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Health and Wellbeing Board

Date: **TUESDAY, 1 APRIL 2014**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Statutory Members (Voting)
Councillor Raymond Puddifoot MBE (Chairman)
Councillor Philip Corthorne MCIPD (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Douglas Mills
Councillor Scott Seaman-Digby
Councillor David Simmonds
Dr Ian Goodman (CCG)
Jeff Maslen (Healthwatch Hillingdon)

Statutory Members (Non-Voting)
Statutory Director of Adult Social Services
Statutory Director of Children's Services
Statutory Director of Public Health

Co-Opted Members
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group (officer)
Hillingdon Clinical Commissioning Group (clinician)
LBH - Deputy Director: Public Safety & Environment
LBH - Corporate Director of Residents Services & Deputy Chief Executive (VOTING)

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Agenda

CHAIRMAN'S ANNOUNCEMENTS

1 Apologies for Absence

2 Declarations of Interest in matters coming before this meeting

3 To approve the minutes of the meeting on 6 February 2014 1 - 8

4 To confirm that the items of business marked Part I will be considered in public and that the items marked Part II will be considered in private

Health and Wellbeing Board Reports - Part I (Public)

5 Better Care Fund: Hillingdon Plan 9 - 40

6 Hillingdon CCG 5 Year Strategic Plan and 2 Year Operating Plan 41 - 44

Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

7	Hillingdon CCG 5 Year Strategic Plan and 2 Year Operating Plan - Appendix 2	45 - 106

The reports listed above in Part II are not made public because they contain exempt information under Part I of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it.

8 Any other items the Chairman agrees are relevant and urgent

Minutes

HEALTH AND WELLBEING BOARD

6 February 2014

Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW

	Statutory Board Members Present: Councillor Ray Puddifoot (Chairman) Councillor Philip Corthorne (Vice-Chairman) Councillor Douglas Mills Councillor David Simmonds Dr Kuldhir Johal – Hillingdon Clinical Commissioning Group (substitute) Stephen Otter – Healthwatch Hillingdon (substitute) **Statutory Board Members:** Merlin Joseph – Statutory Director of Children's Services Sharon Daye – Statutory Director of Public Health Tony Zaman – Statutory Director of Adult Social Services **Co-opted Members Present**: Nigel Dicker – LBH Deputy Director: Public Safety & Environment Maria O'Brien – Central and North West London NHS Foundation Trust (substitute) Mike Robinson – The Hillingdon Hospitals NHS Foundation Trust (substitute) Dr Tom Davies – Hillingdon Clinical Commissioning Group (Clinician) Ceri Jacob – Hillingdon Clinical Commissioning Group (Officer) (substitute) Nick Hunt – Royal Brompton and Harefield NHS Foundation Trust (substitute) **LBH Officers Present:** Kevin Byrne, Glen Egan and Nikki O'Halloran **LBH Councillors Present:** Councillors Phoday Jarjussey and John Major **Press & Public:** 2 public
49.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Councillors Jonathan Bianco, Keith Burrows and Scott Seaman-Digby, Mr Jeff Maslen (Mr Stephen Otter was present as his substitute), Dr Ian Goodman (Dr Kuldhir Johal was present as his substitute), Mr Shane DeGaris (Mr Mike Robinson was present as his substitute), Ms Robyn Doran (Ms Maria O'Brien was present as her substitute), Mr Robert Bell (Mr Nick Hunt was present as his substitute), Mr Rob Larkman (Ms Ceri Jacob was present as his substitute) and Ms Jean Palmer.
50.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* Councillor David Simmonds declared a non-pecuniary interest in Agenda Item 8: Update – Allocation of S106 Health Facilities Contributions, as he was registered at one of the surgeries included within the report, and stayed in the room during the

	consideration thereof.
51.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* This was confirmed.
52.	**JOINT HEALTH AND WELLBEING STRATEGY ACTION PLAN UPDATE 2013/2014** *(Agenda Item 5)* Consideration was given to the Joint Health and Wellbeing Strategy Action Plan performance achievements since 1 April 2013. It was noted that, as at 31 December 2013, 2,645 new service users were in receipt of TeleCareLine which was helping them to live safely and independently at home. It was anticipated that extending the service to residents aged over 80 from April 2014 would complement the reablement work that was already underway. It was noted that there were plans to further extend the service to those aged over 75. The Board was advised that a range of new activities were available to Hillingdon residents to keep them active which included free swimming, planned cycle rides, healthy walks, tea dances and targeted exercise programmes and lessons for the over 65s. Although the review of CAMHS (Children and Adolescent Mental Health Service) was underway and on track, concern was expressed that further work would be required to improve the service. It was suggested that consideration be given to looking at this in more detail. It was noted that the NHS had recently produced a series of health maps. Although Hillingdon had scored low with regard to dementia services, the Borough had scored high in relation to respiratory disease. As such, consideration would need to be given to what action could be taken to raise the profile of respiratory disease. The Board was advised that Chronic Obstructive Pulmonary Disease (COPD) was the most likely cause of respiratory disease. To address the issue, GPs were being identified as clinical leads within each practice. It was agreed that future reports to the Board would include updates on the outcomes being achieved through the Better Care Fund work. **RESOLVED: That:** **1. the Health and Wellbeing Board notes the report; and** **2. this report include an update on the outcomes of work undertaken in relation to the Better Care Fund.**
53.	**PUBLIC HEALTH ACTION PLAN 2013/2014** *(Agenda Item 6)* Consideration was given to the Public Health Action Plan 2013/2014. It was noted that roles and structures were being reviewed to ensure that they were flexible and able to deliver the services that residents needed. The review of the sexual health services had included a series of workshops and discussions and was now nearing completion. It was recognised that obesity was still an issue in the Borough. Although consideration needed to continue to be given to encouraging healthy eating, additional

	resources needed to be put into encouraging the elderly and the young to become more active, for example, rebuilding or refurbishing bowls clubs. The Board noted that the refurbishment of the libraries in the Borough had resulted in an increase in the number of older residents that were using the venues for socialising. **RESOLVED: That the Health and Wellbeing Board notes the report and action plan.**
54.	**HILLINGDON CCG FINANCIAL RECOVERY PLAN UPDATE REPORT** *(Agenda Item 7)* The Board was advised that current expectations were that the CCG would deliver the majority of its Recovery Plan targets (£11m) by March 2014. However, it was anticipated that there might be a shortfall of approximately £2m. It was acknowledged that, although it was difficult to provide accurate information in relation to the cost of prescriptions (an unfilled prescription could only be written off if it remained unfilled for more than 6 months), steps had been taken to address this issue and it was anticipated that the impact would soon become apparent. Concern was expressed that the CCG would need to achieve £14½m savings in 2014/2015 and again in 2015/2016. Furthermore, it was suggested that regardless of whichever political party won the next general election, it was likely that there would be a subsequent reduction in health funding. It was acknowledged that the 'low hanging fruit' had already been picked some time ago so consideration would now need to be given to service transformation. It was believed that the health service in Hillingdon had been underfunded for quite some time and that this imbalance had continued through successive Governments. To compound this historical imbalance, the CCG budget had been further reduced. It was noted that the health service was demand driven and that it was important that, despite a reduction in resources, the quality of the service must not be put at risk. It was suggested that reference to the historical imbalance be made in future Financial Recovery Plan update reports from the CCG and that comparisons also be made with other London boroughs. The Board was advised that, during the budget setting process, the CCG built in population figures and other relevant demographics identified within the JSNA. The majority of the budget was used in relation to young people and the elderly and was closely monitored throughout the year. Although sound financial management was not listed in the report as one of the four underlying principles behind the CCG's financial planning, the Board was advised that this was deemed to be implicit. It was noted that the Financial Recovery Plan was regularly and robustly reviewed by the CCG's financial team. **RESOLVED: That the Health and Wellbeing Board notes the update report.**
55.	**UPDATE - ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 8)* The Board was advised that excellent progress had been made through the year with regard to the allocation of s106 health facilities contributions and that funds that had previously been stuck had now been allocated and released. Although there had been some confusion with regard to the Hesa Centre project, this was progressing.

	Furthermore, some of the Yiewsley Health Centre s106 monies had been diverted towards the planning application and would be given back to NHS Property Services at the fitting out stage. Concern was expressed that the development would be bringing three surgeries together under one roof and that they would all be under increased pressure. As time progressed and more patients registered at the new surgery, consideration could be given to recruiting additional GPs. In the meantime, the Board was advised that the GP network encouraged practices to share expertise amongst themselves which alleviated the pressure. The Board was advised that discussions were continuing with the CCG in relation to the St Andrews Park development. **RESOLVED: That the Health and Wellbeing Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.**
56.	**BETTER CARE FUND - DRAFT HILLINGDON PLAN** *(Agenda Item 9)* The Board was advised that 11 different schemes had been identified within the Better Care Fund (BCF) draft plan which prioritised the frail and elderly. The draft plan had been shared with partners and would be submitted to NHS England on 14 February 2014. It was noted that the BCF provided the authority and its partners with an opportunity to shape services from a local perspective. It was noted that Healthwatch Hillingdon had submitted its views on local need but had not yet commented on the draft BCF plan. An additional Board meeting had been arranged for 2.30pm on Tuesday 1 April 2014 to enable Board members to sign off the final plan prior to submission on 4 April 2014. The Board was advised that the plan would continually evolve even after the 'final' version had been submitted. Although collaborative working had been incredibly useful in identifying issues and developing the draft plan, the BCF was not the only focus of joint working. Partners were also working on issues such as mental health and that additional information relating to this (and other) work could be included over time. It was noted that one of the 'National Conditions' of the scheme related to the provision of seven day health and social care services across the local health economy. It was suggested that further articulation needed to be given to how the measures that were already in place at THH would benefit residents. It was also noted that Hillingdon Hospital was an 'early adopter'. Concern was expressed that the draft plan was not as ambitious as it could have been. It was suggested that future consideration be given to the creation of a new delivery vehicle and to the pooling of budgets. This approach would ensure that the Board not only delivered the service that the Government expected but that it also went much further to deliver more comprehensive services to residents. The Board was assured that the draft plan was currently a high level document and that there was plenty of scope to develop more ambitious approaches. **RESOLVED: That:**

	1. the Board agrees the vision and scope of the BCF plan as set out in Appendices 1 & 2 of the report, so that this can be submitted on its behalf to NHS England by 14 February 2014. In particular, the Board notes that: **a) the initial plan prioritises supporting frail elderly residents as the first target group under the BCF.** **b) the proposed plan is based on offering the minimum fund (of £17.991m in 2015/16) at this stage.** **c) the eleven schemes set out at paragraphs 4.8 to 4.23 (and in more detail in Appendices 1 & 2) provide the starting point to develop business cases and proposals for delivery under the plan.** **d) in addition to the mandatory indicators provided in the guidance and set out in detail in Appendices 1 & 2, Hillingdon sets a local indicator relating to shared care plans, all of which will support the financial reward element of the fund from 2015/16.** **2. an additional meeting be scheduled for 1 April 2014 to enable to Board to agree the final plan for submission by 4 April 2014.**
57.	**LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT** *(Agenda Item 10)* It was noted that many of the Council's partners had been involved in the development of the Local Safeguarding Children's Board (LSCB) Annual Report. The LSCB had identified a number of action points which would need to be undertaken by the Council and other statutory agencies and was keen to ensure that these were delivered and that any arrangements put in place were fit for purpose. The Board agreed that the development of a protocol would enable the Health and Wellbeing Board to formally sign off / comment on the LSCB Annual Report. This would also highlight which actions had been delivered. An amendment would need to be made to the Board's Terms of Reference to reflect this change. The Board thanked the Chairman of the LSCB for all of her hard work in producing the Annual Report. It was agreed that the report would be passed to the BCF Working Group to see how the actions could be moved forward. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the report, the actions identified in the report that are being taken by the LSCB and its constituent agencies to improve the safeguarding of Hillingdon's children and young people, and the concerns raised about the risks to future safeguarding;** **2. commits to ensure that the Health and Wellbeing Strategy gives a high priority to safeguarding and promoting the wellbeing of children and young people, and that particular attention is given to improving support for children who experience neglect and emotional harm;** **3. asks officers to developed a protocol between the LSCB and the Health and Wellbeing Board that clarifies how the two Boards will work together and inform each other's strategic priorities; and** **4. pass a copy of the Annual Report to the BCF Working Group with a view to the Group moving the recommendations forward.**

58.	**SAFEGUARDING ADULTS PARTNERSHIP BOARD (SAPB) ANNUAL REPORT** *(Agenda Item 11)* Consideration was given to the Safeguarding Adults Partnership Board (SAPB) Annual Report. It was noted that the SAPB had made significant progress in better targeting resources to where they were most needed. Although the Care Bill had not yet been enacted, it was thought important to ensure that a protocol was developed between the Health and Wellbeing Board and SAPB. The Board thanked the Chairman of the SAPB for the work that she had undertaken in producing the Annual Report. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the report and the actions identified that are being taken by the SAPB and its constituent agencies to improve the safeguarding of vulnerable adults in Hillingdon;** **2. asks officers to develop a protocol between the SAPB and the Health and Wellbeing Board in preparation for the enactment of the Care Bill; and** **3. notes the implications of the actions arising from the Winterbourne Review.**
59.	**TO APPROVE THE MINUTES OF THE MEETING ON 5 DECEMBER 2013** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 5 December 2013 be agreed as a correct record.**
60.	**REVIEW OF THE BOARD'S TERMS OF REFERENCE AND MEMBERSHIP** *(Agenda Item 12)* Consideration was given to the Board's Terms of Reference and membership. It was noted that any changes made to the Terms of Reference would subsequently need to be agreed by Council. Members were aware that, as time progressed, it was likely that there would be an increasing amount of confidential information being considered by the Board. As such, all non-voting co-opted members would be required to sign a confidentiality agreement (voting statutory members were required to sign the Code of Conduct). It was noted that the CCG Board comprised three GPs from each of the three localities within the Borough. As a matter of course, each year, one of these GPs from each locality would stand down. Dr Tom Davies would be standing down with effect from 1 April 2014 but was currently unaware who would replace him on the Health and Wellbeing Board. The Board membership would need to be updated once the replacement member had been identified. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the Board's Terms of Reference and Standing Orders;** **2. notes the Statutory Board Membership and the Co-opted Members, as set out in Appendix 2 of the report; and** **3. notes that all non-voting Co-opted Members will be required to sign a confidentiality agreement.**

61.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 13)* Consideration was given to the Board Planner and future agenda items. The CCG was asked to identify what reports it would need to have agreed by the Health and Wellbeing Board over the next year (as far as was possible). Consideration could then be given to the timings of each meeting and dates rescheduled if necessary. **RESOLVED: That the Health and Wellbeing Board notes Board Planner.**
62.	**HILLINGDON CCG 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATING PLAN - VERBAL UPDATE** *(Agenda Item 14)* The 2 year operating plan had been put together by the Hillingdon CCG and would need to be submitted by 4 April 2014. It was noted that the operating plan would need to be signed off by the Health and Wellbeing Board at the additional meeting that had been scheduled for 1 April 2014. The Board was advised that the Hillingdon CCG 5 year strategic plan was being put together at North West London level and would need to be submitted to NHS England in June 2014. This date had been moved back from 4 April 2014. The CCG advised that, by the time the additional meeting on 1 April 2014 arrived, the strategic plan would have been well worked up and would give the Board a good opportunity to comment. **RESOLVED: That the Health and Wellbeing Board:** **1. note the verbal update; and** **2. consider and comment on the Hillingdon CCG 5 Year Strategic Plan and 2 Year Operating Plan report at its meeting on 1 April 2014.**
	The meeting, which commenced at 2.30 pm, closed at 3.20 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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BETTER CARE FUND: HILLINGDON PLAN

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Paul Whaymand, LBH Finance Tony Zaman, LBH Adult Social Care Ceri Jacob, Hillingdon CCG
Papers with report	Appendix 1 - Final BCF Plan Appendix 2 - Final Financial Summary

1. HEADLINE INFORMATION

Summary	The Board agreed a "first take" of a Hillingdon Better Care Fund Plan, at its meeting on 6 February 2014. This report provides the Board with a proposed final Hillingdon Plan, due for submission by 4 April 2014. This version includes updated content in Appendix 1 together with more detail in the financial summary at Appendix 2.
Contribution to plans and strategies	Hillingdon's Joint Health & Wellbeing Strategy Hillingdon's Joint Strategic Needs Assessment Hillingdon's Out of Hospital Strategy
Financial Cost	The Government announcement with regard to the BCF sets out a minimum fund of £17.991m for Hillingdon from 2015/16. The guidance also set out how this figure is arrived at and the fact that it is not new money but comes from existing budgets.
Ward(s) affected	All

2. RECOMMENDATIONS

2.1. The Board is asked to agree the Hillingdon Better Care Fund plan and the financial summary at appendices 1 & 2 for submission to NHS England.

2.2. That the Board instructs the core officer group to develop business cases and implementation plans for the 11 schemes, in accordance with the governance arrangements in the plan, for discussion at the Board's next meeting on 17th June.

3. INFORMATION

Reasons for recommendations

3.1. To agree a plan to develop more integrated health and social care services in Hillingdon, focused on improving services for residents.

Financial Implications

3.2. The total s256 funding for 2014/15 is £4.772m and for this year is being utilised to assist in managing social care spending pressures and support expenditure that has a benefit to health and will contribute towards the BCF plan. For 2015/16, the total Better Care Fund allocation for Hillingdon is £17.991m, including capital grants of £2.349m that currently come into the Council. A breakdown of the schemes is provided at Appendix 2.

3.3. Further information has now been provided by the Department of Health on the indicative funding within the overall BCF allocation for 2015/16 that will contribute towards the implementation costs of the Care Bill due to start coming into effect from April 2015. A sum of £612k revenue funding is estimated to cover the implementation of carers' assessments, information and advice to clients, training social care staff in the new legal framework, etc. A further sum of £217k capital funding has been identified for developing IT systems etc. This allocation of funding is described as illustrative to help authorities develop more detailed estimates of the funding required to bring the requirements of the Care Bill into operation. There is still significant analysis and modeling work to be undertaken before these estimates of the costs of implementation Care Bill can be properly validated.

Legal Implications

3.4. The Borough Solicitor confirms that there are no specific legal implications arising from this report.

4. BACKGROUND

4.1. The Board noted at its meeting on 6 February 2014 that the Council, the CCG and providers of health and social care services in Hillingdon had improved and aligned services in recent years. The plan agreed set out 11 draft schemes which build on existing activity from integrated care pilots around falls to new pathways for early supported discharge from secondary care. The BCF provides an opportunity to consolidate partnership working and to lay the foundations for closer working in the future. It also offers a stepping stone towards new forms of potential delivery structure as a result of joint working, which the board has indicated it may wish to consider in the future.

The BCF at National Level

4.2. An assurance process for emerging BCF plans was announced by NHS England and the LGA, which considered the emerging plans from February. The feedback received stated:

- **Hillingdon**; Good plan but further work was needed on mitigating risks and developing a more detailed risk register

Further work has, therefore, focussed on these areas as well as refining the content of the plan.

4.3. Since coming to the Board in February there have also been some adjustments to the scheme as first published:

- The Department of Health has announced that it will not now withhold money from areas that "struggle to improve" services under the BCF. Instead the Department, together with NHS England and the LGA, will offer “support” to areas in which the fund fails to realise

improved performance on the metrics (including delayed transfers of care and reduced emergency department admissions).

- Earlier statements talked about ministerial sign-off of individual plans and it has been recognised that this is neither very practical, nor desirable. It is now expected that an assurance process will operate primarily at a regional level, with aggregation to meet ministerial requirements and escalation by exception.

4.4. The proposals have been developed by the core officer group and come to the Board having been considered by respective governance arrangements in the Council and by the CCG Governing body. The published BCF technical guidance and pro-forma has been followed to produce the plan.

Finalising the Better Care Plan for Hillingdon

4.5. The latest draft takes on board feedback received, updates the narrative in a few areas, clarifies the figures and the metrics and the approach to be taken. Particular areas that have been addressed are:

- **Metrics** - further work has taken place to better understand the implications of the mandatory metrics and agree the baselines. Indicators have also been benchmarked and trends analysed. The core group has also reviewed each indicator against potential scenarios using confidence intervals, risk assessed the final indicators used, to gauge achievability and include stretch elements.

- **Governance** - the approach to governance has been updated to reflect the role of individual approval processes within the Council and CCG before issues come to the Board for final sign off. The drafting also identifies that budgets for s.75 schemes would be hosted by the Council but jointly managed through the s.75 management group.

- **Engagement** - the section in Appendix 1 has been updated to refer to further events held and feedback received. In addition an Equalities Impact Assessment has been completed which identifies a significant benefit for older people (65+) whilst also recognising that there could be potential new burdens on carers. This impact will be monitored and mitigating actions considered within workstream plans.

- **Risk Register** - additional risks have been included to flag up potential impacts and costs of the Care Bill and to recognise the importance of involving patients and carers in new developments given that new approaches are likely to require changes in behaviour i.e. to avoid admission, embrace reablement, telecare etc.

- **Financial Summary -** Sets out the costs in more detail (appendix 2). Many of the eleven schemes are closely related to each other and it will be hard to differentiate the impact of one scheme from another one which is closely related. For the purposes of BCF financial monitoring and for elements of internal management, these have been clustered under the following headings:

Project cluster	Schemes included
Integrated case management	Schemes 1, 2, 3, 4, 8, and 11
Intermediate care	Schemes 6 and 7
Seven day working	Scheme 10
Seamless community services	Schemes 5 and 9

5. NEXT STEPS

5.1. It is suggested that the officer group, which has worked well thus far, continues to meet to develop the more detailed business cases for the 11 schemes and to propose plans for implementation, consistent with the governance arrangements set out in the plan (Appendix 1).

5.2. The plan recognises the need to develop our communications and engagement plans further based on the potential impact on carers and need to include views of service users in any changes.

5.3. A progress report will come to the Health and Wellbeing Board at its next meeting on 17th June 2014.

APPENDIX 1

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**06 February 2014**
Date submitted:	**14/2/14**
Minimum required value of ITF pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**
Total agreed value of pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**

b) Authorisation and signoff

Signed on behalf of the Hillingdon Clinical Commissioning Group	
By	Dr Ian Goodman
Position	Chair Hillingdon CCG
Date	05/2/14

Signed on behalf of London Borough of Hillingdon	
By	Cllr Ray Puddifoot MBE
Position	Leader of Hillingdon Council
Date	

Signed on behalf of the Hillingdon Health and Wellbeing Board	
By Chairman of Health and Wellbeing Board	Cllr Ray Puddifoot MBE
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Hillingdon Hospital (THH) and Central and North West London NHS FT (CNWL) are members of Hillingdon's Health and Wellbeing Board, which has set up a sub-committee specifically to take forward our work on integration. The hospital is also a member of the sub-committee.

The sub-committee has charged an officer and partner group to take forward these proposals and to work up schemes, vision, scope, changes and outcomes. Again CNWL and THH are both actively involved in these discussions.

In addition (see answer to d) below) wider providers in the voluntary and community sector in Hillingdon attended a workshop on the 17th January 2014 to share approaches and invite feedback on these proposals. This was agreed to be the start of ongoing discussions on the development of the Hillingdon BCF plan.

Schemes in the Hillingdon plan build on existing co - production work with providers as part of multiagency working on Integrated Care, intermediate care, end of life, community transformation and out of hospital care work streams. The BCF is also part of the wider whole systems work in Hillingdon, with providers fully engaged in the development of provider networks and seven day working.

d) Patient, service user and public engagement and involvement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Hillingdon Council and Hillingdon CCG regularly engage with and seek views from local residents, service users and carers to guide service redesign, maintain quality and safety, and inform commissioning intentions. In developing the BCF plans, both organisations have used this approach to inform the strategic direction.

As a first step the Council and the CCG amalgamated intelligence gathered across a two year period, from forums such as the older people's assembly, *meet the CCG* public events, disabled tenants' forum, patient and carer focus groups and public board meetings.

These findings were then cross referenced with intelligence gathered by Healthwatch Hillingdon, evidence from the Hillingdon JSNA and with local and national patient and carer satisfaction surveys to inform draft plans.

Some themes emerge from these sources, including:

- People in Hillingdon want to remain at home and as independent as possible for as long as possible.
- Telecare line is seen as important in supporting older people and in "taking away worries".
- On domiciliary care, carers and service users value the personal touch and a single point of contact.
- Feedback from forums identify the need for easily accessible services in the community, locally from GP services.

- Older people have said they want to access activities in the community that promote and maintain a healthy lifestyle.

- Residents also want better access and consistency from GP services.

The initial plan for greater integration and the Better Care Fund has been shared with members of the public, patients and carers via the following forums:

- Patient in Partnership (PIP) public event (hosted by The Hillingdon Hospital Foundation Trust).

- A Better Care Fund Stakeholder Workshop (hosted jointly by HCCG and the Council) 17 January 2014 with over 20 key local community and voluntary sector organisations present.

- The Hillingdon Association of Voluntary Services (HAVS) forum on 24th February 2014 where the Council and the CCG led a discussion on the BCF plans.

- A Better Care Fund Public Meeting on 25th February 2014 hosted jointly by the HCCG and the Council on and attended by more than 25 members of the public.

Feedback from these meetings was generally positive about the BCF proposals and in agreement with our proposed focus on older people. Attendees were keen to understand more about any extra demands on carers as a result of community-focused health and care projects. This feedback has been incorporated into the plans presented here and has fed into (for example) our plans for future public involvement. A growing number of the residents of Hillingdon want to remain engaged about the BCF proposals as we move into the implementation phase.

The Council and the CCG will continue to utilise a number of communications channels to inform residents and stakeholders of its local plans via the following channels:

HCCG, LBH and Healthwatch Hillingdon public facing websites and the *Hillingdon People* (Borough wide magazine publication)

Under the plan this initial engagement is seen as the start of journey in working with partners, commissioners, patients, carers and providers to design a truly integrated approach that better serves Hillingdon residents. The voluntary and community sector group will be actively involved in the development of the plan.

Separately, we have completed and addressed an Equality Impact Assessment which identifies the positive benefit to people aged over 65 as well as a potential increased burden on Carers. As schemes are developed the impact of changes on specific groups will be further assessed.

e) **Related documentation – Please** include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) is the means by which Hillingdon and its partners will describe the current and future health, care and wellbeing needs of our population and the strategic direction of service

	delivery to meet those needs.
Joint Health & Wellbeing Strategy	The Joint Health and Wellbeing strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out for the period 2013 to 2016
Hillingdon Out of Hospital Strategy	The Hillingdon Out of Hospital strategy sets out five priorities for improving access; experience of care; and the provision of care closer to home for people in Hillingdon. The BCF and development of Hillingdon Out of Hospital Hubs are aligned for care of frail older people.
Intermediate care and admissions avoidance	*Intermediate Care: review of phase one implementation* Libera Partners LLP May 2013 Briefly reviewed the efficacy of the first phase of implementation of Rapid Response at THH alongside wider admissions avoidance and early discharge initiatives.
Recovery Programme Board paper July 2013	In July 2013 the Recovery Programme Board agreed priority areas that would promote a sustainable health and care system over the short, medium and longer term. This focused on working as a whole system to reduce growth into highest risk needs from lower and medium risk groups through an integrated system of early detection and support.
Mental Health strategy and Dementia Action plan 2013-16	In March 2012, Hillingdon Clinical Commissioning Group (Hillingdon CCG) and the London Borough of Hillingdon (LBH) initiated a refresh of the strategy for adults with mental health problems aged 18-64 years[1] and the development of a plan to improve services for people with dementia in order to create a new all age adult mental health services strategy/plan.
Primary Care Development and Delivery Plan	This document sets out plans for the wider development of primary care in Hillingdon in the context of wider NW London plans.

[1] A strategy for adult services for mental health and wellbeing, 2008-13, NHS Hillingdon and London Borough of Hillingdon, 2008

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is that by 2019, the residents of Hillingdon will be able to *plan their own care; with professionals working together to understand their needs and those of their carer(s), so that they have control over services and that these deliver what is important to them*.

Our initial work under the BCF is therefore targeted at Hillingdon's frail elderly. As ever, this term requires further definition as some intervention programmes will be aimed at all older people and others specifically at people aged 85 and older. Our general approach is therefore to work with the population cohort aged 65 years and over with a specific focus on:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Mature/older people who are at risk of dementia
- Mature/older people who are at risk of falling for a first time.

For the above population segment(s) our services are not as joined up as they should be and this process of integration and alignment is a key objective of our work on the BCF. Having said that, we have made significant strides in addressing their needs in recent years and the programmes below constitute a good platform on which to build:

- Expanded intermediate care programmes, especially in developing the role of rapid response
- An improved and better integrated urgent care pathway
- Early supported discharge programmes
- Integrated care programmes
- Reablement
- The development of GP networks and health hubs
- End of life care including "coordinate my care."

Our plan is to put in place the steps we need to act on to configure and deliver services over the five year period. These changes will involve:

- A focus on improving health outcomes for older frail residents with one or more health

condition or care need

- Better and earlier identification of susceptibility to disease or exacerbation in that cohort alongside joined up management of conditions
- Better coordination of services that are configured around Hillingdon's older residents – including a much stronger focus on case management and prevention
- Reducing the need for older people to go to hospital – and reducing the lengths of stay where they are admitted
- Bringing greater coherence to our present pattern of service initiatives: especially in enabling older people to be treated at or close to their home wherever possible.

Changes in patterns and reconfiguration of services

The joint vision is for services that are based in Hillingdon's communities and support the needs of Hillingdon's residents. The following drivers will bear upon the final configuration of services:

- We will build on the momentum of the existing good work on admissions avoidance and supported discharge as these are successful and will form the basis of the future planned discharge service that will have in-reach characteristics.
- We will offer an appropriate and consistent level of service to local people every day of the week. In some cases, this will involve reconfiguration of existing satisfactory services. In a few cases, we will need to decommission sub-optimal services and replace them with more appropriate ones.
- We will ensure services for frail elderly are focussed on the person – especially those with dementia and with more than one long term health or care need. The focus on mental health will be on anxiety and depression but not initially on crisis.
- We will reshape services to identify and support people who are at risk of falling a first or second time.
- We will redefine the role for case management in Hillingdon – especially in being clearer about the central responsibility of GPs as system enablers.
- We will further develop reablement to work closer with wider intermediate care schemes both in the community and within the acute hospital setting.

The difference for the residents of Hillingdon

Residents will be able to say:

- I'm helped to take control of my own health and social care provision
- It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs
- Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need a stay in hospital

- If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay
- I only have to tell my story once and they pass my details on to others with an appropriate role in my care
- Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We have agreed the following aims and objectives:

1. We will build on our present initiatives around admissions avoidance and supported discharge.
2. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
3. Residents will be able to access the services appropriate to their needs on each day of the week.
4. Health and care providers will persist with a health and care problem until a solution is found, or another provider has taken responsibility for finding it.
5. Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.
6. We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.
7. We will aim to reduce levels of health inequalities in Hillingdon.
8. We will be better at predicting future health and care needs – both across the population and for individual residents.

These aims are agreed with a clear understanding that the redesign of systems or the redesign of organisational boundaries alone will not be enough to meet out aims. Instead, we will give equal weight to behaviours, systems and leadership.

Measuring success – including appropriate health gain

These are set out in detail in the BCF application template excel sheet. The principal measures

of success we will target will include:

National metrics:

1. Reduction in permanent admissions of older people in residential care per 100,000 population
2. Increase in proportion of older people who will still be at home 91 days after discharge from hospital into intermediate care (rehab/reablement)
3. Reduction in delayed transfers of discharge per 100,000 population
4. Reduction in avoidable emergency admissions in secondary care per 100,000 population
5. Patient and services user reported outcomes and reported experience

Local metric:

1. The proportion of people with a care plan who are able to manage their condition.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

New interventions under the Better Care Fund

The short descriptions below set out the new schemes we plan over the first five years of the BCF.

Details of key schemes / changes and how we aim to implement them

The section above provided an overview of the schemes and changes within the health and care system. In this section we will provide details of key schemes and how we plan to implement them across health, social care and the wider system.

Scheme one: Joined up tool for health and social care risk stratification:

We have developed and implemented a risk stratification tool that identifies people with complex health issues and those who are at risk of their condition deteriorating or being admitted to hospital. We know that for older people social risks play a crucial role in defining the outcomes.

As part of a natural progression towards an integrated system, we will:

- Enhance the risk profiling to include social care determinants and factors. This will allow us to identify not just people with health risks but also those with social predictive factors; for example, where changes in social factors such as care requirement, status of partner, social isolation make a difference to outcomes for our population.
- We will also increase the reach of the risk stratification tool to identify people in the lower segments of the risk pyramid (medium risk) i.e. people who are at risk of their health and/or

social care needs becoming more complex. This will allow us to proactively manage them much earlier in a fashion that allows them to retain their independence and improve their overall health and wellbeing.

As part of implementation, we will develop joint health/care assessment approach and incorporate it in the risk stratification tool. In order to do that, we are exploring ways of incorporating key datasets within a common database.

Scheme two: Proactive early identification of people with susceptibility to falls, dementia and social isolation

People with dementia; susceptibility to falls; and/or in social isolation are disproportionately represented in our non elective admissions and admissions to long term residential. Too Many Most of these are identified when people reach a complex stage. There is a loss of opportunity in not being able to identify people with these conditions early on in the stage and intervene. The potential impact on outcome in the medium to long term could be significant.

Too many of these people are visible only to parts of the system such as carers, social workers, GPs, the third sector and alarm services. Hence, it is difficult to pick them up from the risk stratification tool only. We therefore need the entire system to understand factors that create susceptibility to these health and social care conditions.

Key initiatives include:

- Development of frontline workforce: brief intervention training to frontline workers for them to identify people who are susceptible. For example: carers / social workers / GPs / district nursing etc need to understand the key signs of when a person might be becoming socially isolated or susceptible to falling (history of recurrent falls without getting hurt).
- Supporting and developing the role of third sector providers to work with people in their homes and communities.
- Increased support to carers and caring families including the provision of respite care and personalised support for carers.
- Defining a system-wide response to these issues: setting out what to do when we identify people with this susceptibility. We have embarked on a number of initiatives such as a centralised falls service (with multifactorial assessment and management) but other areas will be developed over the next three months.
- One key outcome of this scheme will be to reduce the movement from lower tiers of risk into higher tiers of risk (medium / high risk)
- Defining risk factors for each condition, who does it and how we respond to that.

Scheme three: Further development of care plans that are shared, agreed and implemented jointly

We successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and signed-off by the service user or patient.

We will extend this further to: scale it to all people with complex health and care needs; and include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Key aspects of this scheme are:

- The care plans will be delivered around the MDGs at the level of (or aligned to) emerging GP networks
- The plans will be personalised and centred around the person and agreed with the service user
- They will be developed by integrated and virtual provider networks representing health, social care and third sector.
- An absolute focus on optimising the independence of the person and development of self-care plans in collaboration with service users and carers
- Shared accountability and governance
- Involvement of the third sector especially in provision of health trainers (lifestyle coach or behaviour change agents) to support people, one to one or in groups
- Sharing and the active management of care plans are crucial enablers. We will explore the use of a shared record system can be part of the solution.

The following table shows the care planning spectrum and what we plan to do at each level.

Table: care actions across the planning spectrum

Low risk	Medium risk	Complex
People early in the stage, identified with one or two factors *(low risk is not to be a focus on BCF*)	People with two or more health and care issues *(need to refine the definition)*	People with multiple and complex health and care issues
Care planning will cover: • Self-management plans • Behavioural change support (groups) • Pre-diagnosis pathway (in case of diabetes) • Social factor risk mitigation (such as in social isolation)	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Care navigation (signposting and informing how to access the system) • Social factor risk mitigation	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Case management (proactive management of health and care conditions with a nominated lead professional) • Care coordination (active support in accessing the system using a support worker, potentially from third sector) • Social factor risk mitigation and counselling with person,

family and carer(s)

- Pre-crisis management: Availability of rapid care bundle (includes: medical monitoring support, domiciliary care, telecare, helpline and others as necessary)

Scheme four: Integrated case management and care coordination

People with complex health needs often have social care needs and vice versa. It is prudent to manage both aspects together creating a more efficient and seamless system built around the individual. We have a team of community matrons that manages complex cases in the community and a separate team of social workers that manages cases with complex social care needs. We have identified that a significant proportion of the current workload is in respect of the same cohort of residents. As part of the ICP, we will develop an integrated community team with health, social care, mental health and third sector.

Key attributes of this approach include:

- An approach built around emerging GP networks with a named case manager per person
- Managing health issues, providing reablement/rehabilitation, promoting independence and managing risk factors. A key objective is to manage complex cases in the community and provide care coordination.
- Coordinate with other services in the community such as specialist nursing, district nursing, palliative care teams, assistive technology, equipment, intermediate care (rehabilitation and reablement) and other services as necessary
- Support from care of the elderly physician for case conferences and advice
- Single (or trusted) assessment for mobilisation of resources, reducing duplication

An important point to understand is the continuum along with health and social care spectrum of risk. People who are being case managed have a high risk of deterioration in health or social risk factors. If not managed well in the community, they may end up in hospital or require a high level of care support or potential admission into care homes.

Scheme five: Review and realignment community services to emerging GP networks

We have improved the efficiency of our community health services. However, more work needs to be done to ensure that we get value for money from our existing services and that they are better integrated between health, social care and the third sector. We will therefore do the following:

- Review current community service configuration and realign resources around the emerging GP networks
- Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated serviced provision.

- Develop programmes to support step down from core community services to less intensive care (care bundles).

- Short term assessment followed by signposting to services for target groups e.g. older people and populations with highest needs. Multi-agency signposting including health, housing, social care and benefits.

- Mainstream individual care planning and the development of personalised care planning and patient participation with all professionals

Scheme six: Rapid response and joined up intermediate care

Hillingdon currently has a rapid response service led by CNWL. This service has presence both in the A&E as well as in the community and supports people to stay at home, thus avoiding inappropriate admissions to secondary care.

As part of Better Care Fund, we will develop the model further by:

- Embedding social care within the current team to ensure that joint assessments and planning is undertaken for residents

- Including mental health liaison as part of the core offering

- Enhancing the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence.

- Scaling up the integrated team to ensure that every resident who could be supported at home rather than a hospital receives an opportunity to be so supported

- Embedding seven day working across all the contributors to rapid response

- Creating a joined up, single, intermediate care team which will include reablement, community rehabilitation, equipment, telecare and homecare.

Scheme seven: Early supported discharge

We have initiated an early supported discharge initiative in conjunction with system-partners. As part of the new development, we will:

- Scale the service further to its optimal level with a significant impact on number of overall bed days required, delayed transfers of care and excess bed days for non elective care.

- Develop a proactive cross-service hospital discharge team with input from social care, community services and the third sector

- Agree a discharge protocol and process that starts on the day of admission of an older person to hospital

- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards

- Bring primary care fully into the discharge process

- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way

Scheme eight: Better care for people at the end of their life

We will realign and better integrate the services we provide to people towards the end of their life. Our processes will me more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

Key components will include shared care plans, aligned budgets and common development activity. We will also work towards a trusted assessment framework and local operating model between health and social care.

Scheme nine: Care / nursing homes initiative

Too many of our hospital admissions are from care homes directly. A number of case studies show how the level of care in care and nursing homes can be enhanced by proactive support from multi-disciplinary teams from health and social care.

We have already initiated a number of workstreams such as provision of mental health liaison and diabetes management support but we acknowledge that more needs to be done to support people within care and nursing homes to improve their quality of life and retention of independence.

Key aspects of our proposals are as follows:

- Focus of learning and development of staff within care and nursing homes through an integrated community team consisting of case managers (nurse), contracting leads, social care and care co-ordinator.
- Support from specialist clinical staff and nursing teams as appropriate and aligned input from social care teams
- The team will also support in monitoring improvements in care to people admitted in those care / nursing homes and ensure care homes understand and implement robust environmental risk assessment and dignity challenge
- Focus on managing people optimally in care / nursing homes and reduce inappropriate emergency admissions from care homes to secondary care

The first phase of implementation will commence in 2014/15 and will focus on care / nursing homes with the highest rates of admission with an objective to undertake risk assessments of complex care home residents, identify those patients in need of an advanced care plan, provide clinical support and training to manage conditions in the setting, identify the areas where staff in settings require skills' development.

We will also work with settings to develop skills at dealing with patients with complex conditions.

Scheme ten: Seven day working initiative

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an "early adopter" of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for 'downstream' wards, surgical consultant cover twice daily rounds during weekends), increased support to junior staff from consultants

- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

Scheme eleven: Development of IT system across health and social care with enhanced interoperability

This is an important aspect of the delivery of integrated care in Hillingdon.

We also aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system.

Clustering of our proposals for finance and management purposes

Many of the eleven schemes listed above are closely related to each other and at a practical level we may not be able to differentiate the impact of one scheme from another closely related one. So for the purposes of BCF financial monitoring and for elements of our internal management of these, we have clustered the schemes under the following headings:

Project cluster	Schemes included
Integrated case management	Schemes 1, 2, 3, 4, 8, and 11
Intermediate care	Schemes 6, and 7
Seven day working	Scheme 10
Seamless community services	Schemes 5 and 9

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implications for the acute sector

Our BCF plans have been developed with both acute and community providers. The BCF proposals have been fully aligned with the detailed plans for The Hillingdon Hospital set out in *Shaping a healthier future* (the overarching plan for NW London's hospital provision) and Hillingdon's Out of Hospital Strategy. These set out a clear vision for the range of services to be offered by THH. Nothing presently planned under BCF will threaten the fundamental integrity of

those plans.

Work to date on the development of Out of Hospital Hubs in Hillingdon has incorporated projected changes from integrated working for older people including new ways of working and seven day working.

The successful implementation of the BCF proposals should mean both fewer non-elective admissions of older people to THH and a shorter length of stay. These outcomes are jointly agreed by THH and the rest of the health and care system in the Borough. Initial modelling on assumptions, impact and outcomes for schemes that will impact on unscheduled admissions to hospital has been completed as part of Hillingdon's 14/15 plans. The projected impact on THH for 14/15 is that a minimum of seven patients a day would have their admission avoided through the provision of appropriate rapid response and community based intermediate care services.

Around 25% of Hillingdon's acute activity by cost is actually provided by other institutions and we are in the process of consulting these bodies about future commissioning intentions. Many provide specialist services to our health and care economy and we would anticipate that flow of patients continuing in the short to medium term.

In the longer term, our separate ambitions around provider networks will have an inevitable impact on the acute sector in Hillingdon, but these changes will be carefully implemented and fully consulted upon.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Proposed governance

There are well-established channels of governance to build on in Hillingdon. The BCF governance arrangements mirror those we have in place for the management of funds under Section 75 National Health Services Act 2006, such funds held by the local authority.

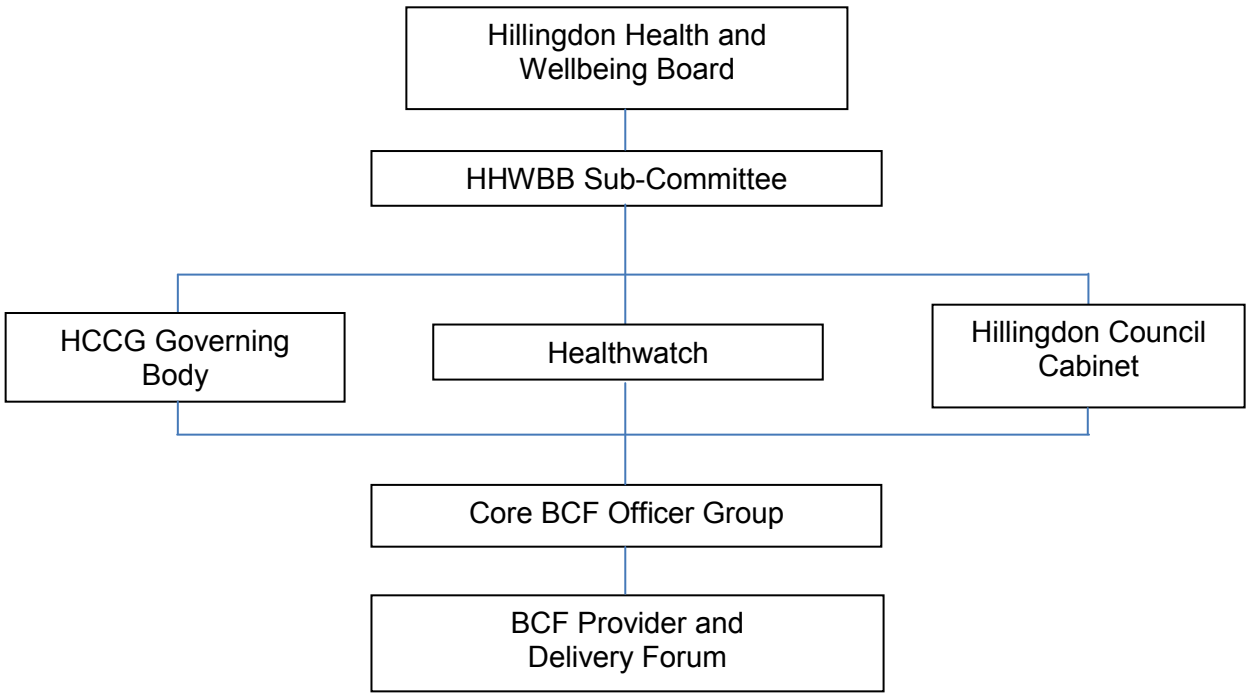
The **Hillingdon Health and Wellbeing Board** (HHWBB) provides leadership in developing a strategic approach for health and wellbeing in Hillingdon and is responsible for holding partner agencies to account for performance on agreed priorities. It is also responsible for collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance. The board therefore takes full strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for BCF. It is responsible for final sign off of plans and reports on behalf of partners. It is the overarching leadership and governing body but does not, however, have authority to take investment decisions on behalf of its members. Individual partners, therefore, need to be satisfied with the proposals going to the Board and, as necessary, to agree them in advance. This applies to the **HCCG governing body** and to **Hillingdon Council's cabinet**.

Healthwatch Hillingdon, as the local "consumer champion" and full member of the Board needs to be satisfied that plans reflect its understanding of what residents and patients say they want.

HHWBB has established a **Sub-Committee** to take forward its transformation work, with wide ranging terms of reference. They provide the sub-group with a broad remit to consider future options for closer integration, including the BCF. The Sub-Committee has instructed a **Core Officer Group** to progress work on the BCF and to report back. This group meets at least monthly with a wider **BCF Provider and Delivery Forum**.

Regular engagement and communication will be required with wider stakeholders including residents, services users, patients, voluntary and community sector groups, care providers and staff.

The arrangements are set out in the diagram below.



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting social care services within the London Borough of Hillingdon means that those identified as being in need of social care support continue to receive the care they require.

The proposals within this plan protect Adult Social care services through managing the demographic pressures; which may otherwise result in a change to the Fair Access to Care eligibility criteria threshold

Please explain how local social care services will be protected within your plans

The NHS transfer monies have been allocated to schemes which support social care and have health benefits.

This plan proposes the continuation of these schemes alongside the funding of new initiatives aimed directly at managing the demographic growth pressures. Furthermore this plan developed from identified gaps within the integration pathway; seeks to shift delivery of care from reactive interventions within an acute setting to a model of personalised joined up care. This supports our vision of Older People living healthy and well maximising their independence and enabling active community engagement. All of which protects social care services and their budgets by optimising independence and supporting people to remain in their own home.

b) Seven day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an “early adopter” of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing a seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for ‘downstream’ wards, surgical consultant cover twice daily rounds during weekends), increased support to junior staff from consultants
- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Our present social care systems already allow the entry of the NHS number. We can adopt this number as a common identifier by 2015 which will allow time for service processes to be amended to ensure the capture of the NHS ID is completed.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems that have APIs and Open Standards. Our social care system provider is currently working on developing APIs for this purpose.

Through our PSN connection we already conform to the secure email standards

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Our commitment is demonstrated by our *green light* status on the code of connections for IGSOC, N3 and PSN. A bi monthly Information Assurance Meeting (HIAG) chaired by our SIRO has been in place for a number of years and is attended by senior member of the Council's leadership team.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The accountable lead professional and joint assessment will build on our current Integrated Care Programme. Currently 85% of practices use risk stratification tools to enable the development of coordinated care plans for people at risk of admission to hospital. The BIRT tool will be adopted as part of the BCF work stream. We are working jointly with CLAHRC to develop a predictive tool to better aligns social and health factors as part of early detection of risk factors to enable better targeted support.

The lead professional role will be aligned with the development of GP based MDGs and emerging networks. The GP will be the responsible clinician, with care coordinators working at MDG level to ensure those identified with risk factors have individual co-designed interventions and care plan initiated with multi provider input and regular review. Complex people most at risk of admission (circa 560 people plus include social care number) will be supported by a community matron lead professional working within a primary care based (or community based) integrated service.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
1. Inability to shift resources from acute into community	High	All our BCF plans have been developed in the context of *Shaping a healthier future* and its picture of the core activity of THH. Our plans have thus focussed on alignment of investment and service changes with subsequent reduction in secondary care. We have prioritised schemes in such that schemes with high impact will implement early, driving a marked reduction in need of secondary care resources. Our planning includes performance reporting that will track benefits (or a lack of benefits) in real time.
2. Lack of engagement from frontline/ clinical staff resulting in no behaviour changes in the frontline services	High	This is a long term project for us. We have been working on our integrated system for the last two years (ICP, rapid response and intermediate care) and our frontline staff (including clinicians) have been involved in designing and implementing these changes. Stakeholders have been involved through the development of the BCF plans. We will develop a detailed engagement plan for frontline workers as part of our implementation. It will recognise the deep culture change needed to change ingrained behaviours on all sides. Senior leaders have committed to demonstrating that culture in their everyday work. The clinical leadership of our projects is designed to ensure a greater sense of ownership of the proposals.
3. Requirements of Care Bill	High	DH are expected to publish draft regulations and guidance to support the Bill for consultation in Spring 2014, in advance of legislation coming into force from April 2015. The statutory requirements of the Care Bill remain unconfirmed at this stage
4. Maintaining Eligibility	High	Within the proposals of the Care Bill is a clause to set national eligibility criteria which Local Authorities (LA) must apply. This is a significant risk and considerable change to the current local arrangement where LA's set the eligibility criteria based on the resources available to them.
5. That initiatives outside of BCF divert effort away from the plan or create duplication or tension between schemes	High	The HWBB will oversee the plan and monitor its implementation and seek to reduce risks. The governance structure outlined within the plan will enforce need for focus on the BCF as the key plan for integration of health and social care in Hillingdon.

Risk	Risk rating	Mitigating Actions
6. Lack of involvement of patients and carers in development of new changes	Medium	It is extremely important that we involve patients and carers in developing detailed plans and use their experiences to affect the changes in the system. A robust engagement and involvement plan will be developed (work already progressing). We have and will continue to involve patient and public representatives (including carers) in designing and implementation through a series of engagement sessions. Health watch as a local consumer champion will play a role in the overall governance of BCF.
7. Continued demographic pressures	Medium	Demographic pressures will grow – addressing them poorly in the key risk. We will approach mitigation in three ways: 1. As part of BCF, we will carefully deploy resources on target groups with complex health and care needs and some whose needs are less complex. The aim being to stop increasing the risk profile and reduce acuity through concurrent investment. 2. We will undertake detailed activity modelling as part of the final submission to better understand the impact of demographic pressures at the micro level (neighbourhood, gender and ethnicity) to ensure that our capacity plans reflect that growth. 3. Our plans are based on ensuring that people are better supported holistically at home. There will an intense effort to ensure that complexities are managed through multidisciplinary teams. This will restrict growth in cases within secondary care and care homes.
8. Potential exposure of financial risks if BCF outcomes are not delivered in 13/14 and subsequently	Medium	A strong focus on benefits realisation through detailed planning Real-time performance planning and a common KPI dashboard Realistic common planning around deliverability testing will be put in place
9. Alignment with other whole system integrated care plans for Hillingdon within the time scale for BCF submission	Medium	A common strategic governance system is now in place. We will strengthen programme-level governance to align projects We will work towards jointly-commissioning a number of such initiatives in the future
10. Lack of accurate data	Medium/	We have used clinical audit information and

Risk	Risk rating	Mitigating Actions
and baseline estimates	low	stakeholder validation where data was not accurate and/or easily available. We have modelled for some of the projects in greater detail to mitigate for data inadequacies schemes and intend to do the same for the remainder. We will reconcile this information through 2014/15 to ensure that any discrepancy is highlighted and addresses before project implementation
11. Other competing pressures from within the organisation (efficiency) and outside could decrease the priority in partner organisations	Low	Strong governance and leadership by elected members and the CCG GB will facilitate honest discussion about priorities. Most pressures (eg from the Care Bill as it is enacted) would have shared consequences and we recognise the need to plan together to address these. Our coterminous boundaries mean that the channels of communication are strong.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1. Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
London Borough of Hillingdon	Y	£ 4,772	£ *2,349*	£ *2,349*
Hillingdon CCG			£ *15,642*	£ *15,642*
BCF Total		**£ 4,772**	**£ 17,991**	**£ 17,991**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

This work builds on mature schemes, where risks are already being mitigated as part of current schemes which are part of wider recovery plans. The BCF is fully aligned with CCG 3 year recovery plan and Local authority 3 year MTFF plan.

Contingency plan:		2015/16	Ongoing
Outcome for All	Planned savings (if targets fully achieved)	5,127	5,267
	Maximum support needed for other services (if targets not achieved)	Any pressures within LBH will be managed through in year budget management. Similarly, within HCCG, any budget pressures will be managed through the recovery programme for CCG. Detailed contingency plans and risk mitigation plan will be drawn up as part of business cases.	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Integrated Case Management	ICP	100				1,945		911	
Intermediate Care	LBH/CNWL	3,272				8,198		176	
Seamless Community Services	LBH/CNWL	747				4,845		4,040	
Seven Day Working	All***	654				654		*0*	
Capital funding	LBH					2,349			
Total		£ 4,772	£ -	£ -	£ -	£ 17,991	£ -	£ 5,127	£ -

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

Permanent Admission to Residential Care Homes for Older People: This indicator is a visible marker as to the whole systems approach to integrated care. Continued decrease in the number of older people admitted into a care home provides evidence of better access into effective and responsive intermediate care services, management of unscheduled and emergency care and optimisation of length of stay in bed based accommodation, signalling a move from a paternalistic model of care to one that offers a more personalised as well as cost effective approach.
The 2014-15 performance target is indicative of progress made to date in reducing admissions into residential care. We will remain ambitious for a greater achievement but our risk analysis highlighted the whole systems dependencies hence the conservative target.

Proportion of older people still at home 91 days following hospital discharge: The benefits, which underpin this indicator, include softer metrics such as better co-ordination and joint discharge planning as part of the discharge process. A key outcome is greater scale and improved effectiveness of the rehabilitation / rehab programmes and ensuring that people gain optimal independence improving their ability to support themselves at home. This will lead to reduction in re-admissions and improved patient outcomes and overall experience. Although the relative performance initially appears conservative we intend for a significant number of additional clients to both enter the reablement service and be remaining at home 91 days later thus increasing both the denominator and numerator.

Delayed transfers of care: A key outcome to be achieved is that patients fit for discharge will not be unnecessarily delayed. The benefits include a reduced length of stay enabling better bed management and prevention in delays in the discharge. Reduction in unnecessary stays in hospital will also reduce dependency, chances of hospital-acquired infections and other effects of institutionalisation. When setting our target as part of the risk analysis we have taken into consideration wider whole system changes which include proposed changes to the acute sector. On this basis the target has been set with a 75% confidence interval.

Avoidable emergency admissions: A key outcome will be reduction in emergency admissions in older people for those conditions that can be avoided or better managed in the community. Better management of people who are at high risk will impact significantly on the experience, quality of life and overall outcomes. Reduction in admissions will also reduce over reliance in traditional forms of health and social care provision such hospitals and care homes. Anticipated performance targets set for 2014/15 with regard to this metric are consistent with progress already made

Local metric: Number if agreed care plans: A key outcome will be development of care plans which are agreed with the patient and carer. This will support patient / user empowerment, promote self care and will mobilise the whole system around the person.
The measurement of all these indicators will be through established pre-existing reporting mechanisms detailed further in the governance section.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

No single national measure of integration currently exists. A national metric is currently being devised for reporting in October 2015. However, work is progressing on finalising a local metric(s) in case national metric is not developed fully or not appropriate for Hillingdon for reason such as availability of data.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Agreement on ALL metrics was done through a robust process of development that included:

• Understanding and agreeing the baseline
• Comparing against national benchmarks and/or trend analysis
• Creation of potential scenarios using confidence intervals
• Risk assessment and final decision making (keeping a balance between achievability and stretch)

A senior executive team from CCG and LA (BCF core group, set up as instructed by HWWB sub committee) agreed all metrics jointly based on a number of factors including; potential impact from schemes in year one, time lag between implementation and actual impact, plausibility & stakeholder acceptance and risks.

Internal check and validation was done using internal processes that included presentation and acceptance from various bodies such as HCCG governing body and senior members from the LBH executive team before being presented and finally agreed in HWWB.

The governance process (outlined separately in the governance section of the main submission) will manage performance on a monthly / quarterly basis. We will trigger data set requests that will be collated from multiple organisations to triangulate overall system impact.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	553.8	N/A	520.0
	Numerator	205		197
	Denominator	36655		37885
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	88.40	N/A	89.00
	Numerator	60		107
	Denominator	70		120
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	208.5	195.1	189.6
	Numerator	440	433	427
	Denominator	218551	221894	225201
		Apr '12 to Jun '13 15	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	1979.8	1949.1	1918.7
	Numerator	5648	5654	5656
	Denominator	285286	290082	294789
		Apr '12 to Mar '13 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		*Dec-13* 1	N/A	*(State time period and select no. of months)* 1
Number of care plans (agreed by patient and or carer) ** Number of care plans agreed: The metric value is derived as total number of care plans per 100,000 population (18+ only). Numerator: Total number of agreed care plans. Denominator: ONS mid-year population estimate. Please note that care plans will be developed for those pople who are identified as 'with risk' based on risk stratification tool and other ways. (Evidence of agreement - audit of care plans in practices clearly stating that it was agreed with the patient / carer)	*Metric Value*	0.0	180.3	444.0
	Numerator	0	400	1000
	Denominator	218551	221894	225201
		Apr '12 to Mar '13 12	*Apr '14 to Sep '14 (6 months)* 6	*Oct 2014 - Mar 2015 (6 months)* 6

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HILLINGDON CCG 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATING PLAN

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Ceri Jacob: Chief Operating Officer
Papers with report	Appendix 1 – Outcomes Measures Appendix 2 – PART 2 - Draft North West London 5 Year Strategic Plan

1. HEADLINE INFORMATION

Summary	The NHS planning guidance 2014-2018 "Everyone Counts" requires Clinical Commissioning Groups to develop and agree with the local Health and Wellbeing Board (HWBB) and NHS England (NHSE) a five year strategic plan with the first two years at operating plan level.
Contribution to plans and strategies	• JSNA • Hillingdon Health and Wellbeing Strategy • Hillingdon CCG Out of Hospital Strategy.
Financial Cost	N/A
Relevant Policy Overview & Scrutiny Committee	External Services Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes and comments on the 5 year strategic plan noting the final submission date of 20 June 2014; and**
2. **agrees local priority set out in the 2 year planning documents.**

3. INFORMATION

NHS England (NHSE) required CCGs to submit 5 year plans across a wider geographical footprint than individual borough level, in recognition of the fact that patients access services from across London and not just within their own borough. Hillingdon CCG's 5 year plan is written at a North West London (NWL) level reflecting existing shared work at a NWL level across key strategic programmes such as the Shaping a Healthier Future acute reconfiguration

programme. A first draft of the five year plan will be submitted on 4 April 2014 and is attached here for comment. A final draft will be submitted by 20 June 2014.

The two year element of the planning submission is at a local Hillingdon CCG level. CCGs has been required to submit information on anticipated activity levels and targets against national and local quality premium measures. National targets relate to:

- Potential years life lost (PYLL) from amenable causes
  Target set locally = 1% reduction
- Avoidable emergency admissions
  Target set locally = 1% reduction
- Proportion of people that enter IAPT treatment against the level of need in the population
  Target set nationally = 15%. HCCG does not expect to meet this target in 2014/15
- Meeting Friends and Family Test targets
  HCCG expect to meet targets
- Agreeing, in conjunction with the HWBB, a specified increased level in reporting of medication errors from specified providers

The Hillingdon Medicines Management Team is currently reviewing the quality premium in relation to medication errors and the submission on 4 April 2014 will not include a figure. A proposed measure will be presented to the Health and Wellbeing Board (HWBB) in June.

The proposed local quality premium in Hillingdon is:

- To reduce the number of admissions and readmissions to acute care for people aged 65 years and over as a result of a fall
  Target set locally =5%

The rationale for this target is that falls and associated fractures can be avoided in many cases and are associated with increased health and social care costs. It aligns with the JSNA priority:

- Community-based Resident-focussed services

Other key measures include:

- A diagnosis rate of 67% of expected dementia prevalence
- An IAPT recovery rate of 50%

Achievement against national and local priorities is monitored at least quarterly by NHS England.

4. FINANCIAL IMPLICATIONS

Failure to achieve all elements of the quality premium will reduce allocation of funds to the CCG in 2015/16.

5. LEGAL IMPLICATIONS

N/A.

6. BACKGROUND PAPERS

NHS planning guidance 2014-2018 “Everyone Counts”

Appendix 1: Outcomes Measures

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
1. Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area.	Improvement to be locally set and no less than 3.2%. CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.	None
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	IAPT roll-out: i. achieve 15% for CCGs below that level ii Additional locally set improvement for those over 15% or near 15%.	• Increase dementia diagnosis rate to 67 per cent by March 2015. • Achieve the IAPT recovery rate of 50%.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	A rate comprised of: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions. • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. • Emergency admissions for acute conditions that should not usually require hospital admission. • Emergency admissions for children with lower respiratory tract infections.	As per outcome measure	None

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
4. Increasing the proportion of older people living independently at home following discharge from hospital.	No indicator available at CCG level. CCGs and Area Teams will not be expected to set a quantitative level of ambition for this outcome. However, they will be expected to set out how they will improve outcomes on this ambition in their five year strategic plans.	None	A level of ambition needs to be established at Health and Wellbeing Board level on the *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.*
5. Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care.	Friends and Family Test: specific actions to improve low scores.	None
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Composite indicator comprised of (i) GP services, (ii) GP Out of Hours.	None	None
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Hospital deaths attributable to problems in care. This indicator is in development.	Improving the reporting of medication errors.	• MRSA zero tolerance • *Clostridium difficile* reduction

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