sharp increases in self-referrals as a result
- Highly popular annual general meetings. The most recent event attracted 150 people from across the community
- Regular meetings and education sessions for GPs, plus an email bulletin for all practice staff updating on key local developments

Over the next three years, we plan to

- Continually improve our existing platforms to ensure they are all clear, engaging and accessible. This will include redeveloping our existing GP website to turn it into a 'primary care' website, with the aim of making this an invaluable resource for practices across the borough
- Establish new communications platforms and processes in order to communicate more effectively with our stakeholders. Those currently being considered include:
    - a mailing list and newsletter for patients and key stakeholders
    - a platform for communicating regularly with voluntary and community organisations
    - a staff intranet
    - social media
- Improve coordination of communication channels. In the past, some communication platforms have been managed by the communications team, with others (such as GP meetings) managed elsewhere in the organisation. We will improve governance structures to ensure the communications team is involved with all key communications platforms and there is consistent messaging across them
- Embed high quality communication across the organisation. We have developed a central communications resource to ensure that CCG communications on key work streams are consistent. We will do further work to embed the use of this resource throughout the organisation, and ensure the materials are updated regularly. This will help ensure that messaging is aligned across all our channels. We will also provide more guidance to staff on how the communications and community participation function can support them.
- Review governance and resources within the communications and community participation functions to ensure they are robust, that new channels are of a high quality and that the team is working as effectively as possible. We will ensure the communications and community participation functions are aligned and work together to develop plans that support staff within the CCG, and the local community, and is able to address the following challenges:
    - the new responsibility for commissioning GP services
    - delivering the Transforming Services Together transformational change programme
    - addressing pressure on A&E services
    - increasing demand for communications and engagement support as our newly formed organisation develops and undertakes larger and more complex pieces of commissioning work

- introduction of the NHS England accessible information standard

Engagement

Strategic Aims and Objectives

The Community Participation Strategy 2015 – 2018 has recently been reviewed, this strategy builds on the work which has taken place during 2013 – 2015. It sets out how we intend to develop our community participation function over the next three years, and compliments our Communications Strategy 2015-18.

For further information click here

http://www.walthamforestccg.nhs.uk/downloads/aboutus/publications/strategies/NHS-Waltham-Forest-CCG-Communications-strategy-2015-18.pdf

Community participation: the statutory basis

The Health and Social Care Act 2012 includes a clear commitment to involving patients and the public in decisions taken. The NHS Constitution includes the right of the public:

'to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way services are provided, and in decisions to be made affecting the operation of those services'.

The Health and Social Care Act 2012 places a responsibility on CCGs to involve patients and the public in the area that they serve in decisions the CCG takes. We intend to do this through our Community Participation Strategy.

How we involve people and how we will strengthen this involvement - We want to involve people in our community at every stage of our commissioning. This includes helping to:

- assess needs in our population to determine what and where services need to be provided;
- review existing services to identify gaps and potential improvements;
- decide priorities and identify what we give priority to;
- design services through involvement at the beginning of the development of a service; and
- monitor performance against our plans.

We also want to hear from the public regarding their experiences of our local health services, and so we want you to be able to contribute views. There is an established Patient Reference Group within WFCCG who have contributed to a number of work streams e.g. Urgent Care Strategy, Better Care Together and Integrated Discharge.

The Terms of Reference (ToR) and membership of this group will be reviewed in the autumn of 2015 with the aim to establish how we can engage with the wider community, including those from marginalised, seldom heard and those with a disability. There is a focus on recruiting to the reference group and with that we plan to provide support to encourage individuals from all backgrounds to join, it is important that the reference group represent all groups including; Mental Health, Learning Disabilities, adolescents and younger people. We feel that the experiences of these people are valuable to our work. Some of the members of The Reference Group on committees within WFCCG.

Working with our partners

A key characteristic of our approach is working with partners on our participation activities. There are positive working relationships with Healthwatch in relation to patient and public engagement. WF Healthwatch have assisted the setup of a focus group in relation to our Urgent Care strategy and Promoting the Health and Wellbeing of Looked After Children (LAC) in transition. There are a number of engagement events and opportunities within the Transforming Services Together (TST) programme, which support a number of our strategic objectives.

Waltham Forest Local Authority

We work closely with the local authority on many initiatives, in particular integrating health and social care through our 'Better Care Together' programme. Better Care Together is our local work stream to deliver the national Better Care Fund programme. We also work closely with the local authority in ensuring that the voice of children and young people is heard in health and social care. Patient and family experiences should not only include the experience of the patient and carer going through the service but also demonstrate how they are involved in assessments, and running and developing future services. (London Children's Strategic Clinical Network, NHS England 2014) The Voice of the child conference in November 2015 gave patients an opportunity to tell commissioners about their experiences and offer suggestions as to how they would like to see services delivered to them.

Voluntary and Community Organisations

Waltham Forest has a considerable number of voluntary and community organisations representing our community, including black and ethnic minority organisations, disability organisations and also organisations that represent the lesbian, gay, bisexual and transgendered (LGBT) population. Many of these have a very wide area of interest, while others focus on a particular issue. We plan to strengthen our relationship with these organisations, either individually or through an umbrella network. We will also meet voluntary and community organisations when decisions we may take would have an impact on the people they represent. Age UK have been commissioned to undertake some work relating to patient experience. This is an exciting piece of work, which will allow us to understand the experiences of older people in the borough.

GP Patient Participation Groups (PPGs)

Some GP practices in Waltham Forest have Patient Participation Groups (sometimes called Patient Engagement Groups). We want to change this, so that all of the GP practices in Waltham Forest have a group. Some PPGs meet fairly regularly; others meet more sporadically. Some PPGs usually meet in face-to-face meetings; others are virtual groups, contacted and consulted by email. The focus of all PPGs is on ways to improve how their GP practice works. As a first step towards this, we will be running a PPG development programme with the Patients Association ('Patients in Participation') from September 2015 to August 2016. To provide a development programme for Patient Participation Groups across Waltham Forest in order to increase their effectiveness and commissioning influence at practice, local, regional and national level and increase the level of patient and public patent participation.

Focus Groups and Participation Conferences

On occasion we will set up small focus groups around a particular topic or issue. Focus groups will allow us to get feedback and advice on a specific issue (mental health, for example) from people who have lots of knowledge and experience of the issue. We also plan to hold Participation Conferences to report on what we have been doing and plan to do, as well as feature some sessions on specific clinical issues, such as managing diabetes and living with dementia. Every conference will include a report on the

information on patient choice and any feedback we have received in the past six months, as well as a summary of how we responded to this.

Digital and Social Media
Our website contains as much information as possible about what we are doing and what we plan to do and It gets updated regularly. There will also be a section that will allow anyone to give their views or make suggestions, and a section on what people have said to us about what we plan to do or have done. We will also assess the value that social media can bring to our function.

Priority areas for the next 3 years;

Over time we will develop the community participation function so that it resembles the function described above. As our next step towards this over forthcoming months we will deliver the following key improvements.

Moving forward there will be a focus on consistent community participation activity and demonstrate its impact. This will be delivered by implementing a governance structure. In the short term we will draw the structures and reports we have in place into this arrangement; and in the long term we will develop the remaining structures and reports.

- We will ensure better alignment between our objectives and resources, so that:
  - There is sufficient resource allocated to deliver participation duties;
  - The Reference Group's work programme is linked to the Governing Body's agenda; and
  - We review the issue of remuneration for patient participation.
- During 2015/16 we will review the membership of our community participation groups, to confirm whether groups identified in the Equality Act as having protected characteristics are adequately represented. We will begin with our Reference Group, Rapid Feedback Group and Maternity Services Liaison Committee.
- We will establish 'you said, we did' feedback loops for all community participation activities.
- We will deliver the 'Patients in Participation' project.

In addition to the above priorities we have renewed the Asthma UK pledge, the quality standard for asthma requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole asthma care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults, young people and children with asthma. We also renew our commitment to ensure all military personnel injured and affected as a result of their current and past service, should receive timely, high quality and effective care from the NHS. The Chavasse Report guides us, as commissioners to ensure better and greater continuity of care for those severely wounded in action, injured in training, or suffering debilitating musculoskeletal infirmity as a consequence of their military service.

10.6 Procurement

The Clinical Procurement Strategic Policy which has been produced to ensure that we follow good practice processes when procuring clinical services and ensuring that procurements achieve value for money. Within this strategic framework we have developed a procurement pipeline which could offer

opportunities to use market forces to achieve savings, for example the Community Health Services Contract or Community Specialist Services (CSS).

Within the procurement strategy framework the CCG is required to ensure that robust decisions are taken and documented to determine the procurement route, that procurements are fit for purpose and are compliant with national regulations and guidance, the CCG's Standing Financial Instructions and European law.

We manage a five year procurement pipeline and are working with the local authority where possible to have a shared collaborative approach to contracting services.

Planned Procurements during 2016/17 include for example anti-coagulation services, GP Out of Hours, extended access, urgent care and 111 services and the mental health wellbeing service.

11How we measure what we do

NHS England Assurance

For 2016/17 NHS England have introduced a new CCG Improvement and Assessment Framework to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework provides a greater focus on assisting improvement alongside the statutory assessment function. It aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

The framework is intended as a focal point for joint work and support between NHS England local area team and the CCG. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View.

Performance and Quality Committee

We have a Performance and Quality Committee established in accordance with the constitution, standing orders and scheme of delegation which meets our governance processes.

Score Card

The management of the Scorecard is to identify specific measurable indictors that can be used to demonstrate improvements in patient care and outcomes over the course of the year. The 2016/17 Scorecard has been designed around priority work streams, and the national outcome assessment framework.

The Scorecard reflects Waltham Forest priorities and objectives rather than replicating national performance frameworks. Where relevant the Scorecard targets have been aligned with the levels of ambition set out in the CCG Operating Plan and Quality Premium submissions to simplify reporting processes.

Whilst the reporting process will focus on performance of the Scorecard indicators, the intention is also to capture the key elements of the wider work being undertaken within each work stream, to the extent that this supports making a difference for the residents of Waltham Forest.

The monthly reporting process will also be used to report by exception on the CCG's performance against national performance and quality targets not covered by the Scorecard so that the CCG is aware of any risks to the local population. This exception reporting includes the NHS Constitution standards and the CCG requirements outlined in the 2016/17 Operational Planning guidance.

Delivery Plan

As part of implementing the our priority work programmes and strengthening our Operating Plan submission, we developed a detailed Delivery Plan which summarised key actions from the work programmes that were planned to deliver our service development ambitions .

The Delivery Plan is managed as a “live” document that is reviewed throughout the year to ensure that the organisation is on track with the programmes. Regular progress reports on delivery will be submitted to the Governing Body to provide assurance on delivery against milestones.

Contract monitoring

The CCG contract management team and commissioned contract management support services maintain the contract management functions. The contracting process ensures that formal agreements with all providers (acute, primary, community, mental health, voluntary sector) are in place, and that these contracts clearly describe what is expected from both the commissioning and the provider.

Within the standard NHS contract the CCG can for example:

- Specify quality requirements or outcomes e.g. CQUIN
- Incentivise the development of new service models or patient pathways
- Ensure quality of care for service users
- Ensure value for money