HLP 2018/19 Proposed Projects				System impact (Z)	Impact timeframes		
Programme	**Issue (X)**	**Priority / Project (Y)**	**Deliverables**	**System impact (Z)**	**18/19**	**19/20**	**20/21**
Digital	30 local information exchanges in London - none of which talk to one another. Health and care systems buy solutions separately but now through a layered architecure there is the opportunity toreduce point to point connection costs, swop in and out suppliers and overtime rationalise the existing infrastructure across London with increased negociating power and deliver a solution for GDPR. As the London Health & Care Information Exchange goes live in February 2018 it will move from progamme into a service for London and along with other London assets it may need to move to a new host. The core specialist HIE team funded by HLP is team is required to continue to configure the exchange to enable local depolyment and drive more and more utility. Thsi is a design once and deploy locally model	**London Health and Care Information Exchange**	HLP's role within this is provding key project management and architecture resources to support the build and roll out of the following capabilities to the 5 STP's in London: • STP to STP connectivity via HIE infrastructure – NB plans agreed in all footprints. Will be configured once and deployed locally during 2018/19. • Support for image exchange in each STP footprint and pan London – key enabler for diagnostic transformation. Configured once and deployed locally. NCL/NEL and SWL are providing initial go live sites • Support for at scale document sharing. Configured once and deployed locally. Engagement has commenced in NWL and NCL • Replacement infrastructure for the U&EC PRM programme • Use of the exchange to support electronic transfer from ambulance to A&E reducing ambulance hand over times • At scale visibility of end of life care plans and migration to virtual care plan model within each STP footprint using federated HIE infrastructure. Project underway with U&EC programme. NB reductions in unplanned admissions Configured once and deployed locally. • Full support for Cancer MDT working across RMH partners. NB discussions opening in other parts of London. Configured once and deployed locally. • Infrastructure to provide nursing and care homes and community providers with access to transfer of care information. Potential for collaboration with SMART London programme being explored. NB National priority. • Support for virtual care co-ordination. Configured once and deployed locally. Initial go live sites being sought. NB opportunity value pan London = up to £0.5b annually. Proof of concept planning underway in NWL and SEL. • Support for subscriptions, notifications and alerting services and workflow management – extends scope of service beyond record viewing. Essential enabler for improved pathway management across organisation boundaries. Configured once and deployed locally. • Support for GDPR implementation – single point of access and single information sharing agreement via Data Controller Service • Integration with NHS Online and Support for connected apps • Deployment and use of national identity service – NB Based on a study by Royal Free, a co-ordinated approach to the use of this service has the potential to save up to £500k per annum across London on an annual basis if patients can be persuaded to receive correspondence electronically. • An event management service for child health enabling clinicians to be notified when key events take place. Please note: all other costs such as infrastructure, license, commercial, legal, IG, finance, assurance and resouce costs (testing, training, etc) are being funded by ETTF. The programme is operating in an Agile way and regulary reviewing the prioritisation of new streams and opportunities of work. HLP will remain as the product owner in the LHCIE programme and will be working with various stakeholders across NHS London region to expand on the capabilities that are currently being buit to date across the 5 STP areas in London. Actions: by Q4 2018/19: - Consolidate the core team and move as many interims as possible into NHS contracts or negociated work packages and investigate options to host the London team - potentilally in the CSU,a trust or CIC. With CSU may be opporunity to augment with exsiting CCG funding and develop a subscription based service as part of BAU beyond March 2019. Opportunity to work with GLA Smart Loondon to generate indusrty contributions to running the Exchange - Offers a major opporunity for the data controller console to Help London achieve GDPR compliance	- Reduced staff time spent on paper handling in community, secondary and tertiary Trusts and faxing - Clinicians report reduced time to access pertinent clinical information - Improved diagnosis and notification times for patients with cancer and non-cancer diagnoses - Improved management of ISAs supporting paper light working - Improved efficiency in managing ISAs, better transparency and visibility - Decreased numbers of agreements with ISAs more visible between approved organisations in the secure DCC - Improved efficiency in communication channels using the DCC with organisation's contacts visible to other members	The anticipated benefits profile of £50m from four projects (Transfers of Care, End of Life, Caner and Data Controller Console) as stated in the business case spans over a 5-year period with the following % being achieved: - Year 1: 1% - Year 2: 6% - Year 3: 14% - Year 4: 26% - Year 5: 53%	The anticipated benefits are expected to continue as per the profile mentioned in 2018/19	The anticipated benefits are expected to continue as per the profile mentioned in 2018/19

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Mental Health	" FYFVMH requires access to IAPT to expand to 25%, from 153k to 260k Londoners, by 2021. The funding, workforce and estate does not exist to meet the targets. Digital solutions including Digital IAPT, the new London Health Information Exchange and the new London Digital Mental Wellbeing provide London with a unique opportunity to close that gap.	**Digital IAPT**	Mobilise London's digital strengths (Digital IAPT, Health Information Exchange and London Digital Mental Wellbeing) to close the IAPT 25% access target, actions: • Identify and support CCGs/ STPs to realise the commissioning efficiency and market management opportunities of commissioning digital IAPT at a larger scale (informed by outcomes current NICE evaluations). • Production and implementation support for a standardised London Shared Care Plan for IAPT/LTC for the London Health Information Exchange, and develop reporting of the linked data this would produce to support STP population health opportunity identification and pathway redesign activity. • Utilise London Digital Mental Wellbeing to deliver personalised low cost mass marketing of IAPT to: • Support delivery 25% access target • Channel shift the digitally enfranchised (including digitally enfranchised hard to reach) segments of the prevalent population from face to face activity to digital IAPT, and thereby also create capacity, improve digital IAPT efficacy, and sustain recovery. • Improve productivity and retention by learning from best practice in the utilisation of digital IAPT in the development of IAPT/ LTC clinical care pathways	• Quantifiable efficiencies from, and quality improvements in, London's Digital IAPT provision. • Quantifiable step improvement in contribution of Digital IAPT to access target. • London wide agreed shared care plan for IAPT/ LTC. • CCG, STP and London wide data on activity shifts produced by IAPT/LTC integration, allowing local identification of quantifiable QIPP. • Step improvement in Digital IAPT Recovery rates.	Impact measures identified and agreed by April 2018 Commissioning Guidance Dec 2018 Shared IAPT/LTC Care Plan in contracts March 2019 London Digital Mental Wellbeing functionality live March 2019.	Quarterly IAPT/ LTC data reported through London Health Information Exchange 2019-20 Identifiable QIPP identified March 2020 Step improvement in Digital IAPT volumes and recovery rates March 2020	Identifiable realised QIPP March 2021 Quantifiable step improvement in Digital IAPT volumes and recovery rates March 2021 Expand IAPT access to 25% of the prevalent population by 2020-21
	The FYFV MH requires expansion in specific areas whilst the sustainability of MH acute care pathways is questioned. There are unrealised ROI and value opportunities in the extraordinary variation delivered by 'unaccountable' MH block contracts.	**MH value in Integrated Care Systems**	Develop the measures, analytical tools and collaborative approaches that will enable systems to extract maximum return (and outcomes) from mental health investment, and so support system sustainability and the expansion required by the FYFVMH. Actions to be delivered through the London collaborative MH Payment and Outcomes board chaired by a CCG MD and Trust CEO: • ANALYTICAL TOOL: Develop the London MH Benchmarking Dashboard to include investment in MH and algorithms that support analysis including opportunity identification at CCG, Trust and STP levels – March 2019 • MH PROM: Implementation DIALOG as the London MH PROM in secondary care as agreed by the CSG CEO, COOs and MDs – March 2020 • MH CROM: Implementation through agreement London analytical model for national MH CROM – HoNOS – March 2019 • SYSTEM VALUE MEASURES: Develop 'System Process Outcomes' for London and for these to be incorporated into the London as in Oxfordshire - March 2020. • MH COMMISSIONING PRINCIPLES: Work with CCGs STPs and Trusts to develop a new MH Commissioning Model/ Principles fit for the challenges of driving value in MH and bringing value through MH for ACOs/ STPs – March 2019 • ANALYSE SYSTEM COST OF MH: Produce and disseminate Tower Hamlets Vanguard linked mental and physical health data set analysis to support design of risk-shares against control totals alongside STPs - August 2019. • ACUTE CARE PATHWAY SUSTAINABILITY: Complete multi variant analysis and produce predictive modelling tool for acute MH pathway with support from the NHSE Operational Research & Evaluation Unit – March 2019 • MH PRODUCTIVITY AND VALUE: Work with NHSI and NHSE to coordinate all regional 'Value' activity across Model Hospital, GIRFT OOA and HLP work-streams – on-going.	• London is able to benchmark finance, activity outcomes by CCG, Trust and STP and so make informed local decisions in system redesign improvement and QIPP to drive out unwarranted variation in system performance and value. • STPs have improved data on MH's contribution to wider sustainability, that is enabled by a new commissioning model. .	CCGs and STPs identify and agree opportunities for improvement informed by benchmarking data – March 2019	• Tangible benefits of implementing new commissioning principles – March 2020 • STPs identify and agree opportunities from the TH linked MH and PH data sets and the acute care pathway predictive modeller – March 2020	• Plans for realising the opportunities identified by the TH linked MH and PH data sets and the acute care pathway predictive modeller are translated into QIPP, contracts and risk shares March 2021 • The variance in Clinical Outcomes reduces from March 2020 • Patients experience improved outcomes driven by the introduction and benchmarking of the London PROM – March 2021
	Section 136 has increased by 19% between 15/16 and 17/18. This creates significant pressure on A&E departments, LAS and mental health trusts, as well as our partners in local authorities and the police. 79% of s136 patients breach the four hour target when in the A&E and more than 35% of LAS conveyances face significant access issues for s136 patients. Due to variation, inconsistent and often inadequate care, London service users do not feel safe or supported when in a mental health crisis.	**Pan-London model of care for those in mental health crisis**	Reconfiguration of London's place of safety sites and mental health crisis pathway by the end of 2020. Actions: • The Health Based Place of Safety options appraisal, pan-London business case and system wide communications, engagement and sharing of learning with all partners will inform the reconfiguration of London's place of safety sites by the end of 2020. • Communications, engagement and system wide support t to plan and deliver new model of care in regards to London's future HBPoS provision - by Mar 2019 - Evaluate new model of care to inform London-wide implementation, begin evaluation of pan-London model of care in Mar 2018. • Implement pan-London HLP/HEE rotation staff programmes between MH and Acute Trusts - Scope of rotation programme agreed by HEE and Trusts – March/April 2018. Rotation programmes to begin June 2018. • Establish task and finish commissioning group with leads from each STP to identify and unblock current commissioning/payment issues with the s136 pathway, identify and deliver short term solutions (e.g. MOUs) and support with the redesign of commissioning structures to align to new model - Short term solutions agreed and implemented by Commissioning T&F group by June 2018. Group to identify and plan for longer term solutions to support model of care by Sept 2018. • Implement consistent KPIs across London HBPoS sites to help measure impact of the new pathway - KPIs agreed on by all stakeholders by May 2018 (as part of evaluation). First measurement against the new KPIs recorded by September 2018. • Pan London rollout of MH voluntary handover form at all Acute Trusts and with all London police forces - Pan-London rollout by March 2018.	• An estimated 20% reduction in s136 detainees presenting at A&E departments • Reduced delays throughout the pathway including improving the access to care, approximately 45% and 23% reduction in average police and ambulance conveyance times respectively and a 29% reduction in time spent at the HBPoS; • A reduction in 20% of admissions to mental health inpatient beds following a MHA assessment at a HBPoS • A 48% reduction in readmission rates of s136 patients • 96% of patients admitted to a place of safety within 30 minutes and a much enhanced patient experience during what is one of the worst possible life experiences. • 86% reduction in AWOL MH patients in A&E due to improved handover process between A&E staff and Police officers	• 86% reduction in AWOL MH patients in A&E due to improved handover process between A&E staff and Police officers	12% reduction in A&E attendances for those on a s136. 15% reduction in MH bed admissions following s136 detention. • 96% of patients admitted to a place of safety within 30 minutes and a much enhanced patient experience during what is one of the worst possible life experiences. • A 20% reduction in readmission rates of s136 patients • 15% reduction in ambulance conveyance times	20% reduction in A&E attendances for those on a s136. 20% reduction in MH bed admissions following s136 detention • 96% of patients admitted to a place of safety within 30 minutes and a much enhanced patient experience during what is one of the worst possible life experiences. • A 48% reduction in readmission rates of s136 patients • 23% reduction in ambulance conveyance times

MH - Thrive	Two million Londoners experience some form of poor mental health every year. Londoners' life satisfaction and feelings of self worth are lower than the national average. Mental health is both a cause and consequence of inequality, and certain communities are disproportionately at risk of poor mental health. 9 out of 10 people with mental health problems experience stigma and discrimination.	**Thrive LDN**	Thrive LDN is a citywide movement to improve the mental health and wellbeing of all Londoners. Thrive LDN is supported by the Mayor of London and led by the London Health Board. In July 2017, we launched Thrive LDN: towards happier, healthier lives, which summarised the work to date and future plans. In conjunction, we launched the Are we OK London? campaign to have an open conversation with Londoners about mental health and wellbeing. The activity plan outlined below was developed through extensive engagement with Londoners and stakeholders across the public, private and charitable sectors through the campaign. There are initial deliverables for 2017/18 that will be built upon in 2018/19. In addition, we are reviewing the overall programme delivery plan to establish where activity requires a central coordination function and where activity could be embedded within STPs. A city where individuals and communities take the lead: •Deliver Are we OK London? campaign and associated localised campaigns; Evaluate impact of the Are we OK London? campaign; Deliver citywide mental health cultural festival in partnership with the Mayor's Culture Team; Further develop and grow Thrive LDN Champions Network, Scale up of Problem Solving Booths, Establish Thrive LDN hubs in London boroughs (six initial pilot sites identified) in partnership with Time to Change; Establish Thrive LDN prevention pilots in London boroughs (three initial pilot sites identified) in partnership with Mental Health Foundation. A city free from mental health stigma and discrimination: • Deliver intersectional discrimination participatory research project and establish small grants scheme to address discrimination barriers affecting Londoners mental health and wellbeing; Deliver Time to Change partnership projects; Deliver MHFA England partnership projects; Deliver This is Me campaign (stigma and discrimination campaign targeting London employers and employees) in partnership with the Lord Mayor's Appeal and Barclays. A city that maximises the potential of children and young people: • Deliver faith and mental health report and establish small grants scheme for young people of faith; Deliver Young London Inspired programme (citywide volunteering and social action programme for young people at great risk of poor mental health) in partnership with Team London and v.inspired; Roll out free mental health awareness training in London schools in partnership with Time to Change; Deliver Youth Mental Health First Aid programme in partnership with Mental Health First Aid England; Deliver Academic Resilience programme in London schools in partnership with Young Minds; Develop and deliver Storytelling and mental health project to educate pre-school aged children and parents about mental health and wellbeing in partnership with Discover. A city with a happy, healthy and productive workforce: • Develop Individual Placement and Support Framework for London. A city with services that are there when and where needed: • Delivered through alignment with Good Thinking, London's Mental Health Incident Response Pathway, Health Inequality Strategy and Prevention Programme.	The majority of projects have built in evaluation frameworks; however, the overall programme impact evaluation framework is still being developed. Appropriate indicators will be developed to evaluate impact across the following outcomes: • Improved mental health and wellbeing of Londoners, including children and young people; • Reduced inequalities and disproportionality that can cause poor mental health; • Decreased mental health stigma and discrimination; • Improved mental health literacy of Londoners, including children and young people; • Increase the number of people with mental health problems in employment; • Increase access to mental health services and support; • Reduce the number of suicides in London	Independent impact evaluation from the Are we OK London? campaign published Apr 18. Mental health cultural festival options appraisal published Apr 18. Initial findings from the faith and mental health and intersectional discrimination projects published Apr 18.	Initial impact evaluations from Thrive LDN hubs and prevention pilots, Intersectional discrimination small grants scheme, This is Me campaign, Young London Inspired programme, Schools and mental health, Storytelling and mental health published Apr 19.	MH Taskforce - 10% reduction in suicides by 2021 Doubling numbers in IPS treatment by 2021.
MH - Good Thinking	75% of people with anxiety, depression and other diagnosable common mental health conditions receive no help from formal NHS services.	**Good Thinking**	High Level Delivery Plan - The main areas of delivery fall into two broad categories: a) Service provision/operations includes data analytics, digital marketing, website maintenance and development, customer support, procurement & contracting, quality & performance management, provider management b) Strategic development programme including sustainability, commissioning and development new products, partnerships/joint ventures, integrated service design (e.gs. LTCs, Primary Care, Urgent) for London into (a) operational service provision. **Key Operational and Development Milestones:** 1st April 2018 Good Thinking/Primary Care Demonstration Project designed/planned with reporting schedule 1st May 2018 Strategic Development and Commissioning Programme Plan signed off in line with strategic priorities for service expansion to be operationalised during 2018/19 31st May 2018 Lead Digital Service Provider Teams commissioned with contracts in place for period 2018 - 20 30th June 2018 Digital interventions suite for depression, anxiety, sleep and stress commissioned with contracts in place 2018-20 30th June 2018 Q1 Service Quality & Performance Report 31st July 2018 P2P Community Platform and Moderation Team commissioned with contracts in place for period 2018-20 31st Sept. 2018 Q2: Service Quality & Performance Report 31st Oct. 2018 Good Thinking/Primary Care Demonstration Project Interim Evaluation Report (indicative milestone subject to project design, scope and planning Jan-March 18) 30th Nov. 2018 Long Term Modelling, Sustainable Funding Options, Business Case delivered 31st Dec. 2018 Q3: Service Quality & Performance Report 31st March 2019 Q4: Service Quality & Performance Report	• An additional beta test went live on the 01 November 2017 and aims to have 50,000 Londoners use the service 31st March 2018 • An exemplar innovative prevention and early intervention digital service at scale, which aims to prevent thousands of Londoners from developing common mental health problems, helping them to enjoy good mental health and thus reducing the burden on services.	200,000 Londoners use the service by 31st March 2019	500,000 Londoners use the service by 31st March 2020	1,000,000 Londoners use the service by 31st March 2021
Homeless Health	Health outcomes and access to services are significantly poorer for people who are homeless..	**Commissioning and payments capability for homeless health services**	• Amend, consult and reissue homeless health commissioning guidance in the light of London Accountable Care system planning and also regulatory changes such as the NHS charging regulations - by September 2018 • Engage with CCGs and STPs to support their responses to local homelessness need with a particular focus on CCGs with the highest number of people sleeping rough. Publish case studies to share learning – throughout 2018 • Develop options for CCGs on enhanced payments for homeless health services in mainstream general practice, publish and engage CCGs on benefits of each option for local delivery - By September 2018.	People who are homeless access primary and community services and reduce their use of urgent and emergency care services.			
		Hospital discharge protocols	• Convening GLA and the NHS to deliver a joint political statement regarding homeless health discharging (based on Manchester model – by November 2018. • To support the launch of political statement develop and publish business case that will show direct and wider system benefit for people who are homeless as well as for ACSs if new protocols are adopted – by September 2018.	Improved morbidity and mortality, improved life chances and reduced hospital re-admission for people who are homeless in London.			
		Explore options for pan-London commissioning of some homeless health services	• Working with CCGs and local authorities to understand the benefits of pan-London commissioning and identifying pan-London opportunities for commissioning homeless health services - By September 2018. • Agreement amongst stakeholders on local vs pan-London homeless health commissioning, develop implementation plan based on London commissioning activity that is proposed - By September 2018.	Improved morbidity and mortality, improved life chances and reduced hospital re-admission for people who are homeless in London.			
		Homelessness Reduction Act	• Develop an agreed work plan to support London health organisations meet statutory responsibilities under the Homelessness Reduction Act – Respond by October 2018.	NHS in London will be compliant with new statutory duties and people who are homeless or at risk of homelessness will be referred for housing advice mitigating the impacts of homelessness.			

		Supporting London's Clinical Leadership forums to understand the issues the needs of people who are homeless	• Engaging key clinical leaders to secure one agenda item a year on homeless health at the Clinical Senate - Clinical Senate item agreed by April 2018.	Improved focus in health planning and service delivery on the health needs of people who are homeless. Increased capability within the NHS to identify and respond to the needs of people who are homeless			

CYP Mental Health	Access to mental health crisis (MH), out of hours and liaison psychiatry services for CYP is variable. None of the HLP CYP MH guidance recommendations are consistently achieved across London and there is inconsistency in achieving national access and waiting standards for CYP with eating disorders. MH treatment pathways will be published by NHSE Jan 2018, need to benchmark services against these.	**CYP Mental Health**	*Crisis care:* • Complete and publish report peer review of crisis care services - by June 18 • Support development of STP level action plans to meet crisis care recommendations/standards. Sept 2018 • Work in collaboration with HLP UEC programme to ensure alignment of initiatives - Safety and coping plan finalised April 2018 and e-version live March 19. Access to mental health help: • Self-assessment against NHSE MH Treatment Pathway recommendations – April 18 • Gap analysis/action plan development to meet NHSE MH Treatment Pathway recommendations – July 18 • Publication of mental health models compendium supporting efficient pathways – Dec 18 *Autism:* • Increased awareness of autism and how to manage CYP with autism for healthcare professionals June 18 • Sharing of best practice across London – through compendium July 18 and event - Sept 18 • Support the creation of autism strategy networks as outlined in the NICE guidance Sept 2018 – Aug 2019 *Speeding up transformation:* • Schools campaign to reduce mental health stigma, bullying and improve self-esteem/counselling awareness - Sept 18 • Supporting STPs with action plans to align forensic CAMHS and local pathways - April 18 and onward *LTP refresh support:* • Publication of LTP refresh resources and facilitation of shared learning across CCGs and providers - Oct 18 *Eating Disorders:* • Eating disorder campaign to raise awareness across health professionals and schools to increase referrals - May 18 *Data and Information:* • Comprehensive set of metrics within London MH Dashboard - by March 19. • Increase in quality/completeness of data flowing via MHSDS. Sept 2018 *CAMHS in Schools Project:* • Development of Menatl Health Toolkit for Local Health & Wellbeing Boards to enable input into CAMHS Transformation Plans for action relating to menatl health in schools - by October 2018.	LTP refresh support - 100% of CCGs have a refreshed LTP every year to 2020/21 which completes NHSE assurance Access to MH help – 35% of those with a diagnosable mental health condition access evidence based treatments Eating Disorders guidance/campaign - 95% of CYP in need receive treatment within 1 week (urgent cases) and 4 weeks (routine cases) Increased use of community based eating disorder services and reduced use of specialist in-patients beds Workforce Approximately 500 additional staff trained by 2020/21 (3,400 national target) leading to better trained workforce and accessible information about available training. Crisis care – 10% of CYP with a mental health condition will have digital access to their safety and coping plan (SCP) by March 2019 leading to 10% reduction in frequent CYP MH attenders to A&E. CYP with ASD being treated in line with NICE guidance with access to the best services for their individual need. Data and information - better access to reliable and consistent data. Ability to benchmark services across CCGs and providers.	100% CCGs have a refreshed LTP assured by NHSE. 10% of CYP with a mental health condition have digital access to their SCP. 100 additional staff trained. 15% access to evidence based treatment pathways of those with a diagnosable mental health condition 95% of CYP in need receive treatment for ED within 1 week (urgent) and 4 weeks (routine)	100% CCGs have a refreshed LTP assured by NHSE. 30% of CYP with a mental health condition have digital access to their SCP. 250 additional staff trained. 20% access to evidence based treatment pathways of those with a diagnosable mental health condition Increased use of community based eating disorder service reduced use of specialist inpatient beds for CYP with ED	25000 CYP with MH condition have access to digital SCP and 10% reduction in frequent CYP attenders to A&E. 500 additional staff trained. 35% access to evidence based treatment pathways of those with a diagnosable mental health condition

HLP 2018/19 Proposed Projects

				System impact (Z)	Impact timeframes		
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London Partnership Programme	London's health and care estate needs significant repair and investment to support new models of care. The large number of organisations involved in planning and decision-making has made it challenging to set a clear vision for health and care estate in London. It is often difficult for leaders at local, multi-borough or London level to have a clear view of the money available to invest in health and care estate, the total investment required or how the estate plans support the health and care service in a given area.	**London Estates**	**Establishing the London Estates Delivery Unit (LEDU):** to bring together the collective technical and professional expertise of constituent organisations across London	Consolidate and align regional and regionally based national resource to better support local estates planning and delivery efforts.	STPs have joined up support from national and London partners that meets their needs		
			Delivering the London Estates Board (LEB) • Provide a single forum for discussions regarding NHS estates, and a forum for wider discussions around the public estate. • Gain clarity from national partners on London's total capital availability and expectations for release. • Engage with local and sub-regional groups within London to ensure the LEB adds value and is complementary to local priorities and emerging governance arrangements. • Engage with London and national partners to ensure that the LEB adds value and is complementary to the wider London system and national priorities. • Engage with DH, NHS Improvement8 and NHS England on wider devolved and delegated powers, including business case approvals, capital allocations and the application of capital receipts generated within the London system. • Provide strategic oversight of London activity to enhance utilisation, taking on HLP estates accountabilities	Overcome challenges of fragmentation and ensure that there is greater clarity on the status of individual business cases and an agreed pipeline of locally-owned health and care estate schemes that London and national partners can help to progress.	Progression to phase 3 (shadow decision making) with clear capital plan by June 2018. Commence business case approvals in FY18/19 (i.e. streamlined business case approvals process through LEB, reducing the time taken for national decision-making); through LEDU; Schemes start to be delivered earlier due to early local government (planning), GLA and regulator engagement and involvement.	Capital receipt retention increases potential capital availability; Londoners statr to see fit for purpose health and care facillities, especially primary and community care hubs.	
			Developing a capital plan for London: • To support development of STP estates strategies • To aggregate the local and STP estates plans into a clear capital plan for London	Provides a robust capital pipeline and clarity on capital availability and expectations. By realising wider public sector estates opportunities in partnership with local government, new health facilities could be co-located with other public sector facilities. This will mean a fit-for-purpose primary and community care infrastructure, through redeveloping existing health, care and wider public land and buildings.	Support the Development of STP Estates Strategies Development of London Capital Plan. STPs have clarity of capital pipeline (requirements, expectations and release), to enable them to clearly plan and phase scheme delivery.		
	In London, much of the integration work has been developed organically at borough or multi-borough levels. As would be expected, support needs and ambitions vary across the city. Through the devolution programme, we heard that developing partnerships within London would value more support to help them achieve their integration aims. There is a need for a flexible and permissive resource -this must helpfully address issues 'once for London' and enable better sharing of learning, but also provide more tailored support dependant on local needs. Delivery of the devolution commitments will also need to be included within the integration programme.	**Integration**	**Support will focus on key enablers to integration, established via a process of engagement with STPs and developing smaller partnerships. This will include:** •Enabling better spreading and sharing of regional and national learning, and supporting with the evidence base for different initiatives; •Enabling developing partnerships across London to collectively explore and solve common challenges; •Providing support to access and navigate the support/knowledge/expertise available within the system; •Enabling congruence across different spatial levels, and across the city (particularly re: boundary issues of providers); •Supporting development of Accountable Care Systems [Structured regional support to be developed via the STP leads]; **Delivery of the devolution commitments** •Delegation of primary care to CCGs and exploring further devolution (NHSE London region leading); •Exploring internal delegations of specialised commissioning (NHSE London region leading); •Exploring changes to immunisation and screening commissioning and delivery arrangements (NHSE London region leading); •Supporting local and sub-regional areas in London to co-develop and adopt innovative models of payment; •Enabling pan-London discussions with regulators and co-developing model of regulation for London; •Considering what further steps could be taken to support more personalised, joined up care at all spatial levels (developing the evidence based and advocating for any further policy/legislative change); and •Supporting delegation of over £100m transformation funding.	By providing support to developing partnerships we aim to: •Make better use of resources within the system and reduce spend on external agencies; •Learn from each other to ensure robust, workable plans; and •Accelerate delivery of local/STP integration plans. By achieving delivery of devolution commitments we aim to enable local systems to more move further and faster with integration ambitions; most notably by: •Enabling more local and integrated commissioning, where this is desired by the local system and beneficial for Londoners. This could help facilitate the development of new delivery arrangements and the rapid integration of services; also enabling commissioners to better respond to local needs. •Ensuring that the model of regulation supports integrated working, does not create a barrier to ambitious plans and helps solve issues which cross multiple organisations; and •Supporting the development of new payment models which incentivise the most appropriate care for patients.	Expect a time-limited programme of work - 1 year only. Once strategic coherence and national interface is clear, ongoing delivery transitions to STPs.		
	There are some health and care workforce challenges and opportunities that will affect all of London. Addressing these solely through a sub-regional or local approach risks duplication, and misses the opportunity for a more consistent and collaborative approach. As new models of care are established, the workforce needs are changing, particualrly for roles that cross health and social care	**Workforce**	The London Workforce Board that will ensure a workforce that supports health and care integration and examines workforce challenges and opportunities that can be met through a collaborative approach. The London Workforce Board will: - Further develop its strategic leadership role, continue to build and develop communication, relationships and collaboration across health and social care partners. - Consider the impact of the apprenticeship levy on the health and social care workforce, learn from employers and networks that are working in partnership to identify opportunities to maximise the apprenticeship benefit. - Explore the potential impact of Brexit on the health and social care workforce across the Capital to support discussions with Partners and inform workforce planning. - Establish a London wide view of the current health and social care workforce in London.	Health and care providers are able to spread the apprenticeship levy across organisations to maximise the use of the levy and to augment wider health and care training and development opportunities; London is in a position to powerfully advocate to mitigate impacts of Brexit on London's health and care workforce, using the political support of the London Health Board; as STPs roll out new models of care, organisations who require roles that cross health and care are supported to negotiate effectively with national bodies to ensure that co-location, joint roles and other practical arrangements are facilitated where required			

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Primary Care	General practice is reporting increased workload and workforce demands and to reach the national average for practice nursing, London requires an increase in 750 WTE nurses. London's GP target is 964 additional doctors by 2020.	**Workforce**	Support the system to expand and develop the current primary care workforce, and develop viable solutions to workload issues through provision of central expertise and London-wide workforce planning. Actions: • In partnership with HEE and STPs, identify workforce issues for London, plan the future workforce, understand attrition rates and retain current and new entries into primary care by developing and implementing retention strategies. • Further development of the National GP supply and demand tool to include localised assumptions for London, giving an indication of the current and future GP workforce across London in terms of demand and capacity. This will enable tracking of progress towards London's target of 964 extra doctors by 2020 both across London and at STP level. • Provision of new workforce modelling tools to allow planning for skill mix and track progress across multiple primary care professions • Supporting STPs to develop bids to increase recruitment and develop a future workforce that is able to deliver the current and future at scale services, including the development of pan-London bids where appropriate for example with International Recruitment. • Provide guidance to STPs to support localised workforce planning, by using our unique pan-London position to share expertise and learning from other footprints, for example with strategies to map GP vacancies. • Supporting initiatives to deliver London's target of 964 new GPs by 2020. Through; • Recruitment of 352 new international GPs via the national recruitment programme - Decision on international GP funding by Dec 2017. • Designing and implementing a workforce dashboard to monitor progress by STP against a local STP target - Dashboard will be running in December 2017. • Task and finish group established to recruit and retain newly qualified GPs (post CCT) - Task and finish group outputs by February 2018 • Development of a pan-London retention strategy, building on STP-level plans for recruitment – Strategy developed by March 2018 • Supporting CCGs and federations to deliver 252 new Clinical Pharmacists working in general practice. This will include support to secure funding and guidance on implementation across our STPs. Waves 1-3 already underway. Wave 4 expected early 2018. • Supporting, recruiting and retaining General Practice Nurses, in line with the recently published 10 Point Plan for General Practice Nursing. Early milestones by December 2017.	• Additional 84 clinical pharmacists working in general practice annually, 252 additional in place by April 2020 • 352 new GPs recruited internationally • Improved care for patients with utilisation of a wider and more appropriate workforce including physician associates	Trajectories per STP TBC		Recruitment of 964 GPs Recruitment of 352 international GPs Delivery of 252 Clinical Pharmacists in General Practice
	IT systems are not always integrated and do not support patient access and self-care. In 2016 only 13% of appointments were available for patients to book online. Improvements in basic practice infrastructure across London are required, which are not appropriate to address through the STP prioritised ETTF programme for London, the latter of which is significantly over subscribed with only 66 estates and technology schemes able to be supported out of 250 schemes on London's ETTF Pipeline. 369 separate applications for funding were made to the London Improvement Grant Programme in 2015/16, and a further 263 applications were received for funding in 201718.	**Digital and Infrastructure**	Supporting roll out of 111 direct booking and NHS Online pilots. Actions: • Working with the 111 team to understand the challenges with direct booking and system providers. Starting to deploy direct booking in South East London – by December 2017 for SEL NHS Online pilot, plans in place for other areas as per wider delivery plan. • HLP infrastructure and access lead is helping to support and guide 111 team, in order to better understand the challenges within primary care and offer a more informed solution. • Online consultations: plans assured by December 2017, delivery is a 3 year programme of work to complete by March 2020. London held an assurance panel for the regional online consultation plans in December where all CCGs except one were formally assured meaning allocated monies can be released. HLP are working with the one remaining CCG to get their plan assured before Christmas 2017. • Developing a digital specification for London to enable online consultations and supporting the development of NHS Approved Apps and Wearable's Library. • Publishing an e-toolkit to support practices implement online consultations • Supporting STPs to submit plans for online consultation and assuring these plans ETTF: • Maintain the successful London's Improvement Grant Programme, by continuing to prioritise funding from the region's capital programme in 2018/19 and 2019/20, to enable infrastructure improvements across London's general practice premises, in line with CCG Local Estates Strategies, and prioritised by London's 5 STPs.	• The ETTF Patient Online project (3 months) increased offering to 1 million appointments every month for patients to book online, this is predicted to result in non-cash releasing savings of £25 million each year • Monitoring of new and improved premises through ETTF will ensure suitable digital infrastructure to support the delivery of care. • Improved awareness and use of online booking, access to health records and use of digital for self-care and other elements such as repeat prescriptions. • A continued stepped change increase in fit for purpose premises, building on the delivery of 195 schemes out of 363 practice bids in 2015/16; and the on-going delivery of 215 schemes out of 263 applications in 2016/17. There are 93 schemes waiting to be funded and delivered on 2018/19 programme. • The ETTF PMO is linked to the TPC team to ensure alignment and measure impacts of schemes on patient care.	All STPs to have NHS 111 Online by March 2019 Online Consultation funds for year 2 allocated and spent to support CCG rollout Delivery of 93 schemes on the London IG Pipeline	Capital funding ring fenced to support the delivery of further schemes eligible for Improvement grants, subject to outcome of bidding process.	

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Proactive Care	Each of the 5 STPs in London have included Social Prescribing in their plans, however current provision across London is patchy and inequitable.	**Social Prescribing**	***Consistent, universal social prescribing provision across all of the boroughs. Actions:*** • Develop a social prescribing strategy for London, bringing together key delivery partners including GLA, London Councils, commissioners and the voluntary sector. Addressing key strategic pan-London issues including; sustainable funding models, digital technology as a support mechanism, supporting the voluntary sector and developing the social prescribing model. - Support CCGs and STPs translate strategy into actions to support the delivery of social prescribing at the CCG and STP footprint, actively working with partners to influence pan-London delivery ensuring this creates consistent approaches that allow for local delivery. • Management of pan-London sustainable Social Investment fund in partnership with GLA to expand, spread and scale social prescribing provision - At least 4 organisations signed up to invest resource and time for pan-London SP fund by May 2018. • Brokering relationships with partners including private sector to develop sustainable delivery of social prescribing. • Supporting robust evaluation of social prescribing provision across London and brokering connections with academic partners to evaluate new schemes. • Further developing the social prescribing Wikipedia to provide mapping of social prescribing across London, shared resources to local partners and on-line forum for supporting deliver. ***Pan-London digital proactive incentivised healthy activities tool.*** ***Actions:*** • Undertake an analysis of the current provider market and funding models including models being offered in international markets. • Work with partners including the GLA to develop funding model and delivery plan for London.	• There is a growing body of evidence that social prescribing reduces pressure on the NHS, with people going to A&E and their GP less, as they get connected to peer support. • Evaluations of different schemes across the country have found an average reduction in GP consultations (28%) and A&E attendance (24%). There is also emergent data that social prescribing can reduce demand for social care, and can help people to gain meaningful employment or as well as reducing medication. The impact for London is dependent on there being consistent, universal social prescribing provision across all of the boroughs. • Tools being used internationally have seen 3% take up rates in broad populations with 80% undertaking increased physical activity over 12 months and less than 27% attrition rates.	On average 28% reduction in demand for GP services and 24% fall in A&E attendance for those referred to social prescribing services.	On average 28% reduction in demand for GP services and 24% fall in A&E attendance for targeted groups.	On average 28% reduction in demand for GP services and 24% fall in A&E attendance across in areas with a full social prescribing service.
	The opportunity presented by the national Fire as a Health Asset agenda to deliver a range of preventive interventions and reduce health inequalities requires health and care system support to maximise the value achieved.	**Working in partnership with the London Fire Brigade**	Implement the national Fire as a Health Asset agenda across London. HLP are providing the health embeded resource (1x8a) to support LFB delivery a programme of work that adds value to health system. Actions: • Supporting LFB in the implementation of 5 pilots across London - fully operational by March 2019. Ten LFB assessors deliver Fire Safe and Well visits to vulnerable individuals identified by health and social care, vists include assessing risks regarding; falls, winter warmth, social isolation and specific health interventions identified by local boroughs. • Evaluation of pilots and sharing of learning across London by June 2019. • Developing proposals about how to expand Fire Safe and Well across London to provide support to health in partnership with London Fire Brigade. • Supporting LFB to scope and plan the delivery of the national Fire as Health Asset programme in London through new partnership working with NHS providers e.g. use of fire stations as community health hubs, during 2018/19 for delivery in 2019/2020. • Assist the development of the blue light collaboration with LFB, the Met, London Ambulance Service, NHS England and develop work plan to support health and fire prevention initiatives and reduce health inequalities by 2018/19.	• Evaluation of comparable projects delivered by health and fire services in Greater Manchester as part of the Fire as a Health Asset initiative have indicated annual savings to the NHS of £635,320 with savings of £2.52 per £1 invested across health, social care and the fire service achieved. The London Fire Safe and Well programme will be evaluated in June 2019 taking learnings from other programme evaluations.	£2.52 saved per £1 invested across Health, Social Care and LFB	£2.52 saved per £1 invested across Health, Social Care and LFB	£2.52 saved per £1 invested across Health, Social Care and LFB

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				System impact (Z)	Impact timeframes		
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Prevention	Rising health needs and the fiscal challenges facing NHS and local government mean that investment in prevention has been declining at a time of rising social need. It is estimated that 20% of GP activity is for a social not a health need. London CCGs have struggled to maintain a stable investment in the VCSE sector. Foundations are increasingly looking towards social investment as a tool to help them achieve their social mission – providing different forms of repayable finance to social enterprises to enable them to tackle gaps in health services, poverty and disadvantage, strengthen communities. London is a low net user of social investment comparative to the North of England.	**Enabling Prevention in a sustainable way: Establishing a Health and Wellbeing Fund for London**	The prevention board explored the feasibility of using a social investment fund to provide an alternative funding source to drive positive community impact and to tackle London's health challenges in an innovative way. It was agreed that we would seek to establish a London Health and Wellbeing Fund to enable local action and leverage the city-wide relationships with business and charities. Funds of this nature take 2 years to be fully established – 17/18 was yr1. Continue work to establish a London Health and Wellbeing Fund • In year 2 we will be moving from fund design to fundraising and establishment (using products developed in year one to increase engagement with London Funders, charities and private sector investors) (March-December 2018) • Invitation process agreed for applications to the fund (September 2018) • Launch the fund and deliver webinars for interested applicants to the fund (January 2019)	Grow the number of funder from 3 to 10 – funds accessible for local initiatives by 2019. Our aim is to achieve a significant increase in prevention activity in London as a result of increased social investment tailored to population health priorities. Initially the fund will be used to create alternative services for the 20% of GP activity that is for a social not health need and to reduce the prevalence of hypertension and support a reduction in childhood obesity, through local social innovation.	Establishing the fund Confirm 19/20 areas of focus/impact	Fund operational (10m) Investment in local initiatives	Fund Growth Projection (30m) Evaluation of impact Yr 19/20 (e.g. how many new jobs created, increase in access to healthy food for how many Londoners, economic impact)
	The London Prevention Partnership Board remit has increased beyond the 5YFV to now including the Mayor of London's Health Inequalities Strategy and devolution. Moving from 3 HLP projects to 8 multi-partnership workstreams and 40 projects. In 18/19 the programme will need additional PMO and communications capacity to carry this function and keep all the wider partners activities visible to local borough's- acting as the joint bridge between regional and local partnerships for both health and care. HLP is the delivery unit for this partnership and all partners have contributed to the programme as a whole. This will enable HLP to dovetail London-wide prevention activity into STP reporting and plans	**Integrated planning and delivery**	Partners are seeking CCGs support to host a delivery and coordination function through HLP. This would include hosting 2-5 collaborative events to galvanise wider London partnerships and connect up local delivery for impact.	• Local delivery priorities and partner work streams enabled • Measuring the impact of prevention activity across London	• Integrated delivery function established • Shared online knoweldge hub and single reporting processes to joint board • Programme oversight grows from 3-40 projects crosses organisation boundaries (GLA/PHE/London Councils/HLP) •Integrated communications to all partners • HIS and devolution delivery commences •Improvement and evaluation partnerships stood up •Deep dive events and oversight completed for yr 1	Ongoing delivery support function - requirement reviewed annually against priorities and any changes to corporate structure	Ongoing delivery support function - requirement reviewed annually against priorities and any changes to corporate structure
	Nearly half of all people living with HIV live in London. Fifty-seven per cent of new HIV diagnoses are in London. One in 12 men who have sex with men (MSM) in London have HIV, with one in five undiagnosed. The black African population is more likely to be diagnosed late (56%) compared to the white population (27%). Our ambition is Getting to zero – Zero Stigma, Zero discrimination, Zero deaths by 2030 and the Mayor of London, NHS England, London Councils and Public Health England have signed the Paris Declaration on Fast Track Cities working together to eradicate HIV and establish support for people living with HIV	**Getting to Zero - HIV Fast Track Cities**	In 2018/19 we will be establishing the HIV programme, including stakeholder engagement, starting with a gap analysis and developing a plan of action for delivery in 19/20.	Preventing infection can save an estimated £360,000 a patient, which is the lifetime cost of treating someone with HIV for which there are an estimated 4000 new diagnoses per annum.	Develop strategic plan of action, which will identify impact targets for 19/20 and 20/21	Delivery against the agreed plan in 18/19	Delivery against the agreed plan in 18/19
	Following the signing of the devolution MoU, there are a number of prevention commitments that partners will need to work on collectively in order to ensure delivery.	**Devolution prevention commitments**	a) Explore how a borough-led London-wide illegal tobacco and counterfeit alcohol enforcement team could be established Explore how to make the best use of existing sanctions and consider new sanctions to tackle illegal tobacco b) London partners will support the development of guidance on how best to spend the allocated revenue from the soft drinks industry levy schools will receive, with the aim that by synergy with wider local public health strategies, good value can be achieved for young Londoners Explore options to further restrict the advertising and marketing of unhealthy food and drink in specific locations based on health harm c) London partners will explore the interaction between planning policy and London's health and wellbeing objectives with DCLG London to explore the opportunities that a) new or enhanced fiscal levers could bring to improve the health and wellbeing of Londoners & b) work to optimise on opportunities to reinvest money raised through fiscal levers in health promoting opportunities. d) Work closely with DCMS as they undertake their review of gaming machines and social responsibility measures. e) To transfer Work & Health Programme funding to assist the very long-term unemployed and those with health conditions and disabilities to (re-)enter work. The work will be led by London councils London and national partners (NHS and DWP) commit to exploring options to overcoming barriers to share data in order to facilitate a robust evaluation of the impact of enhanced local support for people experiencing mental health problems and who are at risk of falling out of work In partnership with the joint Work and Health Unit, DH and DWP commit to working with London partners	a) Reduced health harms caused by smoking illegal tobacco Less illegal tobacco sold in London & reduction in crime Additional tax raised through seizure of illegal tobacco accrued by central government b) Increasing physical activity in schools Reduction in childhood obesity ROI from reduction in non-communicable diseases c) Increased regional use of planning policy for health gain Reduction in fast food opening around schools Reduction in childhood obesity ROI from reduction in non-communicable diseases Increase in the fiscal incentives to leverage healthy environments Increased investment in preventative interventions More proven interventions to reach scale across London Improved health and wellbeing of Londoners d) Reduces risk of bankruptcy and poverty Improves health and wellbeing Prevents mental ill health Prevents health harms e) Increase number of people living with mental illness or learning difficulties who are maintaining employment Reduce future risk of ill health and increase individual economic prosperity Economic benefit to wider society and reduction in reliance on	Year 1 = Establish the delivery groups and complete any initial gap analysis requirements, firm up delivery plans. Establish a research and evaluation framework. Conduct engagement events and implement phase 1 - sugar tax, marketing & advertising, food exclusion, fiscal levers, illegal tobacco. Scope phase 2 - counterfeit alcohol, gambling, work & health to include an evidence review to inform action.	Delivery of phase 2 and evaluation of phase 1 with continued iteration & delivery requirements in year 2	Evaluation of phase 1 & 2 and evaluation of phase 1 with continued iteration & delivery requirements in year 3

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CYP	Over 220,000 CYP have asthma in London with higher than average mortality and morbidity than with comparator cities and countries. There is variation in diagnosis and management of asthma, high numbers of emergency admissions to hospital (4,000) including 172 to intensive care and 12 deaths annually. Current annual costs for these are over £4,600,000.	**Asthma**	Enable a whole–system approach to improving care for CYP with asthma Actions • Roll out peer reviews for asthma services across London – March 18 onwards • Provide education sessions on asthma for primary care federations - throughout 2018 • Support rollout of asthma networks to ensure consistency of treatment using CQUIN • Evaluate asthma friendly schools project and disseminate findings - May 18 • Support new roles for pharmacists in asthma care (linked to primary care project) • Repeat #AskAboutAsthma campaign Sept 2018 • Implementation of annual review templates for SystmOne, Vision and EMIS – templates signed off by April 2018 • Validation of the prevalence finder and roll out May 2018 • Support implementation of the air pollution reduction toolkit for NHS organisations. April 2018 – Mar 2019	• AskAboutAsthma – 80% CYP with asthma have asthma management plan, inhaler technique support and annual review by 2021 leading to 50% reduction in emergency admissions and PICU admissions for asthma by 2021. • Improved identification and diagnosis (should be 10% of CYP) of affected CYP in primary care using prevalence finder /EMIS Systm one templates leading to consistent identification and more effective management • 75% young people with asthma aged 13 – 18 have digital health passport. Monitoring of quality of life impacts	10% reduction in emergency admissions for asthma 10% Reduced days lost from school	30% reduction in emergency admissions for asthma 15% Reduced days lost from school Increased prevalence rate of 10% of children in London identified as having asthma – accessing treatment	50% reduction in emergency admissions for asthma by 2021 20% Reduced days lost from school
	CYP make up 40% of GP workload - only 40% of GPs have had formal training in paediatrics and child health. GP federation level working is developing at pace there is a risk that the needs of CYP will not be addressed within these models	**Primary Care**	Equip primary care with the skill and confidence to include CYP in evolving models of primary care. Actions: Development of multi-professional community provision for CYP: • Complete evaluation and modify GP toolkit as required and roll out April 2018 • Develop specifications for primary care a scale models for CYP July 2018. • Support implementation through input to GP federations and sharing best practice. Mar 2018 • Develop models of practice and community pharmacists' role in supporting care for CYP. Sept 2018 Increasing competencies in the care of CYP amongst practice staff: • Scope out potential areas for development – Aug 18 • Training programme designed and training delivered in pilot sites – March 2019 Raise awareness amongst GPs of emergency available from secondary care paediatric services: • Raise awareness of rapid access clinics and GP advice lines April 2018	• New models of care for primary care at scale including provision for CYP, allowing better access to effective care closer to home contributing to reduction in ED attendances • Development of pharmacists to support the care of CYP in the community, reducing workload of GPs.	10% of GP federated models start to implement CYP at scale models GP toolkit in place, resources downloaded and used in every STP. 10% CYP with asthma offered an inhaler technique review by a pharmacist.	30% of GP federated models start to implement CYP at scale models 30% CYP with asthma offered an inhaler technique review by a pharmacist.	75% of GP federated models start to implement CYP at scale models 75% CYP with asthma offered an inhaler technique review by a pharmacist.

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IUC	Clinicians in London NHS 111 / IUC / GPOOH services currently do not have access to all relevant clinical data for callers or a real-time and up-to-date version of NHS Pathways DoS which prevents the delivery of a 'Consult & Complete' model of care. There will also be interoperability for the patient calling 111 between all IUC services, including GP Practices, GP Federation Hubs, UTCs and NHS 111 Online.	**Digital Integrated Urgent Care**	**Patient Relationship Manager (PRM):** By 2019, with continuous iterative development and improvement across 2018/19 • Extending the reach of the London's PRM to integrate with local STP portals and exchanges which capture care / crisis data, primary care, End of Life and Mental Health data to share with clinicians across the U&EC system (a core IUC / 5YFV requirement). • STPs will have full use of cutting edge telephony and data to inform commissioning decisions and assist with surge management. **Patient Relationship Manager (PRM) Migration:** HLP's role within this is project managing through AGILE. We have an existing relationship with colleagues at Redwood technologies that we are co-ordinating deliverables with on a daily basis. HLP remain the product owners in the PRM migration work and will be working with teams to produce the following: • Migrating the PRM capability to the London Health & Care Information Exchange to be BAU – by April 2019 migration –HLP's role here is to act as the enabling fixture between digital colleagues (Internal and external) and commissioning teams to ensure migration can take place technically and at an agreed timescale with STP colleagues signing off delivery. • Develop a business case, procurement strategy and complete contract mobilisation for remaining components of the PRM. Embed and mobilise the selected digital cloud based solution March – July 2018 (approximate dates) along with continuous iterative agile improvement • Enhancing the data quality of records using clinical standards **Delivering Digital 5YFV requirements and enabling IUC mobilisation:** • Implementation of NHS 111 Online and supporting STPs to procure and mobilise strategic NHS 111 online solutions by March 2019 including: - o NHS 111 appointment booking into primary care services, UTCs and 999 by March 2018 and a clear plan for delivery articulated by December 2017 o Greater access to patient clinical records (primary care, mental health, EoL and 999) into Urgent & Emergency Care venues o Implementing e-Prescribing with NHS 111 services by March 2018 • Using SEL and NCL learning for future digital procurements • Supporting technical requirements within 999 and IUC through national technical requests. Working directly across colleagues at LAS and wider commissioners as well as with provider IT, Operational and medical directors **Directory of Service (MiDos) – On-going** • HLP co-ordinating and monitoring a programme of DoS maintenance and improvement work by London DoS teams. This includes out-of-hours support for minor and major incident response. This will also allow for the identification, review and standardisation of key pathways to 999 to stop referral to 999.	• Reducing ED admission, ambulance conveyance and inappropriate primary care visits o Service evaluation has shown that Special Patient Notes: ▯ Reduce the urgency of management for the most vulnerable patients, reducing ambulance conveyance and admissions to A&E by more than 50% ▯ Lower primary care visits, callers over the age of 85 with a special patient note (SPN)/ crisis or end of life plan, were 5 times more likely to have their call closed within 111 and 5 times less likely to have a referral to an Ambulance Dispatch than comparable callers without an SPN. • Access to 'real-time' service information in a consistent way to increase clinical effectiveness and reduce inappropriate demand on 999/ED by supporting 'right care, first time'. • Pilot learning and requirements feed wider London digital infrastructure to reduce risk of failure, identify quick wins and enable delivery at pace. • Reduced cost for CCGs by streamlining digital initiatives across the HLP portfolio whilst not losing the investment and enhancements to date. • Continuing to harness and support local pilots to improve patient access to NHS services across London; e.g. 111 * lines and mental health crisis services. • The existence of the service of booking in patients to an agreed appointment reduces the necessity for patients to attend higher acuity service, e.g. 999, ED or UTC	• Reduction of management requirement at A&E through use of special patient notes • Improved operational management of ambulance service. Relief on the service by 17k patients. • Increased impact via uptake of NHS 111 *Line pilots and Mental Health Crisis Lines • Increased consult and complete clinical urgent primary care episodes where electronic prescribing is facilitated	Benefits are expected to continue as in 18/19	
	All CCGs across London are required to implement the new IUC national specification released in August 2017 by 31 March 2019. IUC is a complex new service and STPs have a limited number of commissioners with significant experience of mobilisation, technical and operational knowledge.	**IUC Mobilisation**	Support the successful implementation of the new IUC national specification and the Digital Five Year Forward View new requirements as part of the operational go live of IUC services Actions **Embedded IUC mobilisation experts**: Support implementation from April 2018 to March 2019 • To support STPs to interpret and mobilise service specification with providers through procurement/contract variation and wider integration into Urgent and Emergency Care network. • Providing knowledge transfer, lessons learnt and upskilling of local commissioners. • Working directly with providers and commissioner team, through NHS England assurance gateways and testing service before go-live. • Providing challenge and observation to the national team and sharing learning across London. **On-going service development:** Support implementation from April 2018 to March 2019 • Co-ordinating a London approach for the development of IUC and support for their implementation; including successful bids to national and mobilising the service enhancement e.g. prescribing pharmacists, workforce, alternative care pathways. • Supporting the direct transfer of calls from 999 to 111 and 111 to 999 - Leading a Pan-London 999 and IUC working group (5 IUC providers and 999) to develop joint governance arrangements to enable patients to receive enhanced assessment within NHS111 before transfer to 999, and vice versa. • Optimising 999 clinical hub - Working directly with 999 to set up and lead workshops to process map functionality requirements. Implementation will cover direct booking from 999 into UTCs and primary care • Network of stakeholders brought together in multiple forums to enable fast mobilisation, service improvement, impact data reviewing and agreeing the design of new operating models	• STP implementation of national service specification • Deliver national metrics (key targets for IUC in 2019 with full coverage of IUC required) and delivering 'Consult and Complete' by: o Reducing demand on 999/ED with 50% of patient speaking to a clinician and more calls closed through telephone or online consultations, with greater access to clinical and crisis records. o Direct booking across primary care and enhanced clinical assessment. o STP progress through NHSE gateways. o 17,000 fewer ambulance requests, improve technical operational management of patients to enable smooth transfers for enhanced assessment	• Full implementation of national service specification in March 2019 o Increasing clinical input to calls beyond 51% March 2019 o Ambulance dispatch rates of less than 10% o STP successful progression through NHSE gateway procurement process • Patients over the age of 85 and under the age of 1 who are fast tracked to a GP, have a reduced number of ED and ambulance referrals because a senior clinician in the CAS has completed their case or referred them to primary care • Improved operational management of ambulance service. Relief on the service by 17,000 patients.	Benefits are expected to continue in 18/19	

UEC Improvement Collaborative	Londoners have told us they find the urgent and emergency care system confusing and characterised by queues and timeliness of care is recognised as a key component of high-quality care; the four hour standard is therefore a useful indicator of how the whole urgent care system performs – from NHS 111, primary care, ambulance response, emergency admission and discharge to social care - not just how the emergency department performs. In addition, across London more patients choose A&E as their urgent care provider than nationally (7% compared to 4%) and performance against the four hour standard has been in decline since 2012.	**UEC Improvement Collaborative: In Hospital**	Supporting the system through a structured Improvement Collaborative to improve the patient journey (flow) across the whole system. The improvement collaborative aims to develop a culture of continuous improvement with patients, carers and the public at its heart and empower leadership in local health and care systems. Actions: • 4 quarterly collaborative learning events providing a curriculum to strengthen strengthens quality improvement capacity, capability and knowledge spread across local systems • Data analysis on admitted and non-admitted flow to develop a discipline and rigour around using data for diagnosis, action planning and measuring improvement – December 2018 • Repeat Day of Care surveys across London's sites- May 2018 • Provide direct support to local systems for improvement planning, PDSA cycles and QI expertise and facilitation, clinical leadership, online improvement tools and techniques • On-going communications to the system to ensure learning of what works and engagement in the collaborative • Support informal professional networks and action learning sets and administer governance associated with the Collaborative - Clinical Leadership Group; Collaborative Steering Group.	The collaborative has adopted a similar approach as NHS Scotland which has seen an 8% improvement in performance against the four hour standard since it their collaborative was established two years ago and this performance is now sustained. If London sees the same improvement, performance in London would be sustained at 95% following the lifetime of the collaborative.	95% sustainable A&E performance		
	The programme is aiming to reduce delayed transfers of care in the acute and mental health systems, to reduce the demand on A&E particularly from care homes (eg measured in 999 calls and conveyance rates) and to contribute to improved flow in acute and mental health systems (measured through things like stranded patients, bed occupancy and reasons for DTOC). It is also supporting implementation of the 8 High Impact Changes for Hospital to Home.	**UEC Improvement Collaborative: Care Closer to Home**	As part of the UEC Improvement Collaborative we are supporting the London System with implementing the National Enhanced Health in Care Homes framework, we are improving patient experience and flow from hospital to home and supporting delivery of DTOC metrics across London Acute sites and improving patient experience and flow from mental health hospitals to home and supporting delivery of DTOC metrics across London MH sites. ***Actions*** ***Enhanced care in Care Homes:*** • Flu - Implementing an Influenza campaign to increase vaccination rates for care home residents and staff • Significant seven training - Providing facilitated training (and train the trainer) to care home staff to help reduce unnecessary A&E admission by identifying early warning signs of a deteriorating patient and highlighting preventative measure thus reducing A&E admissions and improving patient outcomes • Independent care sector engagement – Working with the independent care sector to address bottlenecks • End of Life care and CC2H alignment work - Developing support packages that will improve the EoL pathway • Demand and capacity tool – Developing a tool that will assess the impact of initiatives changes on system demand and capacity • Hospital to Home tool – Developing the London Purchased Healthcare Team platform to include a live status of care home bed availability aligned with user inputted parameters such as CQC rating, location and price. • Social care skills passport - Ensuring that when carers move employment from one care home to another they don't have to repeat training- ensuring capacity within the system and workforce development • Hospital transfer pathway (inc Red Bag) - Development of a proactive care plan, regularly reviewed and then shared with the hospital through a red bag • Supporting the development digital enhancement across patient pathways • Enhanced Care in Care Homes Learning sessions - Engaging with key stakeholders (including commissioners for CCGs, LA and STSP) to develop improvement opportunities. ***Acute Discharge:*** • Local support - Providing focused local support around discharge to assess and trusted assessor • Standardised district nurse referral pathway - Ensuring there are standard referral pathways, templates and protocols in place across London • No recourse to public funds for TB protocols - Ensuring community providers have access to TB funding to increase patient uptake • Joint working with ADASS on no recourse to public funds ADASS - Making sure community providers have access to available funding – a once for London pot of money • Guardianship/Power of attorney protocols - Ensuring friends and family can easily access personal patient funds for self- funders • Equipment stores access -Making sure AHPs have access to equipment stores 24/7 to improve speed of discharge • Disabled facilities grant access - Making sure patients have access to available funding • Neuro-rehab referrals – Reducing the length of time patients need to wait for neuro rehabilitation inpatient services thus improving patient flow • Learning sessions - Engaging with key stakeholders (including commissioners for CCGs, LA and STSP) to develop improvement opportunities. ***Mental Health Discharge:*** • MH Discharge Top Tips - Developing and implementing a series of Mental Health discharge Top Tips with the system following the model of the High Impact Changes.	• Contribution to national DTOC targets (Delayed transfers of care below 437 per day) • Reduction of 999 calls from care homes • Reduction in Emergency and A&E attendances from care homes • Supporting choices of preferred place of death access across the UEC systems of EoL Plans • Improve the experience of end of life patients • Embed IHI improvement collaborative methodology • Enable patients to get home from hospital safely and quickly • Reducing time spent on referrals freeing up staff time • Support to meet 8 High Impact Changes implementation requirements • Implementation of the approved Pan London Section 117 protocols with ADASS • Embed improvement collaborative methodology • Enable MH patients to get home from hospital quickly and safely	• Contribution to national DTOC targets (Delayed transfers of care below 437 per day) • Reduction of 999 calls from care homes • Reduction in Emergency and A&E attendances from care homes • Supporting choices of preferred place of death access across the UEC systems of EoL Plans • Improve the experience of end of life patients • Embed improvement collaborative methodology • Enable patients to get home from hospital safely and quickly • Reducing time spent on referrals freeing up staff time • Support to meet 8 High Impact Changes implementation requirements • Implementation of the approved Pan London Section 117 protocols with ADASS • Embed IHI improvement collaborative methodology • Enable MH patients to get home from hospital quickly and safely	Benefits are expected to continue in 18/19	
	Shared resources across In Hospital and CC2H						

Key

HLP 2018/19 Proposed Projects

				System impact (Z)	Impact timeframes		
Programme	**Issue (X)**	**Priority / Project (Y)**	**Deliverables**	**System impact (Z)**	**18/19**	**19/20**	**20/21**
Transforming Cancer Services	Cancer is the biggest cause of death from illness or disease in every age group. Diagnosing substantially more cancers earlier could be transformative in terms of improving survival, reducing mortality and improving quality of life. Earlier diagnosis makes it more likely that patients will receive treatments such as surgery and radiotherapy which contribute to the majority of cases where cancer is cured. When bowel cancer is diagnosed at the earliest stage, more than 9 out of 10 people survive at least 10 years. However, if diagnosed at late stage survival is below 5%. Fewer than 1 in 10 people are currently diagnosed at the earliest stage.	**Early diagnosis of cancer work stream**	- Improve population awareness enhancing national BCOC and regional campaigns and profiling evaluation and impact of the campaigns - Increase cancer screening coverage developing and cascading data, information and guidance to key stakeholders and enabling ongoing GPE (GP Endorsement) of bowel screening including process and outcomes evaluation - Continue embedding of NG12 guidance (urgent suspected cancer); updating referral forms and educational materials and developing MUO and MDC resources - Support roll out of e-referral for cancer in primary care pan London via a dedicated resource working closely with NHSE national programme - Plan to integrate NG12 and e-referral in 18/19 - Establish pan London patient choice and safety netting work streams to respectively reduce patient DNAs and strengthen systems to follow up patients with diagnostic uncertainty effectively and in a timely fashion - Support implementation of direct access diagnostics and straight-to-test pathways establishing baseline, understanding gaps and supporting SPGs/CCGs to increase access to these pathways - Develop framework for FIT and ensure DG30 NICE guidance implementation plan including service specification in place across London - Pan-London joint screening commissioner/TCST work programme; working together to improve uptake of screening and implementation of FIT, as well as monitoring against targets - Development of cancer specification for primary care working at scale, in line with national QOF review (joint ED/LWBC)	Increase proportion of cancers diagnosed earlier at stages 1 and 2. Improved detection and diagnosis of earlier stage cancer by primary care team including improved one-year survival rates and reduced proportion of cancers diagnosed following an emergency admission. Robust referral pathways from primary to secondary care in situ to improve earlier detection and diagnosis of earlier stage cancer, including supporting the implementation of new screening initiatives and NICE guidance (introduction of new HPV test, new bowel screening and increase uptake of screening). Implementation of IT systems to support pathways from primary to secondary care which improve earlier detection and diagnosis of earlier stage cancer.	- Roll out of qFIT bowel screening - Introduction of HPV screening	- 62% cancers diagnosed at stage 1 and 2 - TBC metric on %cancers which present as emergency - Bowel screening coverage and uptake at 60% - Breast screening coverage and uptake at 70% - Cervical screening coverage at 80%	- 62% cancers diagnosed at stage 1 and 2 - TBC metric on %cancers which present as emergency - Bowel screening coverage and uptake at 60% - Breast screening coverage and uptake at 70% - Cervical screening coverage at 80%
	Delivering the NHS Constitution 62-day cancer standard is a national 'must-do' of the Operational Planning and Contracting Guidance 2017-19. Meeting the 62-day referral to treatment standard of 85% is a key challenge for many London Providers. London performance against this standard for August 2017 was 81.1% (range 44.4% - 92.3%). The Diagnostics Capacity and Demand baseline completed in 2016 highlighted significant scope to optimise radiology and endoscopy service delivery (diagnostics is one of the key constraints to delivering the 62-day cancer standard).	**Diagnostics Optimisation**	- Providing service improvement expertise, support, training, development and programme management to radiology and endoscopy teams and STPs to deliver optimisation projects, action plans and embed the learning for long term sustainability. - Use and share optimisation tools and techniques that are proven to help improve patient flow and increase capacity utilisation. - Provide practical support for the roll out of cancer pathway changes for lung, colorectal and prostate, drawing on experience and learning from across London and elsewhere. - Hold optimisation action leaning events to share good practice and share new techniques.	Trust diagnostics teams have a detailed understanding of the priority actions needed to improve patient flow and increase capacity utilisation. Over 70 clinicians registered at each of the radiology and endoscopy optimisation workshops showcasing experience and learning in diagnostics optimisation across London. Support to delivery of RTT across London.		- <1% patients waiting 6 weeks or longer for diagnostic test	- <1% patients waiting 6 weeks or longer for diagnostic test
	Delivering the NHS Constitution 62-day cancer standard is a national 'must-do' of the Operational Planning and Contracting Guidance 2017-19. Meeting the 62-day referral to treatment standard of 85% is a key challenge for many London Providers. London performance against this standard for August 2017 was 81.1% (range 44.4% - 92.3%).	**In year Delivery & Sustainability: Cancer Waits**	- Pan-London performance analysis against national cancer waiting standards through monthly reports, dashboards and metrics packs - Deliver cancer Waits training & repository of good practice such as MDT training and PTL training - Preparation for new definitive diagnosis standard – new measurement rules, new national database, new pathways to be developed & implemented (request of NHSE) - Implementation and assessment of using e-Referral system to support with improving 2ww and 7 day median access - Working with Cancer CCB Clinical Advisory Group on implementation of timed pathways, as per national priority - Review levels of Trust MDT Co-ordinator workforce reviewed and pool resources of good practice in one central repository - Supporting improvements in 2ww times by increasing awareness for patients through informed patient choice	Cancer Waits return to target and sustainable delivery of 2 week waits / 31 day / 62 day. Preparation for meeting new 28 day definitive diagnosis or cancer excluded standard. Improving processes and skills in Trusts for the sustainable achievement of cancer standards/targets. Patient experience improved due to reduced waiting times for confirmation of cancer diagnosis and start of treatment. Support local delivery of FYFV and National Cancer Strategy deliverables		- 28 day definitive diagnosis	- 28 day definitive diagnosis
	Cancer is the biggest cause of death from illness or disease in every age group, from the very youngest children through to old age. There are groups of patients for whom outcomes and quality of life are particularly poor. Whilst survival has improved significantly in some types of cancer for others it has remained stubbornly low eg lung. Health inequalities mean there is potentially avoidable variation in survival outcomes.	**Governance & Leadership; Quality & Safety**	- Management & administrative support to London Cancer Commissioning Board; CCB Clinical Advisory Group; CCB Patient Advisory Group; Early Diagnosis and Awareness Group; Living With and Beyond Cancer Partnership Board; Cancer Intelligence Priorities for London Steering Group. - Provide an London assurance role and reporting - Analysis of National Cancer Patient Experience Survey; with bespoke reports produced for CCGs as well as an interactive dashboard - Support the London Cancer Operating Model through TPMO reporting, Performance Delivery Group and Cancer Delivery Group - Working with the London Leadership Academy to develop a developmental programme for Clinical Leads - Aligning with HLP through reporting, senior leads and communications	Provision of infrastructure and leadership across the Cancer System to support improved clinical outcomes, patient experience and performance.	Continuous provision of infrastructure and leadership across the Cancer System to support improved clinical outcomes and performance.	Continuous provision of infrastructure and leadership across the Cancer System to support improved clinical outcomes and performance.	Continuous provision of infrastructure and leadership across the Cancer System to support improved clinical outcomes and performance.

	In London, there are 209,500 people living with and beyond cancer, and half of these have survived longer than five years. 94% of people with cancer experience physical health problems in their first year after treatment, whilst one in four people who have been treated for cancer live with ill health or disability as a consequence of their treatment. Healthcare costs of long term conditions are 50% higher for people affected by depression +/- anxiety. 70% of people affected by cancer have at least one other long term condition (Macmillan). Studies show that 15 months after diagnosis, people with cancer had 60% more A&E attendances, 97% more emergency admissions and 50% more primary care contacts compared to a population of the same age/gender.	**Supporting people living with and beyond cancer**	- Supporting STPs & CCGs to embed*:* 4 point CCR model with a suite of TCST developed tools (service specification, desktop review, education and evaluation) Primary care led pathway for stable management of prostate cancer Train the trainer education programme (primary & community care). - Providing support to STPs and LAs to commission psychological support pathway for people affected by cancer, through the development of a service specification and end-to-end pathway (funded by Macmillan) - Develop business case for mental health pathway work to continue in 18/19 (subject to ongoing Macmillan funding) - Support STPs to commission lymphoedema services equitably and to reduce unnecessary hospital admissions and length of stay (funded by Macmillan) - Produce commissioning guidance for cancer rehabilitation services, including exercise referral schemes (funded by Macmillan) - Support STPs and local authorities to commission cancer rehabilitation services and exercise referral schemes (that accept cancer referrals) equitably (funded by Macmillan) - Potential to develop commissioning guidance for fertility services in 18/19 (funded by Macmillan) - Continue pan-London joint working for Recovery Package/Stratified Follow Up via MOU - Embed LWBC safety netting for cancer patients in primary care (stable management of breast and colorectal cancers, consequences of treatment and subsequent primaries) - Review of London data definitions (Recovery Package & Stratified Follow Up) - Provide cancer intelligence and analytics in LWBC measures through development of Practice Profiles Plus; Mental Health dataset / audit etc (subject to levels of NCRAS funding) - Provide support to Macmillan primary care lead nurse, in SWL, in developing pan-London resources - Provide support to STP(s) in securing Macmillan funding to recruit primary care lead nurse - Support STPs and Primary Care in using TNA and Education portal, and delivering LWBC education - Development of cancer specification for primary care working at scale, in line with national QOF review (joint ED/LWBC) - Provide support to HEE LWBC Clinical Fellows Programme (subject to funding)	Support regional understanding of new quality of life metric STPs are supported to integrate cancer as a long term condition within acute community and primary care System financial burden is reduced by reducing unplanned care, admissions and length of stay Psychological therapy reduces physical healthcare costs by 20% (meta analysis of 91 studies) STPs are supported to commission services that mean patients and their families have access to timely physical and psychological/emotional support including fertility Lymphoedema services - every £1 spent on lymphoedema, saves the NHS £100		- Quality of life metric - Recovery Package available for all cancer patients	- Quality of life metric

Key

Pan-London programme activity being worked through