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Health and Wellbeing Board

Date: **THURSDAY, 3 DECEMBER 2015**

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

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 CBE
Dr Ian Goodman (Chair - Hillingdon CCG)
Jeff Maslen (Chair - 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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Lloyd White
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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 22 September 2015	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)

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

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.

17 Any other items the Chairman agrees are relevant and urgent

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Minutes

HEALTH AND WELLBEING BOARD

22 September 2015

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Statutory Voting Board Members Present: Councillor Ray Puddifoot MBE (Chairman) Councillor Philip Corthorne (Vice-Chairman) Councillor Douglas Mills Councillor David Simmonds CBE Dr Ian Goodman - Hillingdon Clinical Commissioning Group Jeff Maslen - Healthwatch Hillingdon **Statutory Non Voting Board Members Present**: Tony Zaman - Statutory Director of Adult Social Services and Interim Statutory Director of Children's Services Dr Steve Hajioff - Statutory Director of Public Health **Co-opted Board Members Present:** Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust Maria O'Brien - Central and North West London NHS Foundation Trust (substitute) Nick Hunt - Royal Brompton and Harefield NHS Foundation Trust (substitute) Ceri Jacob - Hillingdon Clinical Commissioning Group (Officer) (substitute) Dr Reva Gudi - Hillingdon Clinical Commissioning Group (Clinician) Nigel Dicker - LBH Deputy Director Residents Services Jean Palmer OBE - LBH Deputy Chief Executive and Corporate Director of Residents Services **LBH Officers Present**: Glen Egan, Steve Powell and Nikki O'Halloran **LBH Councillors Present:** Councillor Phoday Jarjussey **Press & Public: 1**
12.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Councillors Jonathan Bianco, Keith Burrows and Scott Seaman-Digby and Ms Robyn Doran (Ms Maria O'Brien was present as her substitute), Mr Robert Bell (Mr Nick Hunt was present as his substitute) and Mr Rob Larkman (Ms Ceri Jacob was present as his substitute).
13.	**TO APPROVE THE MINUTES OF THE MEETING ON 21 JULY 2015** *(Agenda Item 3)* Consideration was given to the minutes of meeting held on 21 July 2015 and the following matter arising: • Minute 2: To Approve The Minutes Of The Meeting On 17 March 2015 (*Minute 48: Primary Care Contraception Service - meeting held on 17 March 2015*) - At its meeting on 21 July 2015, the Board had agreed for further investigation to be

	undertaken by the Hillingdon Clinical Commissioning Group (HCCG) Chairman into the funding of the primary care contraception service and that the temporary funding for the service would be agreed until September 2015. It was noted that the Council's Director of Finance had written to the HCCG Chairman evidencing the authority's belief that, following detailed investigations, the funding had not been transferred to the Council. Dr Goodman believed that the documents forwarded to the Council by Mr Jonathan Wise provided the audit trail for this funding transfer but would undertake further investigations. It was agreed that HCCG would provide the Council with this evidence before the next Health and Wellbeing Board meeting on the understanding that, if this evidence was not provided, HCCG would need to reimburse the Council. In the meantime, it was agreed that Council funding for the primary care contraception service would continue until December 2015. **RESOLVED: That:** **1. the HCCG provide the Council with evidence to show that funding for the primary care contraception service had transferred to the Council before the next Health and Wellbeing Board meeting;** **2. Council funding for the primary care contraception service continue until December 2015; and** **3. the minutes of the meeting held on 21 July 2015 be agreed as a correct record.**
14.	**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)* It was confirmed that Item 13 would be considered in private. All other items would be considered in public.
15.	**HEALTH & WELLBEING STRATEGY: PERFORMANCE REPORT** *(Agenda Item 5)* It was noted that the report included the latest performance against indicators and it was pleasing that there had been reductions in a range of indicators including Under 18 conceptions, preventable sight loss and hospital admissions. In addition, a pilot weight management programme had been introduced to help reduce the risk of chronic disease in obese adults. The Board was advised that, in line with its statutory duties under the Environment Act 1995, the Borough had a declared Air Quality Management Area (AQMA) from the Chiltern-Marylebone railway line to the southern Borough boundary. It was noted that the Council would be responding to the Air Quality Action Plan matrix which was currently out for consultation. The Vice Chairman advised that he had visited the Rural Activities Garden Centre over the summer as well as the drug and alcohol outreach service where he had spoken to staff about the encouraging proactive work that had been undertaken with the hospital. It was noted that the Council had provided TeleCareLine free of charge to Hillingdon residents over the age of 80 for some time. Consideration was now being given to the possibility of extending this to those aged 75 and over but would depend on the extent to which it would have a positive impact on the work of partner agencies. **RESOLVED: That the Health and Wellbeing Board:**

	1. noted the updates in the report and delivery plan. **2. noted the outcome performance indicators in the quarterly dashboard.**
16.	**BETTER CARE FUND: PERFORMANCE REPORT** *(Agenda Item 6)* Officers were thanked for the work that had completed so far and it was noted that further work was still required. The Better Care Fund performance report covered a subset of the activities undertaken by partners and, although the format was similar to Cabinet reports, the quality needed to be improved. The Board was advised that £1m had been included in the budget for Care Act new burdens. However, it was important to ensure that this was monitored and managed and that any discrepancies were identified so that next year's budget was as accurate as possible. It was noted that some of the causes of delayed transfers of care (DTOC) were known about in advance, e.g., a patient not wanting to be moved to a care home. To mitigate this delay, Integrated Assessments were now undertaken with the patient and their family at the start of the process rather than towards the end. Although these discussions were undertaken as early as possible, they could often be protracted, which contributed to delays. The Hillingdon Hospitals NHS Foundation Trust (THH) was familiar with those patients that were regularly readmitted to hospital. Mr DeGaris noted that the Trust's objective was to get these patients back home as soon as practicable with the support that they needed in place. However, as patients with escalating crises would not benefit from this help, the possibility of moving into a care home had to be discussed. The Board noted that, with regard to DTOC, there were issues regarding people with mental health issues in that they were sometime difficult to locate due to their lifestyle. As such, consideration was being given by CNWL to investment in housing stock and additional secure locked beds. It was anticipated that the development of an integrated care plan template would assist with care planning and care coordination across all partner agencies. Hillingdon Clinical Commissioning Group (HCCG) advised that many of the services that it commissioned were block contracts which resulted in a predictable one twelfth of the budget for these services being spent each month. It was noted that a blcok contract would have to significantly over or under perform to trigger a discussion. It was agreed that HCCG would include information about the activity of these contracts in future reports to the Board. A decision had not yet been made about the additional funding that could run alongside this as it was still going through the governance process to ensure that it was deliverable. It was agreed that the Board also be provided with: • a rough breakdown of the overspend from the Council and HCCG in relation to rapid response and joined up intermediate care to identify activity and possible improvements; • detail of the outturn in relation to seven day working; • a breakdown of, and reasons for, the overspend from the Council and HCCG in relation to the review and realignment of community services to emerging GP networks; and • a breakdown from Council officers of the calculation of the £1,686k outturn in relation to the Care Act implementation.

	RESOLVED: That the Health and Wellbeing Board: **1. noted the contents of the report.** **2. approved the increase in the permanent admission to care homes target for 2015/16 from 104 to 150.** **3. would receive information about block contract activity in future HCCG reports.** **4. receive the additional information as detailed in the minute.**
17.	**HILLINGDON CCG UPDATE** *(Agenda Item 7)* The report identified key areas of work being undertaken by Hillingdon Clinical Commissioning Group (HCCG). It was noted that there had been significant constraints on NHS funds, additional pressures on medical and clinical staff and an increase in demand which necessitated the need to look at different ways of working, such as collaborative arrangements. Four GP networks had been established across Hillingdon and the composition and services provided by each had been set out in the report. It was noted that integrated care planning (ICP) had been incorporated into every network and, it was hoped, would be fully effective in time for the winter pressures. The Board was advised that, although there were no savings targets planned for the networks this year, there were targets set in relation to the diabetes service and consideration would be given to the provision of quality improvements as opposed to financial savings. It was suggested that the creation of targets would provide HCCG with something to aim for. It was recognised that there was a direct correlation between a patient's home address and their likelihood to attend A&E rather than go to see a GP. Although there were issues around ease of access, it was noted that a significant number of these patients came from countries where there was no primary care service. In a recent audit undertaken at Hillingdon Hospital A&E, approximately 60% of patients had not contacted their GP before attending A&E. Dr Goodman stated that, at month 4, HCCG was forecasting an outturn of £6.18m (£1.566m variance) against its QIPP (Quality Innovation, Productivity, Prevention) target for 2015/2016. However, it was noted that HCCG was looking to address this by identifying areas for improvement such as MSK activities, chronic pain, dermatology and paediatric schemes. Insofar as HCCG's financial position was concerned, Dr Goodman remained optimistic. He noted that HCCG was on target to achieve a planned surplus of £1.161m and a forecast surplus of £3.482m in line with its plan. In addition, HCCG was looking to develop more GP services across the Borough and would be working with NHS England to address estate management issues. It was agreed that, as not all of the detail in relation to the reserves had been included in the report, e.g., areas of underspend, more specific information would be included in future reports to the Board. **RESOLVED: That the Health and Wellbeing Board note the update.**
18.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 8)* Issues of concern to Healthwatch Hillingdon (HH) identified in the report included difficulty in accessing primary care, outpatients and continuing healthcare treatment. At the next HH Board meeting, it was anticipated that consideration would be given to

	approving a new programme of engagement which would join up issues raised by the community with the work of providers and commissioners to resolve concerns as efficiently as possible. Mr Maslen noted that HH was now in a position to undertake larger and more formal projects which could include: • Unsafe discharges (also known as delayed discharges) - this involved many services that needed to work in an integrated way and, it was hoped, HH would provide a patient perspective to work that was already underway. • Maternity services - following the closure of the service at Ealing Hospital, HH would be investigating the patient experience at Hillingdon Hospital. • CAMHS - as well as being part of the multi agency approach, HH would be testing services. • Primary care - as primary care would be at the heart of the new model of care, HH would be providing a patient perspective. Concern was expressed regarding the extent that the NHS had consulted and engaged with residents. • Care homes - HH was conscious that the Council had a team that inspected care homes so would be looking to complement this work. • Shaping a healthier future (SaFH) - HH planned to spend a lot of time engaging on this programme at a North West London level. It was noted that HH had recently produced a report *Seen & heard - Why not now?* in relation to CAMHS in Hillingdon. Concern was expressed regarding the variation and quality of the support that was provided through schools and what level of influence would be gained through the implementation of a plan. With regard to the HH Board vacancies, members were advised that Mr Maslen had outlined six key projects to be undertaken. It was anticipated that each of the existing Board members would lead on one of these projects based on their skills, knowledge and experience. Recruitment to fill the vacancies would then be focussed on selecting Board members with the relevant background to lead on the remaining projects. Mr Maslen advised that HH would be taking the Council up on its offer to advertise the vacancies through Hillingdon People as it was deemed to be the best hard copy medium that could be used to engage with Borough residents. **RESOLVED: That the Health and Wellbeing Board note the report received.**
19.	**UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 9)* It was noted that the Yiewsley Health Centre development would not be going ahead as it had become apparent that NHS Property Services (NHSPS) was not able to afford the rent. As a result, HCCG would need to consider alternative appropriate local uses for the £398,438 s106 funding that had been set aside for this project. Consideration would need to be given to alleviating any resultant pressure that might felt by the surgeries in Yiewsley. It was suggested that the Board forward its comments to Ministers in relation to the frustration felt at the failure of the Yiewsley Health Centre development after 6 years of discussions with NHSPS. The MP for Uxbridge and South Ruislip had already written to the Secretary of State about this issue and had received an inadequate response back from a Junior Minister. Consideration was being given to forwarding the original letter and the response received to Jeremy Hunt to advise that this was not good enough.

	Concern was expressed regarding the proposed new health hub at St Andrews Park. As development on the site was now moving at a pace, it was becoming increasingly important that NHSPS brought forward a viable proposition to prevent this development from failing in the same way that the Yiewsley Health Centre had. Consideration would also need to be given to the use of £37,732 (H/23/209K) which would need to be spent by March 2016. **RESOLVED: That the Health and Wellbeing Board:** **1. noted the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough; and** **2. recorded its disappointment at the failure of NHSPS to be able to finalise the arrangements for a new health centre at Yiewsley and trusted that NHSPS would not allow the development at St Andrews Park to fail as well.**
20.	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE** *(Agenda Item 10)* In July 2015, it had been reported that further work would be undertaken to prepare a Local Transformation Plan (LTP) and to draw down additional funds. Work was continuing and a strategy document had now been developed and agreed by the Statutory Director of Children's Services, the Director of Public Health, Healthwatch Hillingdon and Hillingdon Clinical Commissioning Group (HCCG). The Plan set out a number of priorities, including: • reducing the waiting times for tier 3 CAMHS; • the development of support services for self harm and crisis; and • preventative work for higher level issues. It was noted that the LTP would need to be agreed before submission and that robust project management arrangements would need to be in place to deliver the Plan for partners. The Board agreed that this be included on its Planner as a standing item every six months and that it would receive a further report at its meeting on 3 December 2015. The Vice Chairman thanked Council officers, Healthwatch Hillingdon and the HCCG Vice Chairman for their efforts so far to implement improvements to prevent individuals from escalating to tier 3. **RESOLVED: That the Health and Wellbeing Board:** **1. noted the progress so far in improving Child and Adolescent Mental Health Services in Hillingdon, through partnership action.** **2. agreed the outline Local Transformation Plan at Appendix 2 of the report and authorised the Chairman of the Board, in consultation with the Chairman of HCCG and Chairman of Healthwatch Hillingdon, to sign off the final submission spreadsheet based on this outline to NHS England by 16 October 2015.** **3. receive a progress report at its meeting on 3 December 2015 and every six months thereafter.**
21.	**IFR/PPWT UPDATE** *(Agenda Item 11)* The report set out the clinical thresholds for treatments. It was noted that policies had been set up in 2011. The NWL Policy Development Group (PDG) had been

	established to review and scrutinise Patient Procedure with Threshold (PPWT) policies and proposals for new introductions against new clinical recommendations and guidance to ensure that they were clinically and financially effective. The PDG comprised a number of organisations including Public Health, pharmacists, Healthwatch and clinicians. Healthwatch Hillingdon believed that, although it might continue to disagree with the Hillingdon Clinical Commissioning Group over cost effectiveness, the PDG brought transparency to the decision making process. **RESOLVED: That the Health and Wellbeing Board noted the update.**
22.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 12)* Consideration was given to the Board Planner and it was agreed that the Board receive a CAMHS progress report at its meeting on 3 December 2015 and every six months thereafter. Furthermore, it was agreed that HCCG's Commissioning Intentions 2016-17 report be brought back to the next meeting on 3 December 2015 for sign off. The Chairman advised that requests for additional reports to be added to the Board Planner should be forwarded as soon as practicably possible. **RESOLVED: That, subject to the above amendments, the Health and Wellbeing Board noted the Board Planner.**
23.	**HILLINGDON CCG COMMISSIONING INTENTIONS** *(Agenda Item 13)* It was noted that the Hillingdon Clinical Commissioning Group (HCCG) was required by the NHS to produce its Commissioning Intentions each year. As the document included on the agenda was considerable, HCCG was planning to produce a two page summary of the important proposed changes and the impact that these changes would have on patients (a copy of the summary would be sent to the Chairman by the end of the week). The Board was advised that the final version of HCCG's Commissioning Intentions 2016-17 would be considered by the HCCG Board in the first week of October 2015. Once it had been agreed it would be published in the public domain. Concern was expressed that the Board was being asked to delegate authority to the Chairman to approve HCCG's Commissioning Intentions 2016-17 without it being in the public domain in final version first. As such, it was agreed that the Chairman would not approve the Commissioning Intentions 2016-17 outside of the Board meetings and that it would need to be brought back to the next meeting on 3 December 2015 for sign off. It was suggested that HCCG revise its timetable in future to ensure that the final version was available for the Board to agree in a timely fashion. It was noted that, as the Chairman would not be agreeing this document in private, HCCG would need to issue its six month letter to contractors without the Board's approval. It was suggested that reference needed to be made to intention and the objectives that needed to be addressed and that finance was an important part of this, as the intentions needed to be affordable. **RESOLVED: That the Health and Wellbeing Board requested a report on the Hillingdon CCG commissioning intentions at its meeting on 3 December 2015.**

	The meeting, which commenced at 2.30 pm, closed at 3.44 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.

HEALTH AND WELLBEING STRATEGY: PERFORMANCE REPORT

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Kevin Byrne, Policy and Partnerships
Papers with report	Appendix A - Health and Wellbeing Delivery Plan progress update Appendix B - Latest Indicator Scorecard

HEADLINE INFORMATION

Summary	This report provides an update on progress against Hillingdon's Joint Health and Wellbeing Strategy Delivery Plan objectives (Appendix A). It also sets out the outcome metrics (Appendix B)
Contribution to plans and strategies	Hillingdon's Joint Health and Wellbeing Strategy is a statutory requirement of the Health and Social Care Act 2012.
Financial Cost	There are no direct financial implications arising directly from this report.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the updates in the report and delivery plan (Appendix A); and**
2. **notes the outcome performance indicators in the quarterly dashboard (Appendix B).**

INFORMATION

Supporting Information

Hillingdon's Health and Wellbeing Strategy was agreed by the Board in December 2014 and regular updates requested from partners setting out progress in delivery.

Four broad priority areas were identified though the Joint Strategic Needs Assessment (JSNA). A more detailed delivery plan and a scorecard of performance indicators was agreed to monitor progress against the Strategy.

Some of the key highlights (note: this does not include all BCF progress or CAMHS progress - see separate reports to the Board) from the Delivery Plan under each of the priority areas are detailed below:

1. Priority one: Improving Health and Wellbeing and reducing inequalities

1.1 **Deliver a mental wellness and resilience programme.** The Time to Change Event in Uxbridge Town Centre on 4 September saw 540 conversations held between volunteers and service users and members of the public. The event was held in collaboration with Hillingdon Mind, CNWL, Rethink and National Time to Change.

1.2 **Antenatal assessments within 13 weeks**. Despite a slight dip during Q1 2014-15, women completing their antenatal assessments within 13 weeks has increased from 85.4% to 94.7% at end Q2 2014-15. This is above the London total and slightly below the England total.

1.3 **Reducing obesity.** The Back to Sport programme is aimed at encouraging adults to participate in playing sport again or for the first time in an informal and fun way. It aims to generate sustainable changes in lifestyle with a variety of things on offer such as Badminton, Cycling, Fencing, Golf, Jog it off, Hockey, Netball, Swimming and Tennis. 'On Your Marks' is a programme run in partnership with Brentford FC and DASH where a variety of sessions including swimming and multi sports are delivered for people with disabilities. Within the last year, over 100 people aged 14 + have engaged in activity.

1.4 **Air Quality**. The GLA is putting in place a London specific local air quality management regime. Guidance from the GLA in terms of how to approach the review of the action plan will be published in early 2016.

2. Priority 2 - Prevention and early intervention

2.1 **Alcohol specific hospital admissions under 18's**. This has shown a steady decline locally with the number per 100,000 of under 18s admitted, falling from 46.9 in 2010/11-2012/13 to 41.9 in 2011/12 to 2013/14. This is, however, significantly higher than the rest of London but roughly in line with the rest of England.

2.2 **Dementia Friendly Borough**. The second meeting of the Dementia Action Alliance took place at the beginning of November which included a showcase of singing, poetry and arts and crafts by people with dementia and some case studies of how people living with dementia continue to live active and fulfilling lives. Ten 'Walk Hillingdon' leaders have now received Dementia Friends training and in September 2015 a further 60 hospital staff became dementia friends including nurses, physiotherapists, occupational therapists and healthcare assistants.

2.3 **Reduce Excess Winter Deaths.** There are a number of activities that aim to reduce excess winter deaths in the Borough. These include providing flu immunisation to people at risk; screening for Chronic Obstructive Pulmonary Disease as part of smoking cessation project to identify smokers at high risk; monitoring Inferior Wall Myocardial Infarction over Coronary Heart Disease; and the Age UK Hillingdon 'Getting ready for Winter' campaign. The Council also continues to provide the Heater Loan Service for homeowners over 65 whose heating breaks down.

2.4 **Rapid response and joined up Intermediate Care**. In Q1 and Q2, the Rapid Response Team received 1,866 referrals, of which 44% were linked to falls, 10% resulting from issues with reduced mobility, 6% relating to back pain and the remainder from issues ranging from urinary tract infection (UTI) to chest pain. Of the 549 discharged home, 57% (310) were discharged with no further assistance required.

3. Priority 3 - Developing integrated, high quality social care and health services within the community or at home

3.1 **Home adaptations**. In Q2, 56 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 44% of the grants provided. 73% (41) of the people receiving DFGs were owner occupiers, 22% (12) were housing association tenants, 5% (3) were private tenants. The total DFG spend on older people during Q2 was £241k, which represented 37% of the total spend (£655k) in Q2.

3.2 **Review and realignment of community services to emerging GP networks**. The multi-disciplinary team (MDT) approach was extended to GP networks in the south of the Borough in Q2 after being successfully rolled out across practices in the north in Q1. The three networks in the south of the Borough are receiving support to ensure that the maximum benefit can be achieved from the use of the MDT process.

3.3 **TeleCareLine**. As at the end of September 2015, 4,501 service users (3,941 households) were in receipt of a TeleCareLine equipment service, of which 3,416 people (3,219 households) were aged 80 years or older. Between 1st July to 30th September 2015 there have been 336 new service users joining the TeleCareLine Service.

3.4 **Carers Strategy**. Task and finish groups have been set up to deliver actions in the delivery plan which includes a review of information available to carers across key stakeholders, a communications campaign to raise awareness of the caring role and a Carers Recognition Scheme for the Borough. The first Carers Assembly for Hillingdon took place on the 12 November 2105 with 22 carers attending. The event was positively received with useful feedback on how future Assemblies could be run.

3.5 **SEND reforms**. Hillingdon's local offer, which was published in September on www.hillingdon.gov.uk/send, provides information on what services children and young people with special educational needs and disabilities and their families can expect from a range of agencies including education, health and social care. The Local Offer was formally launched on 4 November 2015 in the Middlesex Suite alongside the DisabledGo Project. Marketing and promotional materials have been produced to be distributed across a wide range of public venues and services throughout Hillingdon to promote the ongoing engagement of residents and service providers in the development of the Local Offer.

4. Priority 4 - A positive experience of care

4.1 **Children and Young People and families**. Work with ' Headliners' resulted in a film being produced with children, young people and their families. Following the initial screening and workshop, a small group has met to undertake the development of the new approaches which will enable children and young people to participate in the development of a range of initiatives including:

- All-age Disability Register
- Disability Register incentive scheme
- Short Break Strategy
- The Local Offer - peer to peer guidance (example below)
- The DisabledGo Project
- Project Search

4.2 **Improve social care quality of life of carers**. The Council will undertake a survey in Q4 2015/16 to test improvements against the results of the 2014 Carers Survey. This will provide an opportunity to ask additional questions suggested by partners such as Healthwatch Hillingdon.

Financial Implications

There are no direct financial implications arising from the recommendations set out in this report.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The update of the action plan for Hillingdon's Joint Health and Wellbeing Strategy supports the Board to see progress being made towards the key priorities for health improvement in the Borough.

Consultation Carried Out or Required

Updates of actions to the plan have involved discussions with partner agencies to provide up to date information.

Policy Overview Committee comments

None at this stage.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance has reviewed this report and can confirm there are no financial implications arising from the recommendations in the report.

Hillingdon Council Legal comments

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

BACKGROUND PAPERS

NIL.

Appendix A Health and Wellbeing Strategy Delivery Plan Update

Priority 1 - Improving Health and Wellbeing and reducing inequalities				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
1.1 Protect resident's health	**1.1.1** From conception to year 2, Increase the confidence and participation of parents/women to have healthy babies by delivering the 'Having a Healthy Baby' Project	Public Health & Maternity Services	Annually	• The recommendation report from the healthy baby task and finish group has been passed to the Public Health and Early Years Strategic Group to be reviewed and next steps agreed. • The Q2 data for % women smoking at time of delivery will be presented in the next report as it is not yet available.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• The Programme Board have met and work is progressing on agreeing strategic direction and actions across the work streams. • A new children's asthma pathway has been agreed so that children can receive seamless support across schools, primary and secondary care. • A review of clinical guidelines for Ambulatory Care is being undertaken. • Acute Care standards for Children and Young People are currently under review, and once completed will be incorporated into the Hillingdon Hospital Trust Contract for 2016/17

Page 14	**1.1.3** Deliver a mental wellness and resilience programme	Public Health		• Singing For Wellbeing sessions are now run every other week at Uxbridge Library as part of the Dementia Friends Coffee Morning and there are a regular ten people who attend. • The Time to Change Event in Uxbridge Town Centre on 4th September saw 540 conversations held between volunteers and service users and members of the public. • (GP) Orchard Practice Wellbeing Programme - 10 women attended the women's only programme in Hayes where they received lifestyle information on eating, exercise and wellbeing. • Emotional health and wellbeing transformation - as part of the Children and Young people's emotional health and wellbeing transformation, current provision is being mapped in schools in order to identify needs and opportunities. This will feed into the conference being planned for March 2016. • There are a series of wellbeing events planned with West Drayton Community Centre for the autumn and winter. This will include a general wellbeing day for older people, a tea dance, a line dance and then three events aimed at people who are housebound and/or living with dementia. • The Tea Dances continue to remain popular with 160 people attending in September.
	1.1.4 Deliver a smoking cessation service including	Public Health	Annually	• Smoking prevalence is estimated to be 16.5%, a significant drop on previous year.

	supporting the further roll out of Smoke Free Homes in Hillingdon			• The service has been supporting Stoptober with a number of events. • Our local mental health providers, CNWL have implemented a smokefree policy across all treatment settings.
	1.1.5 Reduce prevalence of obesity through a variety of initiatives including the delivery of the Child Measurement Programme, and raising awareness of the importance of physical activity across the life course	Community Sport and Physical Activity Network (CSPAN) & Obesity Strategy Working Group	Quarterly	• The children's weight management programme is being delivered across 3 localities and for ages 2-4, 5-7, 7-13 and 13+. For those aged 2-4, seven programmes have been delivered across the borough at Children Centres with 51 families attending. Of these, 36 were from a BAME background. The programme has seen a 10.7% increase in children eating at least 5 portions of fruit and vegetables a day and a 13.8% increase in parents doing the same. • A pilot weight management programme is in place for obese adults in Hillingdon to reduce the risk of chronic disease and link into disease care pathways. Those who do not meet the criteria are referred into the 'Let's Get Moving' programme for an assessment so they can receive appropriate support. • Back to Sport - is aimed at encouraging adults to participate in playing sport again or for the first time in an informal and fun way. It aims to generate sustainable changes in lifestyle with a variety of

Page 16				things on offer such as Badminton, Cycling, Fencing, Golf, Jog it off, Hockey, Netball, Swimming and Tennis. • Ready Steady Move - this programme encourages schools to engage with parents to increase and maintain a healthy lifestyle offering 3 terms of physical activity to adults at the school facility - class attendance is high with 15 schools engaged. • London Youth Games - Hillingdon is represented in 98% of the events, frequently being the top West London Borough in the overall results. The games have encouraged sustained participation in sport by young people. • 'On Your Marks' is a programme run in partnership with Brentford FC and DASH where a variety of sessions including swimming and multi sports are delivered for people with disabilities. Within the last year over 100 people aged 14 + have engaged in activity. • Walking/older men's football - this new session started in the summer in partnership with Watford FC Community Trust. A local programme is operating with an average weekly attendance of 12 men. • As a follow on to the Council's successful weight management programme for staff, messages relating to healthy eating and physical activity are being prepared for all staff. • A new programme primarily to engage over-weight

				pregnant women in ante-natal exercise started during the summer. • 28 young people took part in one of four 12 week Fit Teen courses aimed at over-weight teenagers.
	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The GLA is putting in place a London specific local air quality management regime. Guidance from the GLA in terms of how to approach the review of the action plan will be published in early 2016.
1.2 Support adults with learning disabilities to lead healthy and fulfilling lives	**1.2.1** Increase the number of adults with a Learning Disability in paid employment	LBH	Quarterly	• To end of September 2015, the % of people in receipt of long term services provided by Adult Social Care in paid employment was 2.5%, a slight increase from 2.1% at end of 2014-15. • Service user reviews are planned and taking place and where employment and education opportunities have been identified, service users are being supported to explore how they will access these. • College courses are being facilitated by Adult Education at Queens Walk in cookery and music. 12 service users have enrolled on these courses which commenced in October. • In the last quarter, 6 service users from across Supported Housing services and the Positive Behaviour Support Service have undertaken voluntary work opportunities. 2 service users have enrolled on college courses and 1 service user has enrolled on a Duke of Edinburgh award.

Page 18				• The summer period was very busy at the Rural Activities Garden centre with the volunteers selling bedding, shrubs and herbaceous plants which they have grown. Vegetables are grown and sold in the on site shop and at the Civic Centre plant and veg sale. The plants displayed outside the Civic Centre this spring, summer and autumn were all planted by the volunteers. • The volunteers also deliver offsite grounds maintenance at Moorcroft complex and maintain the grounds at Brookfield Adult Learning Centre and HACS grounds. • New gardeners started at the centre during the summer and they have settled in well and learnt new skills. Another gardener attends one day a week which is linked with his college course
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• The Autism Partnership Board met in September and agreed an initial work plan to achieve completion of the Autism Plan. • A forum is being established for people with autism to ensure their feedback is central to the work of the Partnership Board. • The draft Autism Plan will be presented to the Autism Partnership Board meeting in January 2016 with a follow up workshop with wider stakeholders in March, hopefully timed to fit with Autism Awareness week. The aim is to have a final Plan

				ready by April 2016.
Priority 2 - Prevention and early intervention				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
2.1 Deliver the BCF workstream 2 - Intermediate Care under Strategy	**2.1.1** Deliver scheme three: Rapid response and joined up Intermediate Care	LBH/CCG	Quarterly	• During Q2 the Reablement Team received 323 referrals and of these 118 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 133 people were discharged from reablement with no on-going social care needs. • In Q1 and 2 the Rapid Response Team received 1,866 referrals, 62% (1,142) of which came from Hillingdon Hospital, 15% (282) from GPs, 10% (190) from community services such as District Nursing and the remaining 15% (252) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. 44% of referrals were linked to falls, 10% resulting from issues with reduced mobility, 6% relating to back pain and the remainder from issues ranging from urinary tract infection (UTI) to chest pain. [extrapolated from September's data] Of the 549 discharged home, 57% (310) were discharged with no further assistance required.
2.2 Deliver Public	**2.2.1** Deliver the National	Public Health	Annually	The aim of the programme is the early identification of individuals at moderate to high risk of cardiovascular

Health Statutory Obligations	NHS Health Checks Programme			disease, diabetes, stroke, kidney disease and related metabolic risk. • In 2015/16, 72,893 Hillingdon residents are eligible for an NHS Health Check • In Q2, the number of first offers made was 2,256 with completed checks of 1,849 which equals a take-up rate of 82%
	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• An HIV health and care needs assessment has been undertaken – additional work is required in order to complete the assessment. The outputs of the needs assessment will be used to inform future sexual health and disabilities commissioning/ procurement decisions. • CNWL surveyed young people to review their needs around the days/opening times of the Young Peoples Clinics which has led to an improved offer with a available Monday-Saturday with revised opening times to suit the needs of young people.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• Seasonal Flu: Winter packs for schools and care homes were sent out in September 2015.
2.3 Prevent premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term	CCG	Quarterly	• Having undertaken a review of the current state of Risk Stratified Cancer Pathways at THH and discovered that Hillingdon is already doing relatively well in this area, the CCG has undertaken research

Page 21	Conditions including cancer, diabetes and dementia			into how we might support patients with cancer in other areas. The Governing Body held an OD session August 2015 to review priorities for 2015/16 and agreed that increasing the update of screening across all cancers and reducing the number of late presentations were top priorities. • The service specification for an Integrated Diabetes Service has now been approved by the Quality, Safety and Clinical Risk Committee and the business case to support this service redesign is being submitted to Governing Body early September 2015. The service has been designed in collaboration with hospital, community and primary care clinicians and managers and focuses on more patients being seen in primary care settings, with support from secondary and community care specialists. Subject to complete sign off by Governing Body, the CCG will work with providers to start mobilising this service from October 2015, with service transition starting January 2016. • The first phase of the cardiology project has been successfully implemented (includes direct access by GPs to key diagnostic tests at The Hillingdon Hospital and Harefield Hospital. The second phase consists of the development of an integrated service with a particular focus on heart failure and cardiac rehabilitation. Collaboration with The Hillingdon Hospital, the Royal Brompton, CNWL and Public Health has led to the development of an Integrated Cardiology service model that has been signed off by the CCG's Governing Body. The CCG is working with providers so that mobilisation phase of this

				project can start as soon as possible. • The Integrated Service for Respiratory Care has also been approved and work has commenced on mobilisation of the scheme with the service expected to be in place by October2015. • A Long Term Conditions Transformation Group overseeing all the CCG's workstreams on LTC has now been established.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• Increasing the levels of physical activity in the borough amongst those suffering from chronic conditions is being taken forward through the inclusion of 'Let's get Moving' programme in disease care pathways. To end of Sept 2015, there were 216 referrals made by health professionals. Those that have completed the 12 week programme have indicated that 97% achieved some or all of their goals, 78% have seen a reduction in their BMI and 72% have increased their physical activity levels. • 6 sessions have taken place with CCG during October and November targeted at BME communities to promote the importance of healthy lifestyle in relation to high blood pressure, high cholesterol and diabetes. A pathway has been designed with local physiotherapists for stroke victims so they can take part in structured activity in a safe and appropriate setting.
	2.3.3 Reduce excess winter deaths	Public Health/NHS		There are a number of activities that aim to reduce excess winter deaths in the borough. These include:

		England		• Providing Flu immunisation to people at risk. • Screening for Chronic Obstructive Pulmonary Disease as part of smoking cessation project to identify smokers at high risk. • Monitoring Inferior Wall Myocardial Infarction over Coronary Heart Disease. • Age UK Hillingdon 'Getting ready for Winter' campaign. • The council also continues to provide the Heater Loan Service for homeowners over 65 whose heating breaks down.
	2.3.4 Reduce the number of children with one or more decayed, missing or filled teeth	Public Health & NHS England		• NHS England and Public Health Team are working on a joint project to improve access to preventative dental care in Hillingdon. • As part of this initiative the Schools Project has recruited 10 schools where dentists will deliver fluoride varnish to pupils. This has so far reached approximately 3700 pupils age 4-7 and plans are in place for parents and children's awareness sessions in the Spring term.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• The second meeting of the Dementia Action Alliance took place at the beginning of November which included a showcase of singing, poetry and arts and crafts by people with dementia and some case studies of how people living with dementia

Page 24				continue to live active and fulfilling lives. • Ten Walk Hillingdon leaders have now received Dementia Friends training and in September 2015 a further 60 hospital staff became dementia friends including nurses, physiotherapists, occupational therapists and healthcare assistants. • The Dementia Coffee Mornings continue to be popular with between 7-10 people regularly attending. The sessions have included talks from the fire brigade and local police cadets on home safety. Feedback from residents has been very positive; they like the venue, staff and appreciate that it is free. • The Drummunity project continues to enable older people with dementia to take part in an activity which allows them to communicate creatively, work on their short term memory skills, increase relaxation and develop strength and coordination. Sessions began at the Alzheimer Society on the 11th September and ten service users regularly attend.
	2.3.6 Improve pathways and response for individuals with mental health needs across the life course including the provision of Child and Adolescent Mental Health Services (CAMHS)	CCG	Annually	• Single Point of Access - a Business Case has now been approved to develop a single point of access in the mental health urgent care pathway for Adults. The service will be operational from 2nd November 2015 • Improving Access to Psychological Therapies - a Business Case has been approved to expand IAPT Services to target hard to reach groups and those

				with Long Term Health conditions such as Diabetes. CNWL is recruiting additional substantive staff to expand the service to ensure 15% access target is maintained throughout 2015/16.The Access target has been met for the first two Quarters of 2015/16 • From April 2016 there will be Access and Waiting time targets for assessment and NICE compliant treatment for first episode psychosis. • A Children Adolescent Mental Health Service (CAMHS) health and care needs assessment has been developed. The Children's Emotional Health & Wellbeing Board has been established to oversee the Hillingdon Transformation Plan and Implementation Plan. This Board will also oversee the NHSE/DH Local Transformation Plan which has to be developed by mid-October. If the LTP meets NHSE assurance additional funding will be made available, for 5 years, to transform CAMHS Eating Disorders from September and generic CAMHS from December. • A Business Case to develop a CAMHS Deliberate Self-harm Team is to be discussed at the HCCG Governing Body in November. • Additional resources for specialist MH provision for children and young people with LD were agreed. With additional funding from NHSE the team will also work with CYPs with challenging behaviour; with an integrated pathway with LBH disability team • HCCG also invested in specialist perinatal MH

				provision. Service implemented January 2015. DOH are to release new monies, new Model of care and access and waiting time targets in Q3 • The provision of Liaison Psychiatry services has been expanded to improve access to specialist mental health services for those patients presenting at A+E and receiving clinical services for other conditions in an Acute Hospital setting. A Business Case will be presented to Hillingdon CCG Governing Body in November 2015 to further enhance this service with the continuation of the Mental Health Assessment Lounge as a separate facility from Accident and Emergency department
Page 26	**2.3.7** Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• Approval of The Vision Strategy will first be sought through Adult Social Care and then HCCG with final approval to the H&W Board.
2.4 Ensure young people are in Education, Employment or Training	**2.4.1** Identify those at risk of becoming Not in Education, Employment or Training (NEET) and implementing appropriate action to prevent it	LBH	Quarterly	• The changes in approach previously reported continue to embed. The Participation Team has been recruited to and is now at full strength. • There are regular drop in's at the Civic Centre for young people to receive information and advice, with sessions at Fountains Mill and Harlington Young People's Centre available by appointment. These arrangements have proved to be popular and adequate for young people and will continue. • The Participation Team has prioritised NEET and potential NEET young people since the beginning of academic year 2015-16. A seasonal spike is to be expected locally and nationally at this time of year

				for NEETS and 'not known's'. • All actual post Year 11 and Year 12 destinations have been acquired from schools and colleges (with the exception of 3 schools despite repeated requests) and reported to the data management provider. • Current in year data to end September 2015, shows that the number of 16-18 year old NEETs is 221 young people or 6.3%. There are 800 young people who require tracking to ensure that they remain in EET. All NEET and 500 of the 800 young people requiring tracking have been allocated for case work to report by the end of October 2015. Once these are reported on, the remaining 300 young people requiring tracking will be allocated.

Priority 3 - Developing integrated, high quality social care and health services within the community or at home

Objective	Task and Metric	Lead	Metric reporting frequency	Evidence of activity against task
3.1 Deliver the BCF Workstream 1 - Integrated Case Management	**3.1.1** Deliver scheme one: early identification of people susceptible to falls, social isolation and dementia	LBH/CCG	Annually	• Initiatives to increase the dementia diagnosis rate in Hillingdon are now delivering positive results, as the rate at the end of September 2015 stood at 67.8%. The target for Hillingdon is 65.4% and is based on the number of people on local GP registers with a dementia diagnosis as a percentage of the number projected to be living with the condition. • A fracture liaison nurse based at Hillingdon Hospital has been recruited and will start in November. This post will support people who have attended hospital

				for the first time with low level fractures, e.g. people who may have fallen from standing height or less, and may be living with osteoporosis (bone thinning). • During 2014/15 there were 871 emergency admissions as a result of falls at a total cost of £2.9m. During Q1 and Q2 2015/16 there were 384 falls-related emergency admissions (198 in Q2), compared to 449 during the same period in 2014/15 (223 in Q2).The cost during Q1 and 2 2015/16 was £1.2m compared with £1.4m during the same period in 2014/15. The target falls-related admissions ceiling for 2015/16 is 761 and activity during the first half of the year suggests that this is on track, although the severity of the winter will influence this.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• The End of Life Forum meeting in November will agree the end of life pathway, i.e. how people identified as being at end of life are supported and where they are referred to. • A market testing exercise for the end of life services funded by the CCG, e.g. palliative beds, night sitting, etc, will be taking place early in Q3. The results of this will inform any procurement activity that may take place in Q4 and, potentially, into Q1 2016/17. The scope for including services funded by the Council is being considered as part of this process, the results of which, subject to Board, Cabinet and Governing Body approval, would be delivered in 2016/17.
3.2 Deliver the BCF	**3.2.1** Deliver scheme four:	LBH/CCG	Quarterly	• The CCG, Hospital and CNWL are working together

Workstreams 3 & 4 - Seven day working and Seamless Community Services	seven day working			to explore ways of ensure that people with complex wound care issues can be treated in the community and appropriate support for people requiring medication to be administered intravenously. • The night sitting service is commissioned by HCCG from Harlington Hospice and provides care and support to both people and their carers at end of life. The main referral route is through Rapid Response but arrangements have been put in place to enable the Hospital to make direct referrals, which will expedite the discharge process for people at end of life whose preferred place of care is at home.
	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• The Deputy Director of Nursing and Patient Experience attended the September Residential and Nursing Care Home Provider Forum in September to give feedback on the Hospital response to issues raised at the June meeting, e.g. improving discharge process by setting targets for wards regarding the discharge process and the exclusion of evening discharge.
	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• The multi-disciplinary team (MDT) approach was extended to GP networks in the south of the borough in Q2 after being successfully rolled out across practices in the north in Q1. The three networks in the south of the borough are receiving support to ensure that the maximum benefit can be achieved from the use of the MDT process. • The integrated care plan template completed in Q1 has started to be rolled out to GP practices across the borough. The effectiveness of this tool is linked

				to the development of the interoperable IT systems.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q2 56 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 44% of the grants provided. • 73% (41) of the people receiving DFGs were owner occupiers, 22% (12) were housing association tenants, 5% (3) were private tenants. The total DFG spend on older people during Q2 was £241k, which represented 37% of the total spend (£655k) in Q2.
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for over 80's	LBH	Quarterly	• As at the end of September 2015, 4,501 service users (3,941 households) were in receipt of a TeleCareLine equipment service, of which 3,416 people (3,219 households) were aged 80 years or older • Between 1st July to 30th September 2015 there have been 336 new service users joining the TeleCareLine Service and we are on target to achieve 750 new users set for this year.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• As at 30th September 2015, Connect to Support Hillingdon had 182 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. Work continues to promote the site both with residents and providers. • From 1st April (launch) to 30th September 2015, in excess of 3,700 individuals have accessed Connect to Support and completed over 5900 sessions reviewing the information & advice pages and/or

Page 31				details of available services and support. • The online social care self assessment went live in July which will help individuals navigate the information and advice pages and give an indication if they are likely to benefit from a more detailed assessment. • As of 30th Sept, 3 financial assessments had been completed on line and submitted to the team for processing. We are the first authority that we know of to have established an online financial assessment. A total of 38 online social care assessments have been completed, 28 by individuals completing on behalf of themselves and 10 by carers/professionals on behalf of someone else. 8 have been submitted to the council to progress, the remainder of whom requested a copy of completed form to be emailed to themselves
	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH/CCG	Biennially	• Task and finish groups have been set up to deliver actions in the delivery plan which includes a review of information available to carers across key stakeholders, a communications campaign to raise awareness of the caring role and a Carers Recognition Scheme for the borough. The first Carers Assembly for Hillingdon took place on the 12 November 2105 with 22 carers attending. The event was positively received with useful feedback on how future Assemblies could be run. • Update reports were presented to Council Cabinet in November 2015 and to HCCG in December.

Page 32	**3.3.3** Deliver BCF scheme seven: Care Act Implementation Task: To implement the following aspects of new duties under the Care Act, primarily in respect of Carers: a) increasing preventative services; b) developing integration and partnerships with other bodies; c) providing quality information, advice and advocacy to residents; d) ensuring market oversight and diversity of provision; and e) strengthening the approach to safeguarding adults.	LBH/CCG	Quarterly	• The number of private and voluntary sector providers registered on the resident portal Connect to Support increased to 182 as at end September 2015. • The online social care self- assessment went live on 1st July 2015 and in the period to 30th September 38 online assessments have been completed and 28 were by people completing it for themselves and 10 by carers or professionals completing on behalf of another person. • The Council also launched the online financial self-assessment on the 1st July and in the period up to 30th September, 3 have been completed and submitted to the Council's Finance Team for processing. • The programme of staff training on new policies and procedures continues as required. • The social care pathway has been remodelled to ensure compliance with the Care Act. All new referrals will be provided with an indicative allocation prior to support planning and have a confirmed personal budget at the end of the process. The Council has reduced handoffs and ensured that the timeliness of decisions about budget allocation have been greatly improved.

	3.3.4 Engage with providers through the development of the Market Position Statement to maintain a diverse market of quality providers that offers residents choice	LBH	Quarterly	• The Market Position Statement has been agreed and published on the website.
3.4 Implement requirements of the Children and Families Act 2014	**3.4.1** Implement the SEND reforms including introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service planning for children, young people and families	LBH/CCG	Quarterly	• There are approx' 408 Education, Health and Care Plans in place. • Hillingdon's local offer which was published in September on www.hillingdon.gov.uk/send provides information on what services children and young people with special educational needs and disabilities and their families can expect from a range of agencies including education, health and social care. The Local Offer was formally launched on the 4th November in the Middlesex Suite alongside the DisabledGo Project. Marketing and promotional materials have been produced to be distributed across a wide range of public venues and services throughout Hillingdon to promote the ongoing engagement of residents and service providers in the development of the Local Offer. • DisabledGo is the UK's leading provider of accessibility and equality services that will soon be available in Hillingdon. The service provides personally assessed, pan disability relevant access information which enables people to make informed, confident choices about places they would like to access. The service covers all types of venues

				regardless of how accessible they are, recognising that people will need to know what is not accessible to them as much as what is. The service seeks to give people the information to make an informed choice, not make these choices on someone's behalf. • Ongoing development will take place with the engagement and participation of children and young people and their parents/carers in the borough to ensure services can be developed to meet their needs. • Joint working with the CCG is in place to agree a specification for an integrated therapy model. A plan has been drawn up with clear timelines in place. • The 'Measuring our Success' workshop took place in October and an Ofsted preparation group will meet on an ongoing basis. A self evaluation framework is being designed and then populated with a data set being established. Ofsted inspections of the SEND Reforms will commence in May 2016. • Evaluations have shown that the "tell us once" approach and development of shared outcomes needs to improve and be widely embedded. A workshop on outcomes was held in October and a new framework and monitoring tool are being designed. Multi-agency training will be rolled out from the spring. • A strategic transition group has been established with partners to address the ongoing challenges in

				the system between children and adult services. There is now a smooth process for children known to the disability service but other improvements are required.
3.5 Enable children and young people with SEND to live at home and be educated as close to home as possible	**3.5.1** Develop a strategy to identify local educational priorities supported by specialist services across education, health and care	LBH	Quarterly	• The working group has been meeting regularly and significant improvements have been made to the data to ensure this is as reliable as possible and can provide forecast numbers. • The number of pupils out of area has reduced and over the next 5 years, a further 63 will leave by age. • Recommendations for the need for additional special school provision will be drawn up by December 2016. Over the next 5 years, additional capacity of around 113 special school places will be required to meet the growth in child population and avoid placing children in expensive out of borough provision long distances from home.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• A draft Short Breaks Strategy has now been developed and the working group will be seeking feedback from service users to identify what amendments may be required prior to circulation. • Work on the Strategy will continue to integrate with work taking place on the Local Offer and Carer's Strategy to ensure consistency and maximum visibility and engagement of Hillingdon residents. • There has been significant customer engagement over the last few months to try to capture as many views as possible from residents who may require access to short breaks.

3.6 Assist vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	**3.5.1** Provide extra care and supported accommodation to reduce reliance on residential care	LBH	Quarterly	• Both Church Road and Honeycroft Supported Housing Units are now open and service users are transitioning into these schemes at the appropriate pace for each individual. Some early comments from service users at Honeycroft are that they love their new flats and are happy with the provider on site. • Sessile Court is now settled and delivering well.

Priority 4 - A positive experience of care

Objective	Task and Metric	Lead	Metric reporting frequency	Evidence of activity against task
4.3 Ensure that residents are engaged in the BCF scheme implementation	**4.1.1** Improve service user experience by 1%	LBH/CCG	Annually	• The Adult Social Care Survey will be undertaken in Q4 to test 4.1.1 - 4.1.3. • Subject to HWBB approval, residents will be engaged in the development of the plan from April 2016.
	4.1.2 Improve social care related quality of life by 2%	LBH/CCG	Annually	

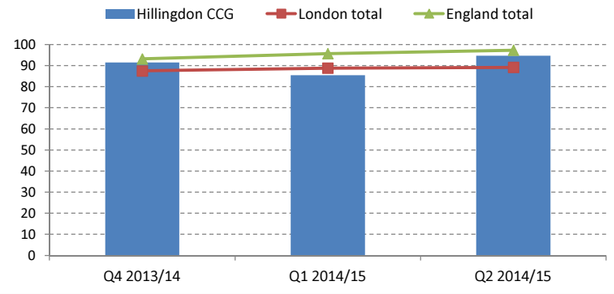
	4.1.3 Increase the overall satisfaction of people who use services with their care and support	LBH/CCG	Annually	
	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	• The Council will undertake a survey in Q4 2015/16 to test improvements against the results of the 2014 Carers Survey. This will provide an opportunity to ask additional questions suggested by partners such as Healthwatch.
4.2 Ensure parents of children and young people with SEND are actively involved in their care	**4.2.1** Develop a more robust ongoing approach to participation and engagement of Children and Young People (C&YP) with SEND	LBH	Quarterly	• Work with ' Headliners' resulted in a film being produced with children, young people and their families. Following the initial screening and workshop a small group has met to undertake the development of the new approaches which will enable children and young people to participate in the development of a range of initiatives including: - All-age Disability Register - Disability Register incentive scheme - Short Break Strategy - The Local Offer - peer to peer guidance (example below) - The DisabledGo Project - Project Search • CYP with SEND have been involved in the development of information for their peers in relation to Preparation for Adulthood. This is now approaching final draft form and is intended for completion during the Autumn term. • Short films, with CYP, are being planned explaining

				various key points of the SEND Reforms to support and enrich the Local Offer.

Health & Wellbeing Board - 3 December 2015

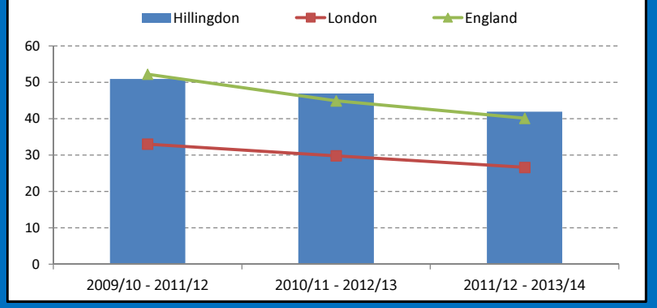
PRIORITY ONE

CCG 1.13	Antenatal assessments within 13 weeks	Q2 2014/15	**94.7%**
		Q1 2014/15	85.4%



PRIORITY TWO

LAPE 5.01	Alcohol specific hospital admissions, under 18s (crude rate per 100,000)	2011/12 - 2013/14	**41.9**
		2010/11 - 2012/13	46.9



PRIORITY ONE

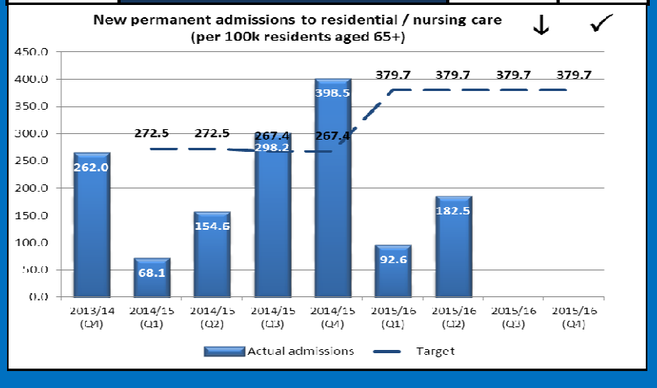
ASCOF 1e	1e - % of LD clients in paid employment	2015/16 (Q2)	**2.5%**
		2014/15 (YE)	2.1%

PRIORITY THREE

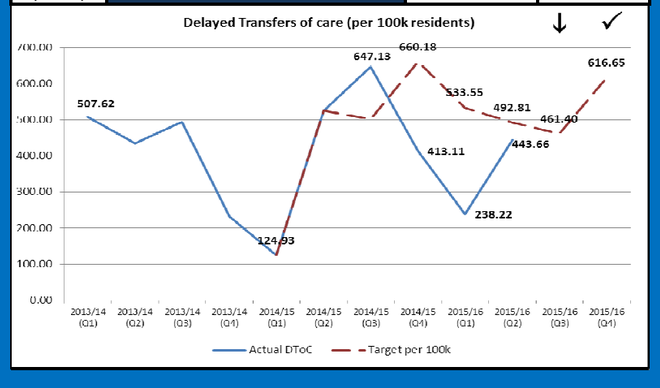
LBH (Local Measure Cumulative)	Number of major adaptations to homes to promote safe, independent living	2015/16 (Q2)	**190**
		2014/15	223
LBH (Local Measure Total)	Number of people in receipt of TeleCareLine (All ages)	2015/16 (Q2)	**4,501**
		2014/15	4,033
LBH (Local Measure Total)	Number of people in receipt of TeleCareLine (80+)	2015/16 (Q2)	**3,416**
		2014/15	3,044
LBH (Local Measure Cumulative)	Number of people in sign ups to TeleCareLine	2015/16 (Q2)	**713**
		2014/15	833

BETTER CARE FUND METRICS

Perm admissions	Perm admissions per 100,000	2015/16 (Q2)	**182.5**
		2014/15 (FYr)	398.50



Delayed transfer of care (DToC)	DToC per 100,000 residents	2015/16 (Q2)	**443.7**
		2014/15 (Q4)	413.1



Perm admissions	Number of permanent admissions to residential / nursing care for residents aged 65+	2015/16 (Q1)	**71**
		2014/15	155
Perm admissions	Annual target for number of perm admissions	2015/16	**150**
		2014/15	104
Perm admissions	Target for number of permanent admissions to residential / nursinge care per 100,000 residents aged 65+	2015/16	**379.7**
		2014/15	272.5
Delayed transfer of care	Total number of days in quarter	2015/16 (Q2)	**1,002**
		2014/15 (Q4)	933
Delayed transfer of care	DToC per 100,000 (Qtrly Target)	2015/16 (Q2)	**492.8**
		2014/15 (Q4)	660.2
Delayed transfer of care	Quarterly target for delayed discharges (total number of days)	2015/16 (Q1)	**1,113**
		2014/15 (Q4)	1,491

Values	Definition
↓ ✓	The lower the outturns the better the performance

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BETTER CARE FUND: PERFORMANCE REPORT (JULY - SEPT 2015)

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
Report author	Paul Whaymand, Finance Tony Zaman, Adult Social Care Kevin Byrne, Policy and Partnerships
Papers with report	Appendix 1) BCF Monitoring report - Month 3 - 6: July - Sept 2015 Appendix 2) BCF metrics scorecard Appendix 3) Hillingdon Hospital Discharge Activity Day by Day April - Sept 2015

HEADLINE INFORMATION

Summary	This report provides the Board with the second update on the delivery of Hillingdon's 2015/16 Better Care Fund.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	This report sets out the budget monitoring position of the BCF pooled fund of £17,991k for 2015/16 as at Month 6.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. **notes the contents of the report.**
b. **agrees to delegate to the Chairman and the Chairman of the Governing Body of Hillingdon Clinical Commissioning Group authority to approve a draft Better Care Fund Plan for 2016/17, which will then be consulted on in Q4 with stakeholders before being submitted to the Board for its consideration in March 2016.**
c. **agrees that a report on the draft digital roadmap across health and care partners in Hillingdon be brought to the March Board meeting for consideration.**

INFORMATION

1. This is the second performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2015/16 and the management of the pooled budget hosted by the Council. The plan and its financial arrangements are set out in an agreement established under section 75 of the National Health Service Act, 2006 and approved in March 2015 by both Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body.

2. **Appendix 1** of this report describes progress against the agreed plan, including expenditure. **Appendix 2** is the BCF performance dashboard which provides the Board with a progress update against those of the six key performance indicators (KPIs) for which data is available.

3. The key headlines from the monitoring report are:

- The month 6 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the s75 for the management of the pooled funds. This shows a forecast pressure of £956k against the pooled funding of £17,991k. In accordance with Schedule 4 of the S 75, the individual Partners in their capacity as Lead Commissioners for the delivery of individual schemes, are responsible for managing any overspends that may occur during the year. The pressure of £956k is split £761k as the responsibility of LBH and £195k falling to HCCG. The Council holds a contingency provision to fund pressures relating to the implementation of Care Act responsibilities.

- During Q2 2015/16, there were 2,571 emergency admissions against a ceiling of 2,660 and this continues the positive trend from Q1 and suggests that admissions avoidance initiatives are having a positive effect.

- During Q1 and Q2 2015/16 there were 384 falls-related emergency admissions (198 in Q2), compared to 449 during the same period in 2014/15 (223 in Q2).

- During the period 1 April to 30 September 2015, there were 1,002 delayed days against a ceiling of 1,113 days. There were an additional 464 delayed days in Q2. The main cause of the delayed discharge was difficulties in accessing secure rehabilitation placements for people with mental health needs.

- During Q2, there were 35 permanent placements to care homes. If the Q1 and Q2 admission rates are replicated consistently throughout 2015/16, then this would result in 142 permanent placements. The revised target agreed by the September Board meeting is 150.

- In Q2, 56 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 44% of the grants provided.

- Funding for the H4All Health and Wellbeing Gateway was approved by HCCG's Governing Body. The service will become operational in Q4.

- A dementia diagnosis rate of 65.4% was achieved against a target of 67.8%, which is on track to be achieved.

<u>2015/16 Plan Overview: How successful has it been?</u>

4. The 2015/16 BCF plan was agreed to be 'minimalist' in nature and featured pooling only of mandated budgets to meet Government requirements. The plan has provided an opportunity to develop a stronger working relationship between the Council and the CCG whilst minimising the risk to both organisations. This can be seen in the development of the following new workstreams that either would not have happened without the BCF or would not have happened so quickly:

- *Care home market development and management* - The Council and HCCG are engaged in mapping the need for bed based services for older people across health and social care as part of the development of a three year older people care home plan that would also include development of the medical model of care. This will enable us to jointly provide the market with details of our current and future needs to shape future provision to address the needs of residents/patients. This work will also lead to the development of procurement options for consideration by the Board and HCCG Governing Body (and Cabinet where appropriate).

- *Model of care development for extra care schemes* – The Council, HCCG, a GP representative and a consultant geriatrician from the Care of the Elderly Team at Hillingdon Hospital are working together to shape the future model of care for existing extra care schemes at Cottesmore House and Triscott House and the two new schemes, Grassy Meadow and Park View that are due to open in early 2018.

5. In terms of outcomes for residents, Q2 data shows that the number of emergency admissions was below the ceiling. This is likely to be the result of a range of contributing initiatives rather than just the BCF plan and it should be noted that a severe winter could have a significant impact on this trend. In addition, initiatives to reduce the number of falls-related admissions are also showing positive results and dementia diagnosis rates have increased in line with agreed targets.

6. Focus groups of Carers will be held before Christmas to get a view as to whether new Council responsibilities under the Care Act are making a difference to the Carer experience. The testing of resident/patient experience will take place in Q4.

Better Care Fund Plan 2016/17

7. In October 2015, the Department of Health and Department of Communities and Local Government confirmed that the BCF would continue into 2016/17. It was also confirmed that the detail about the minimum size of the Fund and the policy framework underpinning it would not be made available until after the announcement of the Comprehensive Spending Review (CSR) on 25 November 2015.

8. As reported to the Board's September meeting, officers have been exploring proposals for the 2016/17 plan and these include some logical extensions of activity undertaken in 2015/16 whilst simultaneously maintaining a cautious and incremental approach to integrated working and the pooling of budgets that minimises the risk to both the Council and HCCG. Proposals under consideration include:

- Extending existing schemes where benefits could be achieved for other adult client groups, e.g., development and management of the care home market that will include all adults;
- Adding funds to the pooled budget where this will have demonstrable benefits for residents/patients, e.g., people at end of life;
- Extending scope of the plan to include new types of activities, e.g., dementia;
- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 2015/16, e.g., intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g., bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget is under the same governance structure.

9. With the Board's approval, it is proposed that officers finalise a draft plan to reflect Government requirements identified following the CSR announcement and that the Chairman of the Board and the Chairman of HCCG's Governing Body be given delegated authority to approve the draft plan, subject to consultation with stakeholders. If this is agreed then officers would submit the final plan to the March 2016 meetings of the Board and HCCG Governing Body. The Council's Cabinet and HCCG's Governing Body would also be asked at their meetings in March 2016 to approve an updated section 75 (pooled budget) agreement.

Digital Roadmap

10. NHSE is requiring all CCGs to develop local plans for their care communities called digital road maps by April 2016, to detail how they will achieve the ambition of being paper-free at the point of care by 2020. NHSE expects CCGs to engage with partners across health and social care in the completion of these plans; and local digital roadmaps will be considered as part of the CCG assurance framework from 2016/17 onwards.

11. The first stage in the development of the local digital roadmap is the completion of a self-assessment of the digital maturity of Hillingdon's health and care community and an analysis of each organisation's IT strategy against local and national clinical and digital goals. The roadmap will be drafted by the multi-agency Pan-Hillingdon IT Group, which includes representation from the Council's Corporate IT Team and also from Adult Social Care, as well as representatives from local health partners. It is then proposed to submit the draft plan to the Board's March meeting for consideration.

12. The Board may wish to note that collaborative working across health, social care and third sector partners is already advanced in Hillingdon, which means that Hillingdon is in a positive position regarding joining up IT systems and sharing information electronically. This is expanded on further in **Appendix 1,** but it does mean that Hillingdon is better placed to develop and deliver a digital roadmap that will result in better outcomes for residents/patients in the near future than many other health and care communities in London and elsewhere.

13. NHSE has advised that an announcement about additional resources to support the implementation of digital roadmaps is due to be made during 2016.

Financial Implications

14. The BCF monitoring report, attached as Appendix 1, includes the financial position on each scheme within the BCF for 2015/16. This shows a pressure of £956k against the pooled budget of £17,991k.

15. There is a pressure on the Care Act implementation scheme of £783k arising from the cost of providing support and care to Carers. This results from the Council's new responsibilities under the Care Act. The Council holds a contingency provision to fund pressures relating to the implementation of Care Act responsibilities, which are not included within the BCF.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

16. The monitoring of the BCF will ensure effective governance of delivery via the Health and Wellbeing Board.

17. The proposed approach for the development of a 2016/17 BCF plan will facilitate timely completion of the approval process for the new plan so that efforts can quickly be focused on delivery.

18. The digital roadmap will commit local health and care partners to a plan that will set out how the ambition of becoming paper-free at the point of care by 2020 will be delivered to support better outcomes for residents/patients and release staff time to care.

Consultation Carried Out or Required

19. The BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents. HCCG, Hillingdon Hospital and CNWL have been consulted in the drafting of this report.

20. Subject to Board approval of the recommendations, consultation with stakeholders about the proposed 2016/17 plan will be undertaken. It is proposed to seek the views of the multi-agency Older People's Integration Group on the outline proposals within the draft plan in Q3.

Policy Overview Committee comments

21. The draft plan will be discussed with External Services Scrutiny Committee and Social Services, Housing and Public Health Policy Overview Committee.

CORPORATE IMPLICATIONS

Corporate Finance comments

22. Corporate Finance has reviewed the report and concurs with the financial position as set out in the detailed financial analysis against each scheme.

Hillingdon Council Legal comments

23. As is indicated in the body of the report, the statutory framework for Hillingdon's Better Care Fund is Section 75 of the National Health Service Act, 2006. This allows for the Fund to be put into a pooled budget and for joint governance arrangements between the Governing Body of Hillingdon's HCCG and the Council. A condition of accessing the money in the Fund is that the HCCG and the Council must jointly agree a plan for how the money will be spent. This report provides the Board with progress in relation to the plan.

BACKGROUND PAPERS

NIL.

Appendix 1

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: November 2015	**Period covered:** July - Sept 2015 - Month 6
Core Group Sponsors: Ceri Jacob /Tony Zaman /Paul Whaymand/Jonathan Tymms/ Kevin Byrne	
Finance Leads: Paul Whaymand/Jonathan Tymms	

Key: RAG Rating Definitions and Required Actions		
	Definitions	**Required Actions**
GREEN	The project is on target to succeed. The timeline/cost/objectives are within plan.	No action required.
AMBER	This project has a problem but remedial action is being taken to resolve it OR a potential problem has been identified and no action may be taken at this time but it is being carefully monitored. The timeline and/or cost and/or objectives are at risk. Cost may be an issue but can be addressed within existing resources.	Escalate to Core Officer Group, which will determine whether exception report required. Scheme lead to attend Core Officer Group.
RED	Remedial action has not been successful OR is not available. The timeline and/or cost and/or objectives are an issue.	Escalate to Health and Wellbeing Board and HCCG Governing Body. Explanation with proposed mitigation to be provided or recommendation for changes to timeline or scope. Any decision about resources to be referred to Cabinet/HCCG Governing Body.

1. Summary and Overview	Plan RAG Rating	Amber
	a) Finance	Amber
	b) Scheme Delivery	Green
	c) Impact	Green

A. Financials

Key components of BCF Pooled Fund 2015/16 (Revenue Funding unless classified as Capital)	Approved Pooled Budget	Spend at Month 6	Variance as at Month 6	Variance as at Month 5	Move-ment from Month 5	Forecast Outturn	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non elective performance fund)	10,032	5,143	81	65	16	10,227	195
Care Act New Burdens Funding	838	707	288	240	48	1,621	783
LBH - Protecting Social Care Funding	4,712	2,290	-66	-37	-29	4,690	-22
LBH - Protecting Social Care Capital Funding	2,349	987	-188	-212	24	2,349	0.0
BCF Programme management	60	30	0	0	0	60	0.0
Overall BCF Total funding	**17,991**	**9,157**	**115**	**56**	**59**	**18,947**	**956**

1.1 The Council hosts the management of the pooled funds with the Corporate Director of Finance undertaking the financial duties and responsibilities as set out in the Section 75 agreement.

1.2 Detailed budget monitoring of each scheme is undertaken and reported monthly to the Core Group of officers responsible for the implementation of the BCF plan with quarterly reports to the HWBB.

1.3 The Board is reminded that HCCG's financial contributions set out above are nearly all commissioned from a range of providers including CNWL, Age UK, GP networks, Medequip etc. The Council's financial input includes contributions to the funding of the reablement service, hospital and mental health social workers, the running costs of telecare service, the provision of disabled facilities grants to support major adaptations to help residents remain in their homes and the costs of implementing the new responsibilities under the Care Act.

1.4 The month 6 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the S75 for the management of the pooled funds. There is currently a shared pressure of £234k against both the Council and CCG's shares of the pooled funds which relates to the supply of equipment and adaptations to residents. This is a reflection that more people with complex needs are being supported in the community in line with agreed priorities. Both the Council and CCG are working together to look at ways of improving efficiency and effectiveness that will enable the existing equipment budget to go further and potentially reduce the pressure.

1.5 There is also a pressure of £783k on the Care Act burdens from the cost of providing support and Care to Carers as a new responsibility following the implementation of the Care Act. The Council holds a contingency provision to fund pressures relating to the implementation of Care Act responsibilities. Some of this pressure is offset by underspends on the TeleCareLine service.

B. Plan Delivery Headlines

1.6 The month 6 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the S75 for the management of the pooled funds.

1.7 During Q2 2015/16 there were 2,571 emergency admissions against a ceiling of 2,660, which indicates that admission prevention initiatives are having a positive impact.

1.8 The number of delayed transfers of care (DTOC), which is measured on the number of delayed days before discharge. During the period 1st April to 30th September 2015 there were 1,002 delayed days against a ceiling of 1,113 days. The main cause of the delayed discharge was difficulties in accessing secure rehabilitation placements.

1.9 During Q1 and Q2 2015/16 there were 384 falls-related emergency admissions (198 in Q2), compared to 449 during the same period in 2014/15 (223 in Q2).

1.10 Progress continues with joining up IT systems in order to reduce the number of times residents with care needs have to repeat their information. For example, an information sharing agreement has been signed between the Council, health partners and the third sector consortium, H4All, which will enable a pilot of a care information exchange platform to be delivered by a software provider called Patients Know Best (PKB) to start in Q4. The pilot will initially be with 17 GP practices in the north of the borough. If successful, this will then be scaled up further to cover the whole borough.

C. Outcomes for Residents: Performance Metrics

1.11 This section comments on the information summarised in the Better Care Fund Dashboard (Appendix 2).

1.12 **Emergency admissions target (known as non-elective admissions)** - During Q2 2015/16 there were 2,695 emergency admissions against a projected ceiling of 2,660. Whilst slightly above the ceiling figure this is still below the Q2 2014/15 position of 2,756, which suggests that the trajectory is heading in the right direction and that admissions avoidance initiatives are having a positive effect. However, the severity of this year's winter is likely to have a significant influence on the sustainability of this trend.

1.13 **Delayed transfers of care (DTOC) target** - This is an all adults target rather than it being restricted to the 65 and over population. Good performance means that there is a low number of DTOCS. During the period 1st April to 30th September 2015 there were 1,002 delayed days against a ceiling of 1,113 days. There were an additional 464 delayed days in Q2. The table below summarises the identified source of the delays during Q1 and 2.

Delay Source	Acute	Non-acute (CNWL)	Total
NHS	154	577	731
Social Care	88	153	241
Both NHS & Social Care	0	30	30
Total	**242**	**760**	**1,002**

1.14 76% (760) of the delayed days concerned people with mental health needs and of these 86% (653) arose due to the lack of availability of beds in a secure rehabilitation unit. The 241 days attributed to social care arose because of issues with securing appropriate packages of care (31 days) and also securing a suitable placement (194 days).

1.15 *'Acute NHS'* in the table above includes Hillingdon Hospital, London North West Hospitals (Northwick Park and Ealing Hospitals) and Imperial College Hospital, London. Of the 154 days attributed to acute trusts, 30 days related to Hillingdon Hospital and 17 days were the responsibility of social care and arose because of issues to do with securing an appropriate placement or package of care.

1.16 **Care home admission target** - The September Board meeting approved the revised admissions ceiling of 150 (from 104) for 2015/16 to allow for increased levels of frailty presenting during the winter pressure period resulting in a higher level of admissions. During Q2 there were 35 permanent placements. If the Q1 and 2 admission rates are replicated consistently throughout 2015/16 then this would result in 142 permanent placements.

1.17 It should be noted that the new permanent admissions figure in paragraph 1.15 above is a gross figure that does not reflect the fact that 45 people who were in permanent care home placements also left during Q2. As a result, at the end of Q2 there were 444 older people permanently living in care homes (230 in residential care and 214 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q2 and were, therefore, counted as older people.

2. Scheme Delivery

Scheme 1: Early identification of people susceptible to falls, dementia and/or social isolation.	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 1 Funding	Approved Budget	Spend at Month 6	Variance as at Month 6	Variance as at Month 5	Move-ment from Month 5	Forecast Outturn	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non elective performance fund)	180	90	0	0	0	180	0
Total Scheme 1	**180**	**90**	**0**	**0**	**0**	**180**	**0**

Scheme Financials

2.1 Current spend is in line with CCG profiled budget which relates to value contracts (Age UK's falls prevention service and GP networks) that are evenly phased (divided equally over 12 months).

Scheme Delivery

2.2 HCCG's Governing Body approved funding for the H4All Health and Wellbeing Gateway. This is for a pilot to test out the model and its benefits for Hillingdon's residents, which will be evaluated towards the end of 2016. The Gateway will become operational in Q4.

2.3 Initiatives to increase the dementia diagnosis rate in Hillingdon are now delivering positive results, as the rate at the end of September 2015 stood at 65.4%. The 2015/16 target for Hillingdon is 67.8% and is based on the number of people on local GP registers with a dementia diagnosis as a percentage of the number projected to be living with the condition. The 2015/16 target is on track to be achieved.

2.4 HCCG has increased its investment in the Memory Assessment Clinic by an additional £200k above the additional funding provided at the beginning of the year.

2.5 In Q2 the London Fire Brigade joined the Dementia Action Alliance, the aim of which is to act as a vehicle to enable Hillingdon to become a dementia friendly borough. Signatory organisations make a commitment to develop their own action plans that will enable them to contribute towards delivering this goal.

2.6 The Health Promotion Team (Public Health) launched the new Police missing person's grab pack at the first quarterly meeting of the Dementia Alliance in August 2015. The pack encourages family members and carers to have information already prepared on loved ones living with dementia in the case where they might go missing to enable police to find them faster and more efficiently. The Health Promotion Team and the Police are working closely to launch the pack to the public.

2.7 A fracture liaison nurse based at Hillingdon Hospital has been recruited and will start in November. This post will support people who have attended hospital for the first time with low level fractures, e.g. people who may have fallen from standing height or less, and may be living with osteoporosis (bone thinning).

2.8 During 2014/15 there were 871 emergency admissions as a result of falls at a total cost of £2.9m. During Q1 and Q2 2015/16 there were 384 falls-related emergency admissions (198 in Q2), compared to 449 during the same period in 2014/15 (223 in Q2).The cost during Q1 and 2 2015/16 was £1.2m compared with £1.4m during the same period in 2014/15. The target falls-related admissions ceiling for 2015/16 is 761 and activity during the first half of the year suggests that this is on track, although the severity of the winter will influence this.

Scheme Risks/Issues

2.9 The impact of the H4All Gateway on Hillingdon's health and care economy in terms of encouraging self-management by older residents/patients of their long-term conditions and reducing reliance on statutory services will be evaluated later in 2016/17. This will also consider the extent to which the current range of services contracted from the third sector are appropriate to meet the changing needs of Hillingdon's ageing population.

Scheme 2: Better care at the end of life	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 2: Better care at the end of life							
Scheme 2 Funding	**Approved Budget**	**Spend at Month 6**	**Variance as at Month 6**	**Variance as at Month 5**	**Move-ment from Month 5**	**Forecast Outturn**	**Forecast Variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non-elective performance fund)	100	50	0	0	0	100	0
Total Scheme 2	**100**	**50**	**0**	**0**	**0**	**100**	**0**

Scheme Financials

2.10 Current spend is in line with HCCG profiled budget, which relates to a value contract that is evenly phased (divided equally over 12 months).

Scheme Delivery

2.11 The End of Life Forum meeting in November will agree the end of life pathway, i.e. how people identified as being at end of life are supported and where they are referred to.

2.12 A market testing exercise for the end of life services funded by the CCG, e.g. palliative beds, night sitting, etc, will be taking place early in Q3. The results of this will inform any procurement activity that may take place in Q4 and, potentially, into Q1 2016/17. The scope for including services funded by the Council is being considered as part of this process, the results of which, subject to Board, Cabinet and Governing Body approval, would be delivered in 2016/17.

Scheme Risks/Issues

2.13 The ability of the Council to participate in the use of Coordinate My Care (CMC) as an advanced planning tool as a key deliverable within the action plan for this scheme has been postponed because of an upgrade in the software which is due to take place in November 2015. CMC is used by most health professionals involved in supporting a person at end of life and arrangements will be made in Q4 to enable social care staff to have read only access to its content, which will still be helpful in supporting people at end of life; however, write access will not be possible for the foreseeable future and this means it would not be possible for social care staff to update an advanced care plan on this system to reflect their intervention. As CMC will be one of the systems available through the care information exchange platform referred to later in this report, this would not be an issue if the pilot of this new facility proves to be successful and is then rolled out more widely.

Scheme 3: Rapid response and joined up intermediate care.	Scheme RAG Rating	Amber
	a) Finance	Amber
	b) Scheme Delivery	Green

Scheme 3 Funding	Approved Budget	Spend at Month 6	Variance as at Month 6	Variance as at Month 5	Move-ment from Month 5	Forecast Outturn	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non elective performance fund)	4,099	2,121	25	22	3	4,151	52
LBH - Protecting Social Care funding	686.0	331.8	-11	6	-17	693	7
Total Scheme 3	**4,785**	**2,452**	**13**	**28**	**-14**	**4,844**	**59**

Scheme Financials

2.14 The Council's share of the funding of this scheme relates mainly to the cost of placements in particular bed based intermediate care and Hospital Social Workers. The current forecast is an overspend against bed-based intermediate care services of £7.8k and Hospital Social Workers forecast under spend £0.3k.

2.15 The HCCG spend is showing an increase cost of Pressure Relieving Mattresses partly due to a change to a new supplier (transitional costs) and an increase in the demand for equipment.

Scheme Delivery

2.16 Rapid access clinics providing access to an holistic assessment, ie consultant, therapy, nursing, and diagnostics, previously only available upon admission to the Acute Medical Unit (AMU) have recently started. There are two new clinics being provided each week, one at THH, which started on 21st August and one at Mount Vernon, which started on 2nd September. They provide 4 slots per clinic for patients requiring rapid access, e.g. within four days of referral, to an holistic assessment. Referrals into the clinics are intended to come from GPs and the Rapid Response Team and community matrons and it is expected that activity for the clinics will increase as awareness is raised.

2.17 During Q2 the Reablement Team received 323 referrals and of these 118 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 133 people were discharged from Reablement with no on-going social care needs.

2.18 In Q1 and 2 the Rapid Response Team received 1,866 referrals, 62% (1,142) of which came from Hillingdon Hospital, 15% (282) from GPs, 10% (190) from community services such as District Nursing and the remaining 15% (252) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. 44% of referrals were linked to falls, 10% resulting from issues with reduced mobility, 6% relating to back pain and the remainder from issues ranging from urinary tract infection (UTI) to chest pain. Of the 1,142 referrals received from Hillingdon Hospital, 816 (71.5%) were discharged with Rapid Response input, 28.5% following assessment were not medically cleared for discharge. All 723 people referred from the community source received input from the Rapid Response Team.

Scheme Risks/Issues

2.19 The scheme is RAG rated as amber because of the projected £59.5k overspend against the scheme budget. The CCG's share of this overspend will be offset by underspends in their overall budget.

Scheme 4: Seven day working.	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 4 Funding	**Approved Budget**	**Spend at Month 6**	**Variance as at Month 6**	**Variance as at Month 5**	**Movement from Month 5**	**Forecast Outturn**	**Forecast Variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care funding	753	365	-11	-10	-0	745	-8
Total Scheme 4	**753**	**365**	**-11**	**-10**	**-0**	**745**	**-8**

Scheme Financials

2.20 This budget is split between Reablement (£653.6k) and Mental Health Teams (£100k). Currently Reablement is forecasting an under spend of £10k and the Mental Health Teams are forecasting a pressure of £1.5k resulting in the net forecast variance of £8.5k.

Scheme Delivery

2.21 **Appendix 3** shows the distribution of discharges from Hillingdon Hospital across the week during the period April to September. Discharges of both older people and the overall population are shown. The data shows the uneven spread of discharges across the week that the seven day working BCF scheme is seeking to address.

2.22 The CCG, Hospital and CNWL are working together to explore ways of ensure that people with complex wound care issues can be treated in the community and appropriate support for people requiring medication to be administered intravenously.

2.23 The night sitting service is commissioned by HCCG from Harlington Hospice and provides care and support to both people and their carers at end of life. The main referral route is through Rapid Response but arrangements have been put in place to enable the Hospital to make direct referrals, which will expedite the discharge process for people at end of life whose preferred place of care is at home.

Scheme Risks/Issues

2.24 The issue about the availability of accommodation at the Hospital to support social care staff being permanently based on site reported to the September Board remains unresolved, which is due to a general shortage of space at the Hospital is making this a difficult issue to resolve. The Council and the Hospital are exploring the possibility of a portacabin being placed on the site and the logistics of this are currently being investigated.

Scheme 5: Review and realignment of community services to emerging GP networks	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 5 Funding	**Approved Budget**	**Spend at Month 6**	**Variance as at Month 6**	**Variance as at Month 5**	**Move-ment from Month 5**	**Forecast Outturn**	**Forecast Variation**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	5,605	2,858	55	43	12	5,748	143
LBH - Protecting Social Care funding	3,272	1,592	-43	-32	-10	3,251	-20
Total Scheme 5	**8,877**	**4,450**	**12**	**10**	**2**	**8,999**	**122**

Scheme Financials

2.25 The key LBH variance for the scheme relates to a forecast underspend on the TeleCareLine service of £94.7k which has increased from Month 5 forecast due to a more accurate forecast for income. Work is underway to review the current service and identify opportunities to expand the service for use by other client groups other than the over 80's and identify any innovations which would allow residents to remain in the community for longer .

2.26 This scheme also includes the expenditure on the HCCG's full community equipment budget and £125k of the Council's share of the spend. The balance of the Council's community equipment budget (£486k) is currently held outside of the BCF section 75. This current forecast expenditure for community equipment is showing an overspend between the organisations of £234k (HCCG £143k, LBH £91k).

2.27 The balance is an underspend due to vacancies within the Council's reablement service.

Scheme Delivery

2.28 The multi-disciplinary team (MDT) approach was extended to GP networks in the south of the borough in Q2 after being successfully rolled out across practices in the north in Q1. The three networks in the south of the borough are receiving support to ensure that the maximum benefit can be achieved from the use of the MDT process.

2.29 The integrated care plan template completed in Q1 has started to be rolled out to GP practices across the borough. The effectiveness of this tool is linked to the development of the interoperable IT systems and progress in this area is referred to later in this document.

2.30 In Q2 **56** people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 44% of the grants provided. **73**% (41) of the people receiving DFGs were owner occupiers, 22% (12) were housing association tenants, **5**% (**3**) were private tenants. The total DFG spend on older people during Q2 was £241k, which represented 37% of the total spend (£655k) in Q2.

Scheme Risks/Issues

2.31 This scheme is RAG rated as amber because of the projected £122.4k overspend. The projected overspend will be offset by other underspends within the CCG's overall budget.

2.32 The September Board meeting was advised about a project jointly sponsored by the Council and HCCG starting in Q2 to identify where savings could be achieved from the community equipment budget**.** This project is now in progress and identified savings will be reflected in the next update to the Board. Any savings realised will be shared equally between the Council and HCCG in accordance with agreed risk and benefits share arrangements.

Scheme 6: Care home initiative	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 6 Funding	**Approved Budget**	**Spend at Month 6**	**Variance as at Month 6**	**Variance as at Month 5**	**Move-ment from Month 5**	**Forecast Outturn**	**Forecast variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	48	24	0	0	0	48	0
Total Scheme 6	**48**	**24**	**0**	**0**	**0**	**48**	**0**

Scheme Financials

2.33 HCCG expenditure is in line with planned activity.

Scheme Delivery

2.34 The Deputy Director of Nursing and Patient Experience attended the September Residential and Nursing Care Home Provider Forum in September to give feedback on the Hospital response to issues raised at the June meeting, e.g. improving discharge process by setting targets for wards regarding the discharge process and stopping evening discharges.

Scheme 7: Care Act implementation	Scheme RAG Rating	Amber
	a) Finance	Amber
	b) Scheme Delivery	Green

Scheme 7 Funding	Approved Budget	Spend at Month 6	Variance as at Month 6	Variance as at Month 5	Move-ment from Month 5	Forecast Outturn	Forecast Variation
	£000's	£000's	£000's	£000's	£000's	£000's	£000
Care Act New Burdens Funding	838	707	288	240	48	1,621	783
Total Scheme 7	**838**	**707**	**288**	**240**	**48**	**1,621**	**783**

Scheme Financials

2.35 The current estimated increase in expenditure on delivering the responsibilities under the Care Act is £1,620.9k, a pressure of £782.9k. These additional costs are detailed below. The financial pressure on this budget arising from the additional demands is fully covered by other Council contingency funds and does not pose any risk to the financial position of the BCF.

Care Act Additional Cost Pressures	
	£000's
Social Care & Carers Assessments	231
Respite Care	415
Carers Services	209
Safeguarding Board	260
Increased clients requiring financial assessments & Contact Centre	82
ICT, Care Market Management & Staff Training	112
Project Management for the implementation of Care Act responsibilities	312
Total	**1,621**

Scheme Delivery

2.36 As at 30th September 2015, Connect to Support Hillingdon had 182 private and voluntary sector organisations registered on the site offering a wide range of products, services and support, work continues to promote the site both with residents and providers.

2.37 From 1st April (launch) to 30th September 2015, in excess of 3,700 individuals have accessed Connect to Support and completed over 5,900 sessions reviewing the information & advice pages and/or details of available services and support. The online social care self-assessment went live on 1st July 2015 and in the period to 30th September 38 online assessments have been completed and 28 were by people completing it for themselves and 10 by carers or professionals completing on behalf of another person. 8 self-assessments have been submitted to the Council to progress and the remainder have been sent to the residents at their request in order for them to decide in their own time how they wish to proceed.

2.38 The Council also launched the online financial self-assessment on the 1st July and in the period up to 30th September 3 have been completed and submitted to the Council's Finance Team for processing. This number is expected to increase over time as a result of greater awareness about the availability of this facility.

2.39 A self-assessment facility for Carers is on target to go live in Q3.

2.40 During Q1 and Q2 313 carers' assessments were completed. On a straight line projection, this would suggest a total of 626 assessments for 2015/16, which would be 256 more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 153 carers have been provided with respite or other carer services during the first half of 2015/16 at a total cost of £1.074k. The forecast for 2015/16 is £1.9m.

Scheme Risks/Issues

2.41 This scheme is RAG rated as amber because of the projected £576k overspend.

Financial Costs not in schemes							
	Approved Budget	**Spend at Month 6**	**Variance as at Month 6**	**Variance as at Month 5**	**Move-ment from Month 5**	**Forecast Outturn**	**Forecast Variation**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Disabled Facilities Grant (Capital)	1,769.0	985.0	100.5	28.9	71.6	1,769.0	0.0
Social Care Grant (Capital)	580.0	2.0	-288.0	-240.7	-47.3	580.0	0.0
BCF Programme Management	60.0	30.0	0.0	0.0	0.0	60.0	0.0
Total	**2,409.0**	**1,017.0**	**-187.5**	**-211.8**	**24.2**	**2,409.0**	**0.0**

2.42 There is currently an overspend in month 6 for DFGs, although for the year this is forecast to be on target. There is also a capital grant of £580k within the pooled fund which has been held to contribute to the funding of a dementia resource centre in the borough.

3. Key Risks or Issues

Joined-up IT Systems

3.1 Joined-up and inter-connected IT systems are key enablers to delivering integrated care. The following summarises where the Hillingdon health and care community has got to with linking up different organisational IT systems:

- All of Hillingdon's 46 GP practices now use a single system called EMIS Web and this enables them to share information between practices where there are common services and care pathways.

- Hillingdon GPs are able to submit orders electronically for diagnostic tests at The Hillingdon Hospital (THH), and see the results in their EMIS Web system, using a system called Sunquest ICE.

- At the end of an episode of hospital care at THH, summary letters are sent to GPs in electronic form.

- GP patient records from EMIS Web are visible in the Acute Medical Unit (AMU) at THH and are also available in the Urgent Care Centre and to the GP Out of Hours and 111 services, via the Medical Interoperability Gateway (MIG) and/or the national NHS Summary Care Record.

- Referrals can be sent electronically from Hillingdon GPs to THH via the NHS e-Referrals system.

- The national Electronic Prescribing System sends prescriptions from GPs to community pharmacies.

- EMIS Web enables patients to book appointments and request prescriptions online or from a smart phone.

- An Information Governance framework is in place to protect patient confidentiality.

3.2 Other projects under way to further increase automation and support greater integration of care include:

- The care information exchange platform called Patients Know Best (PKB), which will enable different IT systems to be linked up and the information from them accessed through a single web-based portal. Initially it will allow the medical care plan and the social care support plan to be viewed by care professionals as well as the patient themselves. This will be first time that it has been possible to do this. It was reported to the September Board that a pilot was due to start in October but this has been delayed whilst information governance arrangements are put in place. Once this has been completed the pilot will start and this will provide practical experience of sharing information across organisations involved in addressing the health and social care needs of residents/patients. The pilot will include patients identified from 17 GP practices in the north of the borough and if successful it will then be rolled out across the borough.

- The Council and Hillingdon Community Healthcare (HCH) are both planning to use MIG to be able to check GP records when appropriate, e.g. for other adults and children and young people as PKB is only supporting older people. It is also proposed to allow GPs to view social care records through the same route. For the Council delivery of this connection is dependent on the interface being established with the social care database, known as Protocol, which has resource implications and discussions are currently in progress with the system supplier to clarify these costs. Once resolved the appropriate expenditure approval authorisation will be sought.

- The EMIS Web system is being extended to enable people to see the whole of their GP record online.

3.3 *Digital roadmap* - NHSE is requiring all CCGs to develop local digital road maps by April 2016 to detail how they will achieve the ambition of being paper-free at the point of care by 2020. This arises from the commitment made by NHSE in its *Five Year Forward View* (NHSE Oct 14) that by 2020 there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in *Personalised Health and Care 2020* (DH Nov 14) that 'all patient and care records will be digital, interoperable and real-time by 2020.' NHSE expects CCGs to engage with provider and commissioner partners across health and social care in the completion of these plans and local digital roadmaps will be considered as part of the CCG assurance framework from 2016/17 onwards.

3.4 The first stage in the development of the local digital roadmap is the completion of a self-assessment of the digital maturity of Hillingdon's health and care community and an analysis of each organisation's IT strategy against local and national clinical and digital goals. The self-assessment will take place between November 2015 and January 2016. The roadmap will be drafted by the multi-agency Pan-Hillingdon IT Group, which includes representation from the Council's Corporate IT Team and also from Adult Social Care. It is the proposed to submit draft plan to the Board's March meeting for consideration.

3.5 NHSE has advised that an announcement about additional resources to support the implementation of digital roadmaps is due to be made during 2016.

Appendix 3

HILLINGDON HOSPITAL DISCHARGE ACTIVITY DAY BY DAY APRIL - SEPT 2015								
Admission Source	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**TOTAL**
Discharges following a planned (elective) admission (65 + age group)	830	846	876	890	958	601	55	**5,056**
Discharges following an unplanned (non-elective) admission (65 + age group)	691	822	777	768	872	408	293	**4,631**
TOTAL DISCHARGES 65 +	**1,521**	**1,668**	**1,653**	**1,658**	**1,830**	**1,009**	**348**	**9,687**
Discharges following a planned (elective) admission (All Ages)	1,797	2,174	2,075	2,298	2,406	1,440	129	**12,319**
Discharges following an unplanned (non-elective) admission (All Ages)	1,824	2,076	1,939	1,885	2,114	1,320	1,185	**12,343**
TOTAL DISCHARGES ALL AGES	**3,621**	**4,250**	**4,014**	**4,183**	**4,520**	**2,760**	**1,314**	**24,662**
% of All Age Discharges aged 65 +	42%	39%	41%	40%	41%	37%	27%	**39%**
TOTAL DISCHARGES	**5,142**	**5,918**	**5,667**	**5,841**	**6,350**	**3,769**	**1,662**	**34,349**

Better Care Fund

Period: 01/04/2015 to 30/09/2015
Month Number: 6

For further information please contact:
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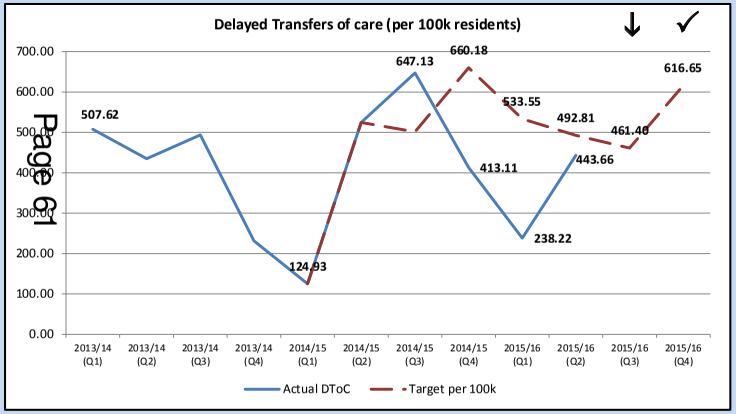
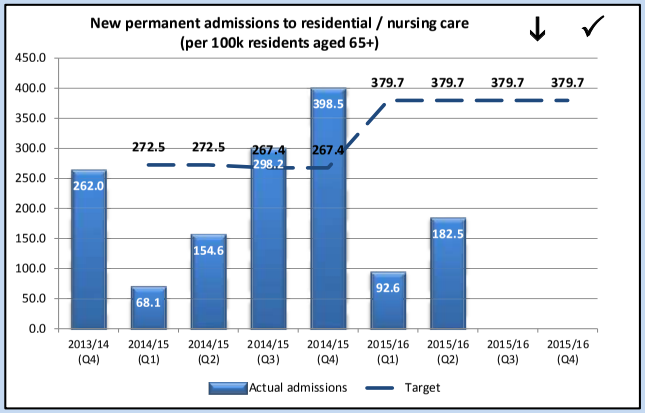
CCG Ceri Jacob

High Level Summary

Non-Elective Admissions		Pay for performance period Q4 (Jan - Mar)	Q1 (Apr-Jun)	Q2 (Jul - Sep)
Non-elective admissions in to hospital (general & acute), 65+.	2014 Actual	2,711	2,818	2,756
	Req. Reduction for 2015	95	99	96
	Target for 2015	2,616	2,719	2,660
	Actual 2015	2,754	2,663	2,571
	Difference from Target	+138	-56	-89
	Target: P4P annual change in admissions			-388
	Target: P4P annual change in admissions (%)			-3.5%
	Target: P4P annual saving			£578,598
	Projected (Based on available and target): P4P annual change in admissions			-395
	Projected (Based on available and target): P4P annual change in admissions (%)			-4.8%
	Projected (Based on available and target): P4P annual saving			£588,407

Key components of BCF funding 2015/16	Budget	Actual Spend to Date (M6)	Forecast
	£000's	£000's	£000's
HCCG Commissioned services funding (including non elective performance fund)	10,032	5,143	10,227
Care Act New Burdens Funding	838	707	1,621
LBH - Protecting Social Care Funding	4,712	2,290	4,690
LBH - Protecting Social Care Capital Funding	2,349	987	2,349
BCF Programme Management	60	30	60
Overall BCF Total funding	17,991	9,157	18,947

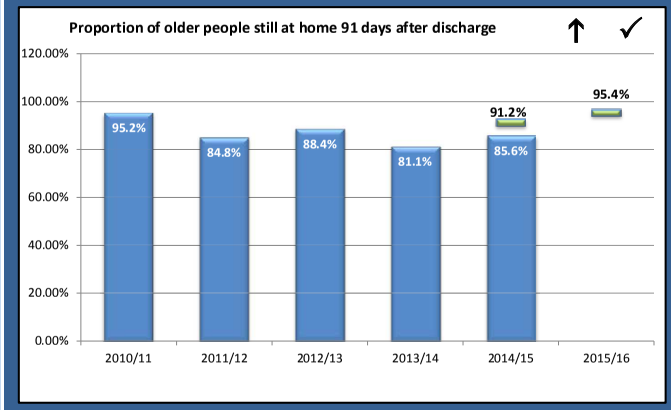


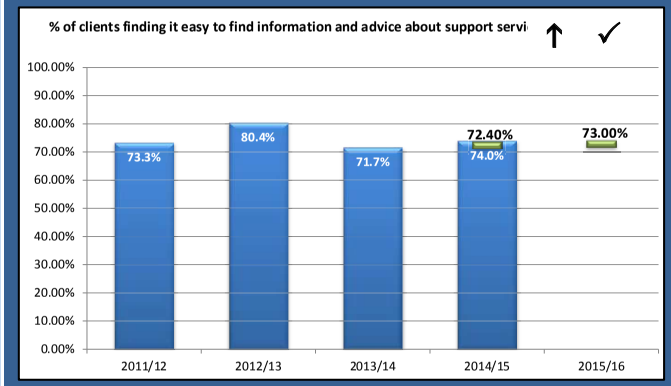


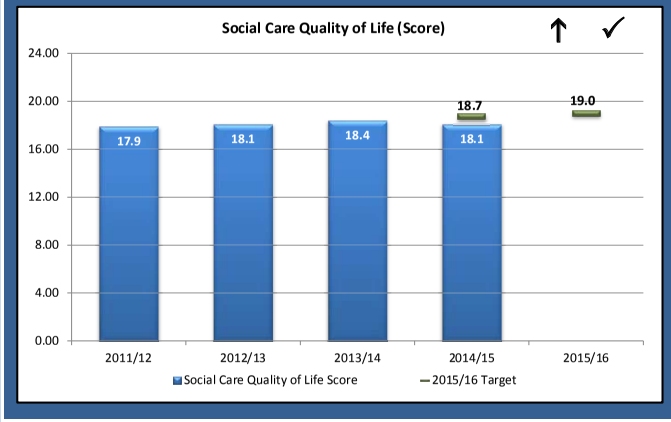
Delayed Transfers of Care (There is a 1 month time lag on the availability of the data)	To the end of period	Number (1/4ly)	Residents	Per 100k
	Baseline (2013/14)	3,666	219,259	1,672.0
	2014/15 (Q1)	278	222,521	124.9
	2014/15 (Q2)	1,168	222,521	524.9
	2014/15 (Q3)	1,440	222,521	647.1
	2014/15 (Q4)	933	225,846	413.1
	2014/15 (Full Year)	3,819	225,847	1,691.0
	2014/15 (Target)	4,053	225,847	1,794.6
	Variance from Target	-234	225,847	-103.6
	2015/16 (Q1)	538	225,846	238.2
	2015/16 (Q2)	1,002	225,846	443.7
	2015/16 (Q3)		225,846	0.0
	2015/16 (Q4)		229,303	0.0
	2015/16 (Full Year)	1,540	229,303	671.6
	2015/16 (Target)	4,790	229,303	2,088.9
	Variance from Target	-3,250	229,303	-1,417.3

Permanent admisisons to Residential / Nursing care (residents aged 65+)	To the end of period	Number (Cum)	Residents	Per 100k
	Baseline (2013/14)	100	36,655	272.8
	2014/15 (Q1)	26	38,169	68.1
	2014/15 (Q2)	56	38,169	146.7
	2014/15 (Q3)	116	38,169	303.9
	2014/15 (Q4)	155	38,895	398.5
	2014/15 (Target)	104	38,895	267.4
	Variance from Target	+51	38,895	131.1
	2015/16 (Q1)	36	38,895	92.6
	2015/16 (Q2)	71	38,895	182.5
	2015/16 (Q3)		38,895	0.0
	2015/16 (Q4)		39,500	0.0
	2015/16 (Target)	150	39,500	379.7
	Variance from Target		39,500	0.0

Annual Measures







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HILLINGDON CCG UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Ceri Jacob, HCCG
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • Integration and development of an Accountable Care Partnership • Primary Care Co-Commissioning • QIPP • Finance
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital strategy • Financial strategy • Shaping a Healthier Future update
Financial Cost	Not applicable to this paper
Relevant Policy Overview & Scrutiny Committee	External Services Overview and Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes this update.

3. INFORMATION

The following section summarises key areas of work the CCG wishes to bring to the attention of the Health and Wellbeing Board.

3.1 Integration update and development of Accountable Care Partnership

Hillingdon's overall aim for integrated care is that the residents of Hillingdon will be able to plan their own care, with their carer or support if needed; 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. This will require a shift to planning for anticipated care needs rather than crisis management.

3.1.1 Update on work in progress and key developments.

Older People Model of Care

Integrated Care Planning (ICP) which provides the lower level support in our older people model of care (noted above) was rolled out in Hillingdon via GP networks in July 2015. ICP includes selecting appropriate patients who would benefit from care coordination, development of anticipatory shared care plans coproduced with patients, care coordination and collaborative working with other professionals and partners. Since ICP service commenced, work is underway to further refine and develop this element of the model of care.

Metro health GP Network, are testing a better way of selecting patients for care planning. This includes using a combination of multi-provider risk stratification tools, informed practice intelligence and informed provider intelligence. As these selection tools are refined and linked to real time intelligence, earlier signs of frailty can enable a trigger to earlier support.

Work is progressing to enable networks to track benefits for patients which in turn will help improve the impact of care planning in terms of patient experience and outcomes of care.

In addition to ICP care planning and care coordination, some people will require escalated care and a pilot commenced in MetroHealth GP Network in Nov 2015 comprising a new Care Connection Team (CCT) to support these people. This includes a guided care nurse and care co-ordinator working with the GPs over 2 practices. The GPs, guided care nurse and care co-ordinator are further supported in the pilot by dedicated care of the elderly consultants available on the phone for advice and support. The care connection team will assist GP pilot practices with proactive care of patients, enable the rapid escalation of people in urgent need of support, active case management and daily monitoring of patients. The GP will continue to oversee the whole care pathway.

New Rapid Access Clinics for the Elderly (RACE) have been commissioned by HCCG and provision commenced in August 2015, which can further support patients and clinicians in the community and be accessed by the CCT as part of the pilot.

From January 2016, further support to GP practices will be piloted through a single health and care gateway offering low level support and signposting via the third sector. The single gateway to services provided by the wide range of Hillingdon voluntary and community groups is being managed by H4All, a consortium of the 5 largest third sector provider in Hillingdon. The team will;

- take direct referrals from health and social care professionals to support people with low to moderate social care needs;
- attend the MDTs to ensure appropriate access and support to those requiring a social level of care;
- Primarily identifying residents who are isolated, anxious and de-motivated.

The gateway model has been developed to use a Patient Activation Measurement tool (PAM). This tool provides both a baseline on which to evaluate intervention and support and a measure to target support and resources to people that require it. The service will work with residents to raise their participation and motivation in self-management. It is anticipated that this service will

reduce unnecessary GP appointments, allowing the GP more time to review patients requiring medical care.

Development of the Accountable Care Partnership

The Accountable Care Partnership is Hillingdon CCG's preferred model of delivery for integrated care. Commissioning integrated care from the Accountable Care Partnership will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. Hillingdon CCG and shadow ACP are discussing the scale and pace of this ambition linked to benefits for people in Hillingdon.

The Accountable Care Partnership (ACP) will function (deliver services) in shadow form for a year from April 2016. Prior to this, a memorandum of understanding will enable both the CCG and the providers to test the concepts of commissioning for integrated care including capitation, development of outcomes and coproduction of the model of care.

In order for the ACP to work collaboratively, it is developing a new joint governance structure to enable the ACP to make decisions, allocate funds, manage performance, and hold each other to account for delivering outcomes. The ACP shadow board is leading this work, and have appointed a Programme Director to commence in January 2016. An ACP development group will support this work stream.

Further detail on development of the ACP can be provided at a future Health and Wellbeing Board if required.

Enablers

a) Capitation:

Work on capitated budgets for 15/16 includes:

- Scope of overall payment model design
- Collection of activity and spend data assigned to population groups
- Analysis and review of baseline activity and finance
- Reconciliation and creation of a preliminary draft shadow budget

Next steps by April 2016

- Development of contract framework for shadow budget
- Development of a framework for risk and reward sharing
- Sign off by provider Boards and HCCG Governing Body

From April 2016

- Payment to providers will be on the current contractual basis
- A notional capitated budget will be set at beginning of year
- The financial impact on commissioners and providers that would have occurred if the new payment model were fully in place against the notional budget will be tracked.

b) Outcomes:

A common outcomes framework for the Older People model of care is under development, which builds on existing frameworks such as BCF and ICP and will enable a common set of indicators and measures for the whole Older People integrated model of care.

A technical group is currently developing and aligning these indicators, metrics and KPIs so that the impact of the Older People's model of care can be tracked and evaluated.

Commissioning for population level outcomes will require the development of:

- System outcomes –is the care system delivering our vision for older people in a sustainable way
- Clinical outcomes – is the care delivering improved health and care outcomes for the population group
- Patient experience and reported outcome - do people feel sufficiently supported by the health and care system; "nothing about me without me".

c) Shared data and records:

All partners will be a signatory to an Information Sharing Agreement (ISA), and have now signed up to these agreements.

Hillingdon is a pilot site for "Patient Knows Best" an information sharing platform that will enable patients and all professionals to see and update care plans. This is planned to pull data directly from each providers own system. The pilot will commence in October 2015 for 3 months.

A new care record template is now operational with all GP networks

A Business intelligence tool (WYSE) has been developed to support planning, mobilising and delivering integrated care, including GP practice level dashboards and performance tools.

3.1.2 Governance arrangements from December 2015

Governance for whole systems integration in Hillingdon has been reviewed to support moving into the mobilisation and testing stage (figure 1). These governance arrangements will enable dual assurance to both the HCCG Governing Body and the ACP Shadow Board, whilst overseeing progress and outcomes from the programme work -streams. These arrangements will commence in December 2015.

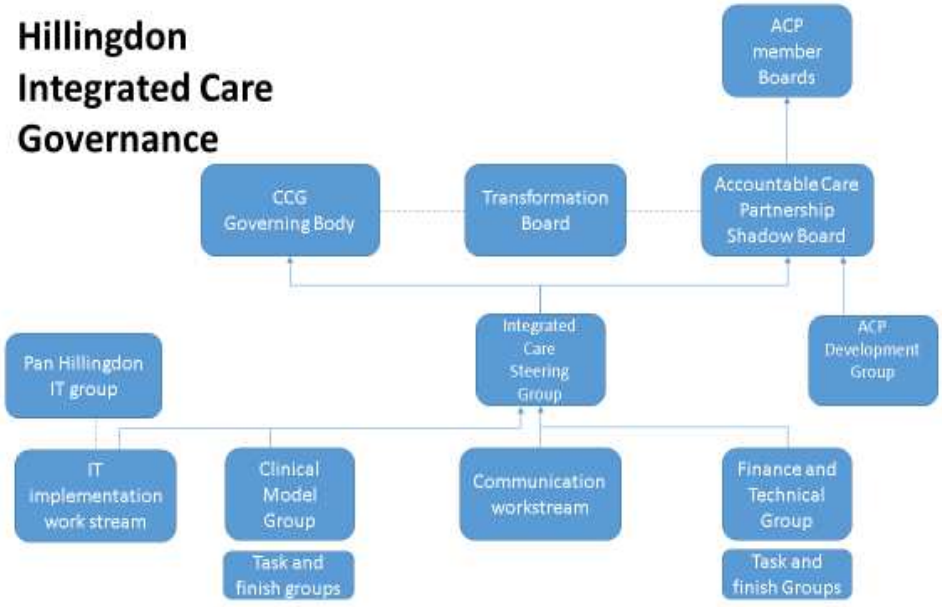

Figure 1

3.2 Primary Care Co-Commissioning

Hillingdon CCG entered Primary Care co-commissioning arrangements with NHS England in April 2015. Currently co-commissioning primary care is restricted to General Practice. Dentists, Pharmacists and Optometrists continue to be wholly commissioned by NHS England.

Each CCG that has entered co-commissioning arrangements must form a Joint Committee with NHSE. Originally it had been proposed that the eight North West London (NWL) CCG Joint Committees would meet in common with each CCG also having a local sub-group to take work forward. It has now been agreed that Joint Committees should be held locally and only meet in common where necessary to secure strategic alignment across NWL. Terms of Reference and membership of the local group have now been amended to reflect this change.

A key area of focus for the committee at the moment is implementation of a new model of care for GP practice that will support GPs to work in a networked fashion and to be part of an integrated care delivery system. The new Model of Care will meet quality requirements set out in the London primary care Strategic Commissioning Framework for example, access to GPs.

A second key area of work is the Personal Medical Services (PMS) review. GPs in Hillingdon work under one of three different contracts:

- GMS (General Medical Services) – nationally negotiated
- PMS (Personal Medical Services) – locally negotiated with premium funding allocated to support specific service initiatives
- APMS (Alternative Provider Medical Services) – locally negotiated and the contract can be held by a non-GP who employs salaried GPs.

In Hillingdon the majority of GPs working with a GMS contract. There are 10 with PMS contracts and 1 with an APMS contract.

The PMS review is being led by NHS England who are carrying out a value for money assessment on services provided via the premium fund (£1m across PMS practices). The CCG will be responsible for agreeing how any premium funding released should be utilised to support service delivery and quality in general practice.

A fuller report on both of the above areas can be provided at a future Health and Wellbeing Board if required.

3. 3 QIPP (Quality, Innovation, Productivity, Prevention)

The CCG's plan for QIPP for 2015/16 is valued at £7.746m and at Month 6 we are currently predicting a Forecast Outturn of £6.361m. The forecast outturn has been improving each month and we expect that trend to continue through the delivery of the following mitigating actions:

- **Intermediate Care:** We expect to negotiate with The Hillingdon Hospital (THH) that any patient taken home with a Zero Length of Stay via either the Homesafe or Rapid Response Teams will not be counted as an admission and will attract the local tariff for admissions avoided. This scheme also links to the Better Care Fund.

- **Ambulatory Pathways:** The ambulatory activity for adults through the AEC (Ambulatory Emergency Care) Pathway and EGAU (Emergency Gynae Assessment Unit) continues to over-achieve and we are seeing increasing numbers each month. In addition, we have agreed with THH to open up Surgical and Paediatric Ambulatory Pathways which will significantly reduce non-elective admissions in this area and contribute to the CCG's QIPP.

- **Community Services/Equipment:** Having successfully completed a number of procurements we are set to exceed our QIPP whilst improving the service provided to patients and service users associated with Wheelchairs and Pressure Relieving Mattresses. We are also seeing an improving position associated with our Community Dermatology Service which is now seeing >200 patients per month. Lastly, our joint work with LBH around Community Equipment is starting to show results with a reduction in the expected spend in this area.

- **MSK:** We continue to work with THH around reducing elective Musculo-Skeletal (MSK) activity and hope that this will be reflected in an improving QIPP situation. However, further to discussions with THH we are seeking to procure a new Community Chronic Pain Service that will have a major impact on Secondary Pain Activity associated with the hospital and in particular with Spinal Injections. Lastly, we are working with THH to develop a new Rheumatology Service although we do not expect this to generate any QIPP directly we do expect a much better service to patients in terms of access and for GPs to help them manage patients in the community, something that we are addressing through a 'Near Patient Testing' LES (Local Enhanced Service) that will focus on DMARDS (Disease Modifying Anti-Rheumatic Drugs).

- **Older People:** Our work to support Older People is increasing in pace with Rapid Access Care of the Elderly Clinics now available to augment our existing Care Homes, Falls and Fracture Liaison Services and our Intermediate Care Services. We will be developing plans for expanding this area of focus in 16/17 and beyond.

- **Long Term Conditions:** We are reaching the point at which our major Long Term Condition programmes (Cardiology, Diabetes and Respiratory) start to realise benefits and this is already supported by the success of our Empowered Patient Programme (EPP) which is exceeding the expected run rate and supporting our strategy for Secondary and Tertiary Prevention. The majority of benefits associated with LTCs will be realised through 16/17 and beyond and this area forms a major part of the CCG's emerging Prevention Strategy.

- **QIPP 16/17 & Beyond:** The CCG is now working up the detail of the new QIPP Schemes for 2016/17. In addition, the NWL CCGs are working to create a 5 Year QIPP View so that the financial sustainability of the entire sector can be assessed and joint activities planned where needed across a longer time period.

3.4 Financial position

The CCG's financial plan for 2015/16 is to deliver a 1% surplus (£3.482m) and to remove the underlying deficit. The plan is based on the following key deliverables/assumptions:

- Funding from NWL Strategy of £10.3 m plus THH Transitional Support of £3m
- Local QIPP Plan delivery of £7.7m (£8m in 14/15)
- Delivery of 15/16 Acute Activity Plan

Overall, at month 6, the CCG's in-year's position is a YTD planned surplus of £1.741m and a forecast surplus of £3.482m which is in line with plan. The CCG is currently facing some financial pressures on its Acute budget (£1.9m FOT over performance at month 6 arising from the shortfall in QIPP highlighted above and other pressures in Rehabilitation services and Critical Care) as well as in its Mental Health Placements budget and GP Prescribing. These pressures are currently being managed by some underspends elsewhere in the CCG's budget (e.g. reduction in Property Charges) and by the release of reserves.

As a result the achievement of the underlying break-even for the CCG by the end of the year remains challenging and this is still reliant on the delivery of the 2015/16 acute activity plan and the continuation of the NWL Financial Strategy funding into 2016/17.

Tables 1 to 4 below summarise the current position.

Overall Position

	Outturn			YTD Month 06		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Programme Costs:						
Revenue Resource Limit	341,867	341,867	(0)	167,771	167,771	0
Net Programme Costs	(338,385)	(338,635)	(250)	(166,030)	(166,030)	(0)
Surplus / (Deficit)	3,482	3,232	(250)	1,741	1,741	(0)
Running Costs:						
Revenue Resource Limit	6,194	6,194	0	2,898	2,898	0
Net Running Costs	(6,194)	(5,944)	250	(2,898)	(2,898)	0
Surplus / (Deficit)	0	250	250	(0)	(0)	0
CCG Surplus / (Deficit)	3,482	3,482	0	1,741	1,741	(0)

Table 1

Year to Date Variances

08G Hillingdon CCG Month 06	Year to Date Variance £m	Commentary on Year to Date Variance
QIPP Variance - Acute	-0.405	Mainly THH non-elective admissions schemes.
QIPP Mental health Commissioning	-0.048	
Other Acute Commissioning	-0.013	
Continuing Care	-0.046	
Prescribing	-0.087	
Community	-0.031	
QIPP Variance Total	**-0.63**	
Acute SLA	-0.388	Primarily relates to an overspend with THH. Other overspends include Frimley, Barts, RBH and East & North Herts.
Prescribing	-0.450	Overspend on GP Prescribing of (£414k) based on 15/16 profile. Actuals for July were higher than forecasted.
Mental Health Commissioning	-0.065	Placements overspent by (£333k) based on Caretrack data, offset by Other of £232k which relates to investments.
Sub-Total Adverse Variances	**-0.903**	
Other Acute Commissioning	1.085	Driven by underspend on NCAs £722k, Re-Admission Credit Reserve £308k, THH Other £153k, UCC THH Main Contract £70k, offset by overspend on UCC NCAs (£139k) and Mount Vernon Beds (£124k).
Continuing Care	0.066	Mainly relates to an underspend on Personal Health Budgets of £35k and CHC Adult Fully Funded £24k offset by overspends on CHC Children (£29k) and Funded Nursing Care (£19k).
Community	0.133	Mainly relates to underspends on Other QIPP Reprovision Schemes £59k, Intermediate Care £46k and Community Services - NCAs £30k mainly offset by overspends on Community Equipment (£16k) and Hospices (£14k).
Corporate & Estates Costs	0.032	Mainly underspends in Estate Charges of £201k fbased on 15/16 Property Services cost schedule, WSIC £40k and GPIT £39k, offset by overspends in QIPP Provision (£177k), Safeguarding (£53k) and SaHF Transformation Funding (£17k).
Primary Care	0.217	Driven by underspends on ICP Project £103k, Primary Care Investments £91k and Local Incentives Schemes £28k.
Running Costs	0	
Sub-Total Released Reserves/Underspends	**1.533**	
Total	**0.000**	

Table 2

Forecast Outturn Variances

08G Hillingdon CCG Month 06	YTD Variance £m	Forecast Variance			Commentary on Position
		Projected (Straight Line) £m	Adjust £m	Forecast Outturn Variance £m	
QIPP Variance - Acute	-0.405	-0.810	-0.147	-0.957	
Mental Health Commissioning	-0.048	-0.096	0.048	-0.048	
Other Acute Commissioning	-0.013	-0.026	-0.001	-0.027	
Continuing Care	-0.046	-0.092	-0.014	-0.106	
Prescribing	-0.087	-0.174	-0.072	-0.246	
Community	-0.031	-0.062	0.060	-0.002	
QIPP Variance Total	**-0.630**	**-1.260**	**-0.126**	**-1.386**	
Acute SLA - Non QIPP	-0.388	-0.776	-0.175	-0.951	
Prescribing	-0.45	-0.900	0.177	-0.723	
Mental Health Commissioning	-0.065	-0.130	-0.494	-0.624	Relates to Mental Health Investments where spend is planned for latter part of the year.
Sub-Total Adverse Variances	**-0.903**	**-1.806**	**-0.492**	**-2.298**	
Other Acute Commissioning	1.085	2.170	-0.108	2.062	
Continuing Care	0.066	0.132	-0.067	0.065	
Community	0.133	0.266	-0.220	0.046	
Corporate & Estates Costs	0.032	0.064	0.588	0.652	Largely relates to 14/15 Property Services creditor for an onerous lease on Kirk House which is expected to be released later in the year creating an underspend of £582k.
14/15 Creditors Balance	0	0.000	0.296	0.296	Unutilised 14/15 creditors relating to CIS.
Primary Care	0.217	0.434	-0.121	0.313	
Running Costs	0	0.000	0.250	0.250	Unutilised Reserves.
Sub-Total Released Reserves and underspends	**1.533**	**3.066**	**0.618**	**3.684**	
Total	**0.000**	**0.000**	**0.000**	**0.000**	

Table 3

Forecast Outturn Actuals

08G HILLINGDON MTH 06	YTD £m	Forecast Spend			Commentary on Adjust Column
		Projected (Straight Line)	Adjust £m	Forecast Outturn £m	
QIPP YTD - Acute	(3.022)	(6.044)	(1.384)	(7.428)	Some schemes due to commence 1.10.2015
QIPP YTD - Continuing Care	(0.010)	(0.020)	(0.006)	(0.026)	Relates to CHC Procurment of complex children scheme starting 01.07.15 and CHC Patient Review.
QIPP YTD - Prescribing	(0.673)	(1.346)	0.072	(1.274)	Prescribing Scheme to be brought back on track.
QIPP YTD - Mental Health	(0.095)	(0.190)	(0.048)	(0.238)	Relates to Shifting settings of care scheme.
QIPP YTD - Community	(0.087)	(0.174)	(0.023)	(0.197)	Relates to Community Rehab Equipment scheme from 01.07.2015.
QIPP YTD - Re-provision (excl outpatient ophthalmology)	1.134	2.268	1.173	3.441	QIPP Reprovision Schemes to be spent in latter part of the year.
QIPP YTD - Running Cost	(0.320)	(0.640)	0.001	(0.639)	Relates to a target reduction in Running Costs
QIPP Total	**-3.073**	**-6.146**	**-0.215**	**-6.361**	
Acute SLAs - Non QIPP	96.298	192.596	1.330	193.926	This is due to phasing of SLA contracts and seasonal adjustments.
Continuing Care	9.478	18.956	(1.696)	17.260	Relates to a year end provision for continuing care appeals and the full amount of retropsective provision risk share contribution is in ytd position.
Other Acute Commissioning	14.412	28.824	(2.005)	26.819	THH SaHF Paeds Reconfiguration and maternity one off payment of £3m has been paid in full. The expectation for Mount Vernon Beds is that the contract ceased in September. Re-admissions spend is planned in the latter half of the year.
Winter Pressures	0.045	0.090	0.984	1.074	£0.98m Winter Resilience - this is in-year contingency for winter schemes to be spent from November onwards.
Mental Health	11.169	22.338	1.079	23.417	£0.8m investments and £0.15m Eating Disorders and Planning to be spent in the second half of the year.
Corporate & Estates Pressures	2.636	5.272	(0.637)	4.635	14/15 Property Service Creditor for the onerous lease on Kirk House will be released into the position in the latter part of the year.
Prescribing	18.211	36.422	0.266	36.688	GP Prescribing forecast based on IPP report. Local drugs phasing includes Seasonal factors - Flu etc.
Primary Care	1.928	3.856	1.805	5.661	Proposed ICP Project, Primary Care Investments, GP Network Development and Local Incentive Schemes planned for the second half of the year.
Community Services	14.605	29.210	1.264	30.474	Better Care Fund and Other QIPP Reprovision Schemes to be spent in latter part of the year.
Sub-Total	**165.709**	**331.4166**	**2.175**	**333.593**	
SLA - Acute Contracts Risk Reserve	0.000	0.000	2.993	2.993	Additional provision for in year investment in schemes to reduce emergecy admissions and re-investment of contract penalties.
Contingency	0.000	0.000	1.705	1.705	Contingency not utilised in year to date position.
14/15 Creditors Balance	0.000	0.000	(0.296)	(0.296)	To be released in the latter part of the year.
Sub-Total Released Reserves and underspends	**0**	**0**	**4.698**	**4.402**	
Running Cost	3.218	6.436	0.147	6.583	Largely relates to unutilised reserves of £0.261m.
Net YTD Spend	**168.93**	**337.85**	**7.02**	**344.58**	

Table 4

The full Month 6 report can be accessed via the following link.
http://www.hillingdonccg.nhs.uk/publications2

4. FINANCIAL IMPLICATIONS

QIPP: - the forecast outturn at M6 for 15/16 is £6.361m against our target of £7.746m.
Financial Plan: - the CCG is forecast to achieve its financial plan for 2015/16.
Integrated care: - the expectation is that the Older People model of care will provide savings of approximately £1.5m

5. LEGAL IMPLICATIONS

None in relation to this update paper.

6. BACKGROUND PAPERS

- North West London 5 Year Strategic Plan
- Hillingdon CCG Out of Hospital Strategy
- Hillingdon CCG Operating Plan 2015/16
- London Primary Care Strategic Commissioning Framework

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HEALTHWATCH HILLINGDON UPDATE

Relevant Board Member(s)	Jeff Maslen
Organisation	Healthwatch Hillingdon
Report author	Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon
Papers with report	None

HEADLINE INFORMATION

Summary	To receive a report from Healthwatch Hillingdon on the delivery of its statutory functions for this period.
Contribution to plans and strategies	Joint Health and Wellbeing Strategy.
Financial Cost	None.
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

RECOMMENDATION

That the Health and Wellbeing Board notes the report received.

1. INFORMATION

Healthwatch Hillingdon is contracted by the London Borough of Hillingdon, under the terms of the grant in aid funding agreement, to deliver the functions of a local Healthwatch, as defined in the Health and Social Care Act 2012.

Healthwatch Hillingdon is required under the terms of the grant aid funding agreement to report to the London Borough of Hillingdon on its activities, achievements and finances on a quarterly basis throughout the duration of the agreement.

2. SUMMARY

The body of this report to Hillingdon's Health and Wellbeing Board summarises the outcomes, impacts and progress made by Healthwatch Hillingdon in the delivery of its functions and activities for this period. It should be noted that a comprehensive report is presented by the Chief Executive Officer to the Directors/Trustees at the Healthwatch Hillingdon Board meetings

and is available to view on our website:
http://healthwatchhillingdon.org.uk/index.php/publications

3. OUTCOMES

Healthwatch Hillingdon would wish to draw the Health and Wellbeing Board's attention to some of the outcomes highlighted by its work during the second quarter.

3.1 Information, Advice and Support

We continue to see a rise in the number of residents that contact our service. During this quarter, we received 307 enquires relevant to our function.

Table A, gives a breakdown of the type of enquiry we have received and how we have helped residents. Reasons remain varied, from advice on how to complain to living a healthy life. We have signposted nearly 120 people. Largely, these have been to the voluntary sector. We have noted a small rise in people seeking bereavement counselling and, in addition to voluntary organisations, we have directed these to the Talking Therapies Services.

A high number of those requesting information were residents who had been in receipt of a letter explaining changes to the Wheelchair Service in Hillingdon. The majority of these being where people had returned their wheelchair, or wanted to return it. We were also contacted by family members of people who were deceased. An error had occurred due to an out of date database and the CEO of CNWL issued a public apology to these relatives.

Type of enquiry	Number	% of enquiries
Refer to a health or care service	32	10%
Refer to a voluntary sector service	87	28%
Requesting information /advice	112	36%
Requesting help / assistance	21	7%
General enquiry	55	18%

Table A

Table B shows the source of our enquiries. It again shows the value of our prime shopping centre location. Due to the volume of enquiries coming through the shop on weekdays, we are currently looking at the possibility of having an open day on a Saturday during the busy run up to Christmas to attract more residents and inform them about Healthwatch.

Source of enquires	Number	% of source
Shopper	168	55%
Engagement and outreach activity	61	20%
Promotional / Advert	8	3%
Voluntary or health sector referral	33	11%
Website	2	1%
Known/existing clients	10	3%
Other / Unknown	25	8%

Table B

Concerns and complaints

Healthwatch Hillingdon recorded 95 experiences, concerns and complaints in this quarter. 66 named specific organisations and these are broken down in Table C.

Concern/complaint Category	Number	% of recorded
Primary care: GP	24	36%
Hospitals	8	12%
Social Care	5	8%
Urgent Care Centre	2	3%
Mental Health Services	10	15%
Patient Transport	3	5%
Voluntary Sector	2	3%
Dentists	6	9%
Community Wheel Chair Service	6	9%

Table C

During this period, to help residents raise their complaints, 12 referrals were made to VoiceAbility (independent NHS Complaints Advocacy) and 2 to Action against Medical Accidents (AVMA).

Overview

The following is to note from the analysis of the recorded data this quarter.

Primary Care

In our last report to the Health and Wellbeing Board, we reported issues for residents being refused registration at GP practices due to some confusion by staff on the legal requirements for patient registration.

This remained a problem early in the quarter but, following Healthwatch intervention, NHS England wrote to all practices to reaffirm the legal position and reissue guidance to the practices. Further work has progressed, with the Hillingdon CCG setting up a Primary Care Access Group, of which Healthwatch is a member and NHS England attends. One of the early results of this is that a new flow chart will be issued to all GP practices outlining registration procedures and training will be given to front line staff.

This group is also giving us an opportunity to directly feedback the information we receive from residents. Particularly those in the West Drayton area who are particularly seeing long waits for appointments and Longford where NHS England intervention is often needed to register a very transient population.

CNWL

During July, we received 3 separate calls directly from patients on Crane Ward in the Riverside Centre expressing concerns. We contacted CNWL and worked closely with the Borough Director and their team. A meeting was arranged on the Ward with all patients present to ascertain their concerns and look to address the problems. The Matron also met individually with those patients who wanted to talk privately.

As a result of the meeting, four main areas were highlighted: access to the garden; visibility of staff on the Ward; staff attitude; and agency staff not being fully informed about vulnerable patients. CNWL put actions in place to address the issues raised and confirmed these in writing to all patients and Healthwatch.

Dental Services

During this quarter, we also noted an increase in the number of residents contacting us with regards to NHS dental services. Most of the comments were to inform us that NHS dentists have claimed that they are no longer accepting NHS patients, or informing them treatment could only be provided privately rather than on the NHS. In some of these incidents, we have interceded for these residents through NHS England and reinstated NHS treatment. We have shared these experiences with Healthwatch England and have contacted the Federation of London Local Dental Committees to gain a better understanding of this issue. We do know, from a preliminary look at the national NHS Dental data (Health & Social Care Information Service), that London as a whole appears to have lower Courses of NHS Treatment (CoT) per 100,000 population than other regions in England (2014/2015 Figures).

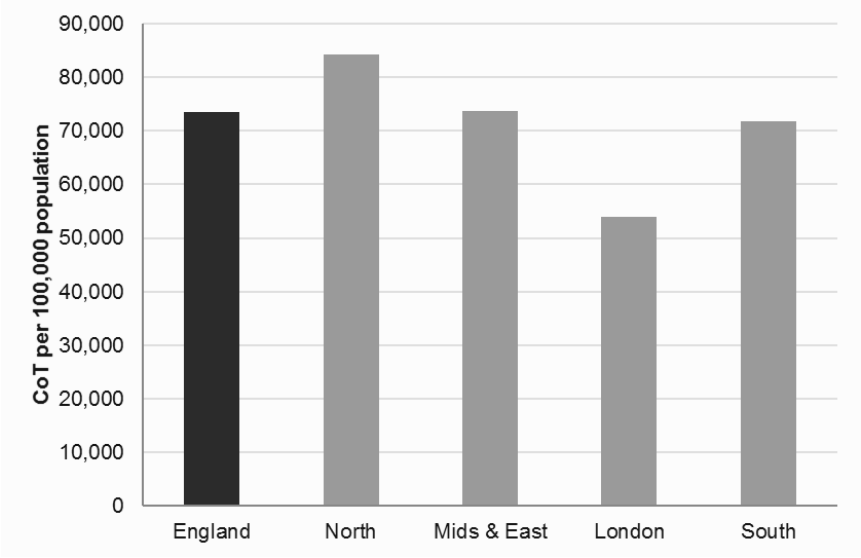

Figure 1d: CoT per 100,000 population, by NHS Commissioning Region, 2014/15.

3.2 Engagement Overview

This quarter, we attended 10 events, indirectly engaged 3,500 attendees and directly engaged with 285 residents. Of these, 29 people gave us information on their experiences of care and we advised or signposted 61 people and signed up a volunteer.

Our website continues to be accessed regularly with over 14,000 different addresses visiting the site 38,000 times this quarter. Nearly 11,000 information documents have been downloaded from the site during this time.

Our social media coverage also remains on the increase with over 800 people now following us on Twitter.

Press coverage has been good this quarter with a number of articles and letters being published in the local papers, including front page coverage of our CAMHS work.
In September, CAMHS in Hillingdon also received a national focus as Healthwatch England featured our work as the main story in their news bulletin and published an extensive article on their website. http://www.healthwatch.co.uk/news/young-people-tell-their-local-healthwatch-what-needs-change-about-mental-health-services

We have also followed up the issues raised about non-emergency patient transport by carrying out a survey in conjunction with Hillingdon CCG and Hillingdon Hospital. The results showed that 91.5% of the 48 people who completed the survey would recommend the service. There was also a similar result at the last Disability Assembly, where similar percentages of the 80 attendees where happy with the service in the Borough. A full report of the results of the survey and Disability Assembly feedback will be made available on our website soon.

4. WORKPLAN PROJECT UPDATES

The Healthwatch Hillingdon Work Plan 2015-17 sets out the organisations Operational Priorities for the next two years. The focus of our work for 2015-17 has been aligned with our Strategic Priorities and selected to reflect our statutory requirements, and the findings from in-depth analysis of data and intelligence gathered from our residents. The 2015-17 work plan is available to view at: http://bit.ly/20QJAcy

4.1 Children's and Adolescent Mental Health Services (CAMHS)

As the Health and Wellbeing Board is aware, Healthwatch Hillingdon has had a pivotal role in the formulation of Hillingdon's Children and Young People's Mental Health and Wellbeing Transformation Plan during this quarter. The insight provided by our 'Seen & Heard – Why not now?' report, has been an important reference, into the experiences of our children, young people and their families and has framed much of the contents of the plan.

The information in our reports has been sourced in the completion of the Children's Mental Health Needs Assessment completed by Hillingdon's Public Health team. It is also pleasing to note that Hillingdon is the only Borough in North West London to complete a needs assessment to inform their transformation plan and this is directly as a result of Healthwatch Hillingdon's request in our Listen to Me! report for this to be commissioned.

Our CAMHS work has also been promoted as an area of best practice by Like Minded, the programme which is looking to transform mental health and wellbeing services across North West London.

As part of the Children and Young People Mental Health and Well-being Board we continue to work with and challenge partners on the delivery of the plan. Although the result of submitting the plan to NHS England will not be disclosed until November 2015, Healthwatch has asked the Hillingdon CCG Governing Body to consider funding the recruitment of staff in advance of the announcement. We are conscious that every region across the country will be looking to recruit specialist CAMHS staff and, by agreeing to this request, it will allow Hillingdon to be ahead of other adjoining areas.

NHS England released funds in July 2015 for the development of a pan North West London Eating Disorder Service. We have also raised with the Hillingdon CCG Governing Body our concern that there seems to be little progress in the development of the service. We have asked for firm timelines to be set in delivering this new service.

4.2 Maternity Care in Hillingdon

Maternity Care in North West London is being reconfigured under the Shaping a Healthier Future programme. Currently, 4,000 births take place at Hillingdon Hospital per annum and this is predicted to rise to 6000 by 2017-18. Ealing Hospital's Maternity Unit closed in July 2015 and it is expected that an additional 600 women from Ealing will give birth at Hillingdon Hospital's Maternity Unit in the coming year.

The objective of the project is to monitor and evaluate the maternity services in Hillingdon, following the closure of the maternity unit at Ealing Hospital; to ensure that women have access, choice and continuity of high quality care, in their local area. We will periodically gather the views and experiences of women using maternity services in Hillingdon. This information will be used to:

- Determine to what extent the closure of Ealing Maternity Unit has impacted on the experience of women giving birth at Hillingdon Hospital.
- Identify any potential inequalities that may have arisen following the maternity service reconfiguration.
- Obtain a greater understanding about the barriers and enablers that shape maternity services.
- Provide commissioners and providers with evidence based data which evaluates current maternity provision and informs future delivery.

The progress of this programme will be periodically reported to the Health and Wellbeing Board.

4.3 Discharge from Hillingdon Hospital

This project will identify and engage Hillingdon residents who have recently gone through the discharge process at Hillingdon Hospital. Through their experiences, we will gain a greater understanding of being discharged from hospital, ascertaining what works well and where improvements may be required. Healthwatch Hillingdon will seek to work in partnership with Hillingdon Hospital, Social Services, Age UK (Hillingdon) and Hillingdon Carers to deliver some parts of this project.

Focusing on adults over the age of 65 with complex needs or long term conditions, who have been recently discharged from Hillingdon Hospital to home, or another care facility, our objective is to provide data, evidence and offer solutions to commissioners and providers that would enable improvements in services, designed to improve the quality of discharge and support in the community.

4.4 Care Homes

One of our work-plan priorities scheduled for 2016-2017 is Care Homes. In preparation for this project, Healthwatch Hillingdon is liaising with the Adult Social Care Safeguarding & Quality Assurance Team to look at ways in which we can work together and increase capacity, by incorporating our Enter and View team into the assurance programme. Initial conversations have been very productive. We are already seeing efficiencies having obtained agreement from the Care Quality Commission to amalgamate our individual meetings into a tripartite meeting.

5 KEY PERFORMANCE INDICATORS (KPIs)

To enable Healthwatch Hillingdon to measure organisational performance, 8 quantifiable Key Performance Indicators (KPIs), aligned to Healthwatch Hillingdon's strategic priorities and objectives, have been set for 2015-2017. The following table provides a summary of our performance against these targets:

Key Performance Indicators

KPI no.	Description	2015/16					Impact this quarter	Relevant Strategic Priority
		Q1	Q2	Q3	Q4	Annual Totals		
1	Hours contributed by volunteers	550	625			1175	• 5 younger volunteers, ages ranging from 16 to 25, completed 176 hours of office based administration	SP4
2	People directly engaged	354	333			687	• Signposted 120 people to appropriate services and recorded 95 service issues/ negative experiences	SP1, SP4
3	New enquiries from the public	232	402			632	• Enabled patients to receive NHS dental treatment who had been previously refused.	SP1, SP5
4	Referrals to complaints or advocacy services	9	14			23	• 2 residents will receive advocacy and assistance from Action against Medical Accidents (AVMA) following allegations of medical negligence.	SP5
5	Commissioner / Provider meetings	49	60			109	• Continued to champion for children in the improvement of CAMHS and mental wellbeing services • Strategic oversight of maternity transfer after closure of Ealing Maternity Department	SP3, SP4, SP5, SP7
6	Consumer group meetings	22	25			47	• Non-emergency transport to be reviewed and service specifications influenced	SP1, SP7
7	Statutory reviews of service providers	0	0			0	• None	SP5, SP4
8	Non-statutory reviews of service providers	7	4			11	• 10 members of our Enter & view team joined staff from Hillingdon Hospitals Trust to carry out 4 PLACE Lite assessments in September 2015	SP5, SP4

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UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS

Relevant Board Member(s)	Councillor Ray Puddifoot MBE
Organisation	London Borough of Hillingdon
Report author	Nicola Wyatt, Residents Services
Papers with report	Appendix 1

1. HEADLINE INFORMATION

Summary	This paper updates the Board on the progress being made in allocating and spending contributions towards the provision of healthcare facilities in the Borough.
Contribution to plans and strategies	Joint Health and Wellbeing Strategy
Financial Cost	None.
Relevant Policy Overview & Scrutiny Committee	Social Services, Housing and Public Health Residents' and Environmental Services External Services
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.

3. UPDATE ON PROGRESS

1. Since the last report to the Health and Wellbeing Board in September 2015, a further meeting has been held between officers from NHS Property Services (NHSPS), Hillingdon Clinical commissioning Group (CCG) and the Council's S106 Monitoring and Implementation officer to discuss progress and to work to bring schemes forward.

Proposed new Yiewsley Health Centre (former Yiewsley Pool site)

2. Due to funding difficulties, it has become clear that the proposed new Health Centre on the former Yiewsley Pool site will not now be going ahead. NHSPS has consequently reappraised the potential for developing the existing Yiewsley Health Centre and has concluded that it would not be viable to redevelop this site to provide a new fit for purpose health centre. Hillingdon CCG has therefore commissioned NHSPS to conduct a property search in the Yiewsley/West Drayton area to find an alternative site.

3. NHSPS had previously "earmarked" a total of £398,438 from five separate s106 health contributions currently held by the Council towards the fitting out costs associated with the proposed new health centre. The majority of this funding is not subject to a time limit for spend and will therefore continue to be held towards a new scheme. However, the contribution held at H/23/209K (£37,723) must be spent before March 2016.

4. The CCG Premise Sub-Group agreed at its meeting held on 13 October 2015 that this contribution should be invested in one of the practices in the Yiewsley/ West Drayton area with a viable scheme that can be implemented before the spend deadline. It is anticipated that a scheme will be brought forward in the next few weeks following the result of the NHS England (NHSE) bidding round (see paragraphs 9 and 10).

Proposed new health hub for Uxbridge (St Andrews Park)

5. Hillingdon Clinical Commissioning Group (CCG), via its Out of Hospital Strategy and Strategic Service Delivery Plan, has identified a need to create a new Out of Hospital Hub in the Uxbridge and West Drayton area. The preferred option is for the new hub to be located within the town centre extension area of the St Andrews Park site.

6. The Council received a healthcare contribution (£624,507.94) from the developers of the St Andrews Park site (VSM) in August 2014 and, in accordance with Schedule 6 of the s106 agreement, VSM has therefore been released from their obligation to provide an on-site healthcare facility. Any agreement to provide a new health facility will therefore need to be a commercial arrangement between the two parties.

7. The CCG remains in contact with VSM and has discussed in principle the possibility of securing a 15,000 sq ft health centre in the North West of the site. However, due to other development priorities, there has been little further progress. The Planning Authority is currently dealing with Phase 3 of the wider site, plus the complex ongoing delivery of the Town Centre Extension Phase. Any potential for a future health facility is currently not likely to come forward until Phase 5.

Proposed capacity improvements at Uxbridge Health Centre

8. As a location for a new health hub in Uxbridge is yet to be determined, realistically it could be several years before a hub will be available. Hillingdon CCG has therefore proposed to provide increased clinical capacity at Uxbridge Health Centre. This will be an interim measure to help deal with the immediate pressures on primary health care and GP services, coming primarily from new developments in the area such as St Andrews Park.

9. The scheme, which is supported by NHSPS, will reconfigure the GP accommodation on the ground floor of the existing Health Centre in order to provide 3 additional consultation rooms and an interview room. Hillingdon CCG anticipates that this will provide adequate additional accommodation for the practice to service the immediate demand for GP services and further anticipated growth in population in the area in the short term.

10. A Cabinet Member report to request that funds totalling (£273,000) from six separate s106 health facilities contributions were allocated and released towards the scheme, received Cabinet Member Approval on 12 June 2015. These funds were subsequently transferred to the CCG to be spent towards the scheme.

11. The project commenced on site in July and is now practically complete. The CCG has advised that the practice has also engaged two newly qualified GPs who will start as soon as the new consulting rooms can be brought into operation.

S106 health contributions held by the Council

12. Appendix 1 (attached to this report) details all of the s106 health facilities contributions held by the Council as at 30 September 2015. New contributions received since the last report to the Board are highlighted in bold. As at 30 September 2015, the Council holds a total of £1,108,823 towards the provision of health care facilities in the Borough.

13. Officers are continuing to work with the CCG and NHSPS to allocate health contributions towards eligible schemes. The CCG has advised that NHS England has set aside a budget of £250 million in 2015/16 to be invested in primary care premises. This is to help manage the increase in demand for primary health care services in England. All local practices were invited to submit requests for funding to NHS England in August, and the results of the bidding process are expected imminently. Once this decision has been made, the CCG has advised that they will work with practices that have been unable to secure funding from NHS England, but have a viable scheme, to identify proposals which might be eligible to benefit from s106 funding.

14. There is now only one unallocated s106 health contribution which has a spend deadline in 2015/16. This is the contribution held at H/23/209K (£37,723) which was formerly earmarked towards the fitting out costs associated with the proposed new Yiewsley Health Centre and must be spent before March 2016. Following the results of the NHSE bidding round, a request will therefore be submitted to allocate this contribution to an eligible scheme within the Yiewsley/ West Drayton area, which was not successful in gaining funding from NHSE (see paragraph 3).

FINANCIAL IMPLICATIONS

As at 30 September 2015, there are £2,147,509 of Social Services, Health and Housing S106 contributions available, of which £1,037,449 has been identified as a contribution for affordable housing and £1,237 towards a social services scheme. The remaining £1,108,823 is available to be utilised towards the provision of facilities for health. It is worth noting that £496,220 of these contributions have no time limits attached to them.

The Yiewsley Health Centre development project is now not likely to go ahead after protracted negotiations with the NHSPS did not reach a resolution. Of the £398,438 formally allocated to the scheme, only £37,723 (H/23/209K) has a spend deadline of March 2016. The remaining contributions have no time limits and therefore can be applied to suitable schemes as and when they are identified.

The S106 contribution held at H/23/209K for £37,723 is now earmarked towards improvements to practice premises in the Yiewsley/West Drayton area subject to an eligible scheme and formal allocation request. Given that the deadline for the contribution is fast approaching and a scheme is yet to be identified, there is a risk that the funding will require returning to the developer with accrued interest if not utilised by the end of the financial year.

S106 contributions which were approved towards the Uxbridge Health Centre scheme totalling £273,000 were transferred to NHS Property Services on 8 July 2015 as set out in the table below:

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/9/184C	34-46 Pembroke Road, Ruislip	£13,115	July 2015
H/10/190D	Armstrong House, Uxbridge	£43,395	July 2015
H/21/237D	Bishop Ramsey School, Ruislip	£22,456	February 2016
H/40306D	Fmr Knights of Hillingdon, Uxbridge	£4,646	n/a
H/41/309D	Former Dagenham Motors, Uxbridge	£12,030	n/a
H/49/283B	Former RAF Uxbridge	£177,358	August 2024
	Interest	£315	
Total		**£273,315**	

The Uxbridge Health Centre transfer included £177,358 from H/49/283B Former RAF Uxbridge (St Andrews Park), reducing the balance from £624,508 to £447,150.

Officers, in conjunction with the CCG and NHSPS, are actively working towards allocating the outstanding health contribution to eligible schemes.

LEGAL IMPLICATIONS

Under the provisions of section 111 of the Local Government Act 1972, a local authority has the power to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of its functions. The work to be carried out in accordance within this report would fall within the range of activities permitted by Section 111.

Regulation 122 (2) of the Community Infrastructure Levy Regulations 2010 states that a planning obligation may only constitute a reason for granting planning permission for the development if the obligation is:

1. necessary to make the development acceptable in planning terms;
2. directly related to the development; and
3. fairly and reasonably related in scale and kind to the development.

Any planning obligation must be relevant to planning and reasonable in all other respects.

The monies must not be used for any other purpose other than the purposes provided in the relevant section 106 agreement. Where monies are not spent within the time limits prescribed in those agreements, such monies should be returned to the payee.

When the Council receives formal bids to release funds, each proposed scheme will need to be assessed and reported to the Leader and Cabinet Member for Finance, Property and Business Services in order for the monies to be released. As part of that process, the Council's Legal Services will review the proposal and the section 106 agreement that secures the funding, to ensure that the Council is permitted to spend the section 106 monies on each proposed scheme.

The use of section 106 monies for future schemes mentioned in the report will need to be assessed against their respective agreements when these are finalised on a case by case basis.

BACKGROUND PAPERS

None.

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CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/8/186D *54	Yiewsley	92-105, High St., Yiewsley 59189/APP/2005/3476	15,549.05	0.00	2015 (Apr)	Contribution received towards the cost of providing additional primary heath facilities in the Borough. Funds not spent by 20/04/2015 must be returned. Funds originally earmarked towards the fitting out costs associated with the new Yiewsley Health centre development. Due to spend deadline, funds have been allocated towards the HESA scheme (25/2/2015). **Funds transferred to NHS PS 29/04/2015. Scheme complete.**
H/9/184C *55	West Ruislip	31-46, Pembroke Rd, Ruislip 59816/APP/2006/2896	21,699.53	0.00	2015 (Jul)	Contribution received towards primary health care facilities within a 3 mile radius of the development. Funds not spent by 01/07/2015 must be returned to the developer. £8,560 allocated towards additional consulting room at King Edwards Medical Centre (Cabinet Member Decision 6/12/2013). Funds transferred to NHS PS Feb 14. **Remaining balance of £13,115 allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Balance transferred to HCCG July 2015.**
H/10/190D *56	Uxbridge	Armstrong House & The Pavilions. 43742/APP/2006/252	43,395.00	0.00	2015 (Jul)	Contribution received towards primary health care facilities in the borough. Funds must be spent within 7 years of receipt. Funds not spent by 29/7/2015 are to be returned to the developer. **Funds allocated towards capacity improvements at Uxbridge Health Centre Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.**
H/11/195B *57	Ruislip	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494	3,156.00	3,156.00	No time limits	Funds to be used to support the provision of local healthcare facilities arising from the needs of the development. No time limits.
H13/194E *59	Uxbridge	Frays Adult Education Centre, Harefield Road, Uxbridge. 18732/APP/2006/1217	12,426.75	12,426.75	No time limits	Funds received towards the provision of healthcare facilities in the Borough. No time limits.
H/18/219C *70	Yeading	Land rear of Sydney Court, Perth Avenue, Hayes. 65936/APP/2009/2629	3,902.00	3,902.00	No time limits	Funds received towards the cost of providing health facilites in the Authorities Area. No time limits. £1,800 earmarked towards improvements to Pine Medical Centre, subject to formal approval. Confirmation received from NHS PS to confirm that the scheme is still valid. £1,800 allocated towards Pine Medical Centre improvements (Cabinet Member Decision 29/05/2015).

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/20/238F *72	West Ruislip	Former Mill Works, Bury Street, Ruislip. 6157/APP/2009/2069	31,441.99	31,441.99	2018 (Jun)	Contribution received as the health facilities contribution towards providing health facilities in the Authority's Area. Funds to be spent towards (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient or user numbers or, new health premises or services at local level or, any new facility required to compensate for loss of health facility caused by the development. First instalment to be spent by February 2018. Second instalment to be spent by June 2018.
H/21/237D *73	Eastcote	Bishop Ramsey School (lower site), Eastcote Road, Ruislip. 19731/APP/2006/1442	22,455.88	0.00	2016 (Feb)	Contribution received towards the provision of primary health care facilities in the Uxbridge area. Funds to be spent within 5 years of receipt (February 2016). **Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.**
H/22/239E *74	Eastcote	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 & 10622/APP/2009/2504	7,363.00	7,363.00	No time limits	Funds received towards the cost of providing health faciities in the Authority's Area including (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient numbers or, any new facility required to compensate for the loss of a health facility caused by the development. No time limits.
H/23/209K *75	Yiewsley	Tesco, Trout Road,Yiewsley. 60929/APP/2007/3744	37,723.04	37,723.04	2016 (Mar)	Contribution received towards the provision of local health service infrastructure in the Yiewsley, West Drayton, Cowley area. Funds to be spent by March 2016. **Earmarked towards capacity improvements at a practice in the Yiewsley West Drayton area, subject to a formal allocation request and approval**.
H/27/262D *80	Charville	Former Hayes End Library, Uxbridge Road, Hayes. 9301/APP/2010/2231	5,233.36	5,233.36	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/28/263D *81	South Ruislip	Former South Ruislip Library, Victoria Road, Ruislip (plot A). 67080/APP/2010/1419	3,353.86	3,353.86	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend
H/30/276G * 85	Townfield	Fmr Hayes FC, Church Road, Hayes. 4327/APP/2009/2737	104,319.06	35,620.80	2022 (Feb)	Funds received as the first and second instalment towards the cost of providing health facilities in the Authority's area including the expansion of health premises to provide additional facilities, new health premises or services (see legal agreement for details). Funds to be spent within 7 years of receipt (July 2019). £68,698.86 allocated towards HESA extension (Cabinet Member Decision 4/12/2014). Formal request from NHS PS received to transfer funds. £68,698.86 transferred to NHS PS 24/02/2015. Final instalment (£35,620.80) received this quarter. Remaining balance to be spent by February 2022.
H/32/284C *89	Yiewsley	Former Honeywell site, Trout Road, West Drayton (live/work units). 335/APP/2010/1615	5,280.23	5,280.23	No time limits	Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend. **Earmarked towards the provsion of a new health centre facility in the Yiewsley area, subject to formal allocation.**
H/33/291C *91	West Drayton	Former Swan PH, Swan Road, West Drayton. 68248/APP/2011/3013	5,416.75	5,416.75	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises at local level. Any new facility required to compensate for loss of a health facility caused by the development. **Earmarked towards the provision of a new health centre facility, subject to formal allocation.**

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/34/282F *92	West Ruislip	Lyon Court, 28-30 Pembroke Road, Ruislip 66985/APP/2011/3049	15,031.25	15,031.25	2019 (estimated)	Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 5 years of completion of development. Estimated spend deadline 2019.
H/36/299D *94	Cavendish	161 Elliot Ave (fmr Southbourne Day Centre), Ruislip. 66033/APP/2009/1060	9,001.79	9,001.79	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of of a health facility caused by the development.
H/37/301E *95	Northwood	37-45 Ducks Hill Rd, Northwood 59214/APP/2010/1766	12,958.84	12,958.84	2018 (July)	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/39/304C *97	Yeading	Fmr Tasman House, 111 Maple Road, Hayes 38097/APP/2012/3168	6,448.10	6,448.10	2020 (Aug)	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/40/306D *98	Hillingdon East	Fmr Knights of Hillingdon, Uxbridge 15407/APP/2009/1838	4,645.60	0.00	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. **Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.**
H/41/309D *99	Uxbridge South	Fmr Dagenham Motors, junction of St Johns Rd & Cowley Mill Rd, Uxbridge 188/APP/2008/3309	12,030.11	0.00	2020 (Oct)	Funds received towards the provision of healthcare services in LBH as necessitated by the development. **Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.**

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/42/242G *100	West Drayton	West Drayton Garden Village off Porters Way West Drayton. 5107/APP/2009/2348	337,574.00	337,574.00	No time limits	contribution received towards providing additional primary healthcare facilities in the West Drayton area (see agreement for details) . **Earmarked towards the provision of a new heath centre facility in the Yiewsley area, subject to request for formal allocation.**
H/44/319D *44	Northwood Hills	117 Pinner Road, Northwood 12055/APP/2006/2510	24,312.54	24,312.54	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/46/323G *104	Eastcote	150 Field End Road, (Initial House), Eastcote 25760/APP/2013/323A	14,126.88	14,126.88	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/47/329E *106	Townfield	Land at Pronto Industrial Estate, 585-591 Uxbridge Road, Hayes 4404/APP/2013/1650	14,066.23	14,066.23	2024 (July)	Funds received the cost of providing healthcare facilites within the London Borough of Hillingdon. Contribution to be spent within 10 years of receipt.
H/48/331E *107	Eastcote	216 Field End Road, Eastcote 6331/APP/2010/2411	4,320.40	4,320.40	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/49/283B *108	Uxbridge North	Former RAF Uxbridge, Hillingdon Road, Uxbridge 585/APP/2009/2752	624,507.94	447,149.63	2024 (Aug)	Funds to be used towards the provison of healthcare facilities serving the development in line with the Council's S106 Planning Obligations SPD 2008. Funds to be spent within 10 years of receipt. **£177,358 from this contribution is allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). £177,358 transferred to HCCG July 2015.**

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/50/333F *109	Yiewsley	39,High Street, Yiewsley 24485/APP/2013/138	12,444.41	12,444.41	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. **Earmarked towards the provision of a new health centre facility in the Yiewsley area, subject to formal allocation.**
H/51/205H *110	Eastcote	Former RAF Eastcote (Pembroke Park), Lime Grove, Ruislip 10189/APP/2014/3354 & 3359/3358 & 3360	17,374.27	17,374.27	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/54/343D *112	Harefield	Royal Quay, Coppermill Lock, Harefield. 43159?APP/2013/1094	8,698.77	8,698.77	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/53/346D *113	Northwood	42-46 Ducks Hill Road, Northwood 49987/APP/2013/1451	8,434.88	8,434.88	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
H/55/347D *114	North Uxbridge	Honeycroft Day Centre, Honeycroft Hill, Uxbridge 6046/APP/2013/1834	12,162.78	12,162.78	2022 (May)	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to spent/committed within 7 years of receipt (May 2022).
H/57/351D *	**Northwood**	**103,105 & 107 Ducks Hill Road, Northwood 64345/APP/2014/1044**	**6,212.88**	**6,212.88**	**No time limits**	**Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits**

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	DETAILS OF OBLIGATION (as at mid November 2015)
			AS AT 30/09/15	AS AT 30/09/15		
H/58/348B	North Uxbridge	Lancaster & Hermitage centre, Lancaster Road, Uxbridge 68164/APP/2011/2711	7,587.72	7,587.72	No time limits	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
		TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES	1,474,654.89	1,108,823.15		

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HILLINGDON'S JOINT STRATEGIC NEEDS ASSESSMENT

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Dan Kennedy, 01895 250 495
Papers with report	Appendix 1 – Hillingdon's Health Profile 2015 Appendix 2 - JSNA work plan 2015 - 2017

1. HEADLINE INFORMATION

Summary	The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health needs of Hillingdon's residents used to inform commissioning plans to improve health and wellbeing. Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments to be discharged through the local health and wellbeing board. This paper provides an overview of the key health and wellbeing needs in Hillingdon from the JSNA and presents priorities for developing the JSNA in Hillingdon.
Contribution to plans and strategies	The Joint Strategic Needs Assessment is used to inform improvement priorities set out within the Health and Wellbeing Strategy and within commissioning plans.
Financial Cost	There are no direct financial implications arising from the recommendations set out within this report. The findings from the JSNA are considered in developing commissioning plans which will be presented to the Health and Wellbeing Board for consideration.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1) **notes the headlines from Hillingdon's Joint Strategic Needs Assessment (JSNA) which are being considered in developing updated commissioning plans.**
2) **notes and comments on the proposed JSNA work priorities (as set out in Appendix 2) which ensures that it remains a key source of local intelligence to underpin effective service planning.**

3. INFORMATION

Background to the Joint Strategic Needs Assessment (JSNA)

1. The Joint Strategic Needs Assessment is an assessment of the current and future health needs of the local community. The JSNA represents a key source of local intelligence which exists to underpin the work of local health and wellbeing boards to develop local evidence-based priorities for commissioning to improve health and reduce inequalities. The JSNA is a requirement set out in legislation. Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments to be discharged through the local health and wellbeing board.

2. The statutory guidance for JSNAs and Joint Health and Wellbeing Strategies issued by the Department for Health in March 2013 sets out that:
   - JSNAs should be produced by health and wellbeing boards, and are unique to each local area. These are the needs that could be met by the local authority, CCGs, or the NHS Commissioning Board.
   - Health and wellbeing boards should also consider wider factors that impact on their communities' health and wellbeing, and local resources that can help to improve outcomes and reduce inequalities.
   - Local areas are free to undertake JSNAs in a way best suited to their local circumstances. There is no template or format that must be used and no mandatory data set to be included.
   - A range of quantitative and qualitative evidence should be used in JSNAs.
   - Health and wellbeing boards are also required to produce a Pharmaceutical Needs Assessment to inform the commissioning of local pharmacy services.
   - Health and wellbeing boards can request relevant information to support JSNAs from organisations represented on the board (core members and others).

3. The JSNA should be used to help to determine local priorities for health improvement and in turn these priorities should inform what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. CCGs, the NHS Commissioning Board, and local authorities' plans for commissioning services will be expected to be informed by the JSNA. These organisations are expected to consult the health and wellbeing board about their commissioning plans.

4. The JSNA in Hillingdon is informed by a range of data. This includes the demographics of the area, and needs of people of all ages including how needs vary for people at different ages; the needs of people with complex and multiple needs; and wider social, environmental and economic factors that impact on health and wellbeing.

5. Data is drawn from a wide range of sources including:
   - population and deprivation data;
   - mortality, the prevalence of illness and birth rates;
   - take-up of health, social care and relevant universal services;
   - where available, the outcomes of commissioned services.

Summary of Hillingdon's Joint Strategic Needs Assessment

6. Overall, the health and wellbeing of Hillingdon's residents is good and continues to improve. Based on key indicators (Hillingdon's Health Profile 2015 – Appendix 1) and other data, the key headlines from the needs analysis shows that for people living in Hillingdon compared to England on average:
   - Life expectancy for both men and women in Hillingdon is higher.
   - Lower levels of mothers smoke during pregnancy.
   - There are higher levels of breast feeding.
   - Rates of hip fractures as well as road injuries and related deaths are lower.
   - Early deaths from cancer is similar.
   - Those living in deprivation are lower.
   - There are lower levels of teenage pregnancy.
   - Hospital stays related to alcohol and self-harm are lower.
   - Long term unemployment and drug misuse is lower.

7. As with all Boroughs, local analysis indicates some challenges to improve health and wellbeing. These include:
   - Historically higher levels of violent crime in Hillingdon.
   - Higher rates of homelessness.
   - Higher rates of sexually transmitted infections and tuberculosis.
   - People diagnosed with diabetes in Hillingdon is higher than average.

8. The biggest causes of death in Hillingdon are cardio-vascular disease (heart disease and stroke), cancer and respiratory diseases. Diabetes is a significant cause of illness (morbidity) and predisposes to other diseases, e.g., heart disease and stroke, kidney disease and blindness.

9. Certain lifestyle factors will increase the risk of ill-health, including smoking, poor diet, lack of regular exercise and higher levels of alcohol consumption and/or binge drinking. The estimated 2014 prevalence of smoking in Hillingdon (17.1%) is slightly lower than the estimated proportions for London (17%). In Hillingdon, 24% of adult population is estimated to be obese.

10. Age and other related conditions also affect health and wellbeing. Many people aged 65 and over are diagnosed with one or more long term conditions, of whom over half are typically diagnosed with multiple long term conditions which increases dependency on care and support. Other conditions include learning disability and child and adult mental health, including dementia. It is estimated that 4,600 children in Hillingdon have a specific mental health need which requires support.

11. To improve health and wellbeing, commissioning plans should consider how to prevent ill-health, early identification of any long-term condition, early intervention to prevent harm from long term conditions and tackling risk factors.

Developing Hillingdon's JSNA

12. There are a number of routinely available health and social care data sets which are used to update Hillingdon's JSNA. This includes data available from the NHS and the Office for National Statistics: mortality, birth rates and the prevalence of disease are datasets

available for local use and have been recently updated within the JSNA. Updates to the JSNA are shared with commissioners.

13. To underpin commissioning plans, a set of priorities are proposed to develop the Hillingdon JSNA (Appendix 2). The work plan has been informed by discussions on the CCG 'core offer'. Comments are invited from the Board about the proposed JSNA work plan.

Financial Implications

There are no financial implications arising from the recommendations in this report. Commissioning proposals arising from the evaluation of the Joint Strategic Needs Assessment will be subject to further reports.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The JSNA is a key source of local intelligence that informs and underpins effective commissioning to improve health and wellbeing for Hillingdon's residents.

Consultation Carried Out or Required

The ongoing development of Hillingdon's JSNA will involve close working across the Council and with key partners and other stakeholders.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance have reviewed this report and confirmed that there are no direct financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

The Borough Solicitor confirms that there are no specific legal implications arising from this report. Hillingdon's JSNA complies with the Statutory Guidance issued by the Secretary of State for Health

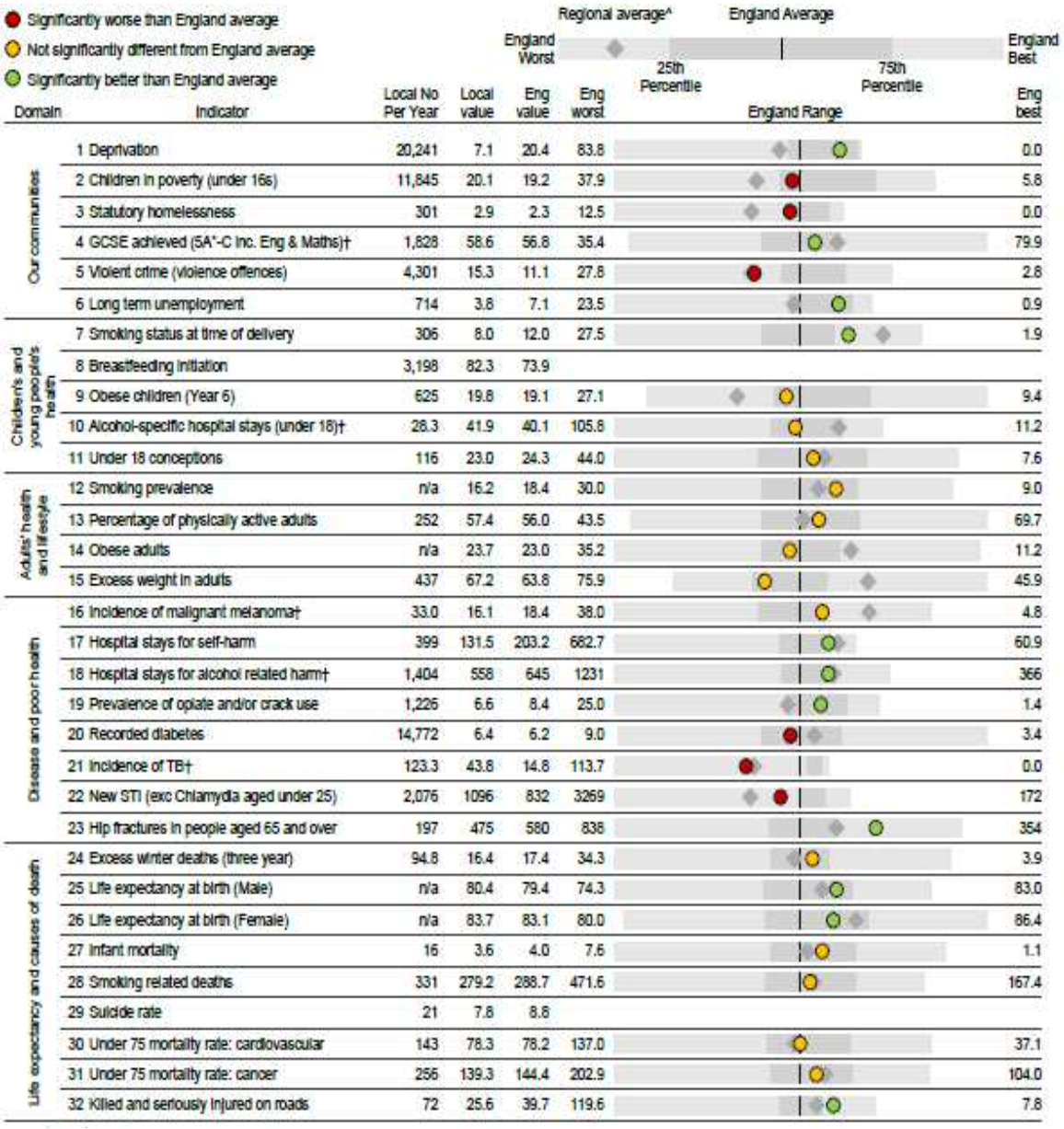
6. BACKGROUND PAPERS

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, Department of Health, 26 March 2013.

Appendix 1

Hillingdon Health Profile 2015

The chart below shows how the health of people in Hillingdon compares with the rest of England. Hillingdon's results for each indicator is shown in a circle. The average rate for England is shown by a black line, which is always in the centre of the chart. The range of results for all local areas in England is shown in a grey bar. A red circle means that this area is significantly worse than England for that indicator.



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	20,241	7.1	20.4	83.8	0.0
	2	Children in poverty (under 16s)	11,845	20.1	19.2	37.9	5.8
	3	Statutory homelessness	301	2.9	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,828	58.6	56.8	35.4	79.9
	5	Violent crime (violence offences)	4,301	15.3	11.1	27.8	2.8
	6	Long term unemployment	714	3.8	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	306	8.0	12.0	27.5	1.9
	8	Breastfeeding initiation	3,198	82.3	73.9		
	9	Obese children (Year 6)	625	19.8	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	26.3	41.9	40.1	105.8	11.2
	11	Under 18 conceptions	116	23.0	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	16.2	18.4	30.0	9.0
	13	Percentage of physically active adults	252	57.4	56.0	43.5	69.7
	14	Obese adults	n/a	23.7	23.0	35.2	11.2
	15	Excess weight in adults	437	67.2	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	33.0	16.1	18.4	38.0	4.8
	17	Hospital stays for self-harm	399	131.5	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	1,404	558	645	1231	366
	19	Prevalence of opiate and/or crack use	1,226	6.6	8.4	25.0	1.4
	20	Recorded diabetes	14,772	6.4	6.2	9.0	3.4
	21	Incidence of TB†	123.3	43.8	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	2,076	1096	832	3269	172
	23	Hip fractures in people aged 65 and over	197	475	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	94.8	16.4	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	80.4	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	83.7	83.1	80.0	86.4
	27	Infant mortality	16	3.6	4.0	7.6	1.1
	28	Smoking related deaths	331	279.2	288.7	471.6	167.4
	29	Suicide rate	21	7.8	8.8		
	30	Under 75 mortality rate: cardiovascular	143	78.3	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	256	139.3	144.4	202.9	104.0
	32	Killed and seriously injured on roads	72	25.6	39.7	119.6	7.8

Appendix 2 – **Hillingdon's Joint Strategic Needs Assessment – Work Plan (2015-2016)**

The following table summarises the key work plan activities scheduled to develop the JSNA. These activities complement routine analysis of national and local data which are undertaken to keep the JSNA up-to-date (e.g. annual data about birth rates, mortality etc.). The plan will be regularly reviewed and updated to ensure the JSNA is responsive and informs the priorities within the Joint Health and Wellbeing Strategy.

Ref	Area of Development	Description	Timescale
1	Older People's Needs assessment	Analysis of the key health and social care needs of older people across Hillingdon including an analysis of data available from universal services.	By December 2015
2	Alcohol Mis-Use	Analysis of alcohol related needs and diseases.	By December 2015
3	Drug Mis-Use	Analysis of drug mis-use related needs and diseases.	By December 2015
4	Child and Adolescent Mental Health Services	Updated analysis of the needs and services available for children and adolescents with mental health needs.	By December 2015 Some analysis still to be completed.
5	Learning Disability	Analysis of the needs and services available for adults with a learning disability.	By January 2016
6	Sexual Health / Disease	Analysis of the prevalence of sexual health diseases.	By January 2016
7	Adult Mental Health	Updated analysis of the needs and services available for adults with mental health needs.	By March 2016
	Work Completed		
1	Children and Young People's Needs Analysis	Analysis of the key health and social care needs of children across Hillingdon including an analysis of data available from universal services e.g. education	Data analysis completed July 2015
2	Pharmaceutical Needs Assessment (PNA)	Analysis of key health needs across the Borough and how pharmacy services are meeting these needs in specific localities.	Analysis completed and PNA agreed by HWB in December 2014. PNA published on the Council website January 2015.

Ref	Area of Development	Description	Timescale
3	Drug and Alcohol Mis-Use	Analysis of drug and alcohol mis-use related needs and diseases.	Data checking and analysis completed October 2014
4	Physical Activity Needs Analysis	Analysis of physical activity data.	Completed August 2015.

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LIKE MINDED – NORTH WEST LONDON MENTAL HEALTH AND WELLBEING STRATEGY – CASE FOR CHANGE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Strategy & Transformation Team, North West London Collaboration of CCGs
Report author	Jane Wheeler, Acting Deputy Director Mental Health, Strategy & Transformation, North West London Collaboration of CCGs
Papers with report	Improving mental health and wellbeing in North West London Case for Change – a summary. **APPENDIX:** Summary mental health profile for Hillingdon.

1. HEADLINE INFORMATION

Summary	This report introduces *Like Minded*, North West London's Programme for improving mental health and wellbeing, and seeks the Board's endorsement of its *Case for Change*. The Case for Change describes a shared understanding of the Mental Health and Wellbeing challenges across North West London, and articulates our ambitions for change. It is designed as a call to action - outlining the areas of work that should be developed in the next phase of the programme.
Contribution to plans and strategies	The Case for Change is the first stage of the joint North West London Mental Health and Wellbeing Strategy. This will be developed by the North West London Strategy and Transformation Team, on behalf of all eight North West London CCGs
Financial Cost	There is an expectation of involvement and commitment by public, private and voluntary sector organisations across the Borough as the Strategy is developed and implemented. All CCGs have been required to invest approximately 8% more recurrently in mental health services in 2015/16 and this funding will support changes set out in the Like Minded Programme along with existing budgets.
Ward(s) affected	All.

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the work undertaken to date in development of the Like Minded programme, including the input and involvement from citizens, service users and clinicians in Hillingdon;**
2. **endorses the case for change; and**

3. **notes the proposals for developing the next phase of the Programme.**

3. INFORMATION

Supporting Information

3.1 Background

In June 2014 the NWL Collaboration of CCGs agreed to build on the previous mental health strategy (called 'Shaping Healthier Lives', 2012-15) and initiate a North West London-wide mental health and wellbeing programme, called 'Like Minded' (2015-2020).

We are working across North West London because there are services where it makes sense to deliver change across a larger population. A good practical example is the recent work on Children's Mental health services:

- Hillingdon had already undertaken lots of local work defining current issues and how these could be addressed
- There were similar issues across North West London and it was agreed that a combined plan recognising shared challenges provided a powerful message on collaboration
- The combined plan described how each borough would address the shared priorities differently dependent on local needs
- In some areas we must work together – best practice dictates that the new Eating Disorder service is only viable for populations of 500,000 or greater.

The first phase of the Like Minded programme has focused on the development of a 'Case for Change'. This describes the eight major issues identified across NWL relating to mental health and wellbeing, and our vision and ambitions for the future (see section 4 below).

The Case for Change is built on a wide range of data, people's experiences, best practice and a structured approach to prioritising, which should enable local partners to target and accelerate improvements to mental health care and wellbeing in our communities. The mental health needs assessment and local consultation in Hillingdon have been critical sources of input – as has the input of the Hillingdon GP clinical lead and local commissioners. Our work included a detailed mapping of current service provision in Hillingdon, including wellbeing, prevention, care, support and treatment.

The governance of the programme is through the NWL Mental Health and Wellbeing Transformation Board. The Board has representation from CCGs, Local Authorities, both Mental Health Trusts, other stakeholders, service users and carers. It will manage the interdependencies with other related programmes and transformation work across the 8 boroughs as well as from service user and carer groups. It includes clinical and managerial and representation from Hillingdon, as well as service user representation from the Making A Difference Alliance, which includes service users from Hillingdon.

3.2 Priority Areas

The Case for Change identifies eight major issues that we currently face in NW London, and our ambitions for improvement by 2020:

1. **Issue:** Too many people face mental health needs alone
   Ambition: We will ensure that mental health needs are better understood and more openly talked about, and we will improve the range of services for people with mental illness in NW

London.

2. **Issue:** Not enough people know how to keep mentally well
   Ambition: We will improve wellbeing and resilience, and prevent mental health needs where possible, by: supporting people in their workplace, giving children and young people the skills to cope with different situations, and reducing loneliness for older people.

3. **Issue:** We need to improve the quality of care for those with serious and long term mental health needs
   Ambition: For people with serious and long-term mental health needs we will: make their care journey simpler and easy to understand, develop new, high-quality services in the community and focus care on community based support rather than just inpatient care so people can stay closer to home.

4. **Issue:** Too many people experience common mental illnesses, such as depression and anxiety, in silence
   Ambition: For those people experiencing depression and anxiety we will: improve how quickly we identify, especially when people are not currently receiving other healthcare, and improve the quality and quantity of therapy that doesn't require medicines.

5. **Issue:** 3 in 4 lifetime mental health disorders start before you are 18
   Ambition: We will ensure that implementation of the national strategy for children and young people responds to our local needs.

6. **Issue:** New mothers, those with learning disabilities, the homeless and people with dementia do not get the right mental health care when they need it
   Ambition: We will improve the care for specific groups in our community and support available to those who don't always get the mental health care they need within existing services.

7. **Issue:** Too many people with long term physical health conditions do not have their mental health taken into account…and vice versa
   Ambition: We will make sure that physical health and mental health are supported for people with existing physical or mental long term conditions, learning from other work in NW London around the importance of joining up care.

8. **Issue:** Our systems often get in the way of being able to provide high quality care
   Ambition: Make sure that our systems help, rather than hinder, joined up care.

These are high level ambitions, which are applicable across North West London (and indeed more widely). A key task for our next phase of work will be developing and translating this vision into concrete – and tailored – proposals for action in each Borough. This has already been completed in some areas (for example Children and Young People's mental health).

In doing this, we will be mindful not only of our collective ambitions, but also of the specific mental health needs of Hillingdon residents and of the care they are currently receiving, including:

- 14.1% of the population are estimated to have a common mental health need such as anxiety and depression.
- The number of people reporting anxiety and depression in Hillingdon is the second lowest in NWL, and the number of people with depression as recorded by GPs (4.9% of people) is significantly lower than both the UK average (5.9%), and the best estimate of

overall prevalence (9.0%). This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work. This may be more of an issue in Hillingdon than elsewhere in NWL.

- The proportion of patients with severe mental illness who have a recorded diagnosis, and the proportion who have a comprehensive care plan, are amongst the highest in England.
- There are an estimated 2,000 people aged 16-19 in Hillingdon with neurotic disorders.
- There are an estimated 480-620 children and young people who have both a Learning Disability and mental health problem.
- Suicide age standardised rates and self-harm rates in Hillingdon have been higher than London average. Un-diagnosed depression is one of the main risk factors for suicide.

3.3 Key Implications

Based on our Call to Action priorities, we have identified six work streams to ensure we deliver on our ambitions. These have been convened with partner involvement and with distributed leadership from across sectors:

1. **Wellbeing and Prevention:** Focussing on workplace wellbeing interventions and prevention of conduct disorder. The work stream will be led by public health.
2. **Serious and Long Term mental health needs:** Developing a new model of care, based on best practice and detailed engagement across all eight NWL Boroughs, which will focus on treating people in the least intensive appropriate setting. Modelling and analysis for the model is currently being worked up, building on local mental health whole systems work. We will then work with CCG leads and others to 'localise' the model, developing tailored service change proposals to meet with needs of people with serious mental illness in Hillingdon, and which take account of current service provision in the Borough.
3. **Common mental health needs:** Our thinking in this area is at an early stage, but is likely to take a holistic approach, focusing on undetected need, prevention as well as broadening out the treatment offer available. We aim to harness the resources and assets available across the community, not just from the NHS, and for the model to be locally led.
4. **Children and Young people:** In response to the Future in Mind report, the NWL Children and Young People's Mental Health and Wellbeing Transformation Plan has been submitted to NHS England. Hillingdon led the way in local engagement and joint working on their local plans, which are an integral part of the overarching NWL approach. Implementation is progressing within Hillingdon and joined up with the other CNWL commissioners.
5. **Existing mental health projects,** such as perinatal, dementia care pathway and learning disabilities, and report to the programme's Strategic Implementation & Evaluation Board.
6. **Enablers:** We will seek agreement to develop and address enablers (such as workforce, estates, finance) with other Strategy & Transformation programmes, in particular Whole Systems Integrated Care and Primary Care.

Financial Implications

One of the stated objectives of the programme is to develop improved outcomes – and ensure a financially sustainable system for at least the next 5 years. In working up detailed models with partners, the financial impact will be a key consideration.

It is too early to quantify the impact at this stage of the programme. There are therefore no financial implications identified yet for the Council. The cost of developing the models, and any financial implications within them, will be met by existing resources. This includes investment in new services by Hillingdon CCG in 15/16 including CAMHS, dementia, perinatal and urgent care, which equates to an 7.6% increase in overall allocation.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

The Board's endorsement will allow us to proceed to the next stage in developing the *Like Minded* Programme, as outlined at section 3.3 above.

This will allow us to begin designing the new services and service changes to allow us to meet our ambitions for mental health and wellbeing – in Hillingdon and across North West London.

The Case for Change has already been endorsed by the Hillingdon GGC Governing Body, the Governing Bodies of the other seven CCGs in North West London, and four other Health and Wellbeing Boards. It is scheduled for discussion at all other NWL HWBB's during November.

Consultation Carried Out or Required

In developing the Case for Change, the Like Minded programme has engaged with local residents across all 8 boroughs. We held a series of workshop events with specific groups, including children & young people, socially excluded groups, and mental ill health prevention. All of these workshops have had significant input from Hillingdon residents.

In addition to these workshop events, we have a number of links with Hillingdon citizens, service users and clinicians who provide on-going advice and input to the programme, including:

- A mental health focused community of interest whose members input to all work streams. This includes 4 Hillingdon representatives with lived experience of mental health problems, supported by the National Survivor User Network.
- We engage through existing forums in Hillingdon to provide updates and seek input. In developing the case for change these included attendance at Hillingdon Mental Health Transformation Board and Hillingdon Patient Public Involvement & Equality Committee. These links will be developed further in the next phase of the programme.
- The North West London Mental Health and Wellbeing Transformation Board, which oversees the Programme, includes Dr Stephen Vaughan-Smith (Hillingdon clinical lead), Rob Larkman as the (Accountable Officer for Hillingdon CCG), and Raj Grewal (Healthwatch Hillingdon).

Next Steps:

As we further develop the Programme, it is more important than ever that we talk to local groups – to hear how models that work across North West London can be improved and better adapted to local needs, and also how we can collaboratively support Hillingdon's local work on Mental health and improving outcomes.

Policy Overview Committee comments

None at this stage.

5. BACKGROUND PAPERS

Supporting documents can be found in the following web page:
http://www.healthiernorthwestlondon.nhs.uk/mental-health

Like Minded
WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

August 2015

Improving mental health and wellbeing in North West London

Case for Change - a summary

What this paper is about

We are setting out the vision for improving mental health and wellbeing across North West (NW) London. We don't say how we are going to do this – that's next – but it is an important step in bringing people together and agreeing a common goal for what the improvements need to be.

Why mental health and wellbeing is important to us all

We all have mental health – for some of us it's great and for some of us it is a real struggle. For many of us, it will be an issue at some stage either personally or for a friend or family member. Mental health needs can affect any of us, although we know there are certain things which makes us more at risk such as family history, abuse, debt, drugs, unemployment and loneliness.

Too many of us think it won't affect us, but it could. Mental illness affects more of us than cancer. It affects more of us than heart disease or stroke. It affects more of us than diabetes.

Over the course of a year, almost one in four people will have a diagnosable mental illness… Perhaps the person in the queue with us at the checkout. Three of the children in the class with our child. Thirteen people on the bus with us in the morning; maybe a hundred on the same tube train.

We want to help people improve their personal mental wellbeing, to know how to look after themselves and keep well. But we also want to make sure that if you do need help, that it is there for you.

There is some excellent care and support but we need to do more

In many places across NW London, the NHS, councils and charities are already working together to provide critical support for those in need. However, many of us still don't get the help we deserve and we want to change that.

25% of people with mental health problems receive treatment, compared to **75%** of those with heart disease and **92%** of people with diabetes.

For example, only a quarter of people with anxiety and depression receive treatment compared to more than 90% of people with diabetes.

The issues and our ambitions

The goal is to promote wellbeing and to improve the mental health care and support we receive if we need it.

We have identified eight major issues that we currently face in NW London and the ambitions that we must all sign up to if we are to improve things.

1 Too many people face mental health needs alone

The issue:

- Mental health needs are experienced by many of us but only a minority receive treatment.
- Depression and anxiety are by far the most common issues, affecting around 1 in 6 of the adult population in London.
- In NW London we estimate that 2 out of 3 people living with mental health needs are not known to health services.
- Too many people face their issues alone, afraid of the stigma or don't know where to get help.

Our ambition:

We will ensure that mental health needs are better understood and more openly talked about and we will improve the range of services for people with mental illness in NW London

The issues and our ambitions

2 Not enough people know how to keep mentally well

The issue:

- Mental wellbeing is about how happy we are and how satisfied we feel with our life.
- What makes us feel good is different for everyone but will often include things like relationships, work, housing, exercise, money and friendships.
- Whilst we don't always know exactly what causes mental illness, we know that certain things can put us at risk and looking after our personal wellbeing can help that.

Our ambition:

We will improve wellbeing and resilience, and prevent mental health needs where possible, by:

- **supporting people in the workplace,**
- **giving children and young people the skills to cope with different situations and**
- **reducing loneliness for older people.**

3 We need to improve the quality of care for those with serious and long term mental health needs

The issue:

- Serious long term mental health needs can have a devastating impact on our lives from our relationships, jobs and friends.
- Around 23,000 people in NW London have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average. Around 60% of these people are supported in the community.
- The demand on existing services means sometimes people wait too long to receive routine care.
- Between 13% and 52% of people accessing mental health care are also accessing substance misuse services.

Our ambition:

For people with serious and long-term mental health needs we will:

- **make their care journey simpler and easy to understand.**
- **develop new, high-quality, services in the community.**
- **focus care on community based support rather than just in-patient care so people can stay closer to home.**

The issues and our ambitions

4 Too many people experience common mental illnesses, such as depression and anxiety, in silence

The issue:

- Common mental health needs – such as depression, anxiety, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder – are experienced by nearly a quarter of million people in NW London.
- The impact on lives is significant with women typically unwell for 7 years and men for 10 years.
- The suicide rate amongst this group is 20 times higher than average.
- Too many people do not seek help and when people do, often the mental illness is missed.
- This means that two-thirds of people not receiving any care.
- For those who do receive care, the quality of community based services are not always good enough.

Our ambition:

For those people experiencing depression and anxiety we will:

- **Improve how quickly we identify, especially when people are not currently receiving other healthcare.**
- **Improve the quality and quantity of therapy that doesn't require medicines.**

The issues and our ambitions

5 3 in 4 of lifetime mental health disorders start before you are 18

The issue:

- The mental health needs of children and young people have been neglected for too long.
- Around half of all mental health needs in adults emerges by the age of 14, and three-quarters of lifetime mental health disorders have their first onset before the age of 18.
- However less than 10% of CCG mental health spend is invested in care for young people.
- The national Children and Young People's Mental Health and Wellbeing Taskforce identified the problems which stop us from providing excellent mental health care.
- The publication of the *Future in Mind* report is enabling people working with children to look at how they can improve experiences for young people.

Our ambition:

We will ensure that implementation of the national strategy for children and young people responds to our local needs.

Around **50%** of mental health needs start before the age of **14**

The issues and our ambitions

6 New mothers, those with learning disabilities, the homeless and people with dementia do not get the right mental health care when they need it

The issue:

- Depression affects many thousands of new mothers across NW London and tragically, suicide remains a leading cause of death for expecting and new mothers.
- 25-40% of people with learning disabilities have mental health needs and the prevalence of schizophrenia in this groups is three times that of the general population.
- People who are homeless often have both physical and mental health needs as well as substance misuse needs. Their situation means they often cannot manage their own condition.
- Dementia is a rising challenge for NW London and many people remain undiagnosed.

Our ambition:

We will improve the care for specific groups in our community and support available to those who don't always get the mental health care they need within existing services.

7 Too many people with long term physical health conditions do not have their mental health taken into account... and vice versa

The issue:

- People with mental health needs are at higher risk of developing significant, preventable physical health conditions such as respiratory disease.
- People with Schizophrenia are twice as likely to die from cardiovascular disease.
- Similarly, too many people with long-term conditions do not have their mental health needs properly taken into account despite being two to three times more likely to have a mental health need than the general population.

Our ambition:

We will make sure that physical health and mental health are supported for people with existing physical or mental long term conditions, learning from other work in NW London around the importance of joining up care.

The issues and our ambitions

8 Our systems often get in the way of being able to provide high quality care

The issue:

- We must make sure we have the right number of staff and that their skills are developed.
- We must ensure more people - including nurses, social workers, police, housing officers, and teachers - have awareness of mental health issues.
- We need better data and information sharing to know where we are successful and where we are not.
- We need better buildings in which to provide the care for those needing mental health support.

Our ambition:

Make sure that our systems help, rather than hinder, joined up care.

Next steps

In developing our understanding of the challenges we have listened to our residents, professionals and other interested parties. We have been heartened to hear great examples of sensitive care where our teams go the extra mile. But our plans described here are based on the examples we heard where we can do better.

We will continue to listen to feedback to make sure that we have identified that right issues and ambitions to be able to improve mental health care and support in NW London.

Once we have agreement, we will continue to work with patients and organisations across NW London to develop the plan on how to achieve our ambitions.

MENTAL HEALTH AND WELLBEING IN NORTH WEST LONDON

2 million

The total population of North West London.

£460 million

Mental health accounted for almost 12.5% of **£460 million** of the total NHS spend across NW London in 2012/13. West London has the 4th highest rate of SMI (serious mental illness) in the country (1.46%) Rates of SMI are estimated to be 1.08% across NWL (compared with 0.84% in England).

250,000

people with MH conditions including.

30,000

people with SMI.

16,000

people with Dementia.

What is Like Minded?

Like Minded is a project which brings together service users, carers, the workforce, third sector and other experts to co-design the strategy to improve mental health and wellbeing across North West London.

Contact: LikeMinded@nw.london.nhs.uk

Annex 2 - Like Minded – The North West London Mental Health and Wellbeing Strategy – the Hillingdon context and population

In developing the Like Minded Case for Change across NWL we have drawn on data, experience of our population, examples of best practice and the views of our health, social care and voluntary sector colleagues.

We work across North West London because there are services where it makes sense to deliver change across a larger population. A good practical example is the recent work on Children's services:

- Hillingdon had already undertaken lots of local work defining current issues and how these could be addressed
- Not surprisingly there were similar issues across North West London and it was agreed that a combined plan recognising shared challenges provided a powerful message on collaboration and learning from across the patch
- The combined plan described how each borough would address the shared priorities differently dependent on local needs
- In some areas we must work together – best practice dictates that the new Eating Disorder service is only viable for populations of 500,000 or greater. In many areas a local focus with local integration is needed.

The key question we have been asked is 'what does this mean for Hillingdon and our people'. We can answer this in 3 ways:

1) How we ensure local needs inform any North West London plans

2) How local people – Service Users and carers, professionals, voluntary sector - can input to developing North West London plans

3) How these North West London plans will be implemented to join up with existing local services and developments.

We are not yet at the stage where we are planning for implementation and so, above a commitment to ensure we localise implementation, we cannot as yet provide a detailed answer to point 3. This paper therefore aims to address the questions 1 & 2.

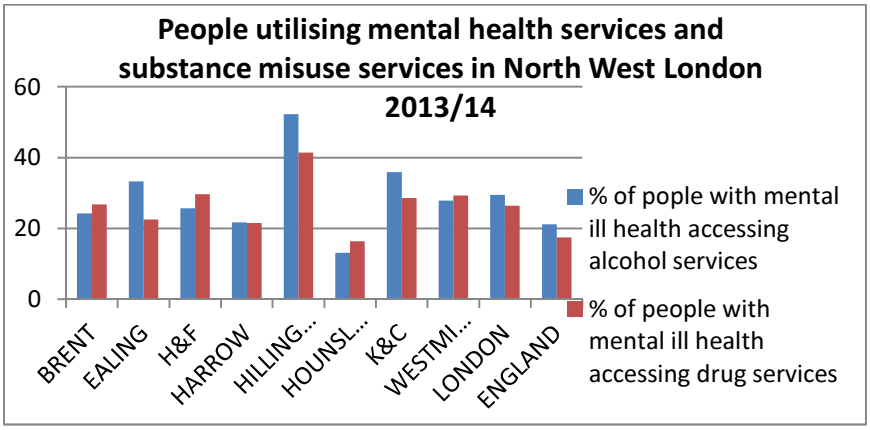
The needs of the Hillingdon population - a public health perspective

Through research and engagement we have a built a picture of the current needs of the population of Hillingdon. Please see below some of the key statistics that define Hillingdon and have helped to shape the Like Minded Case for Change. Please also see Appendix 1 for the full data information we have utilised.

- Hillingdon is outer London borough with app. 300, 000 people registered with GPs. There is a high proportion of children under 18 years of age registered with GPs (23%), the highest in North West London. [1]
- GP registration data from 2013/14 in North West London suggests that there were 23,692 people with severe and long-term mental health needs on their registers and prevalence varied from 0.3% to 15. 59%. In Hillingdon, there were 2, 154 people registered with GPs with serious & long term mental health needs; a prevalence of 0.74%.

[1] PHE GP Profiles

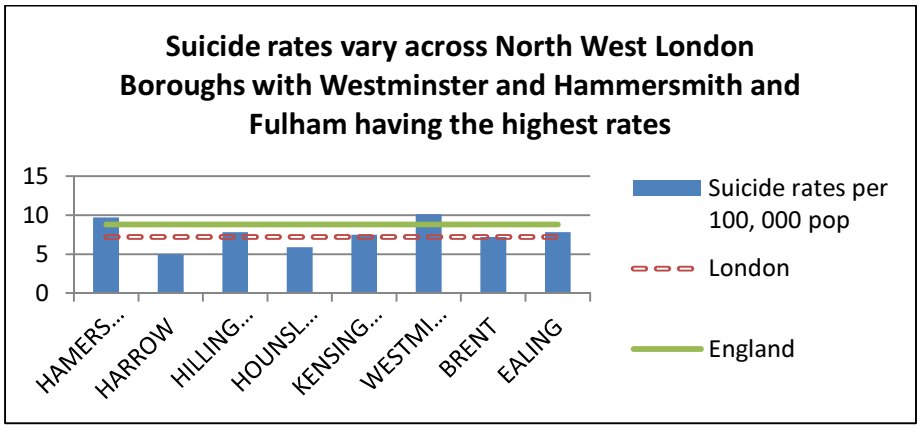
- Studies suggest that dual diagnosis may affect between 30 and 70 per cent of those presenting to health and social care settings[2]. In North West London, there is a great variation across the borough in people accessing both, mental health services and substance misuse services and in Hillingdon is as high as 52 %(Chart below). This could be due to the actual high population needs or effectiveness of local services in detecting and treating people with dual diagnoses.



Source: PHE National Treatment Agency, 2013/14

- North West London data on the estimated prevalence of common mental health problems compared to current detection rates in general practice (QoF) suggest that approximately, only one third of people living with mental ill health are known to health services. This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work. In Hillingdon, 11,805 people with common mental health problems were registered with GPs versus estimated 31,860 people potentially living with common mental problems. This is 5.15 recorded prevalence versus 10.53 estimated prevalence.

- Un-diagnosed depression is one of the main risk factors for suicide. Suicide age standardized rates per 100,000 population in NWL boroughs vary greatly with the rates in Hillingdon been higher than London average.



- Number of looked after children in NWL ranges from 30 to 73 per 10,000 under 18 years of age; of those, it is estimated that 45% will have mental health problems. That is approximately 2,100 children across NWL with the highest numbers in Ealing, Brent and Hillingdon.

[2] Reference: Crome, I, Chambers, P. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues. SCIE Research briefing 30. Available from: http://www.scie.org.uk/publications/briefings/briefing30/

- Most common conditions in children are conduct disorders (behavioural and emotional problems also named 'antisocial behaviour') and estimated prevalence across NWL boroughs varied from 5.4% in Harrow and 5.6% in Hillingdon to 8.3% in Brent (Green et al, 2005).

Good examples of current care – and where we have heard we can improve

In developing our Like Minded work we heard of areas where we can do more work – but also great examples across North West London

5 to thrive

MindEd
e-learning to support young healthy minds

mind Hillingdon
for better mental health

We worked with local teams to map current services – wellbeing, prevention, care, support and treatment – for example:

Service type	Service provider
JSA Long Term Employment Service	WCC
Individual Placement and Support	CNWL
Age Concern Hillingdon Interactive Older Peoples Club	Age Concern Hillingdon Interactive Older Peoples Club
Northwood Live at Home	Northwood Live at Home
Hayes anf Harlington Social Club for the Blind	Hayes anf Harlington Social Club for the Blind
As One Club	As One Club
Children Centres	Children Centres
Hillingdon NCT	Hillingdon NCT
Hillingdon LGBT Christian Group	Hillingdon LGBT Christian Group
Hayes Thamil Kalvi Koodam	Hayes Thamil Kalvi Koodam
Sahan Society Centre (Somali Women)	Sahan Society Centre (Somali Women)
Asian Womens Group	Asian Womens Group
Refugees in Effective and Active Partnership - REAP	REAP

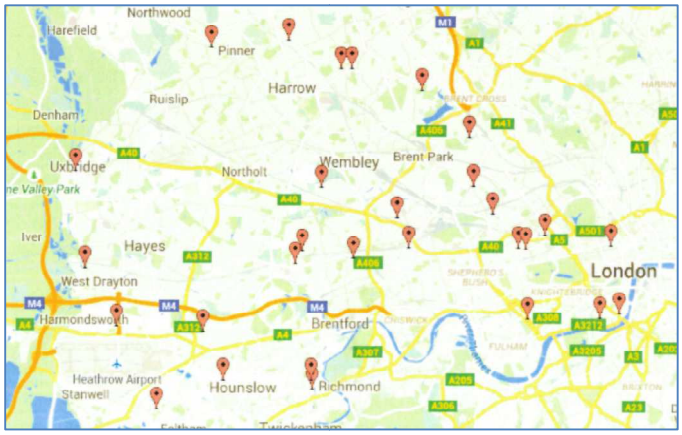
Service type	Service provider
Hillingdon Interfaith Network	Hillingdon Interfaith Network
H Kurdish Association	H Kurdish Association
League of jEWISH woMEN	League of Jewish women
Healthy Schools	Healthy Schools
Support Group - LGBT	LGBT YP groups Fountains Mill
Parenting Support	Parenting – bell farm centre

Service type	Service provider
Psychology	CNWL
Arts Therapy Team	CNWL
Personality Disorder Service	Personality Disorder Service, Cassel Hospital
Autistic Care and Support	Autistic Care and Support
P3 - Single Homeless in Hillingdon	P3 - Single Homeless in Hillingdon
Hillingdon Aids Response Trust	Hillingdon Aids Response Trust
Support Group	Diabetes UK
Social Activities for Multiple Sclerosis (SAMS)	Social Activities for Multiple Sclerosis (SAMS)
Residential Care	Wallis house Care home
Breathe Easy Group (COPD)	Breathe Easy Group (COPD)
Community Cancer Care	Community Cancer Care
Parkinsons Disease Society Hillingdon	Parkinsons Disease Society Hillingdon
Support group	Alzheimers Society - dementia support group
Hillingdon MENCAP	Hillingdon MENCAP
DASH	DASH

Service type	Service provider
Crown Centre for the Deaf & Hard of Hearing	Crown Centre for the Deaf & Hard of Hearing
Hillingdon Action Group for Addiction Management	Hillingdon Action Group for Addiction Management
Support group	Miscarriage support group
East African Community Support	East African Community Support
Iranians Womens Group	Iranians Womens Group
Counselling	Inclusion Team - with clinical psychologistics
Counselling	Irish children Spt
Counselling	Harrow mind – Young people services
Counselling	Hillingdon Drug and Alcohol Services
Counselling	Link - Youth Information and Counselling Service
Counselling	Woman's Trust - West London
Find and Treat TB team	UCLH
London Street Rescue outreach teams (No Second Night Out)	Thames Reach
Specialist supported accommodation for people with mental health needs	Look Ahead

Building on Local consultation

Like Minded has coproduction embedded in our way of working. This means building on local Hillingdon work (for example from HealthWatch - with Raj Grewal as a member of our Transformation board) and also developing a cohort of Service User leaders supported by the National Survivors and Users Network (NSUN).



The leadership development course has had 3 Hillingdon participants and we are working with local commissioners and communications team to now ensure these individuals are connected into local development work as well as into Like Minded.

We have had good representation and input from Hillingdon at our Innovation and Design workshops which were focused on understanding the local experiences and needs for people with mental ill health (including Director of Hillingdon Mind Christopher Geake, and the Healthy Schools Lead for Hillingdon, Tessa Pike). We have also been fortunate to have heard first hand from St Mungo's Broadway on the work the organisation had been doing in providing a Mental Health Advocacy Service in Hillingdon.

Next steps

As we further develop the North West London model it's ever more important that we talk to local groups – to hear how models that work across North West London can be improved and also how we can collaboratively support Hillingdon's local work on Mental health and improving outcomes.

We will link through your local Hillingdon Mental Health Transformation Group which includes clinical engagement via the GP Mental Health lead (Dr Stephen Vaughan-Smith), and service user engagement via Health-watch (Raj Grewal) . We will strengthen local Service User engagement in Hillingdon for the next phase of Like Minded and plans are underway to address this. Hillingdon will engage through the NWL Mental Health Strategy and Implementation Board with attendance from Hillingdon SRO, CRO, and London Borough of Hillingdon Mental Health Transformation Board including with Stephen Vaughan-

Smith and Raj Grewal as members. There are also opportunities to link in directly via LikeMinded@nw.london.nhs.uk

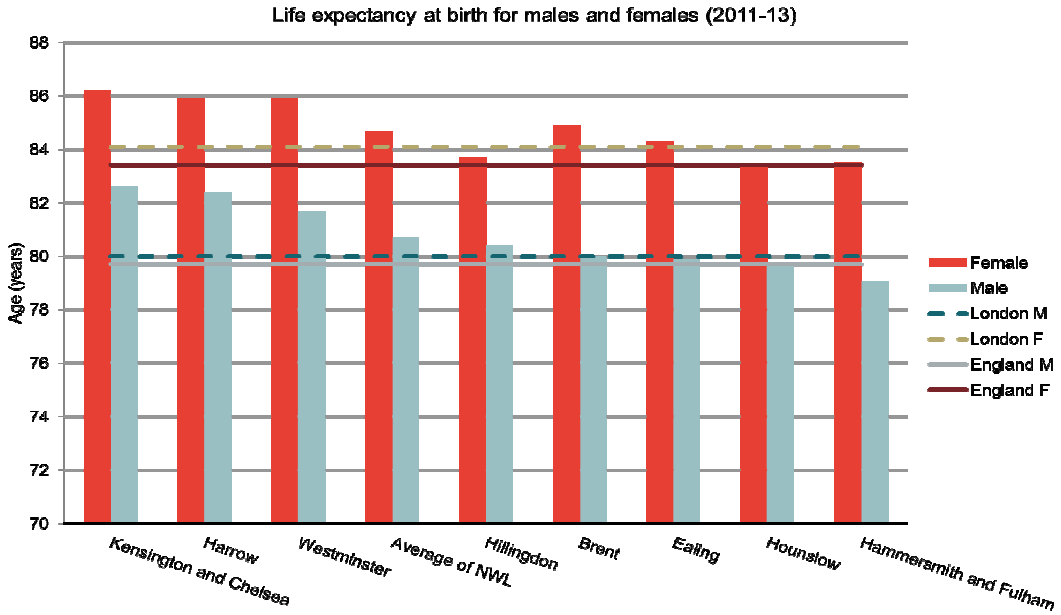
In the NWL Case for Change we identified a number of shared issues – which build on the data we have about our population:

Issue one: awareness and attitudes to the scale and significance of mental health needs in North West London

North West London has a diverse and fast growing population of approximately 2.2 million. Of those, over 900, 000 are from Black and Minority ethnic origin (42%)[3]. This proportion ranges from to 65% in Brent to less than 30% in Kensington and Chelsea.

There is a high proportion of inward and outward migration in each borough in NWL with an average of 4,000 net loss per borough reported by the Office of National Statistics in 2013 locally. Hillingdon had lowest migration loss of ~ 500 people while Westminster had the highest net loss of ~ 6,000 people. There are approximately 400,000 children under 18 years of age across North West London and the proportion ranges from 17% of the total GP registered population in West London CCG to 23% in Hillingdon CCG highest proportion in North West London).[4]

The overall life expectancy (LE) and healthy life expectancy (HLE - how long people live in a good health) for each of the boroughs in NWL is generally similar or higher than England's average, apart from male healthy life expectancy in Hammersmith and Fulham that is significantly lower than England's average (60 years vs. 63.3 for H&F and England respectively).



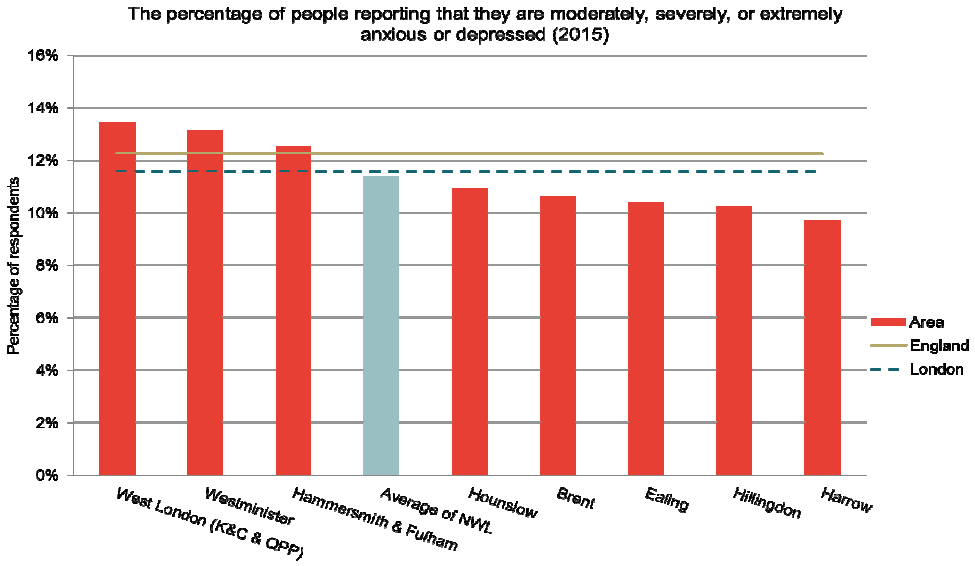
Described healthy inequalities, migration, deprivation and a high proportion of BME communities are factors that have a significant impact on mental health service demand, the way people seek appropriate care and the overall levels of mental health literacy and awareness.

[3] ONS Census, 2011

[4] PHE GP Profiles

Issue two: promotion of wellbeing, resilience and prevention of mental health needs for people in North West London

One of the main personal drivers impacting on the overall wellbeing is mental ill health. Our mental health has a great impact on our ability to live happy and fulfilling lives, to achieve our goals, have good social relationships and to contribute positively to society. However 1 in 4 people nationally and locally will experience some form of mental health problems during their lives ranging from mild anxiety and depression to severe mental illness. In North West London, reported prevalence of anxiety and depression[5] in 2014 was above the national average in Westminster, West London and Hammersmith and Fulham.



Source: GP Patient Survey, NHS England 2015

Issue three: the quality of care, coverage and outcomes for people with serious, long-term mental health needs

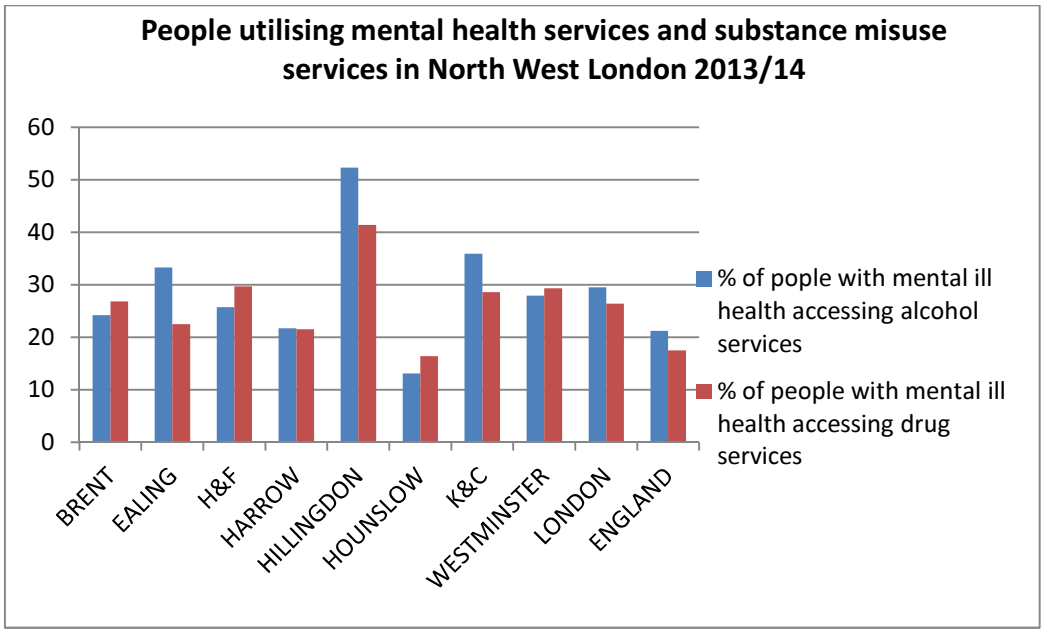
People with serious, long-term mental health needs (SLTMHN) have complex care needs and are often requiring a number of different services at some point on their care pathway. They are at higher risk of dying earlier and are affected by lifestyle risk factors that often cause long term physical conditions.
GP registration data from 2013/14 in North West London suggests that there were 23, 692 people with severe mental ill health (SMI) on their registers. Proportion of people registered with SMI varied greatly across the practices from 0.3% to 15. 59%. In Hillingdon, there were 2, 154 people registered with GPs with SLTMHN, a prevalence of 0.74%.

In terms of understanding how people known to mental health services live in the community, it is important to note that, in all North West London boroughs apart from Harrow, proportion of people with Care Programme Approaches (CPA) in settled accommodation was higher than England's average of 58.5% and London's average of 79.4%. Proportion of people on CPA in settled accommodation ranged from 77.8% in Harrow to 87.5% in Hammersmith and Fulham.

Similarly, proportion of people on CPA in employment ranged from 5.8% in Westminster to 7% in Harrow and Kensington and Chelsea to 10.5% in Hounslow and 10.2% in Hillingdon. England's average in 2012/13 was 8.8% and London's average was 6.9%.

[5] GP Patient Survey, NHS England 2015

Mental health and substance misuse problems are major public health and social issues. Studies suggest that dual diagnosis may affect between 30 and 70 per cent of those presenting to health and social care settings[6]. In North West London, there is a great variation across the borough in people accessing both, mental health services and substance misuse services and it ranges from 13.1% of people in Hounslow accessing mental health services and alcohol treatment services to as high as 52% in Hillingdon (Chart below). This could be due to the actual high population needs or effectiveness of local services in detecting and treating people with dual diagnoses.



Source: PHE National Treatment Agency, 2013/14

Issue four: identification of common mental health needs and access to good quality care

The risks to mental ill health in adults and older people vary by age, sex and ethnicity. Some parts of North West London have higher levels of factors impacting on mental ill health such as large proportion of ethnic minorities, deprivation, low levels of education, unemployment, substance misuse, violence and crime, social isolation and homelessness.

Statutory homelessness households rate across NWL boroughs varied from 1 in Hillingdon to 8 in Kensington and Chelsea compared to London (5) and England (2) (2012/13) and households in temporary accommodation rate across NWL boroughs varied from 3 in Harrow to 32 in Brent compared to London (11.9) and England (2.3).[7]

Unemployment rate across NWL boroughs varied from 6.7% in Westminster to 11.3% in Brent compared to London's average of 8.7%.[8]

A number of carers who reported feeling lonely across NWL boroughs is particularly high in some boroughs and varies from 24% in Brent, 34% in Hillingdon to 49% in Harrow compared to London (36.5%) and England (41.3%).[9]

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[6] Reference: Crome, I, Chambers, P. (2009) The relationship between dual diagnosis: substance misuse and dealing with mental health issues. SCIE Research briefing 30. Available from: http://www.scie.org.uk/publications/briefings/briefing30/

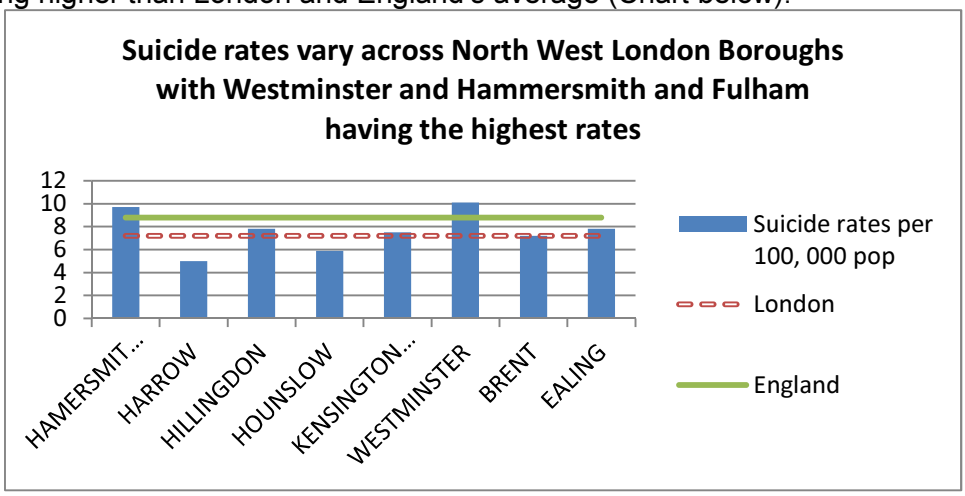
[7] DCLG 2013

[8] ONS 2014

It is estimated that common mental health problems (mainly anxiety and depression) will be increasing over the next ten years by 25-30%. This is probably due to people living longer and in a more challenging economic climate.

North West London data on the estimated prevalence of common mental health problems compared to current detection rates in general practice (QoF) suggest that approximately, only one third of people living with mental ill health are known to health services. This is possibly due to the stigma and discrimination surrounding mental illness coupled with a lack of trust and understanding of how statutory health services work. In Hillingdon, 11, 805 people with common mental health problems were registered with GPs versus estimated 31, 860 people potentially living with common mental problems. This is 5.15 recorded prevalence versus 10.53% estimated prevalence.

Un-diagnosed depression is one of the main risk factors for suicide. Suicide age standardized rates per 100, 000 population in NWL boroughs vary greatly with the rates in Hammersmith and Fulham and Westminster being higher than London and England's average (Chart below).

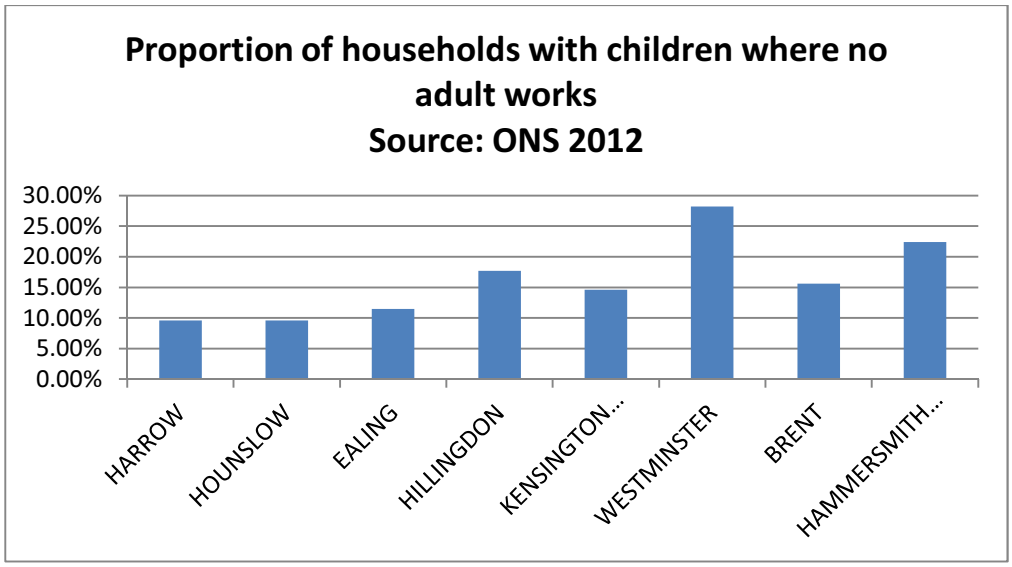


Issue five: mental health needs of Children and Young people are often neglected

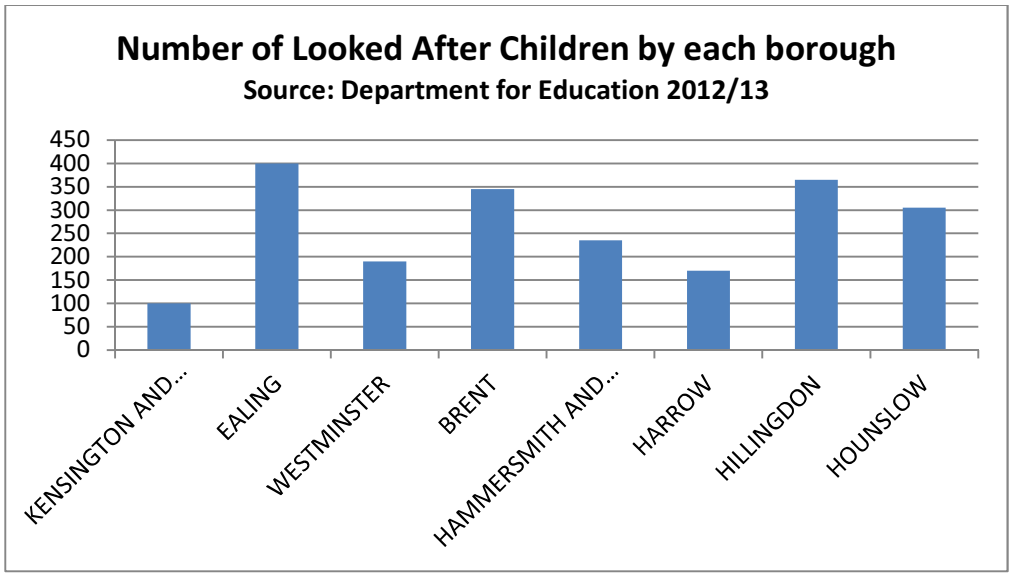
Some children and young people in North West London may be at greater risk of developing mental health problems than those living elsewhere in London and nationally. This is attributed to the number of socio-economic factors impacting on mental health such as high deprivation levels in particular wards, low educational attainment, parental mental health problems or substance misuse, parents or carers unemployment rates or exposure to emotional abuse or severe neglect. Furthermore, some particular groups of children and young people may be more likely to develop mental ill health such as looked after children, young offenders, those in need of social care or those with special educational needs. Parental unemployment is associated with several fold increased risk of mental ill health in their children.

Proportion of children living in households with no adults in employment ranges across NWL from 9.6% in Hounslow to 28% in the Westminster borough; a total of 57, 480 households across North West London (Chart below).

[9] Public Health Outcomes Framework 2012/13



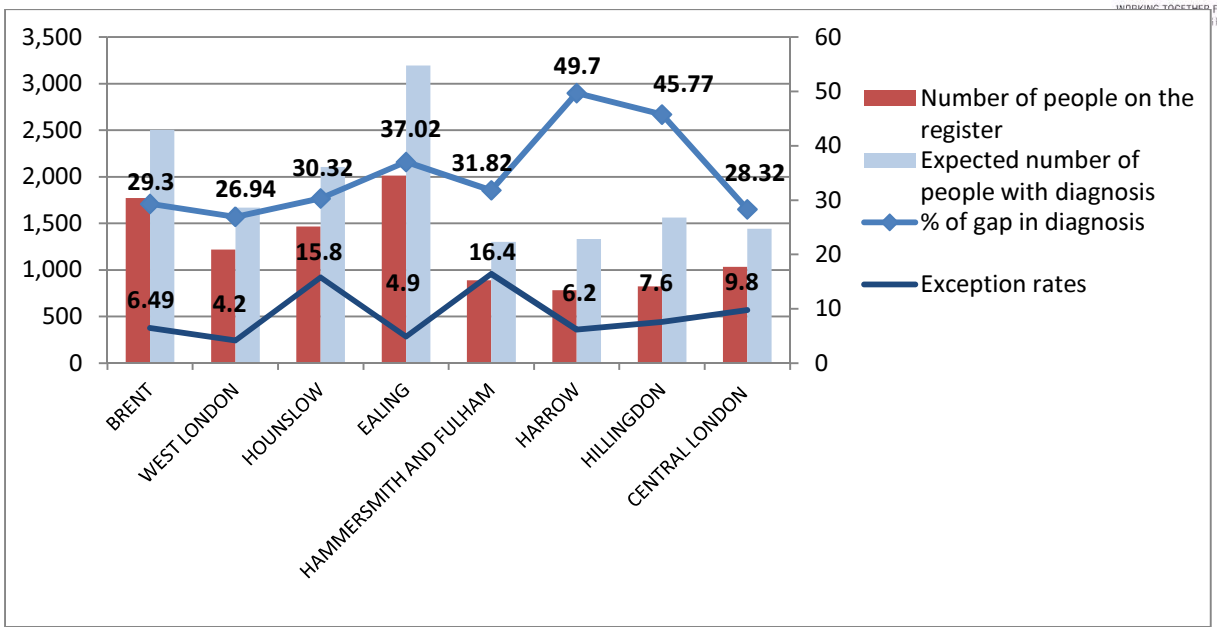
Number of looked after children in NWL ranges from 30 to 73 per 10,000 under 18 years of age; of those, it is estimated that 45% will have mental health problems. That is approximately 2,100 children across NWL with the highest numbers in Ealing, Brent and Hillingdon.



Most common conditions in children are conduct disorders (behavioural and emotional problems also named 'antisocial behaviour') and estimated prevalence across NWL boroughs varied from 5.4% in Harrow and 5.6% in Hillingdon to 8.3% in Brent (Green et al, 2005).

Issue six: the quality of care for other population groups with specific needs
Chart below describes variation across CCGs in the North West London. Overall diagnosis rates varied from 70% in Hounslow to 51% in Harrow against the national average of 67% and London's average of 65.8%.

GP diagnosis of dementia against estimated number of cases, diagnosis gap and exception rates



Source: NHS England Dementia Prevalence Calculator, March 2015

Annex 3 – What does our Transformation Work – locally and described within the Like Minded Case for Change mean for people in Hillingdon

The case for change is aligned with current Hillingdon plans for Mental health and wellbeing (all ages) via the Hillingdon Mental Health Transformation Group.

We describe below how our work locally in Hillingdon is aligned with the NWL strategy and how our local priorities feed the work at a NWL level, and can benefit from the overarching NWL approach.

Key issues described in the Case for Change:

Issue one: Awareness and attitudes to the scale and significance of mental health needs in North West London.

For people in Hillingdon this will mean: we will refresh the Equality Impact Assessment for Mental Health at a NWL level, but also describing borough specific needs and how our work addresses them. As part of our co-production, we record the demographics of our service users who are involved which is a key part of ensuring our developing models have been tested with the local population. In addition to local work prioritising Mental Health awareness and training for our workforce, the Like Minded programme across NWL builds on work to ensure improved detection of anxiety, depression and dementia rates for our population. Built into all local and NWL-wide transformation work is a focus in reducing stigma and parity of esteem in relation to mental health – for example, without a Whole Systems Integrated Care programme locally, mental health needs are not recognised.

Issue two: The promotion of wellbeing, resilience and prevention of mental health needs for people in North West London

For people in Hillingdon this will mean: effective engagement of Public health via the mental health and wellbeing prevention agenda delivering the CAMHS Transformation plans approved by Governing Body in September 2015. Taking an all ages approach, Like Minded has a programme of work focused on wellbeing and prevention. Supporting our residents to stay healthy, we have focused on workplace wellbeing and supporting local teams to use evidenced approaches to improve mental wellbeing in work.

Issue three: The quality of care, coverage and outcomes for people with serious, long-term mental health needs

For people in Hillingdon this will mean: The NWL Model of Care and support was agreed at the NWL Transformation Board (attended by Stephen Vaughan-Smith) on 23rd October 2015. This describes an approach to ensuring the right wrap-around support is available outside of hospital, rapid access to crisis services when needed, and the need to manage the flow through our beds ensuring the right kind of beds are available in the right settings.

Issue four: Identification of common mental health needs and access to good quality care

For people in Hillingdon this will mean: Improving access to IAPT services for 15% prevalence disorder, easier access via self-directed care, improved engagement with Third sector providers to ensure case mix included under-represented groups and improved recovery rates from IAPT services. Like Minded across NWL is building on local IAPT work to ensure we consider the needs of people with common mental health needs in the broader sense – also considering the needs of those who are not diagnosed and how we ensure prevention and early intervention are part of the pathway as well as good access to treatment such as IAPT.

Issue five: Mental health needs of Children and Young people are often neglected

For people in Hillingdon this will mean: Implementing our CAMHS transformation plan, commissioning community eating disorder services across NWL CCGs, evaluation of the CAMHS OOH service model across NWL commissioned in April 2015, and improving engagement of children and young people in Hillingdon. Hillingdon has a particular commitment to Children's and Young people's mental health; Like Minded across NWL has supported areas of work which cut across the different CCGs including where workforce development programmes are common.

Issue six: The quality of care for other population groups with specific needs

For people in Hillingdon this will mean: In local Hillingdon plans we reference specific needs of our local population including those of BME groups. In our Children's Transformation Plan we describe again specific needs of our young people, informed by recent consultation via HealthWatch. Through co-production in developing the Like Minded Case for Change we heard a strong message that whilst specialist services that address specialist needs are required, we also need to plan new models of care which mean our universal services are non-judgemental and more sensitive to people with specialist needs.

Issue seven: The relationship between mental health and physical health

For people in Hillingdon this will mean: Implementing the agreed Hillingdon Mental health priority plan for 15/16.

- Community and crisis care for CAMHs
- Crisis care
- Dementia
- Improved access to talking therapy IAPT
- Improving outcomes for people with Learning Disability
- Access to Psychiatric Liaison in Acute trusts
- Perinatal MH pathways
- Community assessment and brief treatment including Personality Disorder
- Access to support in Primary Care
- Market development 3rd sector
- Housing and supported Living

We have embedded mental health provision in our local Whole Systems Integrated Care work and have structures in place to share learning within our integrated teams. The Like Minded programme builds on this work, sharing good practice across the 8 boroughs

Issue eight: Our systems hinder integrated care

For people in Hillingdon this will mean: We develop pathways across the whole system where people experience joined up care and treatment. Their information is shared easily (with permission) and the care and support they receive is local and best practice.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE

Relevant Board Member(s)	Dr Ian Goodman Councillor Philip Corthorne
Organisation	Hillingdon CCG London Borough of Hillingdon
Report author	Elaine Woodward, HCCG Sunny Mehmi, LBH
Papers with report	Appendix 1 - Final Local Transformation Plan

1. HEADLINE INFORMATION

Summary	The report sets out progress in developing partnership working on Child and Adolescent Mental Health Services (CAMHS) in Hillingdon. It includes the final Local Transformation Plan - Implementation Plan as submitted to NHS England on behalf of the Board on 16th October 2015.
Contribution to plans and strategies	Hillingdon's Health and Wellbeing Strategy 2015
Financial Cost	NHS England has identified additional funding of £524,623 per annum that will be provided to CCG's from December 2015 for 5 years. The funding specifically requires focus on Eating Disorders (additional funding of £149,760 per annum) and Service Transformation (additional funding of £374,863 per annum). The final Hillingdon Local Transformation Plan was signed off by Hillingdon's Health and Wellbeing Board's Chairman under delegated powers, the HCCG Governing Body and by NHSE Specialised Commissioning and submitted to NHSE on 16 October 2015. NHSE have now confirmed that the plan has been "successful with amendments ".
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board:

1) **notes the final Local Transformation Plan submitted and agreed by NHSE for CAMHS services in Hillingdon and progress so far in improving Child and Adolescent Mental Health Services in Hillingdon, through partnership action.**
2) **requests regular performance updates against the partnership plan, including detail of metrics, such as reducing waiting times, and of financial spend against workstreams to enable it to monitor progress and risks.**

3. INFORMATION

Background

At its previous meetings (17 March, 21 July and 22 September 2015), the Board received updates on development of a partnership approach to improving Child and Adolescent Mental Health Services (CAMHS).

The Board was made aware that the Government had announced additional funding for 5 years to enable the Transformation of CAMHS with the outcome of this to include that, by 2020 an additional 100,000 children and young people nationally will receive treatment. To receive this additional funding, a Local Transformation Plan was developed and a draft presented to the Board on 22 September, with final sign off agreed to be delegated to the Chairman of the Hillingdon Health and Wellbeing Board, the Chairman of Healthwatch Hillingdon and the Chairman of the Hillingdon CCG Governing Body. The Plan was submitted to NHSE on 16 October 2015. NHSE has now confirmed that the plan has been successful but highlighted amendments to strengthen the plan.

A Hillingdon Joint Children and Young Persons Emotional Health & Wellbeing Transformation Board, chaired by the CCG Clinical Lead for Children and attended by senior representatives from the CCG, London Borough of Hillingdon, Hillingdon Healthwatch and Hillingdon MIND has been established. This Board is responsible for reporting to the Health and Wellbeing Board and will provide performance and programme management for implementation of the Local Transformation Plan. The CAMHS Local Transformation Plan will also be reported to HCCG GB and the Local Mental Health Partnership Board.

Implementation and Progress

Appendix 1 sets out the final LTP Implementation Plan for the agreed priorities:

1. Developing Outcomes based services
2. Ensuring the service pathways are communicated to the children, young people and families and Children's workforce in Hillingdon
3. Reducing the waiting times for tier 3 CAMH Service
4. Development of Self Harm, Crisis and Intensive support service
5. Development of comprehensive LD service for children with mental health, challenging behaviour and autism
6. Development of a Community Eating Disorder service
7. Understanding the role of Schools/College in emotional well-being and commissioning services such as counselling
8. Development of primary CAMHS for non MH specialist staff
9. Development of MH training for the Children's workforce
10. Introducing co-production

Good progress has been made in establishing draft specifications for new services in:

- Self harm, crisis and intensive support service;
- Community Eating disorder service; and
- Learning disability specialist community support.

These workstreams are moving towards implementation now that NHSE approval has been confirmed but are still dependent on recruitment of additional staff, which has commenced.

The Implementation Plan has been annotated to provide performance updates and RAG rated against established baselines and action required. Most ratings are Red or Amber reflecting the fact that they have not fully started as confirmation of funding has only just been received.

NHSE Assurance

The joint plan covering all eight CCGs in North West London was considered comprehensive, and clearly sets out the ambitions for the transformation of CAMHS. The assurance team highlighted a number of amendments to further strengthen the plan:

- Engagement and partnership – The plan could be further strengthened with inclusion of specific examples of work with Specialised Commissioning and Health in Justice Teams in NHS England as well as work with Youth Justice and the Police.
- Governance – More detailed governance information for each individual CCG is required.
- Finance – Further detailed financial information is needed, for example a clear breakdown of costs, current levels of investment in services and a mitigation strategy for any potential underspend.

Risk Management

Whilst the plan demonstrates commitment from across partners to utilise the new investment available from NHSE, to design new services, reduce waiting times and to improve early intervention and prevention, the complicated nature of CAMHS provision means that there remain inherent risks to the success of delivery. A risk register is being developed to assist the project and programme management but the key overall risks identified are:

Risk	Mitigating action
Inability to recruit CAMHs clinicians to establish the self harm service or specialist LD clinicians, due to demand for staff across NHS. These service will ultimately reduce waiting times (tier 3),	Preparatory work for recruitment undertaken. HCCG will be approaching NHSE re the possibility of rolling over any underspend in 2015/6 into 2016/7
Lack of buy-in or support from Schools on role in emotional wellbeing	Active discussions with schools forum, offering training and support to recognise and develop services. Mapping will enable direct contact where gaps are identified. Council school nursing functions being considered to support approaches to schools. Aim for MH champions in every school.

Investment into Hillingdon CAMHS

The Board has previously sought more detail on the levels of expenditure attached to existing services to enable it to see new investment in context and understand the service pressures better. The plan identifies current investment specifically in relation to these areas as:

Hillingdon CCG There is a block contract with CNWL for all Mental Health Services commissioned. **For CAMHS this is £2,079K**. In 2015/6 this budget has seen an increase of £606K, which is a 29 % increase.	**NHSE** The budget for CAMHS inpatient care in Hillingdon is **£338.8K**	**Hillingdon Council:** Link (Tier 2) £83.4k Sorted (Tier 2) £69.8k Kiss (Tier 2) £117.5k CAMHs for LAC (Tier 3) £397k **Total: £667.7k**

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The transformation of children and young people's emotional wellbeing and mental health services will enable more young people to access evidence based mental health services, which meets their needs. For the wider population of Hillingdon children and young people will develop skills which will improve their emotional health and wellbeing and develop skills to improve their emotional resilience.

Consultation Carried Out or Required

The report is based on CAMHS Strategy 2013 which is the outcome of consultation undertaken jointly by HCCG and Hillingdon Council. It is also based on the Future in Minds report, Healthwatch Hillingdon's 'Seen & Heard' report and the CAMHS Joint Strategic Needs Assessment 2015.

Policy Overview Committee comments

None.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance have reviewed this report and note the agreed funding level of £524,623 from NHS England to contribute to Hillingdon's Health and Wellbeing Strategy 2015 through providing increased access to emotional wellbeing and mental Health services for Children and young people in the Borough.

Hillingdon Council Legal comments

The Borough Solicitor confirms that the strategy complies with guidance issued by NHS England. There were no legal impediments to the Board agreeing the recommendations set out in the report.

6. BACKGROUND PAPERS

NIL.

Year 1: 2015/16

Ref	Areas for Development	What are we going to do	When will this happen	Evidence base	KPIs	KPI Target	KPI Performance Baseline / Dashboard rating	Additional Resources required In 2015/6	Link to National Priorities 1. Build capacity and capability across the system 2. Roll-out the CYP IAPT 3.Develop evidence based community Eating Disorder services 4. Improve perinatal care. 5. Bring education and local children and young people's MH services together	Link to Hillingdon CAMHS Strategy 2015-18 & Lead THRIVE Categories: **1.Coping** **2.Getting help** **3.Getting more help** **4.Getting risk Support**
1.	**Embedding the outcomes based model in the CNWL Contract**	Using the 2015/6 CQUIN which requires CNWL to move to the principles of CYPIAPT all CAMHS services will be monitored for outcomes and user engagement in care planning.	This work started in the 2015/6 contract and will continue into the CNWL contract negotiations for 2016/7 and beyond	CORC outcomes framework	Compliance with CYP IAPT.	100% of data submissions are validated and submitted on time.	**CNWL CAMHS is not CYP IAPT compliant** **RAG: Amber (in-progress)**	This will be undertaken by the HCCG CAMHS and the LBH MH Commissioner and CCG Contracting team.	Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes	2.Getting help 3.Getting more help **Lead-** CNWL/Elaine Woodward/Sunny Mehmi
2.	**Ensuring the service pathways are communicate to the children, young peoples and families and Children's workforce in Hillingdon**	Using information from the JSNA, LBH Personalisation Directory and the 111 directory develop a comprehensive Directory. The family Information Service will assist with ensure this goes to all relevant bodies in Hillingdon This will include using online resources such as Young Minds	February 2016	Future in Mind	Improved access to timely advice, information and specialist support when needed for CYP, parents, professional	Up to date Directory in place	**No CAMHS directory in place** **RAG: Amber (in-progress)**	Admin and IT	Build capacity and capability across the system	1.Coping 2.Getting help 3.Getting more help 4.Getting risk Support **Lead**- Public Health
3.	**Long waiting lists for treatment at CAMHS Tier 3**	Use the LTP funding to invest in non-recurrent funding to CNWL to enable them to recruit Therapists to work with CYPs on the waiting list	March 2016	NICE	Numbers seen; waiting times; numbers receiving NICE treatment.	No CYPS waiting more than -4 weeks for routine treatment - 1 week for urgent treatment	**RAG: Amber (in-progress)** **63 on waiting lists for assessment;** **192 on waiting lists for treatment**	£100k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes	2.Getting help 3.Getting more help **Lead**- CNWL
4.	**Lack of self harm, crisis and intensive**	Use the LTP funding to invest in a team who will	December 2015	Crisis Care Concordat	All emergency referrals seen < 4	85% of target	**No dedicated service in place**	£100k (Re-current)	-Build capacity and capability across the	2.Getting help 3.Getting more

	support service	deliver across a new pathway for self-harm. Given the co-existence of substance misuse and self harm this will require co-working to be developed	Fully functional team by March 2016	NICE QS 34 NICE Guidance CG28	hrs; urgent < 48 hrs; routine < 2 wks; reduction in inpatient admissions and incidences of self harm.		**RAG: Amber (in-progress)**		system -Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes -Bring education and local children and young people's mental health services	help **Lead**- CNWL
5.	**Lack of services for CYPs with co-morbid MH/LD/Autism Spectre Disorder**	Use the LTP funding to invest in additional staff to work in the current MH/LD team who will deliver across a new pathway which will include CYPs with co-morbid challenging behaviour and Autism	December 2015 Fully functional team by March 2016	NICE Transforming Care	Pathway in place with a fully staffed team; including a service specification. Linkage with special schools Referral to treatment time is reduced. Reduction in use of residential education. <13 weeks referral to treatment	Pathway in place 85% target referral to treatment	**No dedicated service in place** **RAG: Amber (in-progress)**	£100k (Re-current)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Bring education and local children and young people's mental health services	2.Getting help 3.Getting more help **Lead**- Elaine Woodward/Sunny Mehmi
6.	**Under developed mental health training packages for the workforce**	Undertake a Training Needs Analysis; devise and deliver a training programme based on this	March 2016	Future in Mind	75% of the children's workforce contacted to take part in Training Needs Analysis. Training needs analysis is complete. Training scheme is identified and/or developed. Training programme in place and training rolled out to children workforce including - Schools - Social Care - Youth Service - GPs - Health Visitors - School Nurses - TSO - Early Help Team	Publication of training needs analysis. Publication of training opportunities. 75% attendance rate at training programmes. 75% rate as useful.	**No dedicated service in place** **RAG: Red**	£30k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Bring education and local children and young people's mental health services	1.Coping 2.Getting help 3.Getting more help 4.Getting risk Support **Lead**- Elaine Woodward/Sunny Mehmi
7.	**Understanding the role of Schools/College in emotional well-being and commissioning**	Use the LTP funding to commence work with local Schools and College to gain this understanding and to support schools to	March 2016	Future in Mind	Mapping of current provision in schools and college The Participation Team and PH to	100% of special schools engaged with. 30% of mainstream schools engaged with.	**No clear information on provision** **RAG: Amber**	£20k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT	1.Coping **Lead**- Public Health

	services such as counselling	commission emotional well being services			undertake engagement to encourage them to embed emotional health and well-being in every school and college. Achieved by sharing good practice from other schools and developing the workforce. Aim for a MH champion/lead in every school who can be provided with funding for CYPIAPT training. Support to school in commissioning high quality emotional well being services;				-Bring education and local children and young people's mental health services	
8.	**Lack of a community Eating Disorder service**	Work with colleagues across NWL to deliver a service which is compliant with the NHSE model of care, and ensure pathways are in place with other local mental health services	April 2016	Access and Waiting Time Standard for Children with an Eating Disorder; NICE guideline CG9; NCCMH Commissioning Guidelines	CYPs have rapid access to assessment and treatment, in compliance with the new NICE model of care A new ED service is operational. Referral to treatment time for ED is reduced. Reduction in inpatient admissions. Numbers accessing treatment align with NCCMH/NHSE guidelines.	85% of targets reached.	**No dedicated service in place** **RAG: Amber**	£145k (Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Develop evidence based community Eating Disorder services for children and young people -Bring education and local children and young people's mental health services together	2.Getting help 3.Getting more help **Lead**- Elaine Woodward/CNWL
9.	**Development of a new services based on early help/well-being**	Develop a pathway and model of care for a non-specialist CAMHS services, with the aim of preventing most CYPS form developing complex MH issues	March 2016	THRIVE/NICE	Service specification in place to deliver: time limited interventions and advice and support to professionals, with ease of access. Service roll-out early 2016/7	100% achieved	No dedicated service in place RAG: Red (Not started)	£0	- Build capacity and capability across the system -Roll-out the Children and Young People's Improving Access to Psychological Therapies -Bring education and local children and young people's	1.Coping **Lead**- Chris Scott

									mental health services together around the needs of the individual child through a joint mental health training programme programmes	
10.	**Lack of systematic engagement with CYPs and their families**	Work with patient and user engagement colleagues in LBH/HCCG/CNWL to establish user and family consultation. Develop support for carers/families as CYPs regardless of where they are on the pathway Ensure all carers are offered a carers assessment	April 2016	NEF: Co-production in Mental Health. A literature review. OPM: Co-production of health and wellbeing outcomes.	Ensure all CAMHS commissioned services undertake family work, where appropriate Ensure parents/carers receive advice and support which may include a carers assessment and/or referral to MH services such as Talking Therapies Formation of CAMHS Forum Workshops and events held with key stakeholders Outputs from Forum and workshop inform commissioning intentions and service specifications Number of meetings/events with CYP's involvement in co-production.	Commissioners task & Finish Group to be set up Quarterly sessions/meetings with at least 1 CYP &/or parent rep at each meeting or event.	**No system in place specifically for CAMHS** **RAG: Amber**	£25k (Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT	1.Coping 2.Getting help 3.Getting more help 4.Getting risk Support **Lead**- All

HILLINGDON CCG COMMISSIONING INTENTIONS 2016-2017

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group (HCCG)
Report author	Mark Eaton, HCCG
Papers with report	HCCG's 2016/17 Commissioning Intentions

1. HEADLINE INFORMATION

Summary	The CCG is required to publish a set of Commissioning Intentions each financial year. These documents are published in October of the preceding year so that any significant changes are notified to providers with the required six months' notice. They are based on the JSNA and engagement with patients, public and other stakeholders. A summary of the Commissioning Intentions and the full Commissioning Intentions are attached with this document.
Contribution to plans and strategies	The Commissioning Intentions contribute to all significant strategies for the CCG with main ones being: • NHS 5 Year Forward View • Out of Hospital Strategy • Long Term Conditions Strategy • QIPP plans
Financial Cost	Commissioning Intentions inform how areas of health spend will be utilised in the coming year.
Relevant Policy Overview & Scrutiny Committee	External Services Overview and Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes and comments on the Hillingdon CCG Commissioning Intentions for 2016/17.

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NHS
Hillingdon
Clinical Commissioning Group

Commissioning Intentions 2016-17

October 2015

Content

Section 1: About Hillingdon CCG (HCCG) & Aim of the Commissioning Intentions

Section 1a: About Hillingdon CCG

Hillingdon Clinical Commissioning Group (CCG) is the public agency responsible for purchasing most of the health services for the people of Hillingdon*. We operate within a financial budget and aim to ensure that we use the money given to us to purchase health services that are appropriate, effective and safe and that offer value for money.

Hillingdon CCG's role is to ensure that the health services in Hillingdon are designed in a manner that meets the highest possible standards of quality as well as the needs and reasonable expectations of our population now and prepares the way for changing health needs over the coming years. We are required to meet statutory financial obligations to remain in balance and maintain a 1% surplus. To help us achieve this we will be focusing on supporting people to care for their own and their families health needs more independently so that people in Hillingdon remain healthy and independent for as long as possible and reduce the demands placed on health care services.

**The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of health care is commissioned by the London Borough of Hillingdon (LBH) and, particularly for Primary Care, others such as NHS England (NHSE). In 2015/16 the CCG entered into an agreement around Co-Commissioning for Primary Care with NHS England (where the parties will for the first time share responsibility for commissioning GP Based Services in Hillingdon). The CCG will further develop this work in 2016/17.*

Section 1b: Aim of the Commissioning Intentions

The aim of these Commissioning Intentions is to provide an overview of Hillingdon CCGs plans to purchase (commission) high quality health care to improve the health outcomes for Hillingdon patients for the Financial Year 2016/17 (FY16/17) and to set the scene for how we envisage services developing over the next 3 years.

To develop these Commissioning Intentions we have engaged our patients, carers and the wider public along with our member practices and other providers and have drawn on a wide range of sources of information and feedback as shown on the next page.

The Commissioning Intentions for 16/17 is a living document that will evolve over time based on further engagement activities with the public, partners and providers. This document should also be read in conjunction with the Commissioning Intentions stated for NHS England (NHSE) and for North West London.

Section 2: Delivering HCCG's Vision for 2016/17

Hillingdon CCG's (HCCG's) Vision is to: "Ensure that the residents of Hillingdon can access high quality, evidence-based care in a setting appropriate to their needs by transforming the way care is delivered to keep Hillingdon people healthy, independent and enjoying a better quality of life."

In this section we explore how HCCG will deliver its stated vision through four specific aspects: Quality, Value, Our Commissioning Principles and Transformation.

Section 2a: Delivering HCCG's Vision (Quality)

Quality is at the heart of the work of Hillingdon CCG. We remain committed to improving the quality of care delivered by providers of health care services in Hillingdon and aim to ensure quality is embedded into the services we commission for our local population. Hillingdon CCG's Vision for Quality is to deliver excellent health and wellbeing outcomes and great services for the people of Hillingdon that are delivered in the right place and within budget. This includes the requirement that robust assurance systems are in place so the public can have confidence that high quality standards are set within the services we commission and are regularly monitored.

Hillingdon CCG is closely associated with the CCGs in Harrow and Brent and together form the BHH (Brent, Harrow & Hillingdon) CCG Federation covering the outer part of North West London (NWL) where we share a number services to reduce costs and ensure consistency across our numerous providers. This shared resource includes the Quality Team who are managed centrally but have a local presence in Hillingdon CCG (as well as in Harrow and Brent).

Hillingdon CCG, with the support of the Quality Team, will continue to manage quality within our commissioned services through the following:

- Conducting regular detailed analysis of hard and soft quality data and information is used to triangulate the quality of services.
- Gathering data from all of our commissioned services. This analysis allows for continuous monitoring to identify good practice as well as areas where quality standards are not being met which initiates a deeper dive.
- Maintaining good working relationships with our providers and continuing to hold monthly Clinical Quality Group (CQG) meetings with our main providers. These are formal meetings held with the provider where there are open discussions in relation to performance and quality with the use of data and reports.

- Where we are not the lead commissioner, but we have commissioned services, we will continue to work closely with the Lead CCG to receive assurance that services are being delivered to the highest standards possible.
- Focusing on improving patient safety, patient experience and clinical effectiveness and will continue to share learning from serious incidents, never events, safeguarding cases, complaints and any associated reviews with providers to enhance services to patients.
- Working with regional and national initiatives and partners such as the "Sign Up To Safety" initiative and continuing our work with Imperial College Health Partners for the Foundations of Safety Programme.

Section 2b: Delivering HCCG's Vision (Value)

HCCG operate within a financial budget. Historically the CCG has been financially challenged but has worked hard to ensure that the services we commission both meet the changing needs of our population as well as the financial constraints we work with. This work has ensured that in Financial Year 14/15 the CCG was able to achieve financial balance and in delivering our vision for 16/17 we must ensure this situation continues. To do this we need to consider the increasing population within Hillingdon that need to be supported and how best we can achieve this whilst at the same time continuing to reduce our overall costs so that we meet our financial obligations to make savings.

Hillingdon CCG will continue to ensure that we offer value for money within our commissioned services through the following:

- Benchmarking all services against local (North West London), London Wide and National Metrics to identify areas for improvement.
- Monitoring spend patterns and identifying where efficiencies can be made.
- Working with patients, carers, partners and providers to identify different models of service delivery to achieve the same or better levels of quality and outcomes for patients whilst offering improved value for money for the tax payer.
- Selectively testing the market for services to determine whether other providers can offer a more cost effective solution to the delivery of high quality services.

Specific areas where HCCG will focus on during 16/17 to ensure that we are delivering value for money include:

- Ensuring that we provide alternatives to attending hospital for patients with an unplanned care need (whether physical or mental health) where the need is not urgent or does not require the facilities of an acute hospital and helping those that do need to attend to avoid an unplanned admission where possible.

- Helping to support patients safely going home more swiftly should they be admitted including ensuring the Out of Hospital facilities effectively support Patients.
- Working to prevent disease or illness and empowering more patients with Long Term Conditions to enable them to better manage their own health and reduce exacerbations.
- Monitoring performance and variation across our providers and seeking to integrate services more effectively between organisations to achieve efficiencies.

Through the above and other actions outlined within these Commissioning Intentions, HCCG will ensure that we provide high quality services that offer value for money.

Section 2c: Delivering HCCG's Vision (Commissioning Principles)

In commissioning high quality services that offer value for money HCCG will continue to utilise the following Commissioning Principles:

We will:

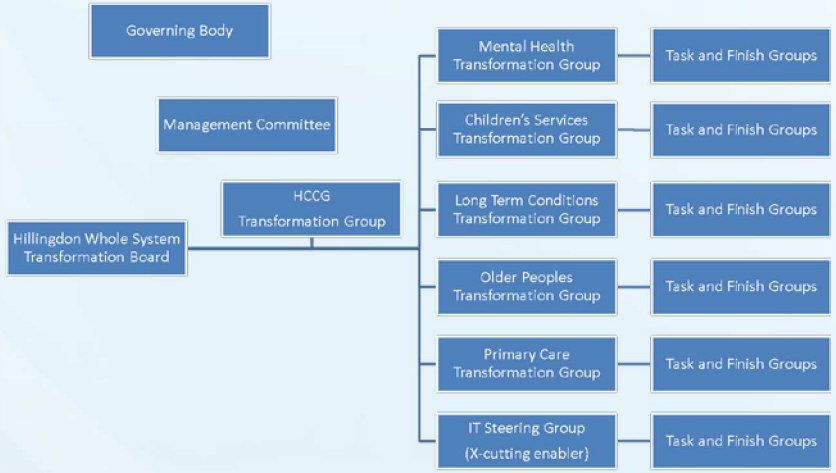
- Commission high quality, clinically effective care with a robust evidence base.
- Demonstrate and evidence equality and consistency in access to services and health outcomes within Hillingdon that continues to reduce health inequalities.
- Work with other commissioners where integrated commissioning will deliver innovative and effective healthcare solutions in line with the commissioning strategy.
- Work with providers, patients and carers to co-design an affordable integrated care system with an increased focus on Out of Hospital care.
- Develop patient and public engagement that ensures meaningful public involvement in commissioning.
- Achieve financial balance and a viable local health economy within existing and future resources with particular emphasis on robust contract monitoring across the entire contract portfolio.
- Commission care in line with health needs as identified within the JSNA and in line with the Joint Health & Wellbeing Strategy.
- Commission services that continue to move toward outcome-focused care, driven by the NHS Outcomes Framework with a key quality focus on the care and treatment of vulnerable adults.

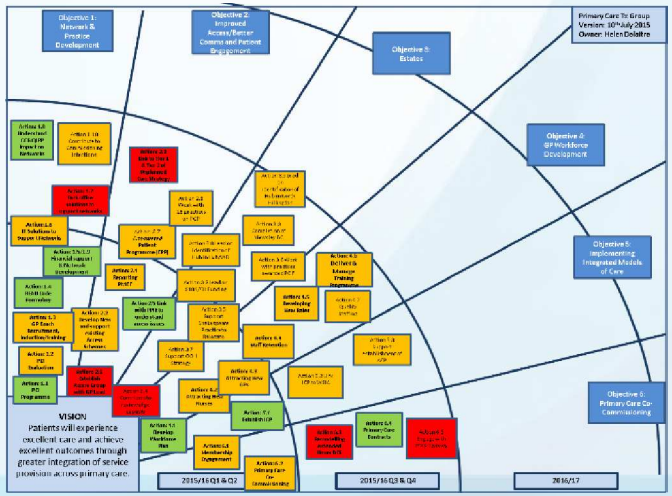
Section 2d: Delivering HCCG's Vision (Transformation)

The last of the four aspects of our Vision is concerned with Transforming Services. Hillingdon CCG, along with other CCGs in London, is committed to supporting the NHS London Transformation Programme and will ensure that the work being undertaken at a London Wide and North West London wide level is aligned with our own local transformation work.

In the increasingly complex world in which we operate we need to be clear on how we want to transform services over the coming years in the face of changing needs, changing commissioning models, developing partnerships and the use of existing and emerging technologies. The Transformation element of our Vision is concerned with six primary areas, each of which has an established Transformation Group involving different partners that varies depending on the transformation group each of which are; Mental Health, Older People, Children & Young People, Long Term Conditions, Primary Care and IT.

Each Transformation Group aims to have an up to date strategic Transformation Map that looks 2 to 3 years into the future and also to have a corresponding implementation plan and a dashboard of measures that enable each transformation group to monitor the impact they are having. A picture of the overall Transformation Group structure is shown below along with an example Transformation Map.





Section 3: The Health Landscape in Hillingdon

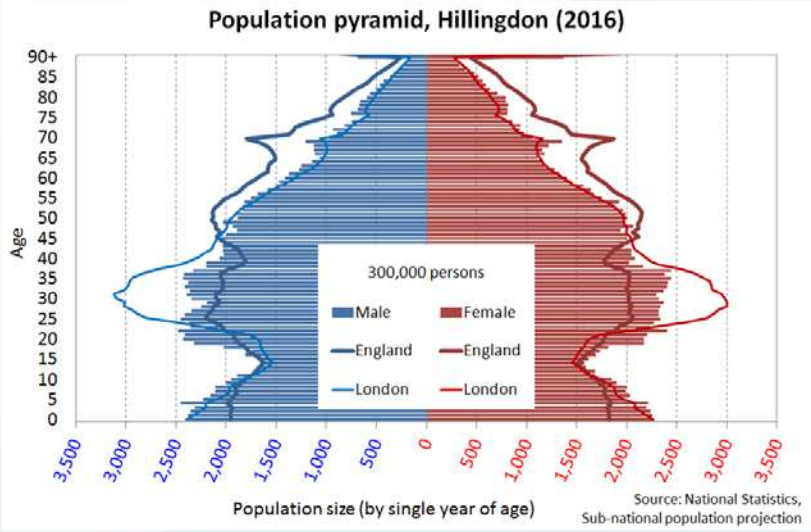
Section 3a: Demographics

Hillingdon has the second largest area (116 km^2) of London's 33 boroughs (strictly, 32 boroughs + City of London) with the 12th largest population. The overall size of the population for the London Borough of Hillingdon is shown in the following table.

• **National Statistics, 2012-based sub-national population projections (SNPP)**	**2016**	300,000
• **Greater London Authority (GLA) 2014 round short-term projection**	**2016**	301,000
• **Hillingdon Clinical Commissioning Group (CCG) GP registered population**	**2015**	301,000
• **Hillingdon CCG GP registered population that actually resides in Hillingdon**	**2015**	283,000

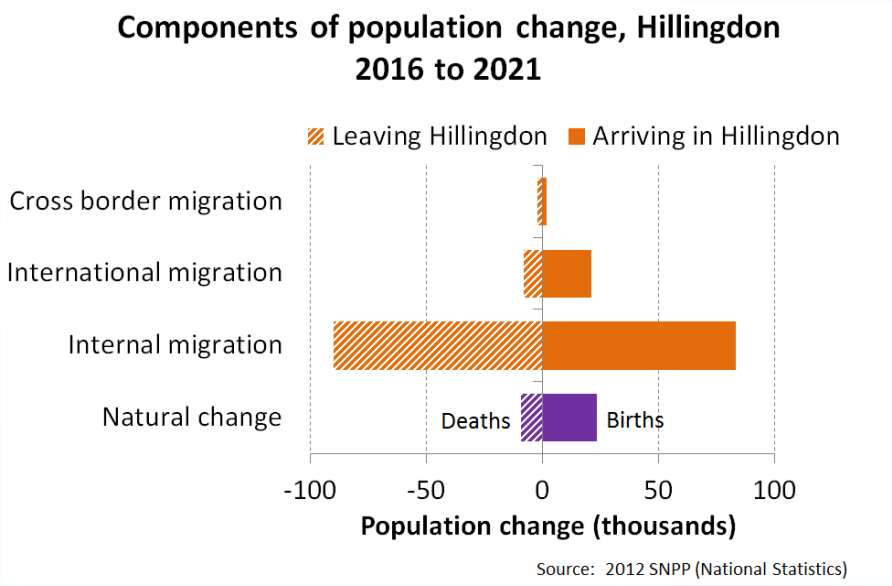
The population pyramid shows the population of Hillingdon by age band and gender and contrasts it with the population of London and the population of England as a whole. The populations for England and London are scaled so the proportion of the population in each age band can be compared with Hillingdon.

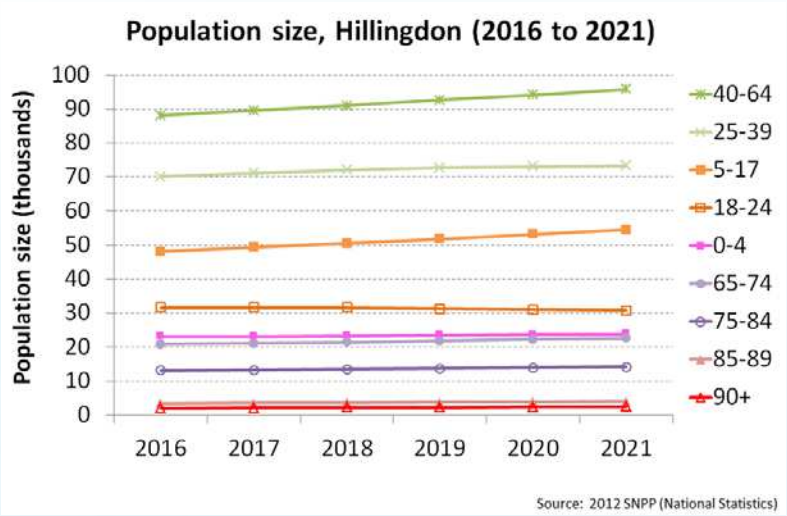
The age structure of the population in Hillingdon is intermediate between that for London and that for England, with, for the most part, a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England.



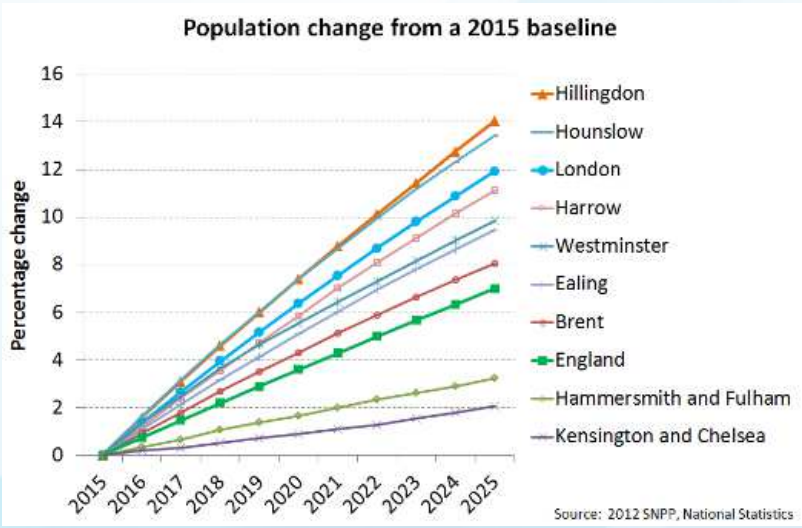
Section 3b: Population Growth Projections

The population increase in Hillingdon over the next 5 years is expected to be 7.1% (around 1.4% year on year). The corresponding 5-year increase in London is 6.1% and in England overall is 3.5%. The main driving force behind the increase in the population between 2016 and 2021 is natural change, i.e. 14,800 more births than deaths. Net migration is expected to account for around 6,600 persons over the same period.





The number of people in the following age bands are expected to increase in the next 5 years: 5-17, 25-39, 40-64 and 65-74. All the other age bands are expected to increase only slightly or remain flat until 2021.

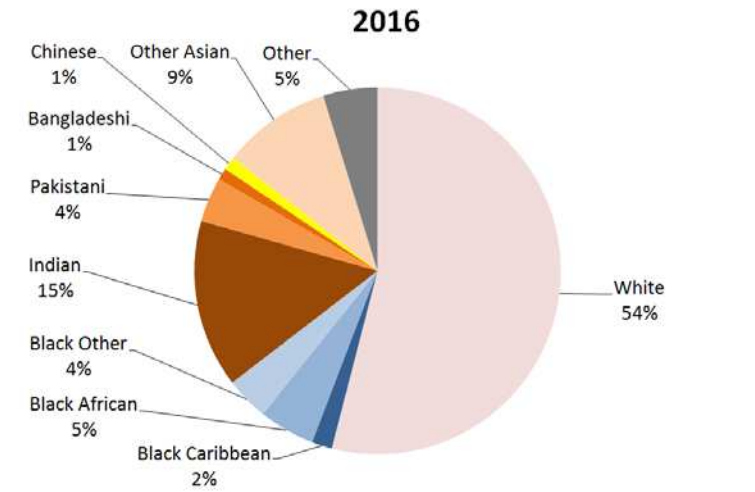


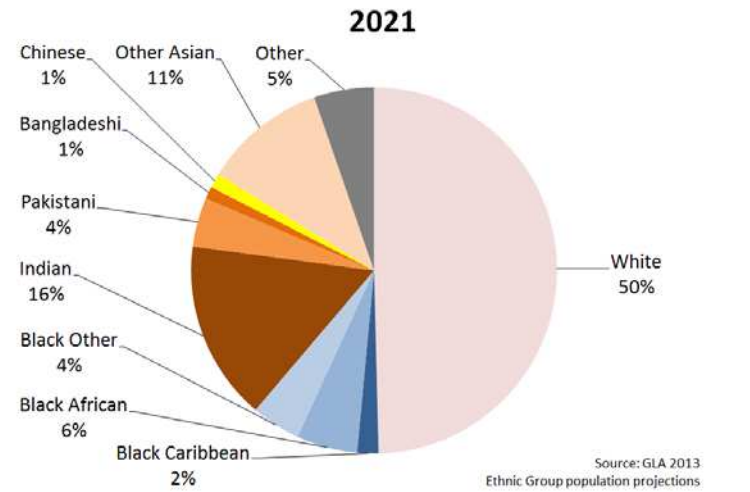
Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG (Hounslow being the possible exception) and will be above both the average for London and England. The projected size of the population (numbers) to calculate the cumulative percentage population increase (plotted in the graph opposite) are shown in the table below.

Total Population By Year (Thousands)								
	2015	2016	2017	2018	2019	2020	2021	2022
England	54,613	55,020	55,415	55,812	56,198	56,582	56,962	57,338
London	8,641	8,759	8,871	8,982	9,088	9,192	9,293	9,392
Brent	322	325	328	331	334	336	339	341
Ealing	351	355	359	362	366	369	372	376
Harrow	251	254	257	260	263	266	268	271
Hillingdon	296	300	305	309	314	318	322	326
Hounslow	272	277	281	285	288	292	296	299

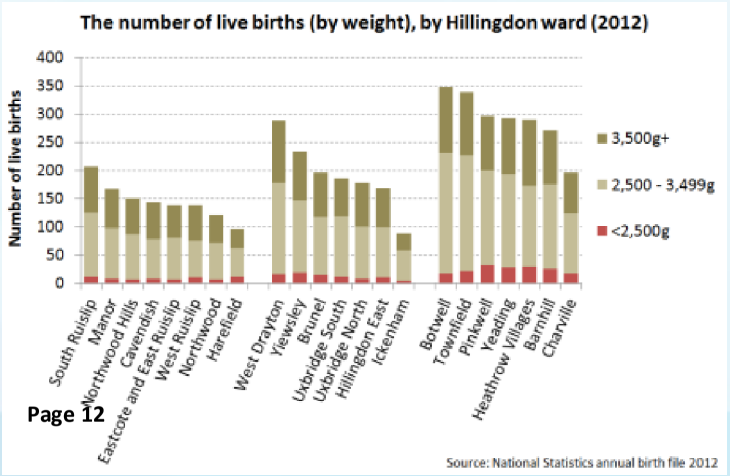
Cumulative Percentage Population Increase From 2015								
	2015	2016	2017	2018	2019	2020	2021	2022
England	100	101	101	102	103	104	104	105
London	100	101	103	104	105	106	108	109
Brent	100	101	102	103	104	104	105	106
Ealing	100	101	102	103	104	105	106	107
Harrow	100	101	102	104	105	106	107	108
Hillingdon	100	102	103	105	106	107	109	110
Hounslow	100	102	103	105	106	107	109	110

Section 3c: Ethnic Breakdown





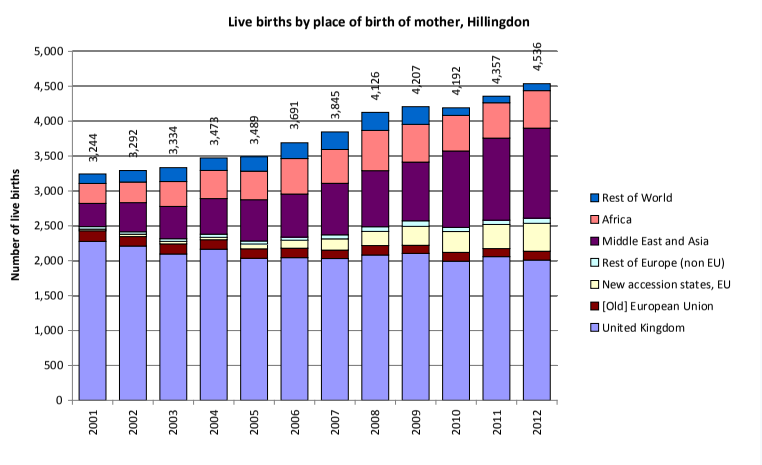
The ethnic group population projections for 2016 and 2021 are shown in the pie charts above. The Black, Asian and Minority Ethnic groups (BAME is defined as all the Greater London Authority ethnic groups except the GLA White group) are all projected to rise in number and proportion between 2016 and 2021. Given that prevalence of long term conditions like diabetes, cardiovascular disease, dementia and cancers varies across different ethnicities, this may have implications for future demands on health care.



There are over 76,000 children and young people aged 0-19 living in Hillingdon which represents 26.2% of the total population, slightly higher than the London proportion of 24.4%. 59.4% of school children are from a minority ethnic group. Generally the wards in the south of the borough have greater numbers of young people who make a higher proportion of the overall population.

Between 2006 and 2012 there has been 23% increase in annual births in Hillingdon (more than 800 births per year) with a total of 4536 births in 2012 compared to 3691 in 2006. There is wide variation between Hillingdon wards in the numbers of births annually, ranging from just over 100 per year in Ickenham to over 330 per year in Botwell and with more births in the South of the borough than the North.

In 2001 over two-thirds of births in Hillingdon were to mothers born in the UK but by 2012 this had fallen to less than 50%. Compared to England, fewer mothers in Hillingdon were born in the UK, and more were born in the Middle East and Asia and in Africa.



Section 3d: Influencing Factors

There are a number of influencing factors that need to be considered in planning health services for the people of Hillingdon and these are expanded upon below.

Language Barriers: There are some wards where the number of people (aged 3+) who *cannot speak English* or *cannot speak English well* number more than 2,000; these are Townfield (7%), Barnhill (7%), Pinkwell (6%) and Botwell (6%). The implication being that additional translation support may be required when patients from this demographic present for treatment. However, it is also likely that the younger patients in these areas will develop bilingual capabilities sooner rather than later.

Infant Mortality: The 2011-2013 the infant (before the 1st birthday) mortality rate in Hillingdon (3.7 per 1,000 live births) was lower than, but not statistically different from, the average for London (3.9 per 1,000 live births) and England (4.1 per 1,000 live births).

TB: The TB rate (2013) in Hillingdon is 35.5 per 100,000 population, this similar to London (36 per 100,000) and higher than the England rate (15 per 100,000). While 83% of individuals with TB in 2013 were born outside the UK, TB rates decreased in the non-UK born London population. The most common country of birth of non-UK born TB patients was India followed by Pakistan, Somalia and Bangladesh. Out of all the TB cases in London, 9% were recent entrants to the UK (entered within the previous two years).

Cervical Cancer Screening: Cervical cancer screening coverage for 25-64 year olds is lower in Hillingdon (74%) than either London (75%) or England (78%). There is no evidence from the 2013/14 national report that this is a reflection of lower uptake from certain ethnic groups.

Injuries Due To Falls: Metrics regarding injuries due to falls in Hillingdon in 2013/14 are similar to those for London, however, the rate of injuries due to falls in females aged 80+ years is worse in Hillingdon (7.5%) than England (6.2%) and London (6.4%).

Other lifestyle factors and risky behaviours contribute enormously to long-term (and short-term) health. The most significant of these in the Hillingdon area are shown below:

- **Excess Weight & Obesity:** In Hillingdon in 2012, 67% of the adult population is estimated (loosely) to be overweight or obese; this is similar to England (64%), but higher than London (57%).
- **Physical Inactivity:** In Hillingdon in 2013, 30% of adults age 16+ are estimated to be doing less than 30 minutes of moderately intensive physical activity (in bouts of at least 10 minutes) per week; this is similar to London (28%) and England (29%).
- **Smoking:** In Hillingdon in 2013, 16% of adults age 18+ were estimated to be current smokers; this is similar to London (17%) and England (18%)
- **Alcohol:** In 2014, the rate of alcohol-specific hospital admissions in Hillingdon (121 per 100,000 population) is similar to the England average (117 per 100,000).
- **Conceptions:** The rate of under 18 conceptions continues to decline. In 2013, the conception rate in females aged <18 years in Hillingdon (23 per 1,000 females aged 15 to 17 years) is similar to London (22 per 1,000) and England (24 per 1,000).

There are some illnesses or conditions where Hillingdon may be performing less well than other areas, these include:

- **Communicable diseases:** Mortality from communicable diseases among Hillingdon residents has fallen consistently since 2003-05. In 2011-13 the standardised mortality rate from communicable disease in Hillingdon (70 per 100,000 population) was similar to London (64 per 100,000), but higher than the rate for England (62 per 100,000).
- **Depression:** In Hillingdon in 2013/14, 5.2% of adults age 18+ were recorded with depression on GP registers; this is higher than London (4.8%) and lower than England (6.5%).
- **Dementia:** Epidemiological models suggest that there will be around 2,800 Hillingdon residents living with dementia in 2016; in 2013/14 local GP registers have recorded around 1,200 people (0.39%) which is the same proportion as London (0.39%), but lower than England as a whole (0.62%).

Section 4: National Strategic Context

In developing our local Commissioning Intentions, Hillingdon CCG (HCCG) needs to consider the national strategic context. The on-going financial restraint requires public organisations to reduce costs and whilst the health budgets are 'protected' there are knock on effects that increase the pressure on healthcare services when budgets are cut elsewhere in the public sector. The national strategic context is laid out in the NHS document "The Five Year Forward View" which recognises the complex nature of health and social care needs experienced by older people and those living with Long Term Conditions including those with multiple health problems. The CCG created a 5 Year Strategic Plan before the publication of the "Five Year Forward View" that set the direction of travel for the CCG's Recovery Programme and which is broadly aligned to the newer national strategy.

The National Strategic Context within which HCCG has to operate is laid out most clearly within the Five Year Forward View and highlights from this document are provided in the following section.

Section 4a: Executive Highlights from the NHS Five Year Forward View

Highlights from the NHS Five Year Forward View include the following:

Improvements achieved over the last fifteen years: Cancer and cardiac outcomes are better; waits are shorter and patient satisfaction much higher despite a global recession and austerity.

However, many challenges still exist including: quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted, needs are changing and we face particular challenges in areas such as mental health, cancer and support for frail older patients.

The responses to these challenges that are outlined in the NHS Five Year Forward View include:

- New options to permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care through a **Multispecialty Community Provider**.

- A further new option will be the integrated hospital and primary care provider – **Primary and Acute Care Systems** – combining for the first time general practice and hospital services, similar to the Accountable Care Organisations/Partnerships (ACPs) now developing in other countries too.

- Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

- **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services.

- Midwives will have new options to take charge of the **maternity** services they offer.

- The NHS will provide more support for frail older people living in **care homes**.

- Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years.

- GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

- The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that without efficiencies the NHS will need an additional £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – manage demand, achieve efficiencies and allocate funding appropriately. Less impact on any one of them will require compensating action in the other two areas.

Section 4b: Highlights from the NHS Outcomes Framework 2015/16

Whereas the NHS Five Year Forward View document sets the strategic direction for all NHS organisations, HCCG also need to consider the NHS Outcomes Framework which provides a national overview of how well the NHS is performing. The Outcomes Framework was first developed in December 2010 and has been updated annually since then which enables it to remain a tool which reflects the current landscape of the health and social care system. In preparing HCCG's Commissioning Intentions for 2016/17 we therefore need to consider the latest edition of the Outcomes Framework (2015/16) and the indicators that are outlined within it.

The NHS Outcomes Framework requires NHS organisations, including Hillingdon CCG, to consider performance indicators that are grouped together into the following five domains:

Domain 1: Preventing people from dying prematurely.

Overarching Indicators:

- Potential Years Life Lost (PYLL) from causes considered amenable to healthcare
- Life expectancy at 75
- Neonatal Mortality and Stillbirths

Improvement areas under Domain 1 include focusing on Cardiovascular Disease, Respiratory Disease, Liver Disease, Cancer, Mortality in Adults with Serious Mental Illness, Infant Mortality and reducing mortality rate in adults under 60 with a Learning Disability.

Domain 2: Enhancing quality of life for people with Long Term Conditions (LTCs).

Overarching Indicators:

- Health-related quality of life for people with Long Term Conditions (LTCs)

Improvement areas under Domain 2 include focusing on the proportion of people who feel supported, employment of people with LTCs, reducing time spent in hospital by patients with LTCs, enhancing the quality of life for carers, those with mental illness and those with dementia as well as those with multiple LTCs.

Domain 3: Helping people to recover from episodes of ill health or following injury.

Overarching Indicators:

- Emergency admissions for acute conditions that should not usually require hospital admission.
- Emergency readmissions within 30 days of discharge from hospital.

Improvement areas under Domain 3 include improving outcomes from planned treatments, preventing lower respiratory tract infections in children from becoming serious, improving recovery from injuries and trauma, stroke and fragility fractures, helping older people to recover their independence after illness or injury and dental health.

Domain 4: Ensuring that people have a positive experience of care.

Overarching Indicators:

- Patient experience of primary care.
- Patient experience of hospital care.
- Friends & Family Test.
- Patient experience characterised as poor or worse (primary and hospital care).

Improvement areas under Domain 4 include improving people's experience of outpatient care and accident and emergency services, improving hospitals' responsiveness to personal needs, improving access to primary care services, improving women and their families' experience of maternity services, improving the experience of care for people at the end of their lives, those with mental illness, for integrated care and for the experience of healthcare for children and young people.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidance harm.

Overarching Indicators:

- Deaths attributable to problems in healthcare.
- Severe harm attributable to problems in healthcare.

Improvement areas under Domain 5 include reducing the incidence of avoidance harm (such as deaths from venus thromboembolism (VTE) events, incidence of healthcare acquired infection (HAI), hip fractures and category 2, 3 or 4 pressure ulcers), improving the safety of maternity services and improving the culture of safety reporting.

Section 4c: 8 High Impact Actions for Urgent & Emergency Care

In addition to the NHS Five Year Forward View and the NHS Outcomes Framework, Hillingdon CCG also needs to consider the 8 High Impact Actions for Urgent & Emergency Care that have been recommended by NHS England, Monitor and Trust Development Agency. These 8 Actions have been reviewed and agreed by the Hillingdon System Resilience Group (SRG) and are summarised below:

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive Out-Of-Hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. System Resilience Groups (SRGs) should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support the management of falls patients without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on

7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

Section 5: North West London Strategic Context

Hillingdon CCG is one of eight CCGs that cover the boroughs of North West London (NWL). Hillingdon, along with Brent and Harrow, are responsible for health care in the outer region of NWL whilst the five CCGs of Chelsea & Westminster, West London, Hammersmith & Fulham, Hounslow and Ealing, cover the inner region of NWL. Much collaborative activity occurs across the eight CCGs and there are a number of shared functions between the organisations that help reduce the overall cost of commissioning for NWL.

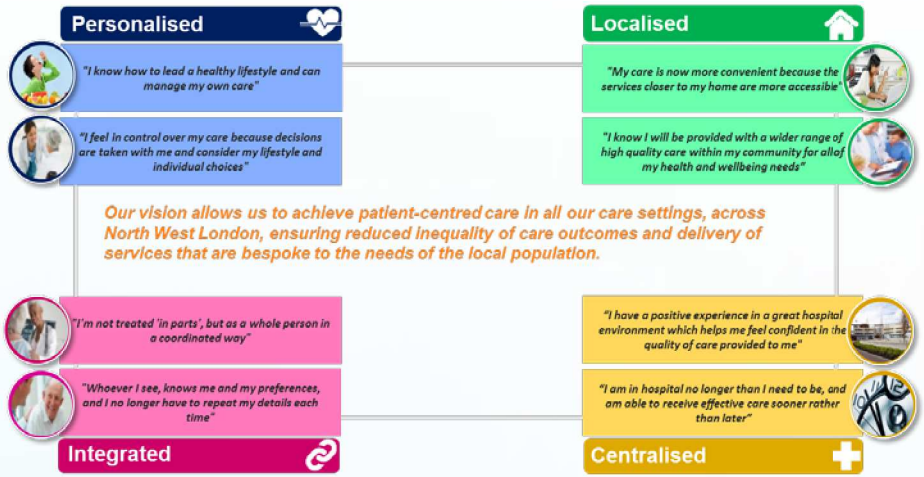
The CCGs in NWL are working together on programmes such as the Whole Systems Integrated Care (WSIC) Programme, Mental Health Transformation and also on our collective activities as part of the Better Care Fund (BCF). However, the major element of the strategic context for NWL is covered by the Shaping a Healthier Future (SaHF) programme, details of which are given in the following section.

Section 5a: Shaping a Healthier Future (SaHF)

North West London (NWL) is changing. We are undertaking a historic transformation of the healthcare system that will dramatically improve care for over two million people. We are on the cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals.
All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement this change. Our vision is to deliver care which is:

- **Personalised** – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures that care is ***unique***.
- **Localised** – Localising services where possible, allowing for a wider variety of services closer to home. This ensures that care is ***convenient***.
- **Integrated** – Delivering care that considers all the aspects of a person's health and is coordinated across all the services involved. This ensures that care is ***efficient***.
- **Centralised** – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures that care is ***better***.

Our vision is centred on the needs of the NWL population, developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.



We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan- NWL level:

- Acute Reconfiguration;
- Primary Care Transformation;
- Whole Systems Integrated Care;
- Mental Health Transformation.

Acute Reconfiguration: *Improved hospitals delivering better care 7 days a week, and ensuring there are more services available closer to home.*

In NWL, we have recognised the changes in population demographics and lifestyles, and, as such, are changing the way we organise our hospitals and community health services. By making these changes, we can ensure that the highest standards of care are met; that our hospitals have the specialist doctors and facilities in place to deal with your specialist needs round-the-clock, and out-of-hospital services are on hand to treat your everyday health needs as quickly and conveniently as possible, either closer to or within your own home. Acute Reconfiguration aim to deliver:

- A major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes;

- The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:

- Deliver a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in NWL;
- The delivery of the transition of paediatric services from Ealing Hospital by June 30, as agreed by Ealing CCG Governing Body (on behalf of all other Governing Bodies in NWL) earlier this year;
- Planning for the transition of other services from Ealing and Charing Cross Hospitals as we continue to transform these sites to their future state.

Primary Care Transformation: *Placing Primary Care at the heart of whole system working, and improving access to GP services*

Primary Care, and in particular General Practice, is at the centre of the NWL vision. However, the model of general practice that has served Londoners well in the past is now under unprecedented strain. There are significant challenges that must be addressed, including increasing demand and projected shortages in workforce. Patients' needs are changing and the systems that are currently in place need to evolve to ensure that they are still fit for purpose in light of this change. The implementation of Shaping a Healthier Future (SaHF) will deliver a vision where patients can benefit from:

- Improved health outcomes, equity of access, reduced inequalities and better patient experience;
- Services that are joined up, coordinated and easy to use;
- More services available, closer to homes;
- High quality out-of-hospital care;
- More local patient and public involvement in developing services, with a greater focus on prevention, staying healthy and patient empowerment.

This will then enables us to provide accessible, coordinated and proactive care, as set out in the London-wide Strategic Commissioning Framework.
To ensure the vision is successfully realised and these benefits become tangible and sustainable, the model of Primary Care needs to be transformed so that it can become the strong and sustainable for Whole Systems Integrated Care (WSIC).
As we move through this year, our priority areas in 16 / 17 are as follows:

- Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across NWL and ensuring that this is a fundamental part of an integrated care offer for patients;
- Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts);
- Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs);
- Progressing with the primary care estates strategy that takes into account the development of out of hospital hubs across NWL. Currently, 19 sites are in the pipeline. Once delivered these will provide significant additional space to deliver primary and integrated care.

Whole Systems Integrated Care: *Coordinating care across commissioning bodies and provider, centred around the patient.*

Across NWL we are approaching year three of a five year journey towards delivering the Whole Systems Integrated Care (WSIC) vision. The characteristics of WSIC (outcome-based models of care, accountable care partnerships, capitated payments and system-wide risk and reward sharing) have been reinforced through national policy as articulated by the "Five Year Forward View".

Full implementation of WSIC will require a multi-year transition towards:

- Jointly commissioned population level outcomes that span health and wellbeing;
- Accountable care partnerships (ACPs) delivering co-produced models of care and managing the clinical and financial risk for their registered populations;
- During 16/17 Early Adopters will begin the transition to WSIC through the roll out of new care models, the development of shadow ACP boards and the roll out of key enablers such as shared analytics, joint governance (commissioner-commissioner, commissioner-provider, provider-provider) and the testing of new approaches to payment and risk/reward sharing.

Therefore the focus for WSIC in 16/17 is to:

- Roll out, review and refine new models of care that reflect the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities;
- Embed new ways of working, culture and behaviours to underpin the system changes required;

- Support and engage with shadow ACP boards as they develop;
- Shape an approach to assurance that will ensure WSIC provides the best quality and best value care for the population of NWL;
- Monitor the new models of care against a shadow population-level capitated budget;
- Introduce a ring-fenced element of real risk share where appropriate;
- Continue to embed co-production throughout ways of working;
- Share learning and best practice across and beyond NWL.

Mental Health Transformation: *Improving mental and physical health through integrated services.*

NWL is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value. Across the system we have agreed to ensure that there is:

- Support for people who have experienced mental health problems to live well in the community;
- Promotion of recovery, resilience and deliver excellent health and social care outcomes including employment, housing and education;
- Development of new high quality services in the community, focusing on community based support rather than inpatient care so that people can stay closer to home;
- Services that provide urgent help and care which are available 24 hours a day 7 days a week for people who experience or are close to experiencing crisis.

As part of our commissioning intentions we would want providers to be proactively involved in transformation work and in implementing the outputs of transformation work. Specifically in 2016/17 we want to focus on:

- Implementation of new urgent care pathways and compliance with national target waiting times;
- Implementation of Future in Mind, the national strategy for children and young people to respond to local needs;
- Work with local specialist Mental Health and Learning Disabilities providers to implement local pathways to enable people to be cared for within NWL;
- Work collaboratively to implement the emerging outputs of the Like Minded strategy.

Section 6: Local Strategic Context

Whilst Hillingdon CCG achieved financial balance for the year there remains an underlying deficit. Demand for health care services continues to increase in both planned and unplanned care services. The previous sections have outlined the National and North West London Strategic Context that Hillingdon CCG need to operate within and locally we are committed to working in partnership with the Council for the London Borough of Hillingdon to deliver the Better Care Fund (BCF). The local context is also shaped by recent CQC (Care Quality Commission) visits to our two main trusts (The Hillingdon Hospital NHS Foundation Trust and Central & North West London NHS Foundation Trust) and the CCG is committed to working with both organisations to help them implement the actions plans that were raised following these visits.

Section 6a: Delivering the SaHF Vision in Hillingdon

Hillingdon CCG's Strategic Response to each of the 4 aspects of the SaHF Programme are detailed in the table below.

NWL Priority	Benefits to Patients	HCCG Strategic Response Area (Duplicates in Italics)	HCCG Actions Arising (Duplicate Actions Not Included)
Personalised	A1. "I know how to lead a healthy lifestyle and can manage my own care."	**Supporting Patients to easily access information & essential advice.**	• Deliver the Empowered Patient Programme (15/16) • Develop a Mental Health Single Point of Access (TBD) • Work with NWL CCGs on the NHS 111 Procurement (15/16) • Implement Patient Champions in Urgent Care Centre (15/16) • Improve Access to Online Advice (16/17) • Expand Community Outreach Programme (15/16) • Improve Cancer Information (As Per National Cancer Patient Experience Survey)
		Commissioning programmes to support Patients to self-manage.	• Expand Medication Reviews in GP Practices with Pts (15/16) • Re-Run the Parent Education Programme (15/16) • Implement Remaining Cancer Stratified Pathways (14/15-15/16)
		Developing the capabilities of our Practices & GP Networks	• Rollout Primary Care Education Programme (14/15-16/17) • Implementing the LTC Strategy: *Cardiology (Heart Failure) (15/16), Respiratory (COPD/Asthma) (15/16), Diabetes (15/16), Cardiology Phase 2 (16/17), Cancer Phase 2 (16/17)* • Align Community Services to Networks (14/15-16/17) • New Planned Care Pathways into Primary Care (ENT, Headaches etc) (16/17)

Personalised		**Commissioning services that provide advice as well as treatment.**	• Implement Remaining Cancer Stratified Pathways (14/15-15/16) • Implement Cancer related 'Direct Access Diagnostics) for GPs (16/17). • Review/Implement the Hillingdon For All (H4All) Business Case (15/16-16/17).
		Investing in technology to support Patient care.	• Develop 'Shared Patient Record' across providers (14/15-16/17). • Integrate our Urgent Care 'Out of Hours' System (16/17). • Improve access to specialist advice for GPs (14/15-16/17). • Implement ESP2 (Electronic Prescription Service) (15/16).
	A2. "I feel in control over my care because decisions are taken with me and consider my lifestyle and individual choices."	**Engaging Patients/Carers in the design of services in Hillingdon.**	• Embed Co-Production Workshops as 'the norm' (15/16). • Enhance Patient/Partner/Carer engagement in Commissioning (15/16-17/18). • Work with partners to access feedback from patients and service users together – ask the questions once.
		Focusing on addressing the residual health inequalities in Hillingdon.	• Update our Equality & Diversity Objectives (15/16). • Map Residual Inequalities (including Cancer) & Produce an Action Plan (15/16). • Enhance our Equality Impact Assessment Process (15/16).
		Transforming community and mental health services.	• Review/Update all Community Service Specifications (15/16-16/17). • Selective Market Testing where appropriate (15/16-16/17). • Use BCF and WSIC to drive increased integration across health providers and health and social care providers. • Embed Integrated Care Planning Programme into Primary Care (15/16).
		Developing fully integrated services where appropriate.	• Develop Pathways for Long Term Conditions (See above). • Implement Older People Integrated Care (including WSIC) (15/16-16/17). • Implement Intermediate Care 'In Reach' from Community/Third Sector (16/17). • Review of Homesafe Programme (Early Supported Discharge) (16/17). • Expand Integrated Discharge Planning (15/16-16/17).
		Giving Patients/Carers direct control of their own health care.	• Progress the implementation of Personal Health Budgets (PHB) (16/17).

Localised	B1. "My care is now more convenient because the services closer to my home are more accessible."	**Developing fully integrated services where appropriate.**	• Refresh Planned Care Strategy (15/16). • Undertake selective market testing (15/16-16/17). • Undertake Cancer "Chemo Closer To Home" Strategy Review (15/16). • Increase number of services delivered from a community site.
		Promoting the use of alternative 'point of contact' for advice/care.	• Rollout Hillingdon-Wide Comms programme (15/16-16/17). • Undertake audit & monitor access point uptake (16/17).
		Making advice more easily available electronically.	• Explore the possibility Remote Monitoring for Cancer Pts (16/17). • Implement Connect to Support (in partnership with Local Authority) (16/17).
		Improving access to Primary Care & OOH Services.	• Explore and if possible implement the concept of a Virtual Practice (15/16).
		Working toward a fully compliant '7 Day' Service.	• Expand Integrated Discharge Planning (15/16-16/17).
	B2. "I know I will be provided with a wider range of high quality care within my community for all of my health and wellbeing needs."	*Developing the capabilities of our Practices & Networks*	*See actions above.*
		Transforming community and mental health services.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*

		Working in Partnership with the Local Authority.	• Develop Joint Commissioning Intentions (16/17-17/18).
			• Develop Cancer Plans (16/17).
			  ○ Screening
			  ○ Early Diagnosis
			  ○ Prevention & lifestyle Promotion

Integrated	C1. "I'm not treated 'in parts', but as a whole person in a coordinated way."	*Transforming community and mental health services.*	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Promoting the use of alternative 'point of contact' for advice/care.	*See actions above.*
		Making advice more easily available electronically.	*See actions above.*
		Committing to the concept of 'parity of esteem' for MH conditions.	• Undertaking a 'Parity of Esteem' review (15/16-16/17).
	C2. "Whoever I see, know me and my preferences, and I no longer have to repeat details each time."	*Supporting Patients to easily access information & essential advice.*	*See actions above.*
		Investing in technology to support Patient care.	*See actions above.*
		Transforming community and mental health services.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Working in Partnership with the Local Authority.	*See actions above.*
Centralised	D1. "I have a better experience in a great hospital environment which helps me feel confident in the quality of care provided to me."	*Investing in technology to support Patient care.*	*See actions above.*
		Engaging Patients/Carers in the design of services in Hillingdon.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Working toward a fully compliant '7 Day' Service.	*See actions above.*
		Developing a 'Planned Care' strategy that is 'future fit'.	• Refresh Planned Care Strategy (15/16).
	D2. "I am kept in hospital for as long as I need to be, and am able to receive effective care sooner rather than later."	*Transforming community and mental health services.*	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Increasing access to Primary Care & OOH Services.	*See actions above.*
		Working toward a fully compliant '7 Day' Service.	*See actions above.*
		Developing a 'Planned Care' strategy that is 'future fit'.	*See actions above.*

Section 6b: Commissioning Priorities for 2016/17

Our Commissioning Priorities for 2016/17 are grouped into four areas which are detailed below:

Priority 1: Ensuring Services Meet the Needs of Our Population

We will achieve this priority by:

- Engaging patients, carers and others in the design of services.
- Focusing efforts into addressing the health inequalities that exist.
- Reviewing, redesigning and selectively investing in Mental Health services as part of our commitment to the concept of 'Parity of Esteem'.
- Seeking to commission services based on 'clinical effectiveness and outcomes' rather than activity alone.

Priority 2: Reducing Unnecessary Demand for Highly Stressed Services

We will achieve this priority by:

- Empowering patients to self-manage elements of their care and providing them with better information and support.
- Promoting alternative 'points of contact' for advice/care where appropriate.
- Enabling providers to share information and advice about access and support more easily.

Priority 3: Moving More Services Out of Hospital

We will achieve this priority by:

- Working with GP Practices and Networks to develop their skills, capabilities and capacity to support the CCG's Out of Hospital Strategy.
- Working with all providers and partners to integrate services particularly focusing on Older People and those with Long Term Conditions.
- Enhancing our work with our Local Authority (London Borough of Hillingdon) on both the WSIC and Better Care Fund (BCF) programmes.
- Continuing work to develop three "hubs" within Hillingdon where services can be co-located.

Priority 4: Delivering Value for Money

We will achieve this priority by:

- Supporting providers to share information to improve the quality of care and reduce the duplication of activities.
- Selectively testing the market on services with a particular focus on Community and Mental Health services and those other services where we can realise significant value for money improvements or where we cannot achieve the scale or pace of transformation we are seeking.
- Enhancing our contract management processes to ensure we get the performance and quality we expect from all providers.

Section 7: A Systems & Outcomes Approach to Health Care in Hillingdon

Hillingdon CCG is committed to commissioning services that work together seamlessly as a coordinated and coherent system rather than as a disparate and uncoordinated portfolio of services. This approach also supports the developing Accountable Care Partnership (ACP) that will bring Provider partners together and will also support an integrated approach to commissioning services with the London Borough of Hillingdon. In addition to commissioning integrated and seamless services/systems, HCCG is seeking to move toward commissioning services based on outcomes rather than outputs and this section provides an indication of the likely KPIs that will be applied to each system although these are subject to change as the CCG's thinking evolves throughout 2016/17.

Description	Expected Outcomes	Indicative Key Performance Indicators
Unplanned Care All services that support patients with an unplanned care need including both acute services such as the Emergency Department (ED), Mental Health Support and Acute Medical Unit (AMU) as well as other services including Urgent Care Centre, GP Out of Hours Services (where commissioned by the CCG), GP and Network Services, Community Services and others including Pharmacies.	• A system that is resilient and can reliably deliver the 4 Hour A&E Standard. • A system that meets the needs of patients with care being offered and delivered in the right setting for the patient's needs. • Patients being routed to the right place of care. • A financially sustainable system. • An integrated system that copes with peaks and troughs in demand.	• GP Urgent Care Slots Availability • GP Out of Hours Performance • Unplanned Attendances • 4 Hour A&E Standard Performance • Ambulance Attendances • Admissions for Ambulatory Care Sensitive Conditions • Unplanned Admissions • Zero Length of Stay Admissions • Average Length of Stay • Readmissions within 2 & 30 Days • Friends & Family Test

Planned Care All planned care services both in acute care (physical and mental health) and in community settings plus all standard primary care services.	A system that continue to deliver the 18 Week Standard and is resilient to demand growth. A reduction in variation in all areas including; referral rates into secondary care, activity in secondary care and productivity of associated community services. A system that is financially sustainable. A system that clearly meets or exceeds best practice standards in terms of activity, outcomes and costs.	• GP Referrals to Secondary Care • Out of Hospital Activity • Outpatient Activity • Day Case Activity • Outpatient Procedures • Elective Inpatient Activity • Average Length of Stay • Readmissions within 2 & 30 Days • Hospital Standardised Mortality Ratio • 18 Week Referral To Treatment (RTT) • Friends & Family Test
Long Term Conditions All services (both planned and unplanned) designed to support patients of any age with one or more Long Term Condition (LTC). This includes increased work to support the prevention of LTCs where possible and all services aimed at improving outcomes for patients with LTCs.	• Better outcomes for patients with LTCs. • More patients self-managing elements of their care. • More care being provided in primary and community health settings. • A reduction in unplanned care needs for patients with LTCs. • Maintenance and improvement in performance around the cancer standards. • A financially sustainable system.	• Registered Patients with LTCs • LTC Patients with a Care Plan • Patients with LTCs (Unplanned Attendances) • Patients with LTCs being Admitted • Patients with LTCs treated 'Out of Hospital' • Patient Reported Outcomes • Patients Feeling Supported • 31 and 62 Cancer Targets • Friends & Family Test

Mental Health All services (both planned and unplanned) designed to support patients with a Mental Health issue.	• Better outcomes and support for patients. • More patients capable of managing elements of their care and knowing how to access services appropriately when needed. • More care being provided in primary and community health settings. • A reduction in unplanned care needs for patients with Mental Health issues.	• Patients with an MH Condition with a care plan. • Patients experiencing unplanned events/crisis. • Patients admitted into inappropriate settings. • Patients supported in Primary Care. • Average Length of Stay.
Older People All services (both planned and unplanned) designed to support older people including those that link to Social Care services.	• Improved outcomes for older people. • Better and more coordinated care for frail elderly people. • Reduced unplanned care needs for older people. • Fewer older people being admitted when they do present with an unplanned care need. • A financially sustainable system.	• Older People with a care plan. • Older People in Care/Nursing Homes with a care plan. • Older People experiencing unplanned events/crisis. • Older People admitted into inappropriate settings. • Older People supported in Primary Care. • Average Length of Stay. • Reduction in Delayed Transfers of Care. • Reduction in Prescribing Costs.
Integrated Care All services delivered jointly between two or more healthcare providers and/or between healthcare and social care.	• Reduced duplication of activity. • Reduced costs of commissioning and a financially sustainable health care system. • Seamless services provided to the Hillingdon population whether their need is social or health care related. • Improved joint decision making.	• These will be determined during 2016/17.

Section 8: Listening to the Voice of Patients & Carers

Hillingdon CCG (HCCG) actively listens to what patients, carers, partners, providers and others tell us they need from the services we commission. Our consultation processes are designed to understand how existing services are being delivered and the changes we need to make to services to ensure they meet the continuing and changing needs of our population. We also consult as part of our statutory obligation to ensure we are meeting our Equality and Diversity objectives which are detailed in the next section.

Section 8a: Hillingdon CCG's Equality & Diversity Objectives (2015)

The current Equality & Diversity Objectives for the CCG are stated in the table below. These objectives have been prepared following extensive consultation as well as analysis of specific areas of inequality in Hillingdon.

HCCG Equality and Diversity Objectives (Revised & Renumbered 2015)
Stakeholder Based Objectives
1. **Hillingdon People:** Enable and ensure all people, patients and carers in Hillingdon (across all nine protected characteristics and intersections) have equal access to engagement processes and are effectively involved the design and quality of HCCG commissioned services.
2. **HCCG Staff:** To reduce health inequalities in Hillingdon and address possible and actual risks of health inequality, support staff to identify, design, commission and procure equitable services for all, including mitigating actions where there is a risk that commissioning or decommissioning services may have a negative impact on any equality population in Hillingdon.
3. **HCCG's Governing Body** will ensure HCCG's work is making progress towards eliminating discrimination, ensuring equal opportunity for all and fostering good relations by ensuring equality analysis and review processes are in place, drawing on sound evidence, and used effectively in HCCG decision-making eg. good quality Equality Impact Analysis (EIA) is used effectively throughout the organisation.
Characteristic / Equality Population Based Positive Action
4. **Identify populations at risk in Hillingdon:** HCCG staff and Governing body together will draw on sound evidence from available sources to identify populations at risk of or facing health inequality in Hillingdon and prioritise positive actions to reduce inequality and mitigate risks of further inequalities that have been identified through EIAs.
5. **Population – BME Children Under 5:** Ensure that Black and Minority Ethnic (BME) children under the age of 5 have improved benefits from taking up appropriate healthcare services and/or self-care management for the treatment of minor conditions and ailments, by empowering and educating their parents and carers to identify and utilise the full range of available services in Hillingdon. (Age/Race).
6. **Population – BME Young People & Adults Mental Health:** Reduce crisis admissions of young people and adults from Black Minority and Ethnic (BME) populations in Hillingdon to acute Mental Health beds under the Mental Health Act. (Age/Race/Disability).
7. **Population – all Carers:** To increase support available for carers of all ages and with all protected characteristics. (Disability-Carers/All).

Section 8b: Significant Consultations Undertaken During 2014/15 and 2015/16

The following is a summary of the major consultations that were undertaken during the 2014/15 Financial Year and up to the end of the first quarter of 2015/16 which is when the Commissioning Intentions start to be produced for the following year:

- Carers Strategy Consultation
- Adult Diabetes Consultation Programme (including feedback from Self-Management Workshops)
- Diabetes (All Age) On-Going Care Consultation
- Wheelchair Service Re-Design & Co-Production Programme
- COPD Consultation Programme (including feedback from Self-Management Workshops)
- Asthma in children (Awareness Sessions in School Assemblies)
- Community Outreach Programme
- Access in Primary Care Consultation Programme
- CCG Membership Feedback (Feedback from the GPs based within Hillingdon)

The feedback we received is summarised in Section 8c below and has been used to help inform the Commissioning Intentions that can be found in Section 10 of this document.

Section 8c: Summary of Feedback

Based on the consultations undertaken during the year as detailed above we have summarised the main feedback received. This feedback has been used to help shape the Commissioning Intentions defined in Section 10 of this document.

AREA	WHAT YOU TOLD US
Carers Strategy Consultation	• Improve respite care to provide breaks from caring. • Reduce bureaucracy in accessing support. • Manage/improve the standard of care provided. • Provide someone to talk to and better access to advice. • Support/training to help carers manage specific issues for the person being cared for (such as incontinence).
Adult Diabetes	• Improve access to information on self-managing diabetes. • Improve support to help diabetics to manage their weight. • Improve education to enable patients to manage medications and the best way to inject their insulin. • Improve access to blood testing in the community rather than at hospital. • Improve health screening for diabetics and improve access to eye screening (diabetic retinopathy).
Diabetes On-Going Care	• Improve consistency of podiatry services provided. • Improve the number of patients receiving regular foot checks. • Provide patient checklist to help them ask the right questions when seeing a GP or other professional who is helping them manage their condition. • Reduce reliance on clinicians supporting care and transfer some responsibility to the patient where appropriate. • Educate patients and enable them to self-manage where appropriate including providing specific support for BME groups. • Increase the number of patients with care plans, particularly for those over 65 with diabetes.
Wheelchairs	• Provide an out of hours emergency helpline. • Enable concerns to be raised directly with the CCG. • Involve service users in the development of the service. • Shorten lead-time from assessment to provision of equipment. • Improve follow-up support for when service user needs change. • Improve access to equipment to enable service users to be discharged from hospital in a timely manner. • Improve advice to Occupational Therapists (OTs) around what accessories are available. • Create a fast-track process for service users with a progressive disorder and those with a terminal illness. • Improve support for children under 2.5 years-olds.

COPD	• Improve signposting and education for patients with COPD to help them better manage their condition. • Improve access to weight management support and supervised exercise. • Ensure follow ups with GPs are planned and undertaken on a regular basis. • Enable patients to self-refer back into specialist care if symptoms return.
Children's Asthma	• Improve awareness in schools and provide better information in a range of settings (ie GP Practices, Pharmacies etc). • Help educate children so they understand how they can use their inhalers more effectively and are more aware of the condition. • Promote the Minor Ailments Scheme. • Improve diagnosis of asthma in children under 6.
Community Outreach	• Improve information concerning NHS 111 and when to use it versus when to use 999. • Improve awareness of other options than going to the hospital. • Review screening process for NHS 111 which can be a lengthy process. • Improve awareness of the skills of local pharmacies in dealing with minor ailments particularly amongst BME communities who may not value a pharmacist's expertise. • Expand the number of patient able (and supported) to self-manage their condition at home.
Access to Primary Care	• Increase registration rates of patients from Eastern Europe with a GP. • Reduce reliance on the Urgent Care Centre by improving access to GP appointments. • Make it easier for specific BME groups to raise mental health related issues with GPs. • Improve access to information for BME groups around mental health and learning disabilities. • Raise awareness of the dangers of sharing medication with family and friends that was not prescribed for them.
Membership Feedback	• Need to reduce the stresses faced by GP Partners within their surgery. • Improve networking and peer support opportunities. • Improve links between GPs, GP Networks and the CCG. • Promote Clinical Leadership. • Make it more attractive to practice in the South of Hillingdon. • Improve use of pharmacists to support prescribing issues. • Deal with the 'retirement crisis' facing GPs. • Join up our IT Systems across Hillingdon. • Engage GPs more effectively in CCG decision making. • Continue to develop a workforce that is 'fit for the future'.

Section 9: The Provider Market in Hillingdon

Hillingdon CCG is responsible for the commissioning of the majority of healthcare related services in Hillingdon. These services are delivered by a variety of different organisations (providers) in different settings (such as hospitals, community clinics and GP practices) and collectively these organisations and settings for what is called 'The Provider Market'. This section provides an overview of the Provider Market in Hillingdon as it stands today and gives a look forward as to our intentions for 2016/17.

9a. Overview of the Current Provider Market in Hillingdon

The Provider Market for Hillingdon consists of a network of organisations working together to deliver the healthcare services commissioned by the CCG as well as those commissioned by others such as NHS England and our Local Authority, the latter also commissioning the social care aspects of our combined health and social care system. This section provides an overview of the current situation of the main aspects of the provider market in Hillingdon.

Primary Care

Primary Care services are predominantly those delivered by GPs in practices and are mostly commissioned by NHS England although this is starting to change with the CCG starting to play a bigger role through the concept of Co-Commissioning where the responsibilities for commissioning, monitoring and assuring primary care services will be shared between the CCG and NHS England. There are currently 46 GP Practices within Hillingdon and these (with the exception of two practices) are organised into four GP Networks which provide opportunities for shared learning, capacity building on a scale greater than an individual practice and also for developing and delivering new services. The vast majority of GP Practices provide their own Out of Hours support to patients with only a very small minority 'opted out' which places the responsibility for provision with the CCG.

Community Services

This is a broad title covering a wide range of services from District Nursing to Wheelchair Services. The vast majority of Community Services are delivered by Central and North West London NHS Foundation Trust (CNWL) and Hillingdon CCG is the lead commissioner for CNWL's Community Services acting on behalf of all other commissioners who use these services. Other aspects of community services, such as the provision of community equipment, is jointly commissioned by the CCG with the London Borough of Hillingdon through a shared funding agreement called a Section 75 Agreement, whilst other aspects such as Pressure Relieving Mattresses, Wheelchairs and Non-Emergency Patient Transport (amongst others) is commissioned directly by the CCG with a range of other providers.

Mental Health Services

CNWL also delivers the bulk of Mental Health Services in Hillingdon. In the case of these services, Harrow CCG is the lead commissioner for the Mental Health Contract with CNWL and Hillingdon CCG is an associate commissioner. Hillingdon CCG is an are active partner in the North West London (NWL) Mental Health Transformation Programme and work with other CCGs in NWL to develop joint standards and explore how we can adopt best practice and improve services locally.

Acute Care

Our hospital based care is provided predominantly by The Hillingdon Hospitals NHS Foundation Trust (THH) where Hillingdon CCG is the lead commissioner. THH provide the Emergency Department and associated services with an Urgent Care Centre operated by Greenbrooks on behalf of the CCG but operating from the main THH site. THH also provide the bulk of all elective or planned care, from such things as knee operations through to maternity services. THH is set to continue as a 'fixed point' within the transformation of acute care services that is occurring across NWL via the Shaping a Healthier Future (SaHF) programme and has already absorbed increased activity following the closure of the maternity unit at Ealing Hospital in July 2015. Work is now underway to prepare for closure of the Ealing paediatric unit in 2016.

Hillingdon CCG is also the lead commissioner for Royal Brompton & Harefield NHS Foundation Trust (RBH) on behalf of all CCGs who commission services with RBH although the main commissioner of services from RBH remains NHS England due to the specialist nature of services provided by RBH.

Voluntary & Third Sector

Hillingdon has a vibrant voluntary and third sector who deliver a wide range of services that are commissioned by Hillingdon CCG as well as a broad range of services that are commissioned through other routes including through charitable donations. These organisations make a valuable contribution to the health and social care system in Hillingdon.

Local Authority Commissioned Services

Our Local Authority (London Borough of Hillingdon (LBH)) is responsible for commissioning many important aspects of the health and social care system in Hillingdon including Public Health services, Health Visiting, School Nursing, Alcohol & Drug Addiction Services and of course Social Care to name just a few. In the increasingly interconnected world of health and social care LBH and the CCG are working together to develop, commission and manage a wide range of services.

9b. Our Intentions for 2016/17

This section provides a high level overview of our Commissioning Intentions for 2016/17 in respect to the Provider Market. To meet our strategic objectives and to ensure we can provide a financially sustainable healthcare service that continues to meet the growing and changing needs of our population we are committed to reshaping services.

General Intentions

The following apply to all providers:

- We expect all providers to make full use of e-Referrals and aim to eliminate any referrals issued via other means.
- We expect all NHS providers to utilise EMIS compatible systems to access, update and use the Shared Care Record (SCR) to improve patient care.
- We will implement a schedule of clinical and quality audits guided by anomalous activity, CQC reports, patient feedback or other sources.
- We will seek to develop new contracting models to enable us to respond more flexibly to changes in the health and social care environment.
- We recognise that many service specifications across the board need revision to reflect the current health and social care economy in Hillingdon and whilst these will be addressed with individual providers on a service by service basis as a general point for 2016/17 all service specifications will, as a default position, apply to all patients registered with a Hillingdon GP (whether they live in or outside the borough) and to all patients who are not registered with a GP but who live within the London Borough of Hillingdon.
- We will work with surrounding boroughs and areas to discuss how patients registered with their GPs but living within Hillingdon can be effectively supported.

Integration

- The CCG is committed to the concept of an Accountable Care Partnership (ACP) or similar structure as outlined in the NHS Five Year Forward View and will use 2016/17 to test the concepts and processes for an ACP within the scope of Older People and supporting patients with Long Term Conditions.
- We recognise that the membership of an ACP type structure may need to flex and change to accommodate the other changes we are considering.
- We will be taking a more proactive approach to the integration of urgent and emergency care systems both locally and across North West London.
- The CCG is also committed to seeking additional opportunities to jointly commission services with our local authority and to the delivery of the joint objectives outlined in our Better Care Fund programme.

Primary Care

- We will continue to support the development of our GP Networks.
- Primary Care will continue to play an essential part in supporting our Out of Hospital Strategy and an increasingly important role in supporting patients to self-manage elements of their care. To do this we will increase the amount of secondary care advice that is available by expanding the scope of email advice lines and will increase the number of educational opportunities for Primary Care professionals.
- We will continue to develop the Integrated Care Programme that will be delivered through GP Networks.
- We will continue to provide feedback to practices and via Sub-Group Meetings and enable them to access data via the WHYSE Programme. We will be reviewing the effectiveness of the Practice Commissioning Initiative in the light of emerging themes in Co-Commissioning and may change or stop this programme.
- We will take on additional responsibilities for the monitoring on Out of Hours Services in collaboration with the Local Medical Committee (LMC).
- We will continue to seek ways for Primary Care to help us reduce demand for secondary care services especially around unplanned care services.
- We remain committed to supporting Primary Care in areas such as access, premises and workforce development to enable practices to support the CCG's Out of Hospital and QIPP Agendas.

Community Care

- We recognise the need to rapidly transform community services in light of such things as the Out of Hospital Strategy, the transformations underway to support patients with Long Term Conditions and the need to demonstrate value for money for tax payers and achieve the expected quality and safety standards we require for our patients.
- Where we cannot achieve the scale and pace of transformation required we will test the market and procure services either individually, in logical groups or on a wider scale. Specifically for Community Care this covers such areas as: Community Rehabilitation, District Nursing, Podiatry, Rapid Response, Tissue Viability, Twilight Nursing, Community, Paediatricians, Paediatric Speech & Language Therapy and the End of Life Service Portfolio.
- We recognise that service specifications that were written in the past may not now reflect the way forward and as such need to be revised in line with the direction of travel for the CCG.
- We recognise the need to improve the ability of the CCG to manage the contract including improving the amount and quality of data provided so that effective monitoring can occur and effective decisions made.
- We will require providers of Community Services to work more effectively and in an integrated manner with other providers to support the CCG's objectives.
- Specifically, we will seek to move the budget for dressings into the 16/17 Contract with our main Community Provider.

Mental Health

- Much of what has been written above about Community Care in terms of transforming services, testing the market and procuring where appropriate also applies to Mental Health Services as does the elements around improving service specifications, working more effectively as part of an integrated system and improving contract monitoring processes.
- As for Community Care, where we cannot achieve the scale and pace of transformation required we will test the market and procure services either individually, in logical groups or on a wider scale. Specifically for Mental Health Services this cover Primary Care Mental Health Services, Improving Access To Psychological Therapies (IAPT) (aka Talking Therapies), Mental Health Rehabilitation Services and Children & Adolescent Mental Health Services (CAMHS).
- Whilst we will require our Mental Health provider to work more effectively as part of an integrated system we will specifically be seeking to improve the links between Primary Care and the Community Mental Health Teams (CMHTs).
- Decisions around the direction of travel for Mental Health services will take into account the fact that Harrow CCG is the lead commissioner and the need for Hillingdon CCG to align any work done with the NWL Mental Health Transformation Strategy.

Acute Care

- We will improve contract monitoring processes and continue to challenge areas where activity seems anomalous compared to North West London averages. This will include the following areas as a minimum: Respiratory Medicine, Cardiology, Trauma & Orthopaedics, Rehabilitation Services, Paediatric ENT, Geriatric Medicine, Pain Management, General Surgery, Midwifery, Endocrinology, Ophthalmology and Cardiac Surgery.
- We will specifically be seeking to procure a new Community Chronic Pain Service and to either negotiate a new arrangement for Musculoskeletal Services (MSK) or test the market if a negotiated settlement cannot be reached.
- We will seek to establish more high quality and responsive services 'Out of Hospital' and increase the number of sites from which services are delivered.
- We will seek to reduce unplanned admissions to the North West London average for our population and will continue to work to create a resilient and integrated unplanned care system.
- We will work to achieve relevant 7 Day Standards in partnership with THH.
- We will be seeking to improve the coding of appropriate co-morbidities with THH so as to improve the ability of the CCG to plan services and access data, particularly in relation to Long Term Conditions such as Diabetes, Cardiology and Respiratory.
- We will also work to control costs and ensure we remain a financially viable healthcare system.

Voluntary & Third Sector

- We will seek to strengthen the voluntary and third sector involvement in delivery of services and to integrate where them into the ACP where appropriate.
- We will look at alternative ways of contracting with voluntary and third sector organisations that make it easier for them to engage productively with the NHS.

Section 10: Commissioning Intentions

The following sub-sections outline Hillingdon CCG's (HCCG) Commissioning Intentions by area. The areas considered are as follows:

- 10a. Integrated Care (including Whole System Integrated Care (WSIC) and Better Care Fund (BCF))
- 10b. Services for Older People
- 10c. Unplanned Care
- 10d. Planned Care including Out of Hospital & 7 Day Services
- 10e. Long Term Conditions
- 10f. Mental Health (incorporating Learning Disabilities)
- 10g. Children & Young People (CYP)
- 10h. Medicines Management
- 10i. End of Life
- 10j. Community Services
- 10k. Primary Care
- 10l. Continuing Health Care (CHC) & Complex Care
- 10m. Patient & Public Engagement & Empowerment
- 10n. IT & Technology
- 10o. Safeguarding

In addition to the specific actions that are detailed in the following sections there are some generic commissioning intentions that apply to the majority, if not all, services and service areas and these are listed below.

GENERAL COMMISSIONING INTENTIONS FOR 2016/17
Expand educational support provided by secondary care to primary and community care to support an increase in the number and complexity of patients managed out of hospital.
Improve use of the shared care record by secondary care with the aim of improving the quality of care provided and reduce duplication of tests and other areas.
Expand access to email advice and support available to GPs from secondary care to enable GPs to manage more patients out of hospital.
Expand the use of e-Referrals and introduce Decision Support Tools (DSTs) to Primary Care.
Seek to develop a Common Clinical Record across Hillingdon.
Work with THH to improve the quality of coding particularly coding of appropriate co-morbidities.
Improve the usage of Smart Cards by THH.
Reduce variations across all providers.
Improve the compliance with the NWL Internally Generated Demand (IGD) policy within acute providers.
Audit of the application of THH's access policy within THH and incorporation of any revisions needed into the contract.
Ensure that the CCG is refunded appropriately for Out of Area patients including treatment provided to non-EU patients.
Agree a schedule of clinical audits for 2016/17.
Work with THH and other providers to reduce DNA rates and therefore increase capacity.
Improve the reporting of performance and contract monitoring processes across all providers.
Require providers to work with the CCG on the assurance of their CIP Schemes as a contractual requirement.
Undertake selective demand and capacity studies.
Test the market on areas where negotiation cannot achieve the required service changes to meet current/future needs or identified efficiencies.
Improve the quality, effectiveness and accuracy of all service specifications with a particular focus on Community & Mental Health Services.
Explore the expansion of PHBs to Pts with LTCs (outside of CHC) in line with the NHS Mandate and 15/16 Planning Guidance.
Develop a plan to address the residual health inequalities that exist in Hillingdon.
Service Specifications to apply to any patients registered with a Hillingdon GP irrespective of the borough they live within and will also apply to any person resident in the London Borough of Hillingdon but not registered with any GP.

Section 10a: Integrated Care (including WSIC and BCF)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Integration
CLINICAL LEAD	Dr Kuldir Johal
COMMISSIONING LEAD	Joan Veysey

OVERVIEW

Hillingdon CCG's (HCCG's) vision for Integrated Care is stated as: *Through clinically focused commissioning, HCCG will be recognised for delivering a high performing, good quality collaborative and cost effective acute and community based health system for the residents of Hillingdon, within available resources in an environment that delivers quality care, supports clinicians and is satisfying for all staff and members.*

The 15/16 Commissioning Intentions for integrated care focused on the development of specific programmes to improve the outcomes and experience of care for frail older people. These programmes included the Better Care Fund (BCF), Whole System Integrated Care (WSIC) and Integrated Care Programme (ICP) that together aimed to deliver care that is coordinated and person centred meaning that people are directly involved in planning their own care and which delivers outcomes that are important to them. The CCG's Integration Commissioning Intentions also enable the development of the commissioning and provider landscape, enabling more integrated commissioning approaches across health and social care via the BCF, development of outcome based commissioning and capitated payment models as part of the whole system early adopter pilot and development of a new provider accountable care partnership in Hillingdon.

The CCG's Integration Commissioning Intentions for 2016/17 will build on these development s in the following ways:

1. The model of care for older people with one or more Long Term Conditions (LTCs) developed through these programmes will be scaled up and taken forward within the Older Peoples' Commissioning Intentions for 2016/17 as a single model of care (see later in this document).
2. The Commissioning Intentions for Integration will focus on the development of the commissioner and provider landscape through:
    - Integrated commissioning with London Borough of Hillingdon (LBH) via the Care Act flexibilities including BCF.
    - Development of provider landscape and new Accountable Care Models Including a possible Accountable Care Partnership (ACP).
    - Development of key system enablers including information sharing and shared care records.

As part of the provider network we will expect clinicians in our local hospital to develop pathways for populations/patient groups that provide more care in the community alongside GPs and other community clinicians.

STRATEGIC OBJECTIVES FOR INTEGRATED CARE	
Objective	**Expected Outcomes**
1. Increase the scale and pace of Integrated Commissioning.	• Agreed arrangements with London Borough of Hillingdon (LBH) for joint commissioning (where appropriate) for health and social care services. • Commissioning for outcomes with a capitated budget on a section of the CCG's portfolio including possibility Older People and those <65 years old with a Long Term Condition. • Decision on the long term full integration model for Hillingdon.
2. Expand the BCF programme with LBH.	• By 2020 residents of Hillingdon able to plan their own care with control over services that matter to them. • Decision made on cohort of patients covered by the Better Care Fund (BCF).
3. Develop an outcomes framework for Hillingdon.	• Delivery of improved system outcomes and patient reported outcomes.
4. Develop a new capitated funding model.	• Increased focus on prevention. • Improved links of outcomes to financial incentives.
5. Support development of new accountable care partnership.	• Agreed governance models with provider for alliance commissioning model.
6. Develop system enablers to support primary care networks to be the coordinating hub of all care.	• Improved coordination of all care for patients whether their health needs are physical or mental. • Improved access to information across the health and social care system.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Expand the BCF and scale up model of care for older people including new aspects such as Mental Health, Dementia, Supported Living and others. • Agree a capitated budget for Integrated Services in 15/16 and prepare to migrate to new contract structure as soon as possible. • Develop plans for how to contract via an Alternative Care Partnership (ACP) via shadow arrangements. • Care Information Exchange (CIE) pilot commenced and PKB (Patient Knows Best) tested across provider partners. • Embed Integrated Care Programme in Hillingdon and evaluate the Hillingdon for All (H4A) gateway provision and agree Phase 2 for programme. • Data sharing agreement strategy developed and rolled out. • Improve integration around Children's Mental Health Services where possible.	

Section 10b: Services for Older People

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Older People's Services
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Jane Walsh

OVERVIEW

The CCG along with its partners has developed a series of aims associated with the Services for Older People that are commissioned in Hillingdon. These aims take into account feedback from patients, residents, and carers, and have been agreed between health and social care providers and commissioners in Hillingdon. The aims for Services for Older People are:

- To integrate the assessment of need and provision of care for older people between health, social care and third sector providers. Care provision will be timely, effective and outcomes based.
- Whatever the care setting, the older person and their family and or carers will be involved in the planning of their care so that they can make informed choices, know who to contact in a crisis and with more general concerns or questions.
- To engage and develop the local workforce and market in order to meet the current and future health and care needs of the population of older people in Hillingdon.

In delivering these aims, the Commissioning Intentions for Services for Older People for 2016/17 has identified six strategic objectives and the associated actions. These strategic objectives are designed to deliver a model of care and associated provision that meets the identified needs of patients and carers in an integrated way between health and social care based on need rather than the source of the funding. This work is intended to transform the way services are able to be delivered and move away from the traditional health and social care barriers to integrated service delivery as well as providing a model of care and provision that is intended to be sustainable both in economic and workforce terms.

STRATEGIC OBJECTIVES FOR SERVICES FOR OLDER PEOPLE	
Objective	**Expected Outcomes**
1. Improve the planning of care and provision of care, including when there is a change in care setting.	• Increased involvement of patients and their families and or carers in the planning of their care so that they are able to maximise their independence and to make informed choices, including on transfer of care setting. • Improved understanding of and meeting the needs of each individual patient. • Better co-ordination between services. • Patients feel better supported and know who to contact when issues arise.
2. Enhance case management.	• A shift from reactive care provision to anticipatory care provision, from crisis management to crisis prevention. • A reduction in unscheduled attendances at A&E and associated admissions to acute care with a corresponding reduction in length of stay when an admission is required.
3. Engage effectively with patients and carers including enabling self-care.	• Local services being developed which take into account patient and carers' feedback and can be accessed as equitably as possible. • Service users, patients and carers feeling involved in the development of care today and for the future.
4. Development of the market to meet current and future needs.	• A provider market with the skills and capability to deliver the needs of our population. • A provider market that provides for a sustainable financial future within Hillingdon.
5. Development of the local workforce to meet current and future needs.	• A workforce that has the skills and capacity to meet the needs of our population.
6. Development of a suite of measures that enable progress and impact to be tracked both in terms of quality and finance.	• A suite of measures capable of demonstrating progress and impact. • A financial environment conducive to a sustainable future for Hillingdon.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Pilot the identification of patients who will benefit from active case management. • Jointly with LBH, scope further integration of intermediate care services and the opportunities for service provision within various care settings. • Start to implement the delivery plan for the carers' strategy and explore opportunities for joint procurement of carers contracts with LBH. • Establish joint contract monitoring processes with LBH and work toward older people having a named contact for coordinating their care. • Jointly with LBH undertake a review of respite care and a review of medical and other support provided to Residential/Nursing Care homes.	

Section 10c: Unplanned Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Unplanned Care
CLINICAL LEAD	Dr Mitch Garsin
COMMISSIONING LEAD	Rashesh Mehta

OVERVIEW

Our commissioning intentions for unplanned care are the product of on-going engagement with our clinical community and stakeholders and represent our current planning and preparation for 2016-17. It is paramount that we maintain our focus on improving quality and ensure the future sustainability of our unplanned care system. We are wholly committed to developing a truly integrated system, and accordingly our plans have been jointly developed with our partners.

There are well documented rising pressures in urgent and emergency care nationally and locally, from both volume and acuity. There are challenges associated with helping patients and others chose the right service, making alternatives to A&E available and accessible when appropriate and enabling responsive community services which help avoid unplanned hospital attendance and/or admission where appropriate.

Building on our baseline activity and in planning for growth and changes in the mix of patients presenting, our 2016/17 Commissioning Intentions bring an opportunity to work to reduce attendances at A&E where appropriate, further reduce admissions to hospital through both the expansion of existing schemes and the development of new schemes. There is also a clear commitment to reducing the average length of stay of non-elective admissions and the associated excess bed days that may occur. Commissioners are seeking to 'engineer' a system where stakeholders, particularly providers, are enabled to work together effectively, so that our unplanned care system can cope with increases in demand whether in winter months or surges at other times of the year.

Additional considerations we have taken into account within our 2016/17 Commissioning Intentions for Unplanned Care include the following:

Urgent & Emergency Care System Redesign – Hillingdon CCG will review all services delivering urgent and emergency care services inclusive of NHS 111, GP OOHs, Urgent Care Centres, Mental Health & Community Services, Secondary Care, Social Services and the new/emerging models of care in federated networks for all patients registered with local GPs with the aim of commissioning a safe, high quality, integrated urgent care system which will align the NHS 111 Service with other parts of the Urgent & Emergency Care (UEC) System.

7 Day Working - Commissioners will work with providers on the implementation of 7 day working across the urgent and emergency care system including that providers deliver national and local targets (including the 4 Hour A&E Target) and appropriate quality standards.

Shaping a Healthier Future (SaHF) – The acute reconfiguration programme in North West London (NWL) is redefining how urgent and emergency care is provided across the region. The Hillingdon Hospitals NHS Foundation Trust (THH) (who are commissioned by Hillingdon CCG) remain a fixed point and will also take on additional activity associated with children during 2016/17.

Ambulatory Emergency Care (AEC) - The CCG is conducting an evaluation of the effectiveness of the current AEC services for adults & children and will continue to work with THH to roll out and expand the AEC pathways and capacity during 2016/17.

Robust Contractual Processes - For the NHS 111 Service, GP Out of Hours (where CCG Commissioned) and the Urgent Care Centre at THH, the performance management of these contracts will transition from "light touch" to robust contract monitoring. The CCG is currently reviewing the use of some of these services by frequent users to understand the level to which they are being used as standard primary care facilities. Depending on the outcome of this, the CCG will put in place a protocol to ensure that the services are used appropriately. We require providers to work with commissioners to help manage patient demand, including promoting self-care, and redirecting patients back to primary care where appropriate.

Procurement - Unplanned care services such as NHS 111, GP Out of Hours and the Urgent Care Centre will be subject to a system level review. Current contracts for these services are due to expire at different time points over the next two years. It is unlikely that individual services will be re-procured in isolation but will be subject to a system procurement during 2016/17 or possible early in 2017/18.This is especially true for the NHS 111 Service where the emerging model of care is to integrate this with GP Out of Hours Services.

We will also be taking an all age approach to improving Unplanned Care services for 2016/17.

STRATEGIC OBJECTIVES FOR UNPLANNED CARE	
Objective	**Expected Outcomes**
1. Ensure our Non-Elective (NEL) System is Resilient.	• Ability of our system to cope with both routine/expected growth and unexpected peaks in activity. • A financially sustainable unplanned care system.
2. Deliver National & Local priorities and standards.	• Delivery of all standards including the 4 Hour A&E Target during each month of 2016/17. • Achievement of the QIPP Targets associated with 2016/17 for Unplanned Care.
3. Ensure patients are routed to the correct part of our Urgent & Emergency Care (UEC) System.	• A system that utilises its capacity effectively and correctly to treat patients. • Empowered primary care, community care, mental health services that support patients to manage their conditions more effectively and to further empower patients to take control of aspects of their care.
4. Provide consistently high quality and safe care across all seven days of the week.	• Achievement of appropriate elements of the 7 Day Standard. • Increased support to patients to help them be discharged safely at weekends.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Expand admission avoidance schemes such as Ambulatory Pathways (Adults, Paeds, EGAU and Surgical) and Intermediate Care and agree tariffs. • Integrate Homesafe and Rapid Response into a single service with joint measures around admission avoidance and reducing LoS. • NHS 111 Extension decision to be made before the end of 14/15 and working with other North West London CCGs on a procurement. • Support the new model for NHS 111 that sees it integrating with GP Out of Hours Services. • Improve the monitoring of and awareness of GP Out of Hours Services. • Continue to focus on reducing demand for unplanned care services and diverting patients to the most appropriate point of care. • Map the entire health system and undertake selective audits and deep dives into areas where activity is anomalous to North West London. • Continue to selectively invest resilience money and readmission credit reserve funds where it will gain the most impact. • Continue to improve the effectiveness of the System Resilience Group (SRG). • Work with LAS to improve the triage service and reduce conveyances. • Develop targeted guidance for key groups with information on how they can self-manage their conditions.	

Section 10d: Planned Care including Out of Hospital & 7 Day Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Planned Care (Including 7 Day Services and Out of Hospital Services)
CLINICAL LEAD	Dr Mehboobali Saleh
COMMISSIONING LEAD	Kamran Bhatti

OVERVIEW

Our aim for all services commissioned by Hillingdon CCG is that we ensure we provide high quality, evidence based services that are clinically effective and have a positive experience for patients. Specifically for Planned Care this means providing as much of those services 'Out of Hospital' (OOH) and closer to home with services available 7 Days per Week where it is clinically appropriate and where it offers 'value for money'. When designing how we will deliver our Planned Care Services we need to ensure that they meet all national and local quality and efficiency indicators and that the services avoid duplication.

The CCG is in its final year of a challenging three year recovery programme where the transformation of Planned Care Services has been one of the driving areas. In collaboration with providers we have delivered a programme of pathway development and service redesign. The outcome has been that ENT, Gynaecology and Urology are now delivered as a community service under contract variation with Hillingdon Hospital. In addition, Ophthalmology and Dermatology services are now delivered under community contracts across locations in Hillingdon outside of the Hospital setting.

The 2016/17 Commissioning Intentions for Planned Care build upon the previous work undertaken in the areas listed above and expand the programme across all appropriate specialties. We intend to focus on an increasing the number of services delivered in a community setting as well as exploring the expansion opportunities for additional sites from where services are delivered. This will predominantly continue to be achieved in partnership with our main acute provider (The Hillingdon Hospitals NHS Foundation Trust) through contract variation although we do expect to test the market wherever a negotiated settlement cannot be agreed or where the scale and pace of change required cannot be achieved otherwise.

As Musculoskeletal (MSK) Services are such a large part of our Planned Care Services there is a section below with additional narrative. The Planned Care Strategic Objectives stated below also apply to MSK as a specialty within Planned Care and therefore the MSK Section only lists the appropriate actions along with some narrative.

We will be taking an all age approach to Planned Care services for 2016/17.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Musculoskeletal (MSK) Services
CLINICAL LEAD	Dr Mitch Garsin
COMMISSIONING LEAD	Russell Foster

OVERVIEW

Hillingdon CCG will reach the end of its three year MSK QIPP plan at the end of financial Year 2015/16. This presents an opportunity to review the successes and learnings of the last three years; look at the National and Local strategic context and decide which approach to MSK services will be of most benefit to Hillingdon patients whilst delivering the CCG's 2016/17 QIPP targets.

The current three year plan clearly delivered QIPP savings of £2.5m in Year 1 (13/14) and £0.938m in Year 2 (14/15). Savings in Year 3 of the programme (15/16) have been more difficult to achieve with increasing MSK first appointment outpatient activity, particularly in Trauma and Orthopaedics (T&O), unexpectedly high activity associated with spinal injections, and delays to the implementation of a Community Chronic Pain Service.

During the remainder of 2015/16 and into 2016/17, Hillingdon CCG will be seeking to bring Spinal activity back to the North West London average, deliver the residual QIPP targets associated with Year 3 and introduce a Community Chronic Pain Service as well as a Community Rheumatology Service. In addition, the CCG is committed to working with our partners at Brent and Harrow CCGs to develop spinal pathways that will apply across all three CCGs.

The Commissioning Intentions for 2016/17 for MSK remain to move patients out of hospital into community care, primary care and self-care where appropriate and to reduce both costs and activity associated with secondary care. As 2015/16 sees the end of the initial 3 year strategy for MSK, it is logical for the CCG to seek to develop a further 3 (or 5) year strategy for MSK given the on-going pressures and costs in this area.

STRATEGIC OBJECTIVES FOR PLANNED CARE	
Objective	**Expected Outcomes**
1. Improve the ability of Primary Care to manage patients effectively 'Out of Hospital'.	• Email and telephone advice available to GPs for all specialties when needed. • Better defined pathways for GPs to follow where gaps exist. • Improved awareness and skills in primary care to support patients 'Out of Hospital'. • Less demand for over-stretched hospital services where clinically appropriate.
2. Improve the quality and effectiveness of acute care services.	• Improved outcomes for patients. • A financially sustainable planned care system for Hillingdon.
3. Reduce variation across Primary and Secondary Care.	• Increased consistency in the way that patients are managed and referrals are made. • Reduced costs for managing patients in secondary care. • Increased conformity to national and local benchmarks.
4. Develop an Integrated Planned Care System.	• Closer alignment between Primary, Community and Secondary Care. • Better information related to activities and costs in Community Care. • A more seamless service experienced by patients.
5. Ensure delivery of the 2016/17 Objectives for 7 Day Services.	• Delivery of Standards 3, 4 and 9 (Phase 2). • Progress toward Standards 6, 8 and 9 (Phase 3).
6. Delivery of the QIPP Targets for Planned Care.	• Demonstrable progress toward a sustainable healthcare economy in Hillingdon. • Achievement of the 2016/17 QIPP targets.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Implement a requirement that all Dermatology activity passes through our Community Service within the 16/17 Contract. • Decommission further non-2WW Dermatology Services including Patch Testing and other appropriate Tier 4 services. • Develop a strategy with THH to provide or co-locate services in the community for both existing and new schemes. • Review the Community Ophthalmology Service and decide whether this should be procured. • Implement a Community Chronic Pain Service and require all Pain Activity (including Spinal Injections) to pass through this service. • Implement email advice, the referral return policy and a primary care education programme with THH across all major specialties. • Implement a series of deep dives and contract challenges where activity is anomalous to that across North West London. • Deliver 7 Day Standards 3, 4, 9 (Phase 2) and progress 6, 8 and 9 (Phase 3) with THH. • Create a new MSK Strategy that will realise QIPP Savings and a reduction in secondary care activity, bringing it to within the NWL Average. • Seek to expand the number of diagnostics that are available in the community and improve selected diagnostic pathways including Ultrasound. • Improve access to GPs 7am to 7pm recognising that this may not need to be at the patient's normal practice.	

Section 10e: Long Term Conditions

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions
CLINICAL LEAD	Dr Mehboobali Saleh
COMMISSIONING LEAD	Helen Delaitre

OVERVIEW

In Hillingdon, an estimated 91,000 have one or more Long Term Condition (LTC) and the NHS costs associated of managing LTCs is estimated to be between £91 million and £116 million.

Hillingdon CCG has published its strategy for patients with Long Term Conditions (*Healthier Together Strategy 2014-16)* which outlines the CCG's commitment to improving the quality of life for patients with LTCs through better prevention, self-management, integration of services, care planning and patient support that takes into account co-morbidities and related complications.

One of the main priorities for this strategy is to reduce existing inequalities in the borough. Public health data helps us to assess the future demand for the treatment of certain conditions which are more prevalent in specific population groups and work on LTCs will focus on the areas where we can expect higher hospital admissions both to reduce the rate of disease occurrence and also target earlier diagnosis. For instance, ethnicity is closely linked to health status, deprivation, health inequalities and poor health outcomes and the CCG will focus effort in areas with the worst health outcomes.

The LTC Strategy sets out three phases for transformation, in line with conditions which account for the highest inequalities in life expectancy as follows::

- **Wave 1:** Cardiology, Diabetes, Respiratory (including Asthma and COPD), Cancer and Rheumatology.
- **Wave 2:** Stroke (where our acute services are well defined and we need to consider an integrated service) and Inflammatory Bowel Disease (IBD).
- **Wave 3:** Multiple Sclerosis, Epilepsy and Parkinson's.

Wave 1 projects are underway and the CCG will be working up plans for Stroke and IBD in 2016/17. In delivering our LTC Strategy for 2016/17 the CCG needs to consider the following issues:

- **Rheumatology** – This is covered by the CCG's Planned Care Agenda and is covered under MSK Services earlier in this document.

- **Empowered Patient Programme** – This is part of the CCG's Patient Empowerment Agenda covered later in this document.
- **Integrated Care Planning** – This will be delivered through GP Networks for the >75s and we also need to consider the wider Integration Agenda.
- **Primary Care Workforce** – Developing staff and reducing variation in care are priorities both of which issues are covered under Primary Care.
- **Health Promotion** – Through the LTC Transformation Group we will work to align CCG priorities to London Borough of Hillingdon plans.
- **Screening** – Public Health England are responsible for screening but the CCG is committed to helping prevent LTCs and also provide earlier diagnosis.
- **Diagnostics** – Each service area will review the needs from diagnostic services and this will be coordinated through a Diagnostic Services Map.

The Strategic Objectives and Expected Outcomes are stated for all LTCs that the CCG will be focusing on during 2016/17 but we have added a section that provides some narrative and the specific actions for each condition we are focusing on during 2016/17.

We will be taking an all age approach to supporting patients with Long Term Conditions (LTCs) in 2016/17.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions – Cardiology
CLINICAL LEAD	Dr Reva Gudi/Dr Diviash Thakrar
COMMISSIONING LEAD	Caroline Davidson (Helen Delaitre, Head of LTCs)

OVERVIEW

Cardiovascular disease (CVD) accounts for 32% of all deaths in Hillingdon (JSNA 2011). The incidence of CVD increases with age. Heart failure rates increase 10% in the over 65s and the risk of developing Atrial Fibrillation (AF) after the age of 40 is 1 in 4. The incidence of AF increases 18% in the over 85s. One in 5 strokes are due to AF rising to 1 in 3 over the age of 80. It is predicted that the number of people in Hillingdon aged over 65 will increase by 9% over the next 5 years and the number of over 85s will rise 22%. Therefore it is important that cardiology services adapt to the needs of an aging population particularly in the north of the borough. 18% of CVD deaths are people aged under 75 (which is higher than the national average) and occur to a greater degree in the south of the borough therefore an integrated cardiology service should also target vulnerable, high risk communities to reduce health inequalities.

Public Health Observatories CVD Health Profiles 2013 profile for Hillingdon indicate that Emergency admissions (2012/13) for Coronary Heart Disease (CHD) and heart failure are significantly higher than the England average. Almost 7000 people in Hillingdon have CHD but it is expected that a further 3000 are undiagnosed and also 27000 people have undiagnosed hypertension. Therefore to reduce A&E attendances and admissions, diagnosis rates in primary care need to improve diagnosis rates.

Patient's conditions are increasing in complexity due to co-morbidities. The National Audit for Cardiac Rehabilitation 2013 found that in 2006, 13% of patients had co-morbidities but in 2012 it was 46% of patients.

There is little capacity within primary care to deliver self-management education to patients and to support them when they are unwell. Therefore patients whose conditions are exacerbating will go to A&E or if over 65, access Rapid Response for support.

The Integrated Cardiology Service will deliver a joined up Adult Cardiology Service for Hillingdon, improving the quality of Cardiology services locally and moving clinical activity from secondary care into primary care to prevent A&E attendances, non-elective admissions, readmissions, outpatient attendances and improve support for patients to self-manage. The developments in the service redesign have been divided into phases to enable a more focused approach to implementation. Phase 1 was implemented in 2014/15 and phase 2 is currently being mobilised. The Commissioning Intentions for 2016/17 are related to initiatives that fall into phase 3.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions: Cancer
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Mary Idowu (Helen Delaitre – Head of LTC)

OVERVIEW

It is estimated more than 30,000 people in London receive a cancer diagnosis every year and over 13,000 die from the disease annually making cancer the biggest cause of premature death in the capital. The number of people living with and beyond cancer is more than 200,000 and this is expected to double by 2030. After Cardiac and Respiratory conditions, cancer is the third largest killer in Hillingdon. The *Five Year Cancer Commissioning Strategy for London* sets out key recommendations to improve cancer services, survival rates and patient experience. The recommendations identify the following themes:

- Prevention
- Screening
- Early detection
- Reducing variation
- Living with and beyond cancer (Survivorship)
- End of life care

These objectives mirror the commissioning intentions and also take into account *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020* which was published in July 2015.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions – Respiratory Diseases
CLINICAL LEAD	Dr Nilesn Bharakhada
COMMISSIONING LEAD	Christine Falzon (Helen Delaitre, Head of LTCs)

OVERVIEW

The 2016/17 Commissioning Intentions for Respiratory Diseases aim to consolidate on the work done in 2015/16 for Adult Respiratory (COPD) patients and upscaling the model developed for paediatrics (asthma).

COPD: Chronic Obstructive Pulmonary Disease (COPD) is the 5th biggest killer disease in the UK, killing approximately 25,000 people a year in England. Premature mortality from COPD in the UK was almost twice as high as the European (EU-15) average in 2008 and premature mortality for asthma was over 1.5 times higher. Although, deaths from asthma have plateaued at between 1000 and 1200 deaths a year since 2000, it is estimated that 90% of deaths are associated with preventable factors and could therefore be avoided. Almost 40% of these deaths are in the under 75-age group. Asthma is also responsible for large numbers of hospital admissions, the majority of which are emergency admissions.

The quality standard for Chronic Obstructive Pulmonary Disease (COPD) requires that services should be "commissioned from and **co-ordinated across all relevant agencies** encompassing the whole COPD care pathway. The Pathway will deliver the **integrated approach** to provision that is fundamental to the delivery of high-quality care to people with COPD".

Paediatric Asthma: The **London Strategic Clinical Network for Children and Young People** has recently developed a number of Asthma Standards for Children and Young People. The Standards set out 37 Quality statements that specify how RCPCH, BTS/SIGN and NICE Asthma Guidelines should be implemented into tangible services on the ground. Asthma and allergy frequently coexist, so an asthma and allergy pathway reinforces the concept of a whole airway approach for effective patient diagnosis, management and education, e.g. shared allergic triggers, inter-related symptoms and treatments. This model is deemed particularly relevant to Hillingdon where there is a large number of paediatric A&E attendances for respiratory disease in children aged 0-5.

Tuberculosis: The TB pathway is mandated by NHSE and will be funded by centrally through CCG co-ordination.

Symptom-Based Pathways are a long-term goal that is being considered in other areas and should be developed locally as new best-practice service models emerge in this area.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions - Diabetes
CLINICAL LEAD	Dr Patricia Hurton
COMMISSIONING LEAD	Sukeina Kassam (Helen Delaitre, Head of LTCs)

OVERVIEW

There are over 16,000 people in Hillingdon registered with a diagnosis of diabetes. The Hillingdon prevalence for diabetes is 6.4%, which is higher than that of London (6.0%) and England (6.2%). Current prevalence rates put Hillingdon as 4th highest compared with the other boroughs in North West London. It is estimated that if the rise in diabetes continues unchecked, in 5 years' time prevalence will be 9.2% in Hillingdon compared with 8.7% in London and 8.5% in England. This suggests that around 3% of our population will become diabetic within the next 5 years unless programmes are put in place to prevent people from developing this long term condition.

There is also significant variation in the management of diabetes in primary care with the Hayes and Harlington locality seeing the highest prevalence.

It is estimated that one in four people with diabetes in London is undiagnosed which in Hillingdon translates to a hidden demand of 3,750 people. These people are at significant risk of developing long-term complications associated with their undiagnosed and untreated diabetes and could be potential patients that get identified once seen through the unscheduled care route.

Hillingdon CCG aims to deliver an Integrated Diabetes Service which will co-ordinate support for patients at risk of developing or who have already been diagnosed with diabetes and supporting those patients to remain at home or in their chosen care setting with less need for secondary care support (either planned or undiagnosed). It aims to reduce the percentage of patients with diabetes developing severe complications of end stage renal disease, amputation, blindness, stroke and coronary heart disease which are associated with this chronic condition.

STRATEGIC OBJECTIVES FOR LONG TERM CONDITIONS	
Objective	**Expected Outcomes**
1. Integration of Health and Social care	• Improved planning of services that require health and social care input. • Seamless services delivered for patients moving between health and social care.
2. Embed Co-Production with Partners and Patients	• Improved engagement of patients and service users in service developments. • Reduced gap in expectations between what is delivered and what patients say they require.
3. Empower Patients to Self-Manage	• Improved outcomes for patients through better self-awareness and skills to manage elements of their care. • Reduced number of exacerbations, improved confidence and better mental health for patients with LTCs.
4. Empower Primary Care to Support Patients	• Reduced need for secondary care support for patients. • More care provided closer to home.
5. Reduce Unplanned Care needs for Patients with LTCs	• Better outcomes for patients with LTCs needing fewer unplanned care interventions. • Reduced pressure on the unplanned care system in Hillingdon.
6. Deliver the CCG's QIPP targets	• Reduced costs for the local health economy enabling better investment decisions to be made. • Improved support available for new, growing, changing or emerging needs where they are identified.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve access to psychological support for patients with a Long Term Condition. • Utilise secondary care expertise to enhance the capability of GPs to manage more patients and more conditions in the community. • Expand the existing Empowered Patient Programme to both increase patient numbers and the number of conditions covered. • Develop plans to strengthen support for patients transitioning from children and adults. • Improve the trust-wide coding of appropriate co-morbidities within the THH 2016/17 Contract. • Introduce the new NWL Chronic Kidney Disease Pathways and a Community IV Diuretic Service. • Develop Multi-Skilled Cardiac Nurses to manage a range of heart conditions in the community such as AF, Hypertension, Angina etc. • Expand the range of primary care based diagnostics available and direct access diagnostics. • Improve the definition of all relevant community service specifications including, where appropriate, undertaking market testing/procurement. • Increase the number of Cancer Risk Stratified Pathways, the use of Holistic Needs Assessments and the number of Pts receiving an early diagnosis. • Develop a Cancer Strategy and establish a Cancer CWG. • Contract with local providers to deliver an Integrated Respiratory and Integrated Diabetes Service. • Develop a Community Based Asthma (including Paediatric Asthma) Service and work with NHSE to plan for TB Services locally. • Work with GPs to improve identification of patients at risk of developing diabetes and focus acute care on the 'Super Six' diabetic conditions. • Implement a Tier 3 Weight Management Programme and align activities for Weight Management with Public Health.	

Section 10f: Mental Health (incorporating Learning Disabilities)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Mental Health (All Ages)
CLINICAL LEAD	Dr Stephen Vaughan-Smith (Adults) & Dr Cherry Armstrong (Children)
COMMISSIONING LEAD	Joan Veysey, Ian Kent & Elaine Woodward

OVERVIEW

During 2014/15 the Mental Health Transformation Board was established to oversee the implementation of the Hillingdon all age Mental Health Strategy. The Strategy was high level and focussed on the following areas: Health Promotion, Recovery, Improved physical healthcare, Support to users and carers reduction in self-harm reduce stigma and discrimination, Extend services to hard to reach groups, Improve Dementia services, Improve services for people in crisis/urgent care and Suicide prevention. All of these initiatives remain relevant for and underpin the Mental Health Commissioning intentions for 2016/17. During the last quarter of 2015/16 there will be significant changes to Mental Health Services in Hillingdon with the redesign of community mental health services and the introduction of a new Urgent Care Pathway and a Single Point of Entry. The impact of these major developments will need to be assessed and evaluated during the first quarter of 2016/17.

In addition the CCG is looking to enhance joint working arrangements with the London Borough of Hillingdon in line with the principles underpinning the Better Care Fund Initiative something that was recently demonstrated with the appointment of a joint Learning Disability Development Manager. The CCG will work in partnership with the Local Authority to develop the universal public health agenda based on the Mental Health Needs Assessment recommendations with a particular focus on dual diagnosis and suicide prevention. It will also undertake a joint review with LBH of the Recovery Pathway looking at an integrated procurement option in 2017/18. Furthermore 2016/17 will see the impact of the full year effect of Business Cases approved in 2015/16 including those for the Memory Services, CAMHS Out of Hours and Perinatal Services. 2016/17 will also see a potential joint procurement exercise with the outer North West CCGs of IAPT and Primary Care Plus Services as well as the beginning of a 5 year CAMHS Transformation Plan and new National Waiting Times Targets for Early Intervention, Perinatal Services and CAMHS.

Finally the CCG intends to finalise discussions and decide on a way forward concerning whether selective or wholesale market engagement, testing and/or procurement may deliver the transformational pace of change that it is seeking for both community and mental health services or not. The decision on the way forward is expected to be finalised during Q4 15/16.

STRATEGIC OBJECTIVES FOR MENTAL HEALTH	
Objective	**Expected Outcomes**
1. Further develop and improve local Dementia services reflecting the growing needs of the population.	• Ensure all services are working effectively together to jointly identify the local expected prevalence rates for Dementia diagnosis. • Improve early diagnosis rates for Dementia and improve the ongoing support for people living with Dementia and their carers.
2. Ensure IAPT Services remain fit for purpose, are meeting Hillingdon's local needs as well as existing and new national targets.	• Ensure the service meets the new waiting times targets for 2016/17 as well as the current Access and Recovery Targets.
3. Develop an effective MH Urgent Care Pathway and Single Point of Access.	• Reduction in Psychiatric admissions and reduction in admissions via Accident and Emergency. • Potential reduction in bed base across 5 CCGs.
4. Further development and stretch for key MH Services.	• Introduction of an Early Intervention Psychosis Service that meets national standards. • Development of a Perinatal Service that supports women from conception up to 12 months post-partum. • Development of an MH rehabilitation pathway in collaboration with London Borough of Hillingdon.
5. Continue with the 5 year CAMHS Transformation Programme which will begin in October 2015 including consideration of extending CAMHS to age 25.	• Establishment of an intensive community support team for children which will be easily accessible, NICE compliant evidence based treatments. • Reduce the number of inpatient admissions to out of area Tier 4 Services.
6. In partnership with key Stakeholders improve the employment prospects of those with mental health problems.	• Attract European Social and Lottery funding into the Borough to establish a Trailblazer Mental Health Employment support project which will support people with mental health problems into sustainable employment. • The Project will focus on the high need areas of Hayes and West Drayton.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Implement the Dementia Action Plan including developing a Resource Centre and rolling out Level 1 & 2 Training. • Integrate IAPT and Primary Care Plus Services and review key services including CAMHS Eating Disorder, Early Intervention for Psychosis. • Revisit all service specifications for Mental Health and undertake market testing/procurement as appropriate to achieve required efficiencies. • Develop urgent care pathways for both adults and children with mental health needs and a programme to support homeless people with MH needs. • Work with public health to support removing remaining stigma associated with MH conditions. • All service specifications will apply to all patients registered with a Hillingdon GP or those resident in Hillingdon but not registered with a GP.	
COMMISSIONING INTENTIONS 2016/17	

STRATEGIC AREA	Learning Disabilities (All Age)
CLINICAL LEAD	Dr Stephen Vaughan-Smith (Adults) and Dr Cherry Armstrong (Children & Young People)
COMMISSIONING LEAD	Joan Veysey, Ian Kent & Elaine Woodward

OVERVIEW

During 2016/17 the CCG will work in collaboration with the Local Authority to identify a new provider for the Community Learning Disability Service, in addition a Joint Business Case will be developed to put in place a comprehensive Learning Disability Service which is not currently available in Hillingdon. This will involve the development of a whole spectrum of services to care from early years to end of life. The CCG and Local Authority will work to ensure that all Local Providers make provision for reasonable adjustments for people with a Learning Disability entering their services, including the utilisation of the Green Light Toolkit and Contractual levers as required.

STRATEGIC OBJECTIVES FOR LEARNING DISABILITIES

Objective	Expected Outcomes
1. Consideration to be given to extend CAMHS services to age 25.	• Improve the transition of children with a Learning Disability from children's to Adult Learning Disability Services.
2. Continue to implement the CAMHS Transformation Programme which will commence in October 2015.	• Establishment of an intensive community support team for children with a Learning Disability will be easily accessible, based on NICE compliant treatments. • Reduce the number inpatient admissions locally and into out of area placements.
3. Implement the recommendations of the LD/S75 Strategic Review completed April 2015	• Develop a fit for purpose specification for the Community Learning Disability Service based on the service model recommended by the Learning Disability Senate. • Utilise this specification as the basis of a procurement exercise to appoint a new provider by October 2015. • Reduction in out of Borough placements and increased local treatment for those with Challenging Needs.

Key Actions For 2016/17

The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17:

- Procure a fit for purpose Community LD Service and review the extension of the CAMHS service to age 25.
- Develop a joint autism plan with LBH.
- Seek to transform the care services that exist for LD.
- Proactively engage the third sector in supporting the LD Agenda and reduce the number of patients with an LD who are sent 'out of borough'.
- Improve transition support for children with an LD transitioning to become adults.

Section 10g: Children & Young People (CYP)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Children and Young People
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Anthony Walters

OVERVIEW

Hillingdon CCG aims to ensure children & young people receive the best possible treatment through high quality integrated care. The views and voices of children and young people will be at the centre of how we design and deliver our services for them. A key commissioning priority will be the accessibility and transparency of clinical pathways for our children and young people. The CCG will review and implement clinical pathways for paediatrics with a view to implementing ambulatory care pathways in 2016/17 across acute and community providers. The ambulatory care pathway seeks to facilitate treatment for children and young people as quickly as possible as well as enhancing patient experience.

Hillingdon CCG is aware of its responsibility to ensure all children and young people have equal access to health services. It is committed to working with our partners to deliver key elements of the SEND code of practice- including joint commissioning of Speech and Language Therapy Services.

We will ensure where appropriate that care and support is provided in the community. We believe this will provide better care for our children and young people and avoid unnecessary attendance at acute hospitals. To this end we will work with Paediatricians to encourage joined up working with GP's to provide support in the community.

As Hillingdon CCG is taking an all age approach to commissioning service areas for 2016/17 most of the actions specific to children and young people can be found in the relevant sections such as Planned Care, Unplanned Care, Mental Health, Long Term Conditions etc.

STRATEGIC OBJECTIVES FOR CHILDREN & YOUNG PEOPLE	
Objective	**Expected Outcomes**
1. Reduce the number of unplanned attendances and admissions associated with children and young people.	• Fewer children admitted following an unplanned attendance. • Better health outcomes for children with an unplanned care need especially for those with a Long Term Condition.
2. Improve the planned care system for children and young people with Long Term Conditions.	• Less demand for acute care services where appropriate. • Fewer unplanned care needs arising for children with Long Term Conditions. • Better long term health outcomes. • Improved patient experience of care.
3. Improve support for Vulnerable Groups.	• Better health outcomes (both physical and mental health) for vulnerable children. • Better support for vulnerable people as they transition from children to adults.
4. Reconfiguration of acute services to better meet the needs of children and young people.	• Improved care provided in acute care. • More services provided closer to home across health and social care. • A financially sustainable system for Hillingdon.
5. Improve early intervention for children and young people.	• Better coordination of services across health and social care. • Fewer children developing Long Term Conditions. • Better health outcomes for children and young people.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Implement Ambulatory Pathways and/or a ZLOS Tariff for Paeds. • Undertake a deep dive into paediatric activity associated with planned care and plan for the potential increase in births following the closure of Ealing Maternity Services. • Develop/deliver a parent education programme in matters such as managing common self-limiting childhood illnesses. • Explore joint commissioning with LBH of speech and language therapy services and develop a common approach to implementing an autism strategy. • Improve service specifications for relevant services and explore market testing/procurement of children's services as appropriate. • Undertake a review of the support for children arriving in Hillingdon as an unaccompanied minor. • Improve coordination of care for Children and Young People between acute care and community services.	

Section 10h: Medicines Management

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Medicines Management
CLINICAL LEAD	Dr Mayur Nanavati
COMMISSIONING LEAD	Vasundra Tailor

OVERVIEW
The purpose of the Medicine's Management Team (MMT) is to work with practices to help them improve medicines usage, get the best out of the medication they prescribe and ensure that budgets are optimised and spend minimised wherever possible. A key focus for the MMT is to promote integrated and coordinated working between providers. Priorities for 16/17 include supporting practices through Independent Pharmacy Prescribers (IPP), reducing polypharmacy issues (including improving safety and reducing incidents) and working with practices to control budgets including defining the Medicines Management Local Improvement Scheme (LIS).

STRATEGIC OBJECTIVES FOR MEDICINES MANAGEMENT	
Objective	**Expected Outcomes**
1. Achieve GP engagement through a named advisor.	• Medicines optimisation advice and guidance is followed and appropriate changes to prescribing made by GPs. • Quality and safety of medicines use is improved. • Medicines waste is reduced and both cost savings and prescribing budgets are achieved.
2. Incentivise GPs to prescribe efficiently, safely and cost-effectively.	• Independent pharmacists working in practices will support their GPs in making appropriate prescribing decisions as recommended in the MM LIS. • Increased use of Scriptswitch which will result in reduced expenditure in prescribed drugs.
3. Increased number of reviews in Care Homes.	• Medication errors related to polypharmacy are significantly reduced. • Patient experience with their medicines and medicine usage is improved.
4. Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks.	• **THH:** Medicines initiated in hospital are appropriate for continued use in the community. Entry of new medicines is managed carefully across the whole health economy. 28 Day Prescribing introduced. • **CNWL:** Improve district nurse prescribing of sip feeds and reduce the amount of wound care products used as well as facilitate the transfer of the wound care budget to CNWL. • **Community Pharmacy:** Greater understanding of medicines-related issues across prescribers. • **Public Health:** Improved medicines-use resulting from closer working between MM Team and PH workstreams e.g. smoking cessation, needle-exchange, health checks, flu vaccinations etc. • **NWL Workstreams** – Independent prescribing pharmacist (IPP) roll out. • **London Leads** – All DH & NHSE strategies shared and actions implemented as required.
5. Provide pharmacy advice to Transformation Groups.	• Medicines-related areas are addressed on a wide front in the Transformation Group Meetings for primary care, mental health, LTCs, elderly care, paediatrics and IT.
6. Provide pharmacy advice for all GP Networks.	• Practice pharmacists recruited have the appropriate skills and competencies necessary for the practice work. • Networks have the correct prescribing tools.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Continue to manage prescribing spend, reduce wastage and develop/manage the Medicines Management Local Incentive Scheme. • Facilitate transfer of Wound Care budget to CNWL for 16/17 and introduce Outpatient Prescribing (including 28 days) with THH. • Seek to review how organisations (including acute care) are incentivised to reduce unnecessary medication expenditure.	

Section 10i: End of Life Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	End of Life Services
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Debra Lake

OVERVIEW

Hillingdon CCG is committed to improving care for patients at the end of their life. This means ensuring that patients who are approaching the 'End of Life' phase are identified and provided with effective support that is integrated across primary, secondary and community care (including the third and voluntary sectors). This extends to supporting and assessing the needs of carers and families during the End of Life Phase.

As part of supporting the challenges at the End of Life, Hillingdon CCG with health and social care partners including London Borough of Hillingdon have an established 'End of Life Forum' that aims to manage the many complex issues and competing priorities for resources that exist in this area. A priority for the CCG for 2016/17 is to both understand, and where possible, streamline the provision of services so that patients, carers and families are correctly supported within the budget available.

2016/17 Will also see the expiration of the current 'End of Life Strategy' that the CCG, along with partners, has been working toward. This strategy will be reviewed and updated (including children at end of life) as part of the actions for the End of Life Services for 2016/17.

STRATEGIC OBJECTIVES FOR END OF LIFE SERVICES	
Objective	**Expected Outcomes**
1. Ensure that patients approaching their end of life phase are identified.	• Early identification will ensure that services are provided in a more-timely manner. • Increased number of patients able to choose where they would like to die and having their wishes met.
2. Provide all patients identified as approaching end of life with effective support.	• Improved support to patients, carers and families. • Improved system-wide awareness of what 'effective support' at end of life looks like.
3. Integrate Services across Primary, Secondary and Community Care plus Social Care, Voluntary and Third Sector.	• A seamless service provided to patients. • Faster access to support where needed.
4. Enhance Carer & Family Support and Assessment of Needs.	• Increase number of carers and family members feeling supported during their relative's end of life phase. • Improved bereavement support.
5. Adopt a whole system approach to communication, planning and monitoring.	• Improved monitoring of the system wide performance in supporting patients at end of life.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Review/improve service specifications and defragment the End of Life Service portfolio through a selective market testing/procurement exercise. • Finalise the End of Life Strategy and review service gaps associated with Bereavement Support and Carers. • Improve access to and use of Coordinate My Care (CMC) and introduce an End of Life Dashboard.	

Section 10j: Community Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Community Services
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Debra Lake

OVERVIEW

Community Services are integral to supporting the CCG's Out of Hospital Agenda as well as the delivery of a wide range of our other strategies including those associated with Long Term Conditions, Planned Care, Unplanned Care and others.

The Commissioning Intentions for Community Services for 2016/17 are focused on the following four areas:

1. Ensuring that the services delivered are specified correctly.
2. Ensuring that the services offer true value for money.
3. Ensuring that the services are fully integrated with GP Networks.
4. Ensuring that the services work effectively as the third arm of the health care economy in supporting patients in an integrated manner.

The CCG intends to finalise discussions and decide on a way forward concerning whether selective or wholesale market engagement, testing and/or procurement may deliver the transformational pace of change that it is seeking for both community and mental health services or not. The decision on the way forward is expected to be finalised during Q4 15/16.

STRATEGIC OBJECTIVES FOR COMMUNITY SERVICES	
Objective	**Expected Outcomes**
1. Improve The Quality & Effectiveness Of Community Services.	• Improved measures and information to enable effective decisions to be made and taken. • Improved contract monitoring and reporting processes for all community services.
2. Redefine The Service Specifications For All Services.	• Ensure that the service definitions and specifications meet the needs of our community and are aligned with our Commissioning Intentions.
3. Improve Integration Between Primary, Community & Secondary Care.	• Community Services aligned to the delivery of our Out of Hospital/Planned Care & LTC Strategies. • Community Services integrated with our developing GP Networks.
4. Deliver QIPP Targets for 16/17 for Community Services.	• Ensure our services offer value for money. • Selectively engage and test the market to identify improved models of care and efficiencies.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve all service specifications and undertake either selective or wholesale market testing/procurement of services. • Align services with emerging GP Networks and support the integration of Community Service into the emerging strategies for LTCs and Older People. • Improve management of community equipment and reduce excess expenditure. • All service specifications will apply to all patients registered with a Hillingdon GP or those resident in Hillingdon but not registered with a GP.	

Section 10k: Primary Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Primary Care
CLINICAL LEAD	Dr Steven Shapiro
COMMISSIONING LEAD	Helen Delaitre

OVERVIEW

The role of primary care remains central to the ethos of the NHS but in order to survive current challenges and make primary care sustainable, primary care needs to:

- Adapt and embrace new models of care
- Review and invest in workforce and skill mix
- Improve and diversify access to services
- Work with partners to integrate services wherever possible
- Reduce variation in provision of services
- Develop premises options that are fit for the future needs of primary care

The CCG will assist primary care to achieve this by:

- Supporting GP networks
- Delivering more planned care services out of hospital
- Reviewing new models of primary care that suit local patient needs
- Developing networks of care using Accountable Care Partnership (ACP) arrangements

STRATEGIC OBJECTIVES FOR PRIMARY CARE	
Objective	**Expected Outcomes**
1. Adapt and embrace new models of care.	• A primary care system that can support the CCG's aspirations for Out of Hospital activity, Long Term Conditions, SaHF etc. • A financially sustainable primary care system that is able to meet the rising demand for services.
2. Review and invest in workforce and skill mix.	• Clinical and non-clinical staff will choose to come and work in Hillingdon because of the training opportunities available and the reputation Hillingdon has as a forward-thinking CCG.
3. Improve and diversify access to services.	• All patients will have access to the right service, at the right time, in the right place.
4. Work with partners to integrate services wherever possible.	• Delivery of integrated support to patients with LTCs and frail Older People. • Seamless services for patients in key areas.
5. Reduce variation in provision of services.	• Hillingdon patients receive the same services and the same level of care wherever they are registered in the borough.
6. Develop premises options that are fit for the future needs of primary care.	• Premises that allow the roll out of Out of Hospital Services and development of network hubs.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Continue to support development of GP Networks and the development of the ACP. • Review the extended hours DES (Directed Enhanced Service) with NHSE colleagues and the Rheumatoid Arthritis NES (following decommissioning by NHSE). • Agree model for Independent Pharmacy Prescribers and Tier 1 & 2 of the Diabetes Service at Network Level. • Ensure 16/17 Primary Care Contract specifications meet the CCG's Commissioning Agenda. • Improve patient awareness of the impact of DNAs on Primary Care access and capacity. • Seek to improve links between Primary Care and Public Health around the prevention agenda. • Review opportunities to use telemedicine to reduce demand for routine follow ups and improve patient monitoring. • Improve the intelligence gathered from primary care through better use of alerts on our extranet and via relevant fields on referral templates.	

Section 10l: Continuing Health Care (CHC) & Complex Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Continuing Health Care and Complex Care
CLINICAL LEAD	Nicky Yiasoumi/ Carole Mattock
COMMISSIONING LEAD	Nicky Yiasoumi/ Carole Mattock

OVERVIEW

Adult Continuing HealthCare is provided when an individual has been assessed by a multi-disciplinary team and been deemed to have a 'primary health need' After this has been defined health will develop a package of care which is arranged and funded solely by the health for individuals outside of hospital who have on-going healthcare needs. You can receive continuing healthcare in any setting, including the patient's own home or a care home.

There is also Continuing HealthCare which is provided when an individual child has been assessed by a multi-disciplinary team and been deemed to have a need arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. As childhood is a period of rapidly changing physical, intellectual and emotional maturation alongside social and educational development there is a need for a wider range of agencies to be involved in the care of a child or young person with continuing care needs than in the case of an adult. These agencies will predominantly be health, social care and education. However additional to this is parental responsibilities as most care for children and young people is provided by families at home, and maintaining relationships between the child or young person, their family and other carers, and professionals is important to the wellbeing of the child.

Since October 2014 the CCG has offered and provide for those patients that wish to take up the offer and are in receipt of Continuing Health Care (CHC) a Personal Health Budget. This budget is provided to deliver care as defined in the patient's personal plan which has to meet their health and wellbeing objectives.

STRATEGIC OBJECTIVES FOR CONTINUING HEALTH CARE (CHC) AND COMPLEX CARE	
Objective	**Expected Outcomes**
1. New referrals will progress through the Continuing Health Care process as described by the National Framework within the spirit of the guidance (28 days).	• All new referrals processed within 28 days. • All Fast-Track referrals processed within 48 hours. • Referral processes audited regularly by CHC team leader with regular external audits undertaken.
2. 3 and 12 monthly Continuing Health Care eligibility reviews will be undertaken at specified agreed intervals.	• Eligibility reviews undertaken and assurance received that patients are receiving the correct package of care at the specified intervals.
3. Regular reviews undertaken to assess the quality and evaluation of an individual's care package.	• At least annual assurance that patients with a CHC care package are receiving the correct package of care.
4. Undertake a strategic workforce and capacity review to meet current and predictable future demand.	• A workforce that meets the needs of our population both now and into the future. • Improved productivity within existing team and resources.
5. Expansion of Personal Health Budgets outside of Continuing Health Care for those with a long term condition or a child with specialist educational needs.	• All relevant patients eligible for a PHB offered one.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Review of workforce requirements to be undertaken. • Develop a local offer for Personal Health Budgets (PHBs) for individuals with LTCs and Children with Specialist Educational Needs. • Develop a 3 Year Plan for PHBs.	

Section 10m: Patient & Public Engagement & Empowerment

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Patient & Public Engagement & Empowerment
CLINICAL LEAD	None
COMMISSIONING LEAD	Diana Garanito

OVERVIEW

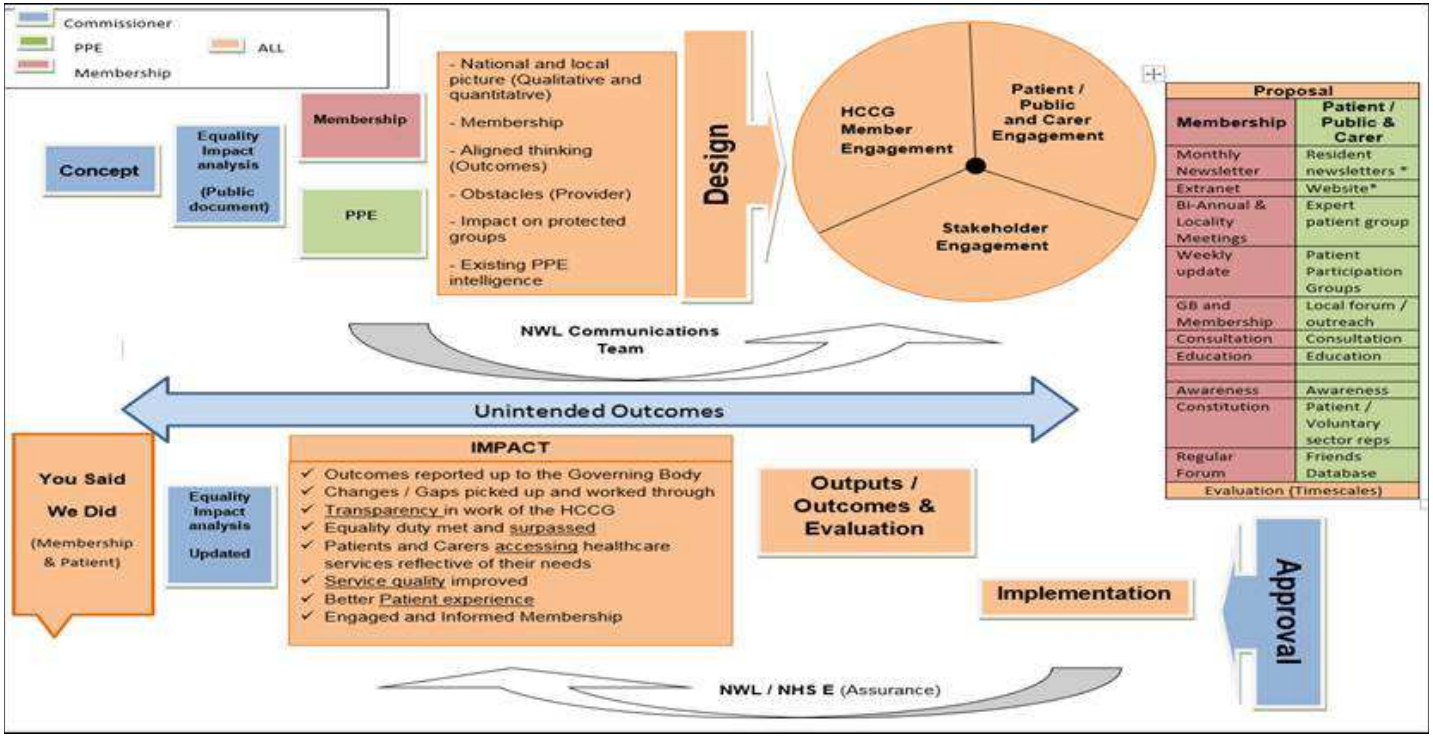
The vision for engagement is that every patient, carer and resident living in Hillingdon is given the opportunity to engage and be involved in the work of the CCG, and where they use a service commissioned by the CCG they experience a positive outcome. Central to this is empowering patients and carers to self-care and be knowledgeable about Hillingdon's health system. Over the years the CCG have tried and tested many methods of engagement, both with its public and its membership. The learning from these experiences has produced two key lessons that the CCG are and have been working on in 2014/15, and will continue to work on in order to sustain its approach to engagement and maximise the benefits of a fully informed health system:

Engagement needs to be delivered as a whole system contribution. For Hillingdon to thrive and for the work of its commissioners and clinical leads to be fully recognised by its outcomes, engagement must encompass the views of those who have experience of the system and those who work for, or with the system. Paramount to this are the views of those with the potential to either enhance the system (voluntary sector, pharmacist) and those who should be / could be users of the system.

Engagement needs to be joined up across the health and social care spectrum. Whilst there are clear benefits to the patient / carer in this process (survey fatigue) there are also longer term advantages to be gained:

- Resource and skill mix – organisations with limited resources would work together towards a project that would otherwise be carried out in isolation.
- Pathway experience mapping – organisations would be better able to detect root causes of a poor patient / carer experience and work together to address problems.
- Reaching the views of a representative population – the CCG's engagement as demonstrated below, is determined in most instances by an Equality Impact Analysis. This is important to ensure that those public engaged are those who are identified to be impacted by our work. Working in partnership not only means that we can reach a wider audience, but that conversations are fed back simultaneously to providers and the CCG.
- We expect providers to seek patient and community feedback and allow this feedback to influence service provision. To support this the CCG will draft what it believes to be good practice in PPE. Providers are also required to support the self-management aims of the CCG.

Figure 1: Hillingdon CCG Vision for Patient, Carer, Public and Membership Engagement



To learn more about the CCGs engagement across 2014/15 and its plans for 2016/17 you can read the CCG Annual Patient and Public Engagement Report. A link is available from Hillingdon CCG's website here.

STRATEGIC OBJECTIVES FOR PATIENT & PUBLIC ENGAGEMENT & EMPOWERMENT	
Objective	**Expected Outcomes**
1. Increase our understanding of the needs of people with LTCs.	• Improved health outcomes for people with LTCs. • Improved correlation between the needs of patients and how services are delivered.
2. Empower young adults and their families/carers to better manage their condition.	• Reduced unplanned care attendances for parents with children. • Improved outcomes for children.
3. Develop resources/tools to help patients better manage their condition.	• A financially sustainable system for Hillingdon. • More patients better able to manage their conditions. • Fewer unplanned care needs for patients, particularly those with an LTC.
4. Work with primary care, social care and the voluntary sector to enhance and improve their support to patients with LTCs.	• Improved health outcomes for people with LTCs. • Improved correlation between the needs of patients and how services are delivered.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Deliver the existing Empowered Patient Programme and expand to include more conditions. • Implement and evaluate the Patient Activation Model (PAM) • Build the capacity of health connectors and voluntary organisations. • Providers to be required to seek out the views of patients and the community and show how this has positively influenced service provision and design. • The CCG will issue guidance about what it believes good practice is in public and patient engagement. • Providers will be required to support the CCG's aims around self-management.	

Section 10o: IT & Technology

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Information Technology
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Eddie Clark

OVERVIEW

Information Technology (IT) plays an ever increasing importance part in patient care and management. From the ability of clinicians to share patient records and diagnostic results, through the ability to seek clarification and on to providing remote support, monitoring and care of patients.

The work of Hillingdon CCG in the area of IT for 2016/17 is focused on three areas:

1. Continuing to support both the CCG and Primary Care to maintain hardware and software that comply with NHS required security, confidentiality and patient access standards whilst maintaining operability of networks at all times.

2. Improving the ability of providers to access, review and update (where appropriate) patient records so that care is optimised, outcomes are improved and duplication is reduced. This also includes expanding the breadth of agencies able to appropriately and confidentially access data.

3. Exploring how to extend the use of IT to improve patient care including exploring decision support tools and other issues such as telehealth solutions that will, in the medium to long term, transform the way that care is provided to a cohort of our patients.

STRATEGIC OBJECTIVES FOR INFORMATION TECHNOLOGY	
Objective	**Expected Outcomes**
1. Maintain Hardware/software to required standards that allows services to be delivered.	• Equipment remains operable. • Security and confidentiality remain protected. • Costs are managed and controlled.
2. Review and renew the Multiagency Information Gateway (MIG).	• Current MIG agreements reviewed. • Integration with other software packages (ie Patient Knows Best) as appropriate.
3. Update and renew other supporting software as appropriate.	• Software meets emerging and planned needs for Hillingdon CCG and our providers and patients as closely as possible.
4. Improve usage of data to support Patient care.	• GP Practices utilising existing software effectively (for example Shared Care Record, EPS2 etc) • Improved appropriate utilisation of the Shared Care Record (SCR) by clinicians with better outcomes for patients.
5. Continue to provide support to Networks.	• GP Networks provided with appropriate levels of support and service to enable to continue to improve and extend the care provided to patients.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve use of the Shared Care Record (SCR) and expand to new (appropriate) providers. • Renew the MIG Agreement and allow other services to see and add to the GP Clinical Record as appropriate. • Update GP Hub Servers.	

Section 10p: Safeguarding (Adults & Children)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Safeguarding (Adults & Children)
CLINICAL LEAD	Dr Reva Gudi
COMMISSIONING LEAD	Jenny Reid (Children's Safeguarding Lead) and Sacha Ikeme (Adult Safeguarding Lead)

OVERVIEW

NHS Hillingdon CCG is fully committed to safeguarding and as part of its statutory responsibility, the CCG will:

- Ensure that, as commissioners of NHS Health Services, health contribution to safeguarding and promoting the welfare of adults and children is effectively discharged across the local health economy through its commissioning arrangements; this includes specific responsibilities for Looked after Children and supporting the Child Death Overview Process specifically for Children.

- Ensure that all Providers of NHS Health Services have clear and effective arrangements in place to safeguard and promote the welfare of all adults and children, especially vulnerable adults, children and young people that assure themselves, regulators and commissioners that these arrangements are effective.

- Ensure that the Organisation and their Providers will, through the CCG's commissioning arrangements and service specifications, be fully engaged to work with partner agencies in order to improve outcomes for adults, children, young people and their families.

- Monitor compliance through its governance arrangements for service contracts.

STRATEGIC OBJECTIVES FOR SAFEGUARDING (ADULTS & CHILDREN)	
Objective	**Expected Outcomes**
1. Ensure that the voice of children and young people are heard.	• Children feel listened to and are able to actively participate in their care in a child and young people friendly NHS. • Improved and increased access to NHS services by children and young leading to improved health outcomes (e.g. teenage pregnancy, STIs, LAC health assessments).
2. Develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE) or Female Genital Mutilation (FGM).	• Improved detection and prevention leading to more appropriately funded services for any subsequent long term conditions e.g. depression, back pain, pelvic inflammatory disease, genito urinary infections, infertility, complex child birth and possible child deaths. • Improved recording and reporting which will inform decision making as regards the viability of locally, across BHH or NWL funded service provision. • Improved access to services leading to early detection of cervical cancers due to increased uptake of screening opportunities.

3. Improve support to vulnerable children and adults including those at risk of radicalisation and/or domestic abuse.	• Assurance through contract monitoring that front line service staff in commissioned services are trained to the appropriate level to:
	  ○ Identify and report interventions so that service demands match service needs.
	  ○ Identify and refer those suspected of, affected by or living in households where these issues exist to ensure that necessary safeguards are in place.
	• Training levels (Prevent & Domestic Abuse), number of staff trained monitored through contractual arrangements to assure compliance.

4. Reduce the incidence of Pressure Ulcers (Grade 3 and 4).	• Reduce harm to patients. • Incremental reduction in pressure ulcers.
5. Ensure adults at risk are protected from avoidable harm.	• Ensure a positive experience of care in a safe environment. • Training levels on Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLs), number of staff trained monitored through contractual arrangements to assure compliance. • Prioritise Best interests of adults at risk
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Work with providers to ensure they listen to the voice of children and young people and implement CSE and FGM Champions. • Implement Child Protection Information Sharing protocols and systems. • Work with providers to improve their systems around recording/reporting domestic abuse and reduce the rate of incidence of pressure ulcers. • Ensure providers have processes in place to ensure that staff receive appropriate Mental Capacity Act and Deprivation of Liberty.	

Section 11: QIPP Requirements for 2016-17

The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care, at the same time as making efficiency savings.

The QIPP efficiency target for 2016/17 will be finalised toward the end of 2015 which is after the date that the Commissioning Intentions are published. At the time of writing we expect the minimum QIPP efficiencies to be in the region of 3% of the CCG's total budget.

The delivery of QIPP efficiency targets allows Hillingdon CCG to ensure that essential services remain funded and operational and can therefore cope with the demands placed upon it. Failure to achieve the QIPP efficiency targets means that Hillingdon CCG will not be in a position to fund specific services and will need to scale back activity.

A summary of the current QIPP efficiency schemes for 2016/17 and other aspects of our QIPP plans are stated below. For the 2016/17 QIPP efficiency programme we have considered three areas:

1. Existing and planned schemes that are already underway or are in development along the planned activity changes associated with them where known.
2. Areas where data analysis shows Hillingdon CCG to be a significant outlier when compared to other North West London CCGs at either a Treatment Function Code (TFC), Healthcare Resource Group (HRG) or Procedure Code (PPC) level.
3. Other areas where it can either be shown via analysis or value for money exercises that efficiencies exist or where it is felt through a variety of means (including soft market testing) that efficiencies can be realised.

This section focuses on the Planned & Existing QIPP Schemes and the associated activity changes. The other areas explored will form the basis of our challenges to providers (including capping activity above the North West London average and not paying for additional activity) and will also form the focus for market testing and possible procurement during 2016/17.

The following is a summary of the planned and existing schemes that will form part of the CCG's QIPP efficiency programme for 2016/17. It should be noted that the schemes described below do not account for the full year QIPP target for the CCG and therefore additional schemes will need to be added as they are defined. Any under-achievement against the 15/16 QIPP Target will roll-over into 16/17.

LONG TERM CONDITIONS			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Integrated Cardiology Programme	Existing	Started in 2015/16	• 52 HF NEL Admissions Avoided • 45 Cardiology NEL Admissions Avoided • 45 Cardiology NEL Re-admissions Avoided
Integrated Diabetes Programme	Existing	Started in 2015/16	• 132 OPFA Reduction • 740 OPFUP Reduction • 180 OPProc Reduction • Note: We expect some NEL Admission Reduction but no. is TBD.
Integrated Respiratory Programme	Existing	Started in 2015/16	• 192 A&E Attendances Avoided • 393 COPD NEL Admissions Avoided • 11389 (Total) Respiratory OPFA and OPFUP Activity Reduction
Empowered Patient Programme (Phase 1 & 2)	Existing	Started in 2015/16	• 2960 Pts in 15/16 • 4000 Pts in 16/17 leading to: • 150 Attendances Avoided • 70 Admissions Avoided
Redesigning Cancer Pathways	Existing	Started in 2015/16	• Activity assumptions are still TBD.
Audiology Diagnostics	Existing	Started in 2015/16	• Reduction in block price. No activity changes.
Paediatric Asthma Programme	Existing	Expansion of pilot started 15/16	• 37 A&E Attendances Avoided • 13 NEL Admissions Avoided • Note: We expect some OP Activity Reduction by no. is TBD.

PLANNED CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Gastroenterology	New	Based on FCP but new for 2016/17	• 120 OP First Appointments
Community Ophthalmology Service	Existing	Rollover of scheme started 14/15	• 1223 OP First Appointments • 3871 OP Follow Ups
Community Dermatology Service	Existing	Started in 2015/16	• 486 OP First Appointments • 2993 OP Follow Ups • 2421 OP Procedures
Urology	New	Based on audit undertaken 15/16	• Activity based on Audit Results due Q3 15/16
ENT (Grommets)	Existing	Started in 2015/16	• 143 OP Follow Ups
Neurology (Headaches)	Existing	Started in 2015/16	• 180 OP First Appointments
MSK	Existing	Refreshed programme for 2016/17	Activity to reduce to North West London Average including: • Minimum of 750 OP First Appointments • Minimum of 300 OP Procedures • Minimum of 200 Spinal Procedure v48 • Minimum of 400 Spinal Procedure v54 • Implementation of Chronic Community Pain Service

UNPLANNED CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Intermediate Care	Existing	Started in 2014/15	• 7 Pts/Day Avoiding Admission via ED referrals • 1 Pt/Day Avoiding Admission via other routes
Ambulatory Emergency Care (AEC) Adults	Existing	Expansion of scheme started 14/15	• Minimum 1000 Additional Patients avoiding admissions over and above activity in 15/16 based on 390/Month from April to June 16 increasing to 420/Month.
AEC Emergency Gynae Assessment Unit (EGAU)	Existing	Expansion of scheme started 14/15	• Included in figures above.
AEC Paediatric Pathways	Existing	Continuation started 15/16	• Minimum of 420 Additional children avoiding admission over and above the 180 children supported to avoid an admission in 15/16.
AEC Surgical Pathways	Existing	Continuation started in 15/16	• Minimum of 640 Patients avoiding admission over and above the 320 Patients supported to avoid an admission in 15/16.
Falls & Falls Prevention Service	Existing	Started in 2014/15	• 60 Patients supported to avoid an admission (full year effect after 60 Patients are supported in 15/16).
Rapid Access Care of the Elderly (COTE) Clinics	Existing	Started in 2015/16	• 3 Patients/week avoiding an admission from September 15 onwards with 78 of these admissions being avoided during 16/17.
STARRS Programme	Existing	Benefits of Northwick Park STARRS	• No activity changes but financial savings will be realised.

COMMUNITY SERVICES			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Community Services Contract	New	Efficiencies from contract	• Efficiencies from selected services through negotiation and/or service redesign and procurement.
Integrated Wheelchair Service	Existing	Started in 2015/16	• Block contract efficiencies following procurement exercise with no major resulting impact on activity changes assumed at this stage.
Pressure Relieving Equipment	Existing	Started in 2015/16	• Block contract efficiencies following procurement exercise with an approximate 10% increase in activity levels taken into account.
Community Rehabilitation Equipment	Existing	Started in 2015/16	• Reduction in spend through better controls and rationalisation of stock list.
Small Contract Productivity	Existing	Started in 2015/16	• Reduction in costs through procurement with potential areas of focus being Non-Emergency Patient Transport Services or End of Life Services (not including those from the Acute Sector).

MENTAL HEALTH			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Urgent Care Impact on Bed Occupancy	New	Based on work done in 2015/16	• Reduction in 5 Beds from Q4 15/16 onwards.
Complex Placement Programme	Existing	Started in 2015/16	• Focusing on 10 Patients during 2016/17.
Primary Care Plus Reduction in Secondary Care	Existing	Expansion of 14/15 programme	• 380 Pts transferred back to Primary Care (or not referred to secondary care) as a minimum.
Efficiencies due to MH Business Cases	New	Based on Business Cases from 15/16	• 350 Admissions from Mental Health Assessment Lounge.
Contract Efficiencies	New	Efficiencies from existing contract	• Efficiencies from selected services through negotiation and/or service redesign and procurement.

PRESCRIBING			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Prescribing & Medicines Optimisation	Existing	Started in 2012/13	• Reduction in spend through better optimisation of medicines and selected initiatives.
Care Homes Admissions Avoided	Existing	Started in 2014/15	• 22 NEL Admissions Avoided

CONTINUING HEALTHCARE (CHC)			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Procurement of services for Complex Children	Existing	Started in 2015/16	• Reductions through purchase efficiencies.
CHC Patient Reviews of Service Needs	Existing	Started in 2015/16	• Reductions due to enhanced assessment processes.

PRIMARY CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Integrated Care Programme	Existing	Started in 2015/16	• 150 NEL Admissions Avoided
Practice Commissioning Initiative	Existing	Started in 2013/14	• Not continuing in existing form but reductions in activity will occur via the following areas: o Decision Support Tools o Reduction in Variation in Primary Care o Formulary of READ Codes

Section 12: List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	AEC	Ambulatory Emergency Care	ACP	Accountable Care Partnership or Alternative Care Pathway
ACO	Accountable Care Organisation	AF	Atrial Fibrillation	AIDS	Acquired Immune Deficiency Syndrome
BCF	Better Care Fund	BHH	Brent, Harrow, Hillingdon CCGs		
COTE	Care of the Elderly	CCG	Clinical Commissioning Group	CSE	Child Sexual Exploitation
CQC	Care Quality Commission	CQG	Clinical Quality Group	CYP	Children & Young People
COPD	Chronic Obstructive Pulmonary Disorder	CAMHS	Children & Adolescent Mental Health Services	CWHHE	Chelsea & Westminster, West London, Hounslow, Hammersmith & Fulham and Ealing CCGs
CHD	Chronic Heart Disease	CHF	Chronic Heart Failure	CNWL	Central & North West London NHS Foundation Trust
CKD	Chronic Kidney Disease	CMC	Coordinate My Care	CHC	Continuing Health Care
CIE	Care Information Exchange	CIP	Cost Improvement Programme	CVD	Cardio-Vascular Disease
DES	Directed Enhanced Service	DTOC	Delayed Transfer of Care	DH/DoH	Department of Health
DNA/s	Did Not Attend/s				
ENT	Ear, Nose & Throat	EoL	End of Life	EGAU	Emergency Gynae Assessment Unit
ED	Emergency Department				
FGM	Female Genital Mutiliation	FY	Financial Year	FUP	Follow Up (Appointment)
FT	Foundation Trust				

GP	General Practitioner	GPwSI	GP with a Special Interest	GB	Governing Body
HCCG	Hillingdon CCG	HAI	Healthcare Acquired Infection	HF	Heart Failure
HRG	Healthcare Resource Group	HENWL	Higher Education North West London	HWB/HWBB	Health & Wellbeing Board
HIV	Human Immunodeficiency Virus				
IT	Information Technology	IV	Intravenous	IPP	Independent Pharmacist Prescriber
ICP	Integrated Care Programme	IAPT	Improving Access to Psychological Therapies	IM&T	Information Management & Technology
ICO	Integrated Care Organisation				
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS	Local Incentive Scheme	LoS	Length of Stay
LAS	London Ambulance Service	LAC	Looked After Children	LTC	Long Term Condition
LD	Learning Disability	LBH	London Borough of Hillingdon	LNWH	London North West Hospitals NHS Foundation Trust
MH	Mental Health	MMT	Medicines Management Team	MSK	Musculo-Skeletal
MIU	Minor Injuries Unit	MDT	Multi-Disciplinary Team		
NWL	North West London	NEL	Non-Elective	NES	Nationally Enhanced Service
NHSE	NHS England	NEPTS	Non-Emergency Patient Transport Service		
OBC	Outline Business Case	OOA	Out of Area	OOH	Out of Hours or Out of Hospital

PKB	Patient Knows Best	PH	Public Health	PCI	Practice Commissioning Initiative
PHB	Personal Health Budgets	PPC	Primary Procedure Code	PYLL	Potential Years Life Lost
PHE	Public Health England	Pt/Pts	Patient/s	PTS	Patient Transport Service
PPE	Public & Patient Engagement				
QIPP	Quality, Innovation, Productivity & Prevention				
RTT	Referral To Treatment	RA	Rheumatoid Arthritis	RBH	Royal Brompton & Harefield Hospitals NHS Foundation Trust
SRG	System Resilience Group	STI	Sexually Transmitted Infection	SaHF	Shaping a Healthier Future
SSoC	Shifting Settings of Care	SCR	Shared Care Record	STARRS	Short-Term Assessment, Rehabilitation & Reablement Service
TB	Tubercolosis	TFC	Treatment Function Code	THH	The Hillingdon Hospital NHS Foundation Trust
UCC	Urgent Care Centre	UEC	Urgent & Emergency Care		
VTE	Venus Thromboembolism				
WSIC	Whole System Integrated Care	WTE	Whole Time Equivalent		
ZLOS	Zero Length of Stay				

2016/17 Commissioning Intentions Overview for Health & Wellbeing Board

Overview

Hillingdon CCG produce an annual Commissioning Intentions document each October that draws together changes planned to CCG contracts with providers for the following financial year. The document draws on national, regional and local strategic needs along with feedback from patients, carers, partners and providers and sets out how the CCG intends to use the contracts it holds to take forward its ambitions for health service delivery in the borough. The primary audience for this document are providers as the commissioning intentions and the associated contract notice letter represent the start of the annual contracting cycle. Financial planning for the following year takes account of commissioning intentions.

The 2016/17 Commissioning Intentions are issued on the 1st October 2015. This date is set so that providers are given sufficient information about activity and service changes that are needed to deliver the CCG's plans and to comply with the requirement to provide 6 months' notice of any activity changes, including any plans to decommission services.

Input into the Commissioning Intentions

The Commissioning Intentions are produced following extensive feedback from a wide range of bodies including:

- **Patients & Carers** – We undertake a year round consultation programme that informs each year's Commissioning Intentions. We also obtain feedback directly through Complaints and Compliments about providers, the Friends & Family Test and via our Healthcare Conference that was held earlier in September. The views of Patients & Carers are also obtained via our PPIE Committee (Public & Patient Involvement & Engagement Committee).
- **NHS England** – In addition to the NHS Five Year Forward View, NHSE provide specific input on key topics related to Co-Commissioning, Assurance, the role of the NHS in Preventing Illness and Disease and Specialised Commissioning.
- **Public Health** – Colleagues within Public Health contribute a whole section on the demographic changes that are faced along with recommendations for where the CCG should focus attention.
- **Local Authority** – Feedback comes via the joint work we undertake together with the London Borough of Hillingdon across a wide range of areas including the Better Care Fund, WSIC and other schemes.
- **Providers** – We obtain direct feedback via contractual monitoring processes and indirect feedback via data analysis from a variety of sources.
- **Partners** – Feedback also comes from Third Sector and Voluntary Organisations as well as Healthwatch and other organisations.
- **Research** – The CCG also undertakes research across other areas and with other CCGs specifically aiming to pull together best practice concepts that may not have been identified through the other routes described above.

Summary of the benefits for patients in 2016/17

The Commissioning Intentions document describes an extremely wide range of actions and issues that the CCG and the providers it commissions will address during the coming year. These actions include outcomes, efficiencies, contractual matters, communications, development and investment. In this section we have highlighted the main outcomes that the CCG expect to be realised through 2016/17 as described within the Commissioning Intentions document.

Area	Main benefits for 2016/17
Primary Care	• Increasing numbers of patients empowered to manage elements of their care 'Out of Hospital' particularly those with Long Term Conditions. • The transfer of care for patients with low level Mental Health needs back to primary care for support by GPs. • Increased number of diagnostics that are directly accessible by GPs to reduce the need for patients to visit a hospital for a diagnostic and also to shorten the time to diagnosis.
Community Care	• New service specifications for existing services that will more clearly set out requirements (including key performance indicators and contract penalties) to enable the CCG to ensure services are delivered to the required quality and access standards. • Focus on efficiency either through negotiation or through selective or wholescale market engagement/procurement to ensure value for money and to ensure community services are delivered to the required quality and access standards.
Mental Health	• Improved access and support to patients with an urgent mental health care need through a Single Point of Access and rollout of an urgent care pathway for mental health. • Expansion of the Memory Assessment Service to improve diagnosis rates for Dementia which in turn will allow patients and carers to receive support and treatment earlier with a view to maintaining their independence and health for longer. • Improved support for people with a Learning Disability including development of a fit for purpose Community LD Service. This is a joint piece of work with the Local Authority. • New service specifications for existing services that will more clearly set out requirements (including key performance indicators and contract penalties) to enable the CCG to ensure services are delivered to the required quality and access standards.
Unplanned Care	• Introduction of ambulatory care pathways in A&E to reduce the numbers of patients being admitted to hospital as an emergency. These pathways ensure patients are diagnosed and treated in a single visit for a range of conditions without the need for admission. In some cases patients may need to return to A&E for a follow up check. • Increased numbers of patients supported home early following an admission. This initiative is focusing on elderly/vulnerable groups and reduces the risk of breakdown of informal support networks, readmission and delayed transfer of care. • Reduction in the number of patients admitted with psychiatric disorders the provision of psychiatric assessment in A&E within

	agreed timescales.
Planned Care	• Expansion of advice and training provided to GPs to enable them to manage more patients in the community. • Procurement of a Community Chronic Pain Service to improve access and to provide more guidance to patients on how to manage their chronic pain. • Continue to provide more planned care (outpatient) services in community settings to improve access. • Development of new community services in areas such as Rheumatology, Phlebotomy and IV Diuretic Services and implementation of the North West London Chronic Kidney Disease Pathways and NHSE TB Pathway to both localise care and improve the quality of care received. • Expansion in the range of services available 7 Days per Week.
Long Term Conditions (LTCs)	• Implementation of our Integrated Service Models for Diabetes, Cardiology and Respiratory Diseases. These will improve the experience of care for patients by ensuring the different elements of care are better co-ordinated and will improve health outcomes (including reduction in complications) by ensuring the provision of regular monitoring, earlier intervention and improved support to self-care. • Review of Cancer Support with the aim of improving access and outcomes for patients with cancer. • Expansion of Talking Therapies (previously IAPT) to cover patients with LTCs. This recognises high levels of depression in people with LTCs.
Integrated Care	• This section reflects joint plans with the Local Authority with a focus on older people. The intention is to embed work to date and expand to the whole borough. This programme will improve the experience and outcomes of care for older people and help older people to be remain independent for as long as possible.
General	• Increased access to and use of data sharing between providers to support integrated care • Support to develop the Accountable Care Partnership (or similar model) as part of our work on integration. • Increased focus for providers on statutory duties related to Child Sexual Exploitation, Female Genital Mutilation and the Prevent Agenda focusing on preventing radicalisation. • Increased focus on Prevention in collaboration with Public Health and other partners. • Introduction of Outpatient Prescribing in Acute Care so that patients don't need to make a second trip to GPs simply to collect a prescription.

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HILLINGDON LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

Relevant Board Member(s)	Councillor David Simmonds CBE
Organisation	Hillingdon Safeguarding Children Board
Report author	Stephen Ashley
Papers with report	Hillingdon Safeguarding Children Annual report and Executive Summary

1. HEADLINE INFORMATION

Summary	There is significant concern that the Annual Report stated that "Further work is needed by both the Board and its partners before we can be assured that children and young people are as safe as they can be across the Borough.' However, it needs to be understood that significant work has been undertaken since March 2015 to address the situation and that the HSCB Chairman has given assurances that this would not occur again. A number of other improvements to the functioning of the Board have been made since March 2015, including improvements to auditing arrangements and the provision of a clearer assessment of the effectiveness of the Board. Work was also being undertaken to better evidence what the Board's priorities should be in the future. It needs to be noted that the Chairman of the HSCB and other key staff were new in post and had been appointed since the time frame covered by the Annual Report. The publication of the HSCB Annual report is expected to take place by the end of May in future years. It has been necessary to publish this year's report later than May in order to enable verification of performance data.
Contribution to plans and strategies	N/A
Financial Cost	No financial cost
Ward(s) affected	N/A

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the content of the report; and**
2. **passes comment on the timing and content of future annual reports.**

3. INFORMATION

Supporting Information

Attached to this paper is an executive summary that provides further detail on the contents of the report. The Chairman would like to highlight the following issues contained within the report:

LSCB Improvement Plan

Following a grading of "requires improvement" on Board performance by Ofsted in December 2013 an improvement plan was put in place. Progress has been made against each identified area but the Board requires further work to be graded as 'good' or 'excellent'. In particular, the Board still needs to improve its levels of auditing activity and training. A performance framework has been developed but is not yet in full use.

Assessment of the quality of safeguarding

To be confident of the effectiveness of the partnership the Board requires regular data, both quantitative and qualitative. Although a start has been made on this with the agreement of the Performance Web, section 11 and school audits in the forthcoming year and a multi-agency audit programme, the Board does not have sufficient data from the reporting year to be confident of the quality of practice.

The performance of partner organisations with regard to safeguarding provides mixed assurance for the Board. The Development of a Multi-Agency Safeguarding Hub is positive, though further development is required to ensure that the contribution of all agencies is embedded.

Children's Social Care has achieved a degree of stability, reducing their assessment backlogs and reducing staff turnover but now needs to consolidate this progress and increase the number of permanent, employed staff.

The Hillingdon Hospital was subject to a CQC inspection during October 2014, with the report being published in February 2015. The overall rating was that the hospital "Required Improvement". The Deputy Director of Nursing and Deputy Lead Doctor for safeguarding attended the Board in March 2015 to update on progress since the inspection. The Board was encouraged by the rapid progress at the hospital following the inspection and will continue to monitor this.

Taking the points above into account, the Board is cautious about an assessment of the effectiveness of safeguarding across the Borough. Further work is needed by both the Board and its partners before we can be assured that children and young people are as safe as they can be across the Borough.

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Financial Implications

No financial implications.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Policy Overview Committee comments

The Chairman of the Children, Young People and Learning POC thanked officers for the report provided, noting that although significant improvement was required to the functioning of the LSCB, work was already in progress to address this.

There was significant concern that the Annual Report stated that "Further work is needed by both the Board and its partners before we can be assured that children and young people are as safe as they can be across the Borough." However, it was acknowledged that significant work had been undertaken since March 2015 to address the situation and that the LSCB Chairman had given assurances that this would not occur again. Some Committee Members expressed concerns about the contribution of the Council to the LCSB's budget as this appeared to be relatively low when compared to neighbouring Boroughs. It was noted that work was ongoing to address concerns in relation to the budget.

A number of other improvements to the functioning of the Board had been made since March 2015, including improvements to auditing arrangements and the provision of a clearer assessment of the effectiveness of the Board. Work was also being undertaken to better evidence what the Board's priorities should be in the future. It was noted that the Chairman of the LSCB and other key staff were new in post and had been appointed since the time frame covered by the Annual Report.

The Committee noted that publication of the LSCB Annual report was expected to take place by the end of May in future years. It had been necessary to publish this year's report later than May in order to enable verification of performance data.

This report has been shared with the Corporate Parenting Board, there were no comments to note. It resolved that:

1. The report be noted.
2. The top three priorities for the LSCB be developed and provided to the Committee at a future meeting.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no direct financial implications from this report, although it does highlight the potential risks to safeguarding of reduced resources.

Hillingdon Council Legal comments

None directly from this report.

6. BACKGROUND PAPERS

NIL.

Executive Summary

Background

The Local Safeguarding Children Board (LSCB) is required to produce an annual report under the auspices of The Apprenticeships, Skills, Children and Learning Act 2009 and the statutory guidance contained in Working Together 2013. It is a requirement that the annual report is published.

The report covers the year from 1st April 2014 to 31st March 2015. Publication has been delayed while verification of performance data took place. In future years there will be an intention to have the report published by the end of May.

It is worthy of note that the LSCB received a 'requires improvement' grading from Ofsted in December 2013 and that the safeguarding partners appointed a new Chairman, Stephen Ashley, in April 2015.

Governance

Over the course of 2014/5 protocols were agreed and signed with the following:

- Health and Wellbeing Board
- Corporate Parenting Board
- Domestic Violence Executive Board
- Youth Offending Service Management Board

Improvement plan

In December 2013 Ofsted undertook an inspection of the effectiveness of the LSCB giving an overall grading of "Requires Improvement". An action plan was put in place to address the issues raised. Progress has been but further work is required in the following areas:

- Performance management and quality assurance (auditing)
- Progress with embedding the voice of children and young people in the Board
- Training

Reports from sub-groups

Performance and Quality Assurance sub-group

A Performance Web was agreed as the main reporting tool for the Board. This work requires embedding.

The subgroup commissioned audits on the Voice of the Child and Private Fostering and both were completed, with the learning added to the Learning and Improvement log.

Child Sexual Exploitation sub-group

A sub-group was established to take this work forward within the year. Significant progress was made assessing the prevalence of CSE across the Borough and developing the multi-agency response to address CSE. A specialist worker was recruited, based within Children's Social Care, and working across agencies in collaboration with the LSCB.

The Board were encouraged by the successful prosecution of three perpetrators of CSE in the Borough. This was the result of multi-agency team work. In particular excellent collaborative work was identified as having taken place by the Metropolitan Police, Children's Social Care and the NHS.

In the latter months of the year the concentration has been on ensuring that there is strategic join-up between the agencies and a strategy and action plan was agreed at the LSCB in March 2014. A training programme has also been agreed and is underway.

Strong governance arrangements, as agreed across London, are in place to address CSE with a MAP (Multi-Agency Panel) for the discussion of individual cases and MASE (Multi-agency Sexual Exploitation) strategic group both of which meet monthly.

Vulnerable children and young people sub group

The group has prioritised the needs of children and young people living in families in which there is domestic violence and has, with the Performance and Quality Assurance sub-group commissioned an audit to better understand the quality of multi-agency practice for these children and young people.

There is, however, a lack of coordination in the approach and the extent of the problem is unquantified at the moment. Further work will be undertaken in the current year to understand the extent of the problem and to encourage a more strategic approach to be undertaken across the Borough.

Learning and Development

The sub-committee met regularly and agreed a feedback mechanism so that we could ascertain the impact that training had on practice. Less positively we were unable to commission courses as the year developed, including the key Working Together training, due to a lack of funding. A charging mechanism was agreed in early 2015 and there is an expectation that a full training programme will commence in the forthcoming year.

Joint LSCB/Heathrow strategic group

Specific achievements with in the year have included working through a route to notify LBH of children and young people identified as being privately fostered ensuring that the right support is identified for them. Identifying risks associated with Ebola, sharing knowledge of operations including one relating to FGM with consequent referrals made to Social Care and sharing information on age-disputed young people.

A work plan for the next reporting year has been agreed.

Serious Case Review sub-group

No Serious Case Reviews were published in the year but one was completed and published in April 2015. This concerned a teaching assistant from a local secondary school who was convicted of sexual activity with a female pupil. The Board accepted the eleven recommendations made in this case and will oversee the implementation of these through the Learning and Improvement Framework.

Two Serious Case Reviews were commissioned with the intention to publish both in 2015, these will be reported upon in the 2015/6 Annual Report.

A further case was discussed but it was agreed that this did not meet the threshold and a joint agency review was commissioned and completed in April 2015

Policy and Procedure sub group

The Policy and Procedure subgroup spent the early part of the year drafting and agreeing a threshold document as required under Working Together 2013, this was agreed by the Board in December and was subsequently published.

The sub-committee also agreed an Escalation policy, Core Group guidance and began work on agreeing guidance for those working with children and young people who are engaged in sexually harmful behaviour.

User Engagement

The Board considers it important to develop its public profile. A communications strategy was agreed by the group with a commitment to run two campaigns per year from the current year. In addition, a new logo was produced and a Twitter feed launched (@hillingdon_lscb) providing general safeguarding information and advice. The Board also launched an e-bulletin for wide circulation and produced two editions within the year. Plans to develop the website with a clear and separate identity to that of the London Borough of Hillingdon site have been carried through to the current year.

The User Engagement subgroup was also established to develop mechanisms for consultation and feedback with children, young people and their families.

Child Death Overview Panel

The Child Death Overview Panel is a statutory requirement of the Children's Act 2004 which came into effect on 1st April, 2008 and conforms to the guidance of Chapter 5, Working Together 2013. The Hillingdon and Ealing Local Safeguarding Children Boards joined together to form a two borough Child Death Overview Panel. The Panel is chaired by a Director/Consultant of Public Health for either Ealing or Hillingdon and has a fixed core membership of senior professionals which is drawn from the key organisations represented on the LSCB.

All deaths of children under 18 years are reviewed by the Child Death Overview Panel and within all categories there are many cases that whilst not preventable have learning points and training issues in different agencies. The reviews of Sudden Unexpected Deaths of Infants have highlighted the importance of 'safer sleeping' and the dangers of co-sleeping, overheating, positional sleeping and include risk factors of smoking, drinking and taking drugs.

Other issues identified during reviews this year were:

- Transfer times by the Children's Acute Transfer Service (CATS)
- The importance of flu and other vaccinations in babies and vulnerable children
- The need for police to be informed of children receiving palliative care

- The importance of sharing emergency access plans with GP's
- The need to share health and social care information across borders when children move or are treated out of borough.
- The importance of early diagnosis of Brain Tumours

Good Practice

Safer Sleeping in Infants Integrated Care Project (SSLIIP)

The Board were very pleased to work alongside lead CDOP paediatrician, Dr Jide Menankaya to introduce a new initiative to the Borough. Sudden unexpected deaths in infancy (SUDI) is a significant cause of death in babies less than 1 year old. In London, a baby dies every 9 days from SUDI and in our boroughs of Hillingdon and Ealing one in nine deaths in children is due to SUDI.

This is a really important initiative to safeguard the lives and well-being of children and requires the participation of key stakeholders in this borough to make it a success.

LSCB Conference

On 10th February the LSCB hosted a conference with the theme of Early Help. 150 people attended with 15 "Market Stalls". The review sheets filled in on the day showed a satisfaction rate of 7.9 out of 10. The most popular sessions were the drama group in the morning and the afternoon round table case discussions. The opportunity to network with others from the community was praised.

Allegations against professionals

The Local Authority Designated Officer, LADO, plays a crucial role within the Local Authority managing and overseeing allegations that are made against professionals. The rate of LADO referrals remains high with the largest proportion received from schools and Early Year's provision. Awareness of the role of the LADO is communicated to staff on a regular basis through training and staff induction.

Independent Domestic Violence Advisor (IDVA) Service

The purpose of an IDVA Service is to address the safety of victims at medium to high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and also the safety of any children.

There has been a steady increase in referrals to the IDVA Service over the last 3 years; however staffing numbers have remained the same resulting in the IDVA Service running out of capacity. In 2015 the IDVA Service will undergo some positive changes as funding from The *Mayor's Office for Policing And Crime (*MOPAC) means that there will be 4.5 additional IDVA positions; one will be permanently located within the Multi-Agency Safeguarding Hub (MASH) and another located within the Housing Department. It is hoped that the additional staffing will enable the IDVA Service to continue to provide the excellent level of Risk Assessment and Safety Planning to residents of Hillingdon.

Assessment of the quality of safeguarding

To be confident of the effectiveness of the partnership the Board requires regular data both quantative and qualitative. Although a start has been made on this with the agreement of the Performance Web, section 11 and school audits in the forthcoming year and a multi-agency audit programme we do not have sufficient data from the reporting year to be confident of the quality of practice.

The performance of partner organisations with regard to safeguarding provides mixed assurance for the Board. The Development of a Multi-Agency Safeguarding Hub is positive, though further development is required to ensure that the contribution of all agencies is embedded. Children's Social Care has achieved a degree of stability reducing their assessment backlogs and reducing staff turnover but now need to consolidate this progress and increase the number of permanent, employed staff.

The Hillingdon Hospital was subject to a CQC inspection during October 2014 with the report being published in February 2015. The overall rating was that the hospital "Required Improvement".

The Board was encouraged by the rapid progress at the hospital following the inspection and will continue to monitor this.

Taking the points above into account the Board is cautious about an assessment of the effectiveness of safeguarding across the Borough. Further work is needed by both the Board and its partners before we can be assured that children and young people are as safe as they can be across the Borough.

Priorities for 2015/6

Addressing **Child Sexual Exploitation** will remain a Board priority until we can be assured that the right multi-agency plans, procedures and guidance are in place to safeguard the potential victims.

With Britain's largest airport and the third largest airport in the world, Heathrow, in the Borough **child trafficking** will continue to remain an issue for the Board.

In addition the Board remains concerned that the response across the Borough with regard to both **FGM** and **radicalisation** has not been fully explored and may lack rigour. Both will be subject to further enquiries during 2015/6.

It is important that, over the year, the Board **develops a sound understanding of the quality of multi-agency practice and the child's journey between the agencies.** Work on this has begun but the programme of multi-agency auditing will be escalated and the Board will work to properly embed the child's voice in the Board.

Finance

There should be a **review of resourcing** for the Board to ensure that it has the ability to operate to, at least, "Good".

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Hillingdon Local Safeguarding Children Board

Annual Report

2014 – 15

'That every child and young person is as safe and physically and emotionally secure as possible, by minimising risk of harm as much as we can.'

Chairman's introduction

The following report provides an assessment and summary of the work undertaken by the Hillingdon Safeguarding Children Board over the last year. I would like to thank all of those that have worked hard this year to improve the level of safeguarding in the Borough. In particular, I would like to thank my predecessor for her hard work over a number of years and wish her well in her future endeavours.

I was appointed this May to take over as the Independent Chairman of the Board. This report focuses on what has taken place over the last year. Whilst much of the attention is focussed on Children and Young People Services, the Board is formed of a partnership of all of those agencies and third sector organisations that are engaged in safeguarding our children. It is clear from recent reports that we can do better for our children and the Board must step up a gear to make sure this happens.

I have met with a number of senior members of the Board and I have been impressed with their determination and clear ambition to see improvement in the level of safeguarding in the Borough. I support their ambition and will do all that I can to see us succeed.

This report does highlight the progress that has already been made. The introduction of a multi-agency safeguarding hub (MASH), where agencies are located together, is just one positive development. I look forward to working with agencies to see further improvements. Moving forward it will be essential that we listen to the views of the public and most importantly the children we are responsible for safeguarding. I am looking forward to the challenge ahead and will provide regular updates throughout the year, on our website, detailing the progress that is being made.

I hope the report provides the information you need and is of interest. Please let us know what further information would be of use and what you feel we should be doing to improve safeguarding in Hillingdon.

Steve Ashley

About Hillingdon

Hillingdon is the second largest of London's 32 boroughs with a population of 292,700 in 2014 of which 25% were under 19. This proportion is slightly higher than England and London. An increase in numbers of young children (0-9 age group) is projected to rise until 2017. However, these growth rates are comparable with London as a whole.

53% of the resident population aged 5-19 and 59% of the schools population (School Census 2014) belong to a Black and minority ethnic (BME) group (a group that is not White British). This diversity is expected to increase as 62% of the very young resident population (age 0-4 years) belong to a BME group. The School Census 2014 shows that 24% are Asian or Asian British, 11% Black or Black British, 10% Mixed background, 8% White backgrounds other than White British, 6% other ethnic groups, and 1% not known. Almost 40% of the school population do not have English as their first language. 183 languages were recorded in Hillingdon schools with 46% of Primary school pupils and 40% of Secondary school pupils having a first language that is not English.

Hillingdon is a comparatively affluent borough (ranked 23rd out of 32 London boroughs in the 2010 index of multiple deprivation, where rank 1 is the most deprived). Within Hillingdon there is variation between the north and south of the borough, with some areas in the south falling in the 20% most deprived nationally. Heathrow Airport is located entirely within Hillingdon boundaries and this has a major impact, particularly in respect of children and young people who pass through the airport. Close and effective multi-agency work has led to Hillingdon being considered a national leader in the field of protecting children and young people from potential and actual trafficking.

Child Population Profile: There are significant variations in the population of children and young people (age 0-19) across Hillingdon, with more younger people in the south of the borough, and also higher proportions who are from ethnic minority groups (e.g. 80% in Pinkwell, compared with 21% in Harefield). About 45% of children and young people (aged 0-19 years) in Hillingdon are White British, 26% Asian or Asian British groups, 11% Black or Black British groups, 8% in any Mixed background, 6% White backgrounds other than white British groups, and 4% in other ethnic groups. Over the last 10 years the proportion of children born to mothers who were born outside the UK has risen to over 50%, with the biggest increases in births to mothers born in Asia and the Middle East and in countries which have joined the EU since 2004.

Poverty: Over a quarter of children aged 0-15 in Hillingdon are deemed to be living in poverty, including over 40% of children in two wards in the south of the borough, and 17% of school age children across the borough are eligible for free school meals.

Vulnerable Groups: Some groups of children and young people are more vulnerable than others to poor health, educational and social outcomes. In Hillingdon 5,600 children were deemed to be in need throughout 2012/13 (latest nationally available data), and this number has increased in each of the previous 3 years. The most common primary need identified was abuse or neglect, followed by absent parenting which was the primary cause in almost 20%, probably related to the number of Unaccompanied Asylum Seekers who become the responsibility of Hillingdon Council through Heathrow airport.

Disabilities: Around 8% of children in need in Hillingdon have a disability, the commonest being learning disabilities, mobility and communication problems. More data on childhood disability in Hillingdon is awaited, but estimates based on national data suggest that 3.0- 5.4% of children and young people (about 2,300 - 4,100) are likely to have some form of disability. Disabilities are more common among children from more deprived socioeconomic groups, and there are more boys than girls with disability at all ages.

Education: A total of 1,200 pupils attending Hillingdon schools (2.9% of the total school age population) had a statement of Special Educational Need (SEN), and 2,470 (6.0%) were subject to School Action Plus (meaning that the school receives external help for the child.) The most common categories of SEN main difficulties are speech, language and communication needs (31%) and behaviour, emotional and social difficulties (16%), with smaller numbers with Dyslexia (11%), moderate learning difficulty (12%) and Autistic Spectrum Disorder (13%). In Hillingdon 19% of the school population was assessed as having SEN. For children with SEN, outcomes within the primary and secondary phases are broadly in line or just above the national picture, but are not yet as strong as London region. Children with some types of learning difficulty are also at significantly increased risk of mental health problems and estimates based on national research and local information suggest that 2.6% - 3.5% of children and young people aged 5-18 in Hillingdon will have both a learning difficulty and an emotional or mental health problem, equivalent to about 480-620 children and young people.

In 2014 around 230 young people in Hillingdon aged 16-18 were thought to be not in education, employment or training (NEET), which represents 2.4% of the population of that age, a lower proportion than in London or England. This proportion has fallen from 5.7% in Hillingdon over the previous 7 years. The largest numbers of the NEET cohort live in Botwell, Townfield, West Drayton and Yiewsley, and White British are over-represented in this group. In the 2011 Census 2,450 (2.6%) of those aged under 25 in Hillingdon reported that they were unpaid carers, with the highest proportions in Hayes and Harlington and lowest in Ruislip and Northwood. Data provided by the Hillingdon Carers service suggests that there are Young Carers as young as 5 in Hillingdon. 206 school children living in Hillingdon were Gypsy or Irish traveller children in the 2014 school census; in the 2013 School census nearly half of

the Gypsy or Irish traveller children were identified as having some special educational need.

Child Deaths: In total there were 138 deaths in persons aged 0-19 years in Hillingdon over the 5 years 2010-2014, 57% of which occur under the age of 1, and 14% in older teenagers aged 15-19. The commonest single cause of death in older children is external causes, accidents and injuries, and adolescent boys are particularly at risk.

Hospital Admissions: The rate of hospital admissions of young people aged under 18 for alcohol specific conditions (those which are causally related to alcohol) is the same in Hillingdon as the rest of England, and the trend has fallen only slightly in the last few years.

Teenage Pregnancy: There has been a decline in rates of teenage pregnancy, almost year on year since 2003; Hillingdon has followed the decline in rates that has been observed across London and England as a whole.

Sexually transmitted infections: The rate of new sexually transmitted infections (all ages) excluding Chlamydia in Hillingdon is significantly higher than the rate for England, but lower than the rate for London. Just over 600 people aged 15-24 years old had Chlamydia detected in 2013; the rate of detection in Hillingdon (1.5%) was significantly lower than the rate for England and London.

CAMHS: Over 1000 children aged 2-18 were referred to Tier 3 CAMHS in 2013/14, of whom 55% met the service's referral criteria and were seen. The number of referrals increases with age and there appear to be more White British children seen in the service than would be expected from the ethnicity profile of children and young people in Hillingdon. Almost one-quarter of those seen had hyperkinetic disorders, 12% had other behavioural and emotional disorders, and 11% other anxiety disorders. Estimates based on national data suggest that the numbers who used CAMHS services in Hillingdon are about half that expected for Tier 2 and Tier 3 services, and about two-thirds that expected for Tier 4. In 2012-13, 112 young people aged 10-24 in Hillingdon were admitted to hospital as a result of self-harm. This rate has remained stable over the last 5 years and is significantly lower than the England average.

A&E Attendance: Almost half of all 1-18 year olds attending A&E were children aged 1-5, and among these younger children injury and poisoning are the commonest reasons for attendance, followed by respiratory conditions. Emergency hospital admissions for intentional self-harm (all ages) are significantly lower in Hillingdon than England as a whole.

Educational Outcomes: Data on educational outcomes in 2014 shows that levels of development at the end of reception year are lower for Hillingdon than in London

or England. However at Key Stage 1 and Key Stage 2 overall achievement in Hillingdon is better than that for England and in most areas the same as London. At Key Stage 4 overall achievement is still better than England in most areas, but is below London. The exception is for White pupils who fare worse than the England average, and this is particularly marked for White boys in Hillingdon.

Commentary.

Although, by and large, Hillingdon offers young people a good place to grow up there are some particular concerns. There is a danger that the overall affluence of the Borough can mask the difficulties for some. The Index of Deprivation scores are expected to be refreshed nationally later in 2015, but the current calculations that 16,000 children aged 0-15 live in poverty in Hillingdon (over 40% of children in some wards) is a particular concern given what we know about the potential outcomes for these children.

Any hospital admission for self-harm and alcohol related incidents amongst children and young people is of concern. This is particularly concerning when linked with lower than average referral acceptances by CAMHS. This will be of particular scrutiny during the forthcoming year.

Governance

Statutory requirements

Section 13 of the Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specified the organisations and individuals (other than the local authority) that should be represented on LSCBs.

The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. Section 14 of the Children Act 2004 sets out the objectives of the LSCB which are:

- a. To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- b. To ensure the effectiveness of what is done by each such person or body for those purposes.

The Hillingdon Safeguarding Children Board (HSCB) has a statutory duty to publish an Annual Report on the effectiveness of child safeguarding and promoting the welfare of children in the Borough.

The report is submitted each year to the Chief Executive, the Leader of the Council and the Chairman of the Health and Wellbeing Board.

The Board were keen to agree protocols with the other key safeguarding strategic bodies in the Borough to ensure that each knew the priorities and main areas of interest of the other. It was agreed that the Chairman, or representative, of the LSCB would attend meetings of the other Board and that a representative would be invited to the LSCB. Over the course of 2014/5 protocols were agreed and signed with the following:

Health and Wellbeing Board
Corporate Parenting Board
Domestic Violence Executive Board
Youth Offending Service Management Board

The Chairman attended meetings of the Health and Wellbeing Board, the Corporate Parenting Board and the Young Offender Board. The interim Business Manager attended the Domestic Violence Executive Board.

Within the year the number of sub-groups was reduced from eleven to eight to include a new Executive group as the "engine house" of the Board. Over the course of the year two additional sub-groups were added, a joint LSCB/Heathrow Strategic Safeguarding and Trafficking meeting and a CSE sub-group. Other sub-groups meeting regularly are:

Vulnerable children and young persons' group
User Engagement
Policy and Procedure
Learning and Development
Child Death Overview Panel
Performance and Quality Assurance
Serious Case Review

One of the priorities previously identified is that the voice of children and young people should be heard in the Board. Progress on this has begun with an inspection of the CAMHS service by members of the Youth Council and the report on this will be included in the Annual Report for 2014/5. We have agreed that once this report is finalised the Young Inspectors undertake further inspections.

Progress with embedding the voice of children and young people in the Board has been too slow over the reporting period and will be escalated through the Business Plan into next year.

How did we do? These were the priorities in 2013/14:

In December 2013 Ofsted undertook an inspection of services for children in need of help and protection; children looked after and care leavers. It also reviewed the effectiveness of the LSCB giving an overall grading of "Requires Improvement". The action plan that followed the inspection set out the following priority areas for 2014/5.

- Ensure that time allocated to LSCB meetings is sufficient for partners to effectively undertake its work. ***Achieved, the LSCB meets on a separate day to the LSAB and there is sufficient time to cover the agenda and to allow for debate of priority items.***
- Improve the communication with other strategic bodies, including the Health and Wellbeing Board, to ensure strategies aiming to improve the lives of children and young people are effectively coordinated. ***Achieved***, ***protocols have been agreed with all key strategic bodies in the Borough.***
- Ensure that the LSCB effectively evaluates safeguarding performance through audit and performance monitoring of multi-agency activity, and make sure evaluation is used to improve services. ***Achieved in part. Some auditing has taken place and a performance framework agreed.***
- Ensure that the LSCB provides effective challenge to partners and holds partners to account to improve safeguarding outcomes for children and young people. ***Achieved in part and evidenced through Board minutes***
- Ensure that children young people and the community are appropriately engaged in the work of the LSCB, strategically and operationally, so that its work reflects their views. ***We have begun this and will further develop the approach next year.***
- Ensure that partners are appropriately engaged in developing and delivering multi agency aspects of the Signs of Safety approach to risk management, so that there is full multi agency engagement in identifying risks and strengths to keep children safe. ***Achieved, Signs of Safety was rolled out from July 2014.***
- Ensure that the impact and effectiveness of multi agency training is evaluated so that its effectiveness can be assessed and improved. ***Achieved in part, the June Board agreed that for training courses running from September 2014 the pilot process would continue with an evaluation prior to, and after, training courses. For the remainder of 2014/5 this will be undertaken for the Domestic Violence, Impact on children course***.

In summary, good progress has been made but there is further work to do for the Board to reach "Good".

Reports from the sub-committees:

Much of the work of the Board is delivered through a series of sub committees, each led by a Chairman from across the safeguarding partnership. The following section of the report sets out a brief summary of some of the sub-committee highlights to give a flavour of the important role they fulfil.

Executive:

The Executive agreed new formats for both the Business Plan and the Risk Register during the Year. Both are reviewed at the Executive and discussion determines the priorities. During the course of the year the Executive agreed that the main concerns of the Board for the reporting year would be Child Sexual Exploitation, children and young people in a household where there is known domestic violence, assessing the Borough's response to youth violence and gang culture and children with a disability.

Performance and Quality Assurance sub-group

At the September meeting a Performance Web was agreed as the main reporting tool for the Board. (see appendix 5). The web identifies seven key questions for the Board to ask and the accompanying dashboard provides the relevant data:

1. *Is safeguarding really everyone's business?*
2. *Do we know that children are safe and the right children have protection plans and that they are being fully implemented in a timely way?*
3. *Are we sure that lessons from SCRs are disseminated and embedded in practice?*
4. *Are we doing all that we can to reduce the risk of avoidable child death?*
5. *Are we satisfied with the quality of care for any child not living with its parent?*
6. *Are we satisfied with the quality and effectiveness of early help and intervention?*
7. *Is the children's workforce fit for purpose?*

At each meeting the Board receives a performance report updating on these questions and, over time, the information will build up to provide the Board with a full picture of performance.

A Scorecard to accompany the web is present to the Board and will receive further development over the forthcoming year. The subgroup commissioned audits on the Voice of the Child and Private Fostering and both were completed, with the learning added to the Learning and Improvement log. The results of the Private Fostering audit have since informed the work of a short-

life group which has further developed the work with the assistance of a specialist worker. The results of the Voice of the Child audit were of concern in that they demonstrated that children and young people were not sufficiently included in meetings about their safety and future and that minutes were not widely circulated. It also noted that the LSCB should undertake some further work on information sharing amongst partners.
The subgroup has agreed that further work on developing an agreed data set is required in the next reporting year and that a programme of multi-agency audits will be undertaken.

Child Sexual Exploitation sub-group
Child Sexual Exploitation (CSE) was adopted as a Board priority and a sub-group established to take the work forward within the year. Significant progress was made over the year with assessing the prevalence of CSE across the Borough and developing the multi-agency response to address CSE. This was aided in no small part by the appointment of a specialist worker based within Children's Social Care and working across agencies in collaboration with the LSCB.

The Board were encouraged by the successful prosecution of three perpetrators of CSE in the Borough. This was the result of multi-agency team work and those involved in bringing the case were asked to give a presentation to the London Safeguarding Board conference in November 2014. In particular excellent collaborative work was identified as having taken place by the Metropolitan Police, Children's Social Care and the NHS. The Board commended the approach taken by the team in respect of preparing the victims for giving evidence and the support that they were given throughout the trial.
In the latter months of the year the concentration has been on ensuring that there is strategic join-up between the agencies and a strategy and action plan was agreed at the LSCB in March 2014. A training programme has also been agreed and is underway.
Strong governance arrangements, as agreed across London, are in place to address CSE with a MAP (Multi-Agency Panel) for the discussion of individual cases and MASE (Multi-agency Sexual Exploitation) strategic group both of which meet monthly. In addition the Board has a CSE sub-group which reports to the Board twice a year.

Vulnerable children and young people sub group
Much of the work in developing the Child Sexual Exploitation strategy has been driven through the Vulnerable Children sub-group this year and, understandably, this has been the concentration of the group. In addition the

group has prioritised the needs of children and young people living in families in which there is domestic violence and has, with the Performance and Quality Assurance sub-group commissioned an audit to better understand the quality of multi-agency practice for these children and young people.
The group also facilitated a workshop to look at how effective the multi-agency response to female genital mutilation is. The outcome from this is that the Board were pleased to note that there are significant resources available in the Borough to address this issue. There is, however, a lack of coordination in the approach and the extent of the problem is unquantified at the moment. Further work will be undertaken in the current year to understand the extent of the problem and to encourage a more strategic approach to be undertaken across the Borough.

Learning and Development

The year was a mixed one for the Learning and Development sub-committee. The sub-committee met regularly and agreed a feedback mechanism so that we could ascertain the impact that training had on practice. Less positively we were unable to commission courses as the year developed, including the key Working Together training due to a lack of funding. A charging mechanism was agreed in early 2015 and there is an expectation that a full training programme will commence in the forthcoming year.
Partner agencies provide their own training returns in the appendix 1.

Joint LSCB/Heathrow strategic group

Heathrow, situated within the Borough, is the busiest airport in the United Kingdom and the busiest airport in Europe for passenger traffic. Every day thousands of children and young people come through the airport some being identified as being of potential concern. Border Force will make assessments on a number of these children and young people and will call in staff from the London Borough of Hillingdon Children's Social Care where there are particular concerns. The working arrangements between the airport and Children's Social Care have been complimented by the Office of the Children's Commissioner.

Another new subgroup in the year, the joint LSCB/Heathrow strategic group was established with the following purpose:

- To provide scrutiny and overview of the safeguarding arrangements for children and young people arriving at Heathrow.
- To oversee the performance of relevant agencies and to advise the LSCB of any shortfall or major risks in respect of children and young people arriving at Heathrow.

New Safeguarding and Trafficking teams were established at Heathrow in April 2014 and, in preparation for this, all Border Force team members were trained in a four-day tier 3 safeguarding package developed within Border Force.

The Heathrow Safeguarding Children group is a sub group of the LSCB and will reports back to the main Board on its activities and outcomes.

Specific achievements with in the year have included working through a route to notify LBH of children and young people identified as being privately fostered ensuring that the right support is identified for them. Identifying risks associated with Ebola, sharing knowledge of operations including one relating to FGM with consequent referrals made to Social Care and sharing information on age-disputed young people.

The LSCB were pleased to note that the airport undertook an awareness raising day on the theme of Modern Slavery. In addition representatives from the Heathrow Safeguarding team contributed to the London Borough of Hillingdon's White Ribbon day.

A work plan for the next reporting year has been agreed.

Serious Case Review sub-group

No Serious Case Reviews were published in the year but one was completed and published in April 2015. This concerned a teaching assistant from a local secondary school who was convicted of sexual activity with a female pupil. The Board accepted the eleven recommendations made in this case and will oversee the implementation of these through the Learning and Improvement Framework. The Board were concerned to learn from the SCR author that there were similarities with an SCR published by the Board in 2010 and that, if the learning from the previous SCR had been fully embedded the child might have been better protected.

Two Serious Case Reviews were commissioned with the intention to publish both in 2015, these will be reported upon in the 2015/6 Annual Report.

A further case was discussed but it was agreed that this did not meet the threshold and a joint agency review was commissioned and completed in April 2015.

Policy and Procedure sub group

The Policy and Procedure subgroup spent the early part of the year drafting and agreeing a threshold document as required under Working Together

2013, this was agreed by the Board in December and was subsequently published. The document includes:

the process for the early help assessment and the type and level of early help services to be provided; and

the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under:

section 17 of the Children Act 1989 (children in need);

section 47 of the Children Act 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm);

section 31 (care orders); and

section 20 (duty to accommodate a child) of the Children Act 1989.

The Document was drafted through the Policy sub-committee and was agreed by the Board at the meeting in December 2014.

The LSCB conference in February 2015 was used to promote the document and the practice changes.

The sub-committee also agreed an Escalation policy, Core Group guidance and began work on agreeing guidance for those working with children and young people who are engaged in sexually harmful behaviour.

User Engagement

The LSCB has been described as the “multiagency window into safeguarding”, for this reason the Board considers it important to develop its public profile. A communications strategy was agreed by the group with a commitment to run two campaigns per year from the current year. In addition a new logo was produced and a Twitter feed launched (@hillingdon_lscb) providing general safeguarding information and advice. The Board also launched an e-bulletin for wide circulation and produced two editions within the year. Plans to develop the website with a clear and separate identity to that of the London Borough of Hillingdon site have been carried through to the current year.

The User Engagement subgroup was also established to develop mechanisms for consultation and feedback with children, young people and their families. Work has commenced via an inspection of the CAMHS service but otherwise has progressed more slowly than we had hoped and progress will be accelerated next year.

Child Death Overview Panel

The Child Death Overview Panel is a statutory requirement of the Children's Act 2004 which came into effect on 1st April, 2008 and conforms to the guidance of Chapter 5, Working Together 2013. The Hillingdon and Ealing Local Safeguarding Children Boards joined together to form a two borough Child Death Overview Panel. The Panel is Chairmaned by a Director/Consultant of Public Health for either Ealing or Hillingdon and has a fixed core membership of senior professionals which is drawn from the key organisations represented on the LSCB.

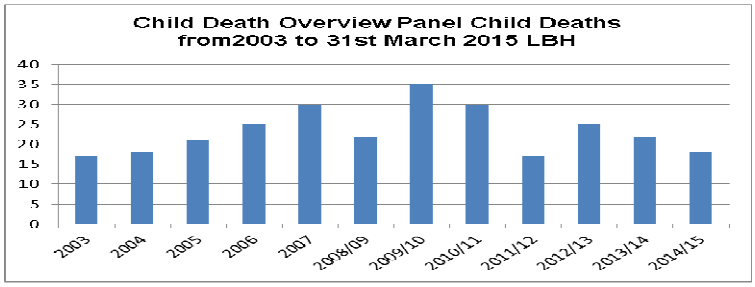
The overarching vision of the CDOP is to prevent future deaths of children by promoting the health, safety and well being of all children and improving the effectiveness of operational procedures to safeguard children and young people across the boroughs. An additional and important aim is to ensure that parents and families who experience the death of a child are appropriately supported.

At the end of each reviewing year Data is collected and submitted to the Department of Education detailing the number of deaths, reviews and outcomes or concerns for national studies/interventions.

The Chairman of the Panel attends the London wide CDOP Chairmans meetings and the CDOP co-ordinator attends the pan London SPOC meetings. There is also a national CDOP online forum which shares important messages in child death prevention that have been identified through reviews across the country and these messages are shared across our boroughs as preventative measures.

Excellent links are established with all agencies and in all relevant tertiary London Hospitals especially Great Ormond Street, Queen Charlottes, St Mary's and Chelsea & Westminster, as well as with bordering boroughs and counties.

CDOP also delivers training to professionals in A & E and for level 3 Child Protection courses in both hospitals. The role of CDOP and contacts and associated information is found on the Hillingdon borough website.



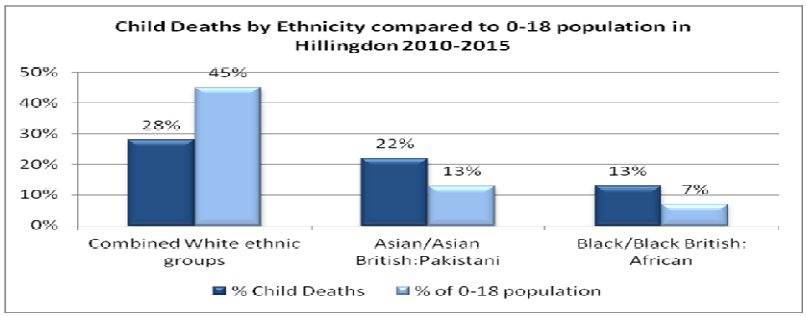
Child Deaths in Hillingdon between 2008 and 2015

Area: 46% of children lived in Hayes and Harlington with a further 19% in the Uxbridge and Hillingdon area. These 2 areas have consistently had the highest number of child deaths every year for the 7 year period.

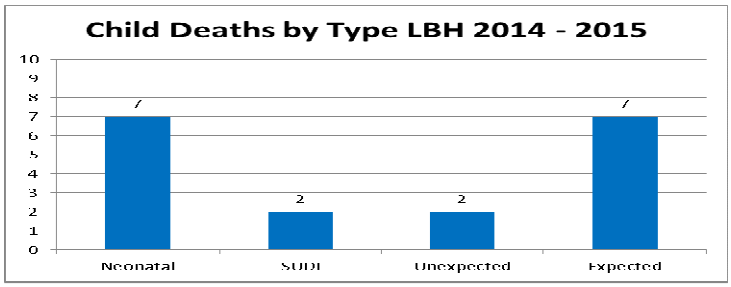
Age: 41% were neonatal (under 28 days), 28% were 29 days to under 2 years, 19% were 2 – 10 years and 12% were 11 – 18 years.

Gender: 48% Female 52% Male

Ethnicity:



Month: There are no statistically reliable trends in the months when child deaths occur in Hillingdon



The Child Death Overview panel met on four occasions from 1st April 2014 to 31st March 2015 and reviewed 15 child deaths for Hillingdon Borough.

All deaths of children under 18 years are reviewed by the Child Death Overview

Panel and within all categories there are many cases that whilst not preventable have learning points and training issues in different agencies. This learning is taken forward with view to improving services and care.

The reviews of Sudden Unexpected Deaths of Infants have highlighted the importance of 'safer sleeping' and the dangers of co-sleeping, overheating, positional sleeping and include risk factors of smoking, drinking and taking drugs. Whilst CDOP has already produced DVD footage and safety leaflets, the Hillingdon CDOP Designated Consultant Paediatrician and Hillingdon LSCB have launched 'The Safer Sleeping in Infants integrated Care Package' (SSLIIP)after CDOP statistics bought out the importance of raising awareness in parents, carers and professionals of the identified risk factors associated with Sudden Unexpected Deaths in Infancy

The CDOP prevention campaign continues to raise awareness of key factors surrounding the unexpected deaths of infants and children i.e. drowning, shooting, road traffic accidents, co-sleeping and falls. The safety leaflets have been distributed to GP surgeries, Children's Centres and Public Health and in this year our DVD and safety leaflets have been requested by and supplied to Public Health England and the CDOP Chairs Meeting for onward distribution. The baby safety messages are included in maternity packs and CDOP took part in the Lullaby Trust Safer Sleeping Week distributing leaflets and giving advice at Hillingdon Hospital.

Other issues identified during reviews this year were:

- Transfer times by the Children's Acute Transfer Service (CATS)
- The importance of flu and other vaccinations in babies and vulnerable children
- The need for police to be informed of children receiving palliative care
- The importance of sharing emergency access plans with GP's
- The need to share health and social care information across borders when children move or are treated out of borough.
- The importance of early diagnosis of Brain Tumours

If new information is identified that indicates abuse or neglect was a factor in the child's death the case is referred to the appropriate Local Safeguarding Children Board, for consideration by the Serious Case Review (SCR) Panel.

Safer Sleeping in Infants Integrated Care Project (SSLIIP)

The Board were very pleased to work alongside lead CDOP paediatrician, Dr Jide Menankaya to introduce a new initiative to the Borough. Sudden unexpected deaths in infancy (SUDI) is a significant cause of death in babies less than 1 year old. In

London, a baby dies every 9 days from SUDI and in our boroughs of Hillingdon and Ealing one in nine deaths in children is due to SUDI.

Through a coordinated approach, Local Safeguarding Boards in many parts of the UK have implemented safer sleeping programmes with significant reduction in SUDI rates in their local communities. With support from our health and social care partners, we hope to adopt this multi-agency approach here.

This is a really important initiative to safeguard the lives and well-being of children and requires the participation of key stakeholders in this borough to make it a success.

LSCB Conference

On 10th February the LSCB hosted a conference with the theme of Early Help. 150 people attended with 15 "Market Stalls". The review sheets filled in on the day showed a satisfaction rate of 7.9 out of 10. The most popular sessions were the drama group in the morning and the afternoon round table case discussions. The opportunity to network with others from the community was praised.

Those attending were asked to fill in a brief form before and after the conference to measure how their knowledge increased as a result of the conference.

By virtue of the feedback on the day, the pre and post conference ratings and anecdotal feedback the conference was a success. We are now moving to planning a conference for February 2016.

The conference was attended by nearly 200 Hillingdon staff.

There was good discussion between young people and Hillingdon staff.

A powerful story enacted by young Hillingdon people

Allegations against professionals

The Local Authority Designated Officer, LADO, plays a crucial role within the Local Authority managing and overseeing allegations that are made against professionals.

This role provides advice and guidance to employers where allegations have been made, and provides valuable liaison with the police and other agencies prior to and during the planning and investigation stages. Working Together to Safeguard Children 2015 advises that the LADO should now be referred to as the Designated Officer, but across the London LADO network it has been agreed that the term LADO will remain, as Designated Officer can be confused with other roles.

The rate of LADO referrals remains high with the largest proportion received from schools and Early Year's provision. Awareness of the role of the LADO is communicated to staff on a regular basis through training and staff induction. This includes how members of staff should conduct themselves when working with children, young people and vulnerable adults and how to report concerns regarding staff conduct through the organisation's whistle blowing policy. The LADO regularly

attends the schools safeguarding cluster meetings and meets with Heads through the Primary Forum and HASH (Hillingdon Association of Secondary Heads).

The findings from the recent Serious Case Review (SCR), regarding a Secondary school Academy within the Borough, highlight the importance of contacting the LADO at the earliest opportunity. One of the main concerns is that lessons do not appear to have been learnt following a previous SCR, also involving a school, where similar concerns were raised. The LADO will be working with schools and other agencies to ensure that the recommendations are implemented and to reinforce the referral process.

The following LADO actions are planned for 2015/2016:

Implement the recommendations from the recent serious case review.

Develop literature to inform employers and employees of the role of the LADO and how the LADO process works.

Continue to develop a database to record allegations against professionals.

Independent Domestic Violence Advisor (IDVA) Service

The purpose of an IDVA Service is to address the safety of victims at medium to high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and also the safety of any children.

Serving as a victims/agencies primary point of contact, IDVAs normally work with clients from point of crisis to assess the level of risk to victim and any child in the family. IDVAs will create bespoke safety plans and action these safety plans to reduce immediate risk and address longer term solutions and preventative planning.

Studies show that when victims engage with an IDVA, there are clear and measurable improvements in safety, including a reduction in the escalation and severity of abuse and a reduction of even cessation of repeat incidents of abuse.

There has been a steady increase in referrals to the IDVA Service over the last 3 years; however staffing numbers have remained the same resulting in the IDVA Service running out of capacity. In 2015 the IDVA Service will undergo some positive changes as funding from The *Mayor's Office for Policing And Crime (*MOPAC) means that there will be 4.5 additional IDVA positions; one will be permanently located within the Multi-Agency Safeguarding Hub (MASH) and another located within the Housing Department. It is hoped that the additional staffing will enable the IDVA Service to continue to provide the excellent level of Risk Assessment and Safety Planning to residents of Hillingdon.

See appendix 2 for IDVA statistics

Hillingdon Association of Voluntary Services (HAVS).

In previous years Hillingdon Association of Voluntary Services has been the main point of liaison for the LSCB with the various community groups in the Borough. For various reasons HAVS are operating at reduced capacity and are unable to sit on the Board. This has left a gap for the Board and we are working with all partners to seek a new solution to ensure that voluntary and community groups are properly represented.

Hillingdon Inter Faith Network

Duncan Struthers, Chairman of the Hillingdon Inter Faith network joined the Board in September and has proved to be an effective link between the Board and the faith communities. An on-going piece of work from the reporting year is the dissemination of learning from a school-based serious case review into faith settings to ensure that the right level of knowledge about safeguarding exists and that the accountability for safeguarding is present and is understood.

Lay Members

The Board has benefitted from the presence of two lay members who have contributed to the development of the Board over the year. In particular one lay member has a background in communications and she was instrumental in drafting and seeing through to fruition a Communications Strategy. The other has a background in education and has led the Board to seek further information with regard to children who are home-educated; this work is continuing to the current year and is identified in the Business Plan.

How do we know that we are effective?

The most important questions to be asked in relation to Local Safeguarding Children Boards are “what difference does an LSCB make” and “what impact does the LSCB have”.

We are clear that within Hillingdon the Board is developing quite well but the pace of this will need to be accelerated in the forthcoming year. In looking for evidence of Board effectiveness we can identify a joint agency review, commissioned in December 2014 and completed in April 2015. It is also positive that two thematic audits, Private Fostering and the Voice of the Child have been completed within the year and have clear recommendations.

The adoption and development of the Performance Web, with further developments planned will allow the Board to see how effective multi-agency safeguarding is across seven domains. This has become the main performance reporting mechanism for the Board.

To be truly effective the Board needs to have the voice of children and young people at its heart. This was only begun in 2014/5 with an inspection of a partner agency and this approach will need further development and consolidation in 2015/6.

Board minutes reflect challenge and an e-folder is kept of challenge and outcome.

Assessment of the quality of safeguarding:

To be confident of the effectiveness of the partnership the Board requires regular data both quantative and qualitative. Although a start has been made on this with the agreement of the Performance Web, section 11 and school audits in the forthcoming year and a multi-agency audit programme we do not have sufficient data from the reporting year to be confident of the quality of practice.

The performance of partner organisations with regard to safeguarding provides mixed assurance for the Board. The Development of a Multi-Agency Safeguarding Hub is positive, though further development is required to ensure that the contribution of all agencies is embedded. Children's Social Care has achieved a degree of stability reducing their assessment backlogs and reducing staff turnover but now need to consolidate this progress and increase the number of permanent, employed staff.

The Hillingdon Hospital was subject to a CQC inspection during October 2014 with the report being published in February 2015. The overall rating was that the hospital "Required Improvement". One of the headlines that the Board was pleased to note was that the trust had a very committed workforce. This coincides with the experience of the Board. Less positively the Chief Inspector of Hospitals set out three relevant key findings in relation to safeguarding children:

- The risk that child protection issues could be missed due to a failure to follow agreed processes had been identified, but not addressed
- The risk of admitting children with high dependencies to wards that aren't appropriately staffed to meet their needs has been on the risk register for over a year without being appropriately addressed.
- Staff records regarding training showed poor performance in key areas such as infection prevention and control, **safeguarding** and moving and handling.

The Deputy Director of Nursing and Deputy Lead Doctor for safeguarding attended the Board in March 2015 to update on progress since the inspection. The Board were particularly pleased to note that safeguarding training, which had been as low as 50% then stood at 94%.

The Board was encouraged by the rapid progress at the hospital following the inspection and will continue to monitor this.

Although all statutory agencies have been affected by public sector change "Transforming Rehabilitation" has significantly altered the Probation Service with 30% of high risk cases going to a new national service and 70% of low and medium cases being held by the local Community Rehabilitation Service, MTCnovo. The CRC representative confirmed to the Board that arrangements are still being worked out with a fuller report being available to the Board later in the year. With a lack of clarity over safeguarding procedures and Board reporting accountability the Board will seek assurance over the forthcoming months that the new arrangements have safeguarding at their heart.

Taking the points above into account the Board is cautious about an assessment of the effectiveness of safeguarding across the Borough. Further work is needed by both the Board and its partners before we can be assured that children and young people are as safe as they can be across the Borough.

Priorities for 2015/16

Addressing **Child Sexual Exploitation** will remain a Board priority until we can be assured that the right multi-agency plans, procedures and guidance are in place to safeguard the potential victims. The Board will also need to continue to be assured that all agencies recognise the risk that CSE poses and that each agency apportions sufficient resources to combating CSE. The Board will monitor the developing response through the CSE sub-committee and will report twice-yearly to the Board.
With Britain's largest airport and the third largest airport in the world, Heathrow, in the Borough **child trafficking** will continue to remain an issue for the Board. The priority for the Board is to measure the incidence of trafficking and to ensure that the multi-agency response is strong enough to safeguard children and young people.

In addition the Board remains concerned that the response across the Borough with regard to both **FGM** and **radicalisation** has not been fully explored and may lack rigour. Both will be subject to further enquiries during 2015/6. The Board will also make enquiries into the extent of gangs and youth violence in the Borough and the effectiveness of the response to this.

It is important that, over the year, the Board **develops a sound understanding of the quality of multi-agency practice and the child's journey between the agencies.** Work on this has begun but the programme of multi-agency auditing will be escalated and the Board will work to properly embed the child's voice in the Board.

The Board will need to be assured that those attending are at the right level in their organisations to be able to influence their own policy and procedures and to offer strong challenge to others. Whilst acting on behalf of their own organisations Board

members will also operate across the Borough as safeguarding ambassadors on behalf of the Board.

The Adult and Children's Boards should take the opportunity to collaborate to ensure that those issues of overlap for young people and adults are covered by one of the Boards, this should include mental health, commissioning and Care leavers.

There should be a **review of resourcing** for the Board to ensure that it has the ability to operate to, at least, "Good".

Appendix 1

Each LSCB partner agency was asked to self-report for this Annual Report on an agreed template describing the agency. These are reported below:

Children and Young People's Services – MASH, Asylum Intake Team, Children's Social Work Teams, Children in Care Teams, Young People's Teams

Name of agency	Children and Young People's Services – MASH, Asylum Intake Team, Children's Social Work Teams, Children in Care Teams, Young People's Teams
Description of service	Statutory local authority children and young people's service.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	To await info from AN
Regulator inspection in reporting period and outcomes	There was no Ofsted inspection during this period.
Challenges in the reporting period	In August 2014 the level of risk in the Children's Social Work Teams was deemed to be unacceptably high. This followed a high degree of disruption and changes in all levels of management and staffing within the service. A significant additional amount of resource was committed to the service which was used to implement a range of recovery actions and ensure that the service was stabilised. The recovery actions have successfully stabilised the service and the Service Improvement Plan will now drive forward further work to embed and sustain service improvements.
Progress on safeguarding priorities in the reporting period	• MASH and Triage are fully functioning • Predicted demand is currently aligned with actual numbers and capacity reducing caseloads to a manageable number across the service • Demand at the front door and conversion rates to referrals continue to be monitored. • Work is being carried out with Early Intervention Services to draft a protocol to ensure step downs are completed in a timely fashion and services utilised in an effective outcome led plan. This interface will deepen the understanding of demand and need in the future. • Audit compliance is now 100% and there has been an incremental increase on cases being graded as being good (including via moderation)

	• The Safeguarding Children's Service introduced the Signs of Safety model in July 2014 in the stated time-frame. • Greater understanding and awareness of the issue of Child Sexual Exploitation with a defined risk assessment • Young People at risk of CSE are monitored and tracked monthly through the MAP and MASE • Missing from Care Protocol completed and implemented • Joint working with UK Border Force embedded • Reduction in timescales in care proceedings
Safeguarding priorities for 2015/6	• Recruitment of permanent social workers and managers across the service • Average caseloads to remain within 14-16 cases per qualified social worker • Improve quality of social worker assessment • Implement revise Practice Standards for Child Protection • Increased awareness CSE and use of CSE risk assessment and toolkits by frontline practitioners • Developing strategies and toolkits for frontline practitioners to risk assess in cases of FGM, Trafficking and Radicalisation
Good news stories	• New social work team structure has been agreed and is currently being recruited to. The flattening of the management structure provides greater management oversight and opportunity to develop and improve practice • MASH and Triage are fully functioning • Skylakes has supported the service to reduce caseloads and ensure that cases have an allocated worker and plan • Reduced caseloads and an attractive social work offer has begun to make Hillingdon a desirable place to work in children's social care

London Borough of Hillingdon - Safeguarding & Quality Assurance

Name of agency	London Borough of Hillingdon - Safeguarding & Quality Assurance
Description of service	• Ensuring that children are properly safeguarded in the London Borough of Hillingdon through the child protection case conference process and also through

	the CP Chairmans quality assuring this work and challenging practice. • Auditing of casework across children's services and through themed audits by the Quality Assurance team. • The Quality Assurance team also has recently employed two Practice Learning & Development mentors to assist and develop staff across a range of identified issues.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	The Child Protection Advisors have attended the Child Sexual Exploitation training which has been delivered by the CSE manager or consulted with the CSE manager in relation to CP conferences.
Regulator inspection in reporting period and outcomes	There was no Ofsted inspection during this period. A reciprocal peer review of a London local authority was requested by the London Safeguarding Children Board and the Association of London Directors of Children's Services. This was carried out in December 2014. A joint report was submitted to the London Councils.
Challenges in the reporting period	Since January 2015 there has been a rise in the number of child protection case conferences being convened which has put a strain on the service.
Progress on safeguarding priorities in the reporting period	• The Safeguarding Children's Service introduced the Signs of Safety model in July 2014 in the stated time-frame. • Greater understanding by staff around the issue of Child Sexual Exploitation. • The monthly MAP (Multi-Agency Panel meets to oversee CSE cases and the MASE meeting looks at the strategic issues arising from interagency co-operation.
Safeguarding priorities for 2015/6	• Ensuring that 'Signs of Safety' practice is embedded in Child Protection Conferences and that its delivery is consistent. Ongoing development of the CP plans to ensure they reduce risk and are outcome focused. • Continued improvement of the auditing process by extending cross-team auditing and use of more user-friendly audit forms.
Good news stories	• Signs of Safety was successfully introduced as a method of conducting child protection case conferences and there has been a general consensus from other agencies that this is preferred to the previous style of conferences through better engagement with the families. • The number of audits undertaken by the managers across children's services has risen steadily from September 2014. There is a trend clearly showing a

	general improvement in the cases audited over time.

Early Intervention Services

Name of agency	Early Intervention Services (LBH)
Description of service	Service purpose Working with families who need our support so that they may develop the skills, knowledge and resilience required to be self-reliant and prosper We do this by securing the following: Child and Family Development Services: Securing and providing a range of early learning, childcare and family development services delivered through early years centres and children's centres; Targeted Programmes: meeting the needs of families by securing and providing targeted programmes of developmental activity that enables children, young people and families to develop the behaviours, skills and capabilities to avoid or overcome problems and risks; Youth Offending Services (LSCB annual report submission provided separately): meeting the needs of young people who have come to the attention of criminal justice agencies by delivering intervention and tracking services with a view to reducing the likelihood of further offending behaviour; and Key-working Services: Meeting the needs of families by providing integrated 1-1 support and challenge to enable them to overcome problems including those identified within the terms of the Troubled Families programme, those concerned with school absence and non participation in education employment and training.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	The service has been going through a significant process of transformation which includes creating a new staffing establishment. The majority of staff within the previous delivery model will have completed the 'Working Together' training and will have also participated in recently provided CSE training. A 2015 / 16 training plan for the new service establishment will be development and implemented this year.
Regulator inspection in reporting period and outcomes	7 Children's Centres have been inspected by Ofsted in this reporting period. 2 were judged as 'good' and 5 as 'requires improvement'.
Challenges in the reporting period	The service has been in a period of transition as it moves towards establishing its new delivery model. Service areas

	have been testing new ways of working in order to develop our approach to providing targeted support to families. This activity has been both challenging and productive. The outcomes have informed the new service structure which is in the process of being constructed.
Progress on safeguarding priorities in the reporting period	Early Intervention and Prevention Strategy actions have been progressed which include the continued implementation of the Lead Professional, Early Help Assessment and Team Around the Family (TAF) processes. Use of TAF increased by 56% in 2014/15. The service has led the process of delivering on Troubled Families requirements to improve outcomes for 555 vulnerable families within phase 1 of the programme. The 555 'turnaround' target was achieved in this reporting period. The service has also embedded the Key-working Service within its revised service design. Managers, Team Leaders and practitioners continue to provide targeted and preventative support to families who are at risk of poor outcomes in collaboration with universal services, partner agencies and social care. This work includes the identification and tracking of children missing education. The service has also worked in collaboration with social work teams to establish clear 'step up' and 'step down' processes between social care and early intervention services in support of families in receipt of statutory intervention. The programmes' area of service has also been developing new ways of working in support of vulnerable families. These include targeted programmes for young people during transition from primary to secondary school and personal and social development programmes for girls and young women and boys and young men at risk. Prototype activity has seen over 250 young people benefiting from participation with learning outcomes including increased capacity to recognise and positively manage personal feelings and emotions. The service's young people's counselling service, Link, has continued to support young people at risk with over 400 young people supported to overcome emotional health and well-being issues. Sexual health services provided by KISS and alcohol and substance misuse services delivered via Sorted continue to enable young people to negotiate risk related behaviour associated in these areas. The prototype programme offer has now incorporated all these functions within the revised service delivery model. The Children's Centre programme has regularly worked with over 26,000 families over the past year with 26% of which were vulnerable families targeted for children's centre support.
Safeguarding priorities for 2015/6	• Finalising of revised Early intervention and Prevention Strategy 2015 - 2018; • Embedding structural changes within the service;

	• Full roll-out and embedding of the lead professional, early help assessment and team around the families process across the partnership; • Refining processes for identifying and targeting families in need of early help; and • Progressing service development and partnership activity in order to deliver outcome requirements of the extended Troubled Families programme.
Good news stories	• Target programme offer endorsed as good practice by Home Office led Peer Review regarding prevention of serious youth violence and gangs; and • The achievement of Troubled Families Phase 1 outcome requirements

The Hillingdon Hospital

Name of agency	The Hillingdon Hospitals NHS Trust
Description of service	The trust delivers acute medical services for the public. The services covered are Adult and Children inpatient and outpatients services, Emergency Department, Minor Injuries Unit (This is at Mount Vernon Hospital), and Maternity Services Statutory safeguarding children arrangements at the Trust are as follows • Executive Lead for Safeguarding Children • Named Nurse for Safeguarding Children • Named Doctors for Safeguarding Children • Named Midwife for Safeguarding Children The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. The Committee is Chairmaned by the Executive Director of the Patient Experience and Nursing.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	Level 1-3 Safeguarding Children Training Trust target is 80%. Successfully driving compliance with this has been an area of focus: <u>Figures for December 2014:</u> Level 1 was 69.38% Level 2 was 63.42% Level 3 was 62.77% By the end of the financial year training figures for all levels were above 80%.

	Figures on 10/03/2015: Level 1 was 93% Level 2 was 89% Level 3 was 91%
Regulator inspection in reporting period and outcomes	Care Quality Commission planned inspection in October 2014. The Trust received a warning notice for Regulation 10, within which were requirements to improve some aspects of Services for Children and Young People; of note directly referring to safeguarding children: • Make sure staff are appropriately trained in safeguarding • Regularly monitor and assess completion of actions agreed at weekly "safety-net" meetings
Challenges in the reporting period	• Due to incumbent's retirement there was 3 month vacancy in Named Nurse for Safeguarding Children. Interim arrangements meant full scope of role was not covered during that period. • The systems in place in the Accident and Emergency department to identify, manage and reduce safeguarding risks to children were identified as not fully robust. • Safeguarding Children Training was below the 80% trust target for a significant period of the year.
Progress on safeguarding priorities in the reporting period	The Named nurse vacancy has been filled, the new post holder commenced at the Trust in January 2015. There has been a great improvement with Safeguarding Children Training since October 2014. Safeguarding Children training continues to be mandatory and is monitored by the live WIRED database to ensure staff compliance. Training will continue to be offered through hospital trainers, external trainers and LSCB.
Safeguarding priorities for 2015/6	• To commence formal Safeguarding Children Supervision for staff working directly with children and families • Raise more awareness of Domestic Violence and Abuse. Devise clear guidance on Domestic Violence Guidelines for frontline staff. This is be in line with the Local Authority Domestic Violence Strategy • Maintaining Safeguarding Children Training above the 80% target • Embedding learning from the 2 serious case reviews to which the organisation contributed

	• Ensure implementation of agreed actions in response to Kate Lampard Report
Good news stories	• Good interagency working. The MASH Senior Practitioner has joined our Accident and Emergency (A&E) Safety Net Meeting. This is a meeting where safeguarding children cases presenting to A&E and Urgent Care are discussed on weekly basis
Good practice examples	• There have been new appointments into the Trust's team of Named Professionals for Safeguarding Children and they are providing visible clinical leadership and taking an active role in driving forward service improvements.
Any other comments	The challenges faced this year were a catalyst for change and created a valuable opportunity to review and strengthen the service.

Central and North West London Foundation Trust:

Name of agency	CNWL
Description of service	CNWL provides a range of physical health, mental health, substance misuse, learning disability, offender care (prison and immigration removal centre) healthcare services across approximately 100 sites. It is one of the largest community facing trusts in England, with approximately 6,500 staff. CNWL provides services to a third of London's population and across wider geographical areas including Milton Keynes, Kent, Surrey, Buckinghamshire and Hampshire. After Milton Keynes joined the Trust in April 2013, approximately 40% of services are community health and 60% are mental health and allied health specialties.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	Level 1: All staff including non-clinical managers and staff working in health care settings (100%) Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers (94%) Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns (90%)
Regulator inspection in reporting period and outcomes	CQC inspection 23rd February 2015, report expected in June.
Challenges in the reporting period	Maintaining high quality of safeguarding practice in light of the unprecedented financial challenges in the public sector. Safeguarding Children training was a high priority for CNWL

	although freeing up time for staff to attend remained problematic across the organisation.
Progress on safeguarding priorities in the reporting period	• *Reviewing the structures for Safeguarding Children within the Trust*- completed. The Named Nurses attend the quarterly Safeguarding Group, a sub-committee of CNWL's Board, Chairmaned by the Divisional Director of Nursing. Following the implementation of the integrated governance review and the divisional restructuring, membership now consists of the Trust Named Doctor and Nurses, Associate Director of Quality, Safeguarding and Safety, Divisional Directors of Nursing and Safeguarding Advisors from Offender Care, Addictions and Sexual Health. This group also covers safeguarding adults due to the commonality of themes and issues and has appropriate leads, for example, from Human Resources, also attending. • *Learning lessons themes from SCRs/LLRs over the last 5 years*- A Trust-wide review of lessons learnt from SCRs and learning lesson reviews (LLRs) produced a briefing note for practitioners. This was disseminated via the new divisions and presented at the Quarterly Safeguarding Group in January 2015. Bespoke training in specific localities takes place run by each LSCB after each review concludes. The format will be further developed in 2015/2016, when the Trust has 13 SCRs concluding and it will be important that any lessons are learnt across the Trust. • *Raise awareness of private fostering procedures*- referral numbers remain low within Hillingdon and nationally. CNWL Safeguarding Children Advisor contributed to the private fostering task and finish group. All levels of training include information on private fostering. • *All Health Care Professionals working directly with children, from birth to 18 years of age, will have access to child protection supervision*- completed. All staff working directly with children receives safeguarding supervision every 3 months as a minimum. • *Carry out clinical audits to ensure a safe, quality service is in place and that local and national standards are followed*- The Trust has developed a folder of supporting information to assure LSCBs which has been well received. The Trust has completed a large number of audits in the last year and had completed all of the audits it had planned for 2014/15. Audits undertaken in Hillingdon: 1. Child Protection and Voice of the Child: Are they reflected in children's records? 2. Evaluation of Safeguarding Children Supervision 3. Accident Prevention in under 5's. • *Raise awareness of female genital mutilation with health*

	care professionals via training and supervision- ongoing, FGM is included in all levels of training delivered and health staff have accessed e leaning courses. In March 2014, NHS England sent a letter to all provider Trusts in London "One of the recommendations in the intercollegiate document "Tackling FGM in the UK" is about empowering frontline professions and being clear about accountabilities, we are both keen to make sure we support this agenda through the multi-disciplinary steering group which was recently set up in London." From April 2014, NHS hospitals were required to record: • if a patient has had FGM • if there is a family history of FGM • if an FGM-related procedure has been carried out on a women - (de-infibulation) • *Health staff are ideally placed to help identify and provide support for those at risk of child sexual exploitation*- ongoing, the CNWL Safeguarding Children Advisor attends the multi-agency child sexual exploitation group and the Safeguarding Children Team have adapted training material to ensure health staff are aware of how potential or actual victims may present and what the local arrangements are. • *Raise awareness in relevant staff groups within Hillingdon's children's services to ensure they are able to identify and support missing children and runaways*- ongoing • *Promote awareness in Hillingdon of the new threshold criteria adapted from the London Board Levels of Need*- completed • *Monitor the relationship of the Trust staff with the MASH and contributing to MASH evaluations. Support health staff during MASH implementation in Hillingdon. Ensure Hillingdon staff access the MASH training courses*- completed. Staff attended training and the MASH health representatives have spoken to staff groups in children's services. • *The Hillingdon Safeguarding Children Team will support health professionals with the new Signs of Safety approach to assessment, intervention and case conferences*- completed. All staff were trained in Signs of Safety and ongoing support is given. • *Publicise the Think Family agenda more widely*- The importance of 'Think Family' is well embedded in the Safeguarding Children training, and is well exampled in the Harrow LSCB DVD on Neglect. The Divisional Directors of Nursing are holding Divisional Quarterly Safeguarding Groups covering adult and child safeguarding, which will strengthen the Think Family approach. • *Increasing the safeguarding children training for Consultant staff*- ongoing

	• *Monitoring uptake of safeguarding children training following the new Learning and Development Zone*- completed. The new system is recording safeguarding children training compliance. • *Adapting the Named Nurse meeting to provide peer group supervision*- completed. The Named Nurses meet six weekly and discuss policy / procedures, training, emerging issues nationally and within CNWL. This group also provides peer supervision for members. Named Nurses also now provide cover for colleagues when on annual leave, etc. The group also considers issues around consistency of practice and share good practice examples. • *Develop Safeguarding Children Strategy*- As the new Working Together guidance was issued in 2015 and the final version of the London Child Protection Procedures in June 2014 it was agreed that the development of a strategy would be put on hold. This will be a priority in 2015/2016. • *Planning for implementation of the new IT System and reporting of data*- ongoing. The decision made strategically is for TPP SystemOne and this will go live in August. The Named Nurses have been consulted and are advising on configuring the software to ensure that the specification of the new IT system meets the requirements for safeguarding children. The Named Nurses are responsible for reviewing the practical application of the system and will link with other providers in London who will be using the same system for like services, to learn lessons and plan accordingly.
Safeguarding priorities for 2015/6	2015/16 includes: • SC Strategy and Training Strategy • Review of safeguarding children arrangements in Divisional structures, particularly for Mental Health & Allied Specialties and Sexual Health Services • Address the Implications of the Care Act • Review of Prevent training for children's workforce • Complete actions arising from the review of Savile Reports • Preparing for Health Visiting Service to be commissioned by Public Health
Good news stories	• MASH now has a full time health visitor as part of the team • School nurses in Hillingdon asked young people in high schools subject to child protection plans about their views. 100% of the young people surveyed said they had been asked for their views about the CP plan, said they felt listened to and were treated with respect.
Good practice examples	• CNWL was represented at the workshop on sexually harmful behaviour by a school nurse and a CAMHS worker • Health partners are sharing information with the multi-agency sexual exploitation panel • CAMHS have a young person on interview panels • CNWL's intranet was updated in January 2015 and the new

	homepage has a dedicated safeguarding children section with easy access to all local and national guidance
Any other comments	Safeguarding children and young people remains a key priority for the Trust. CNWL strives to ensure that local processes meet best practice standards and that lessons are learned from both national and local Serious Case and Learning Lessons Reviews. Work in 2015/16 demonstrated the energy and commitment of Trust staff to deliver a high quality service to the population CNWL serves.

NHS Hillingdon Clinical Commissioning Group (CCG)

Name of agency	NHS Hillingdon Clinical Commissioning Group (CCG)
Description of service	Hillingdon CCG is a statutory NHS body with a range of statutory responsibilities including safeguarding children and adults. Like all CCGs, it is a membership organisation that brings together general practices to commission local health services for Hillingdon's registered and unregistered population. The CCG needs assurance from all organisations from which it commissions health services, that they have effective safeguarding arrangements in place.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	Level 3 – 100% Level 2 – 100% Level 1 – 90%
Regulator inspection in reporting period and outcomes	No inspections have taken place, however the CCG has quarterly Assurance meetings with NHS England (London Region) during which the Health economy Safeguarding concerns e.g. Serious Case Reviews, Domestic Homicide Reviews and gaps in service provisions, are discussed The CCG regularly reviews and monitors Safeguarding Children activities of its Provider organisations
Challenges in the reporting period	Change in office premises Health economy concerns around working with new partner arrangements
Progress on safeguarding priorities in the reporting period	Safeguarding Supervision for relevant staff in place Training arrangements in progress See good practice examples.

	Safeguarding Children profile raised within CCG The CCG is represented on the LSCB and all relevant subgroups
Safeguarding priorities for 2015/6	Safeguarding Training – single and multi-agency (including specific training for Commissioners) Engagement of all Primary Care staff GP Section 11 Audit – collating, reporting and bridging any gaps
Good news stories	Improved engagement and partnership working Co editing the updated Health Chapter in the London child Protection Procedures
Good practice examples	Development of CCG Safeguarding Children Leaflet and Flowchart of Health Economy Safeguarding Children Leads for cascade to all staff Safeguarding Children page on the CCG's extranet Regular Safeguarding Children items on staff newsletter

Sue Pryor, one of two Headteacher representatives on the Board writes about Swakeleys school:

Name of agency	Swakeleys School for Girls
Description of service	Secondary Academy
Safeguarding training undertaken in reporting period. % of staff trained at each level.	100% of all staff – teaching and support
Regulator inspection in reporting period and outcomes	None – Ofsted visited in November 2013 and judged us to be Outstanding
Challenges in the reporting period	Continuity of service – frequent changes in personnel dealing with a case Referral process involves giving the same info over and over again to different people There is still a lack of clarity re thresholds or they are not consistently applied

	There are too many times when professionals do not turn up to meetings or are very late – issues with communication
Progress on safeguarding priorities in the reporting period	Good progress – FGM, sexual exploitation and extremism/radicalisation addressed
Safeguarding priorities for 2015/6	Further work on the Prevent strategy
Good news stories	Since Skylakes have been involved, paperwork is better The LSCB conference was successful Collaboration at Headteacher level re safeguarding priorities and training is better Safeguarding cluster meetings for designated leads are a positive

UK Border Force:

Name of agency	Border Force Heathrow
Description of service	Safeguarding of Children and Vulnerable Adults arriving in the UK through Heathrow Airport.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	All Border Force officers receive training in the core skills for protecting children to give a greater understanding of how to identify children in need and the actions to take once you have done so. The Safeguarding and Trafficking Teams are trained to a higher, more expert level than ordinary front-line officers. In 2014 80 Officers and 12 Managers received this enhanced training. In 2015 104 Managers and 69 Officers have been trained to date, however the training is a rolling programme, and further courses are planned for the summer and winter of 2015. This enhanced training course has been validated by external agencies such as UKHTC and CEOP. This is a joint agency course primarily delivered by Border Force and the Metropolitan Police but incorporates training sessions delivered by Hillingdon Social Services, Salvation Army and ECPAT to provide a rounded experience. Elements of police ABE, (Achieving Best Evidence), training and expertise in areas of exploitation such as Juju, FGM and forced marriage have also been included.

Regulator inspection in reporting period and outcomes	Section 55 Review conducted every 3 months by Heathrow Safeguarding Coordinator and Action Plan reviewed & updated. Regular SAT Assurance conducted by local teams and fortnightly joint meetings with SS to review & progress arriving cases. . Recent visit by HMCIP Prisons & Border Force Operational Assurance directorate to review handling SAT cases..
Challenges in the reporting period	Consistently maintaining a fully trained SAT team and recruiting others to fill arising vacancies. New Vietnam Airways flights into TN4. Addressed by joint frontline operations.
Progress on safeguarding priorities in the reporting period	We have seen excellent results by the pan Heathrow SAT teams. There are 2 SAT officers allocated on shift each day to progress any cases identified.
Safeguarding priorities for 2015/6	We will continue to build on already considerable achievements of the SAT teams and work with other agencies to carry out frontline operations to identify PVOTs or FGM. A national project has been launched to train Airlines and stakeholders in trafficking awareness and to create a national hotline number for them to call BF with any concerns.
Good news stories	A very successful first year for the Heathrow SAT teams, established in April 2014 to replace Paladin. We have seen increased joint working with Hillingdon, including delivery of expert training, job shadowing & involvement in joint operations such as Op Limelight (FGM) and Op Jake (Vietnam Airlines). BF has increased the recruitment of volunteer responsible adults through Heathrow's Ambassador network and NGO organisations. A new quarterly joint strategic forum has been established with Hillingdon LSCB and fortnightly operational meetings held with SS and each Heathrow terminal.
Good practice examples	Designated expert SAT teams. Joint agency working on front line operations.

Police Child Abuse Investigation Team.

Name of agency	Police CAIT
Description of service	Receipt and assessment of referrals from CSC, undertaking strategy discussions/meetings regarding safeguarding of children and joint investigation in appropriate cases within the CAIT remit. Criminal investigation / prosecution in appropriate cases within the CAIT remit. Investigation of sudden unexplained deaths in infancy (SUDI).

	Participation in multi-agency child care conferences. Disclosure of police intelligence to CSC in appropriate circumstances.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	All staff joining CAIT during the reporting period received safeguarding training. 100% of police officers and police staff employed on CAIT received safeguarding training.
Regulator inspection in reporting period and outcomes	None
Challenges in the reporting period	Skylakes managers have an expectation that CAIT will deal with all matters pertaining to children when the reality is somewhat different with borough police, child sexual exploitation teams and other units taking primacy for some investigations involving children. This has led to tensions between Skylakes and CAIT which we are still working to resolve. Staff absence on CAIT continues to be a challenge with 2 officers long-term sick, 2 officers on maternity leave, 3 officers on restricted or recuperative duty and 3 vacant posts. The situation is exacerbated by abstractions for annual leave, court appearances, training and rest days accumulated through weekend working. This has impacted on the performance of the team.
Progress on safeguarding priorities in the reporting period	In the 2015-15 financial year, Northwood CAIT achieved the highest detection rate in London for child rape with 51.3% of cases detected; 15.5% more than any other London CAIT. During the same period reports of child cruelty offences dropped by 30% compared with the previous year.
Safeguarding priorities for 2015/6	Crime reduction and improved detection rates for cases of familial violence against children.
Good news stories	Launch of a Safer Sleeping in Infants Project. This is a multi-agency venture to highlight risk factors associated with infant death. The aim of the project is to reduce the number of sudden infant death syndrome (SIDS) cases. Championed by Dr Jide Menakaya, this is a London-wide reduction campaign.
Good practice examples	Establishment of an agreed escalation procedure between police and CSC for cases where managers from each agency cannot reach agreement. Agreement with borough police CSU regarding their role in strategy discussions with CSC.

Metropolitan Police, London Borough of Hillingdon

Name of agency	Metropolitan Police (MPS)
Description of service	Law enforcement
Safeguarding training undertaken in reporting period. % of staff trained at each level.	The MPS are currently rolling out Multi Agency Sexual Exploitation training for all front line staff. Every officer in Hillingdon will receive this training . Being conducted locally with delivery input from the Child Sexual Exploitation Command (SO17)
Regulator inspection in reporting period and outcomes	Mayor's Office for Policing and Crime (M.O.P.C.)
Challenges in the reporting period	Pulling together stakeholders in the MASH to deliver resources previously promised. Driving the delivery group to a successful conclusion.
Progress on safeguarding priorities in the reporting period	1.Multi Agency Safeguarding Hub ,(M.A.S.H.). go life date 27th of April 2015. 2.Multi Agency Panel (M.A.P.) and Multi Agency Sexual Exploitation (M.A.S.H.) now fully operational with a monthly meeting.
Safeguarding priorities for 2015/6	1.Complete, Child Sexual Exploitation Training cycle. 2. Develop support a bespoke "Operation Makesafe " bespoke to the needs of Hillingdon Borough.
Good news stories	The MASH launch on 27th April was a well attended presentation informing managers & partners of the remit of the MASH. Individual presentations assisted guests with short presentations of how each contributed in the MASH process. This launch was well attended and received and viewed as a success.
Good practice examples	Operation Seacliffe. Investigation into CSE. Four arrested an additional four interviewed. Pending CPS disposal outcome.
Any other comments	A productive year with better joint working between police and partner agencies. This improvement has to increase and improve for the benefit of victims/subjects.

Probation Community Rehabilitation Company

Name of agency	London Community Rehabilitation Company
Description of service	The role of the CRC is to manage the majority of offenders under probation supervision. We work alongside the National Probation Service, which manages offenders who have been assessed as presenting high risk of harm to others. London CRC is one of 21 CRCs supervising offenders across England

	and Wales. London CRC employs around 1,200 staff and manages almost 30,000 offenders at any one time. Service delivery is currently based on geographical borough 'clusters'. The Hillingdon and Hounslow cluster is one of 15 clusters in London.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	London CRC has an Assistant Chief Officer who leads on Safeguarding issues for the whole of London. A Senior Probation Officer has recently been appointed to assist in this work. All operational Senior Managers are required to undertake Safeguarding training on a regular basis. London CRC has recently published its updated Policy and procedures in relation to Safeguarding children which remains one of the key priority areas of work. At a local level the Cluster ACO, lead Senior Probation Officer, Children`s Champion and the Practice Development Officers are responsible for work to improve our Safeguarding practice and quality. This assists in measuring local practice in key areas. London CRC carries out checks of employment history, identity and obtains at least 2 references which comment on suitability of working with children if appropriate. All staff are DBS checked before they commence work with London CRC. Further DBS checks are now to be carried out every 3 years. London CRC has a dedicated and fully trained recruitment team. Probation Officers coming into their first job will have all received the appropriate training in safeguarding as part of their course. Newly qualified probation officers applying for a job with the London CRC must pass an Assessment Centre which tests their knowledge about safeguarding amongst other areas. All Hillingdon practitioner staff (permanent/temporary) are up to date with the required safeguarding training.
Regulator inspection in reporting period and outcomes	The London CRC Safeguarding Children performance framework was launched in Jan 2015 to measure and evidence that key routine tasks highlighted in the safeguarding procedures are implemented such as routine checks with Children's Social Care, responses received from Social Care and home visits undertaken on cases where child protection concerns are registered.

Challenges in the reporting period	As a result of auditing activity in each London Cluster a number of actions will be taken forward as part of the Improvement plan.
Progress on safeguarding priorities in the reporting period	In Hillingdon auditing activity demonstrates that probation staff exceeded the target to complete key practice activities in 3 of the 4 routine tasks identified. The Cluster has just missed the target to complete home visits in registered cases by 5%. Though significant progress was made in the months between Feb-April 2015 auditing activity led by a Senior Probation Officer is now taking place in **each case** where a home visit has not been carried out to identify the reasons why it has not been undertaken, making an assessment as to whether or not there is a good reason and to record these reasons with management oversight on the case record. This activity should provide reassurance that h/v is taking place in every possible case and allow for the current 'target' to be appropriately adjusted on the basis of the evidence complied.
Safeguarding priorities for 2015/6	2015/16 priorities are – Children's Champion conference to take place – not yet achieved Performance Framework in place - achieved First all London report published - achieved. Improvement in performance to be demonstrated by end May 2015 – partially achieved.

Youth Offending Service

Name of agency	Youth Offending Service
Description of service	Carries out the partner's statutory functions with regards to young offenders (aged 10-18)
Safeguarding training undertaken in reporting period. % of staff trained at each level.	50% of managers and 83% of practitioner staff have undertaken the Initial Working Together programme. The majority of trained staff are due to undertake refresher training in 2015. Staff untrained are those new to the service and will be booked on in 15/16. All practitioner staff have been asked to complete the Child Sexual Exploitation - what professionals need to know briefing available this year.

Regulator inspection in reporting period and outcomes	Her Majesty's Inspectorate for Probation undertook a Short Quality Screening Inspection (SQS) in November 2014. The key strengths notes included; • The YOS had made substantial progress since the last inspection • Assessment of diversity factors and barriers to engagement was strong • Work during the custodial phase of sentences was consistently good • Case managers were clearly committed to achieving positive outcome Areas for improvement included; • Assessment of and planning to address vulnerability • More attention needed to be given to victim safety • Actions to manage risk of harm need to be clear and precise, including contingency plans • Managers should provide greater support to staff to improve the quality of their assessments and plans
Challenges in the reporting period	Although the numbers of young people in the system have continued to reduce, the needs of those left in the cohort are increasingly complex and challenging. The assessed risk of harm posed by the cohort to others is also rising requiring greater supervision by the service in the community. There has been a rise in the re-offending rates (historical) for the 12/13 cohort reflecting this steady increase in complexity, although Hillingdon's rate remains below that of London and its family group. In the latter half of the year a number of staff changes have taken place with established practitioners and managers moving on. Recruitment of suitably skilled replacements has proven difficult.
Progress on safeguarding priorities in the reporting period	• A custody improvement plan was developed based on data from previous years and there has been a reduction in custodial sentencing from 26 in 13/14, to 18 in 14/15. • The Combined Risk, Intervention and Safeguarding panel has been reviewed taking into consideration the comments of the SQS, to ensure that it is fit for purpose in meeting its stated objectives with respect to vulnerability and risk management. • Case auditing processes have also been reviewed to support continuous improvement in assessment quality • The Youth Justice Boards Re-Offending Toolkit has been

	used to analyse data on re-offending behaviour and the characteristics of those perpetrating it in order that prevention strategies can be developed and resources allocated. • The YOS has implemented the 'live Tracker' tool for re-offending in order to implement immediate responses to re-offending.
Safeguarding priorities for 2015/6	• To implement the Asset Plus Assessment Tool which should support improved assessments, risk management and intervention planning. • For all practitioner staff to undertake CSE awareness training. • To develop referral pathways into early intervention services for out of court disposal cases. • To identify siblings of those involved in Serious Youth Violence and support their access to Early Intervention Services. • To identify suitable staffing resource to carry out assessments of young people for neurodisability conditions which impact on their vulnerability within the criminal justice system
Good news stories	• The reduction in custodial sentences • There has been a slight reduction in the rate (per 100,000 of 10-17 population) of young people receiving their first court conviction in 2014/15 from 262 to 258.7
Good practice examples	A young person with significant learning difficulties was charged with sexual offences against younger family members. The assessment of his risk of harm to others was significantly affected by his learning difficulty. The YOS and Children's Social Care identified an independent specialist who carried out the assessment over a 12 week period. The assessment concluded that future inappropriate sexual behaviour could be influenced through a specific intervention regimen. Working together agencies developed a package of interventions and support which was accepted by the court in its sentencing. This enabled the young person to remain in the community where his needs were best met whilst maintaining a high level of supervision reducing the risks posed to others. The specific intervention designed to address the inappropriate sexual behaviours should reduce risk of future incidents in the longer terms.

APPENDIX 2 - IDVA STATISTICS

1. Annual Total Victims 2014-2015

Total New Referrals to HIDVAP	**647**	
Total Female	**624**	**(96%)**
Total Male	**23**	**(4%)**
Total Repeat Referrals	**61**	**(9%)***
Total Engaging	**544**	**(84%)**

* repeat referrals can be victims that the service worked with a year or years ago; It can take some victims a few attempts before they finally leave.

2. Children and Young People

Total Children	**749**
Total Victims who stated that their children witnessed violence.*	**259**
Total Victims who stated that their children had experienced direct abuse from the perpetrator. *	**71**
Total Victims who were pregnant at the time of recent/referral or had a new born baby.	**70**
Total 16-24 Year Old Clients	**85**

*It is important to recognise that this data is gained from information shared by the client through the Risk Assessment process. Some clients may not disclose if their children have experienced direct or witnessed abuse.

APPENDIX 3 - LSCB Partners and Attendance

Membership of Local Safeguarding Children Board and attendance during 2014-15

Organisation	Attendance 2014-15
London Borough of Hillingdon including Public Health	100%
CNWL	100%
Public Health	100%
Hillingdon CCG	100%
Schools	100%
Probation and CRC	100%
Voluntary Sector	100%
Hillingdon Hospital	75%
CAIT	25%
CAFCASS	25%
UKBF	Unable to send a representative

APPENDIX 4 - Finance

LSCB Budget

Income 2014-15

London Borough of Hillingdon:	£96,100
NHS:	£61,200
Metropolitan Police	£5,000
Probation (NOMS and CRC)	£2,000
Total:	**£164,850**

Outgoings 2014-15

Staffing:	£97,775.35
Non-staffing:	£39,512.73
Conference:	- £183.33
Training:	£22,872.50
Licences:	£8,750.00
SCR:	£17,884.80
Chairmanman:	£26,850.00
Total:	**£213,462.05**

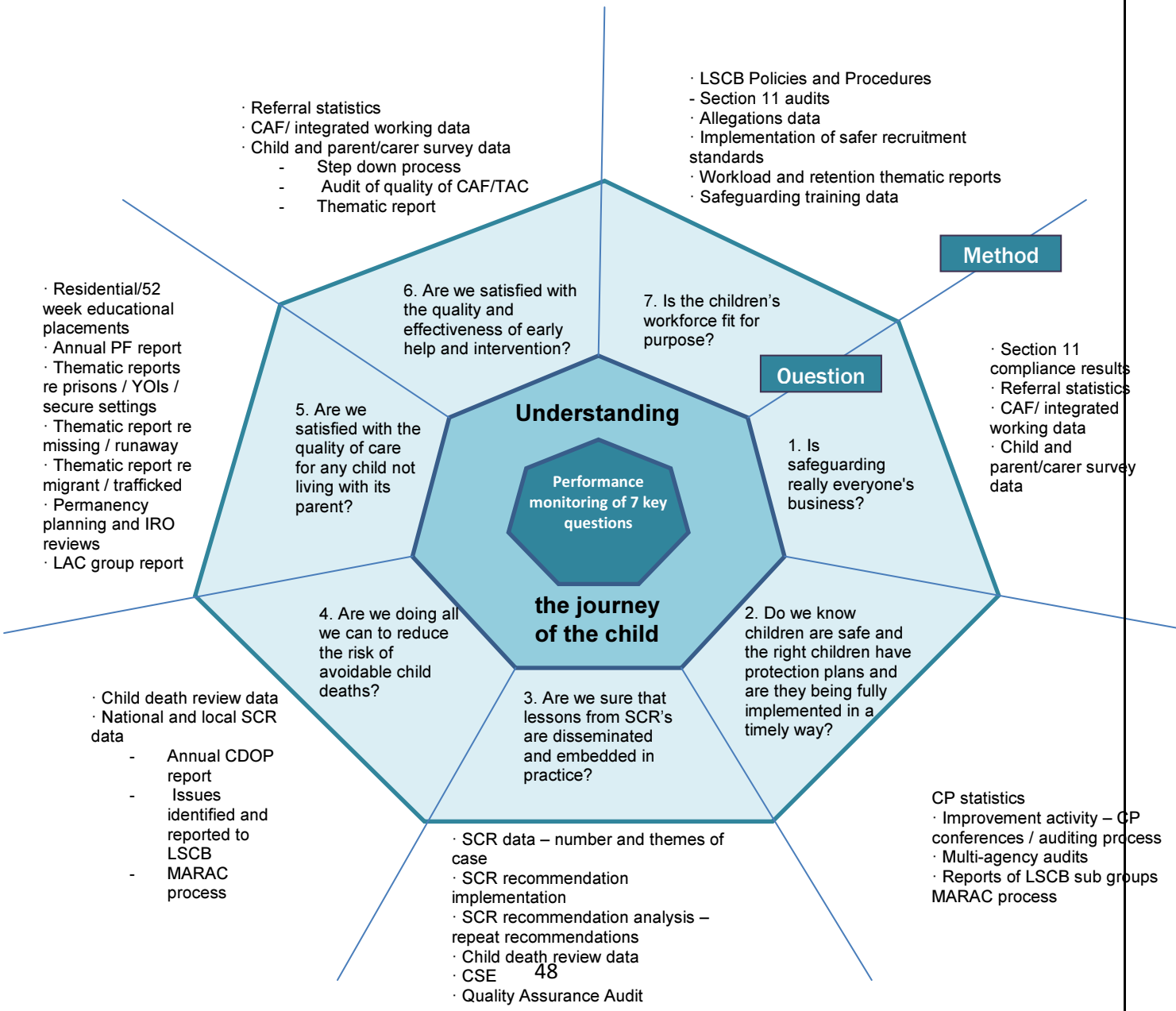
Variance: £48,945 Overspend.

APPENDIX 5 PERFORMANCE WEB

Hillingdon LSCB

Performance Web

Quarter



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SAFEGUARDING ADULTS PARTNERSHIP BOARD

Relevant Board Member(s)	Councillor Phillip Corthorne
Organisation	Safeguarding Adults Partnership Board (SAPB)
Report author	Stephen Ashley
Papers with report	(SAPB) annual report

1. HEADLINE INFORMATION

Summary	The annual report of the SAPB is a statutory requirement from April 2015. This annual report covers the year 2014/15 for which the production of an annual report was discretionary. The annual report describes the work of the partners engaged in Adult Safeguarding in the Borough, for the year ending 31 March 2015. It will be published and available to view on the Council's website.
Contribution to plans and strategies	N/A
Financial Cost	No financial cost
Ward(s) affected	N/A

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the content of the report; and**
2. **passes comment on the timing and content of future annual reports.**

3. INFORMATION

Supporting Information

Review of Safeguarding Adults

In January 2015 the SAPB commissioned a review to assess its effectiveness as a Board. The review followed the Local Government association peer review/challenge methodology.

Key recommendations for the Board to be Care Act compliant are:

- The Board should establish a revised structure with senior members from each agency to demonstrate commitment and importance of the board and enhance its ability to operate effectively.
- Resourcing of the work of the Board and infrastructure that effectively ensures delivery of core functions and the work programme should be agreed between the statutory partners and reviewed annually. This would include the setting up of the integrated safeguarding hub.

Effectiveness Of Local Safeguarding Arrangements.

A number of workshops have been held to clarify and promote a better understanding about safeguarding thresholds in order to achieve a more consistent and proportionate response.

The council has developed a range of reports to facilitate effective performance monitoring. These are:

1. Dashboard, a report to improve performance and quality information available to the SAPB.
2. Monthly reports to enable service Managers and Team Managers to keep abreast of performance in their area.
3. Provider performance reports to facilitate operational and strategic oversight of safeguarding practice.

Serious case reviews

One serious case review was carried out in 2014-15. All actions from the review have now been completed. The key learning points are:

1. The need for clear communication between agencies at critical points: for example, when a patient is brought to A&E by ambulance there must be a clear handover to hospital staff.
2. Non attendance at health appointments should be followed up more rigorously.
3. Agencies should remain vigilant for indicators that a carer might be in need of a carers assessment.

Discharge should not be the default position when contact cannot be made with a vulnerable patient

Financial Implications

No financial implications

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Policy Overview Committee comments

The Committee welcomed the report which highlighted that services across Hillingdon were supporting residents and safeguarding vulnerable adults.

The Committee noted that the establishment of the Care and Governance Board and the Vulnerable People Panel had created positive bodies which should enhance multi -agency communication and information sharing.

Partnership working was also strong. However, the Committee raised concerns in a number of areas. In particular, it was noted that staff were not confident about using the Mental Capacity Act and that further improvements were required in relation to information sharing regarding high risk transition points such as admission and discharge from hospital. The Committee noted that there had been a significant rise in the number of authorisation requests for Deprivation of Liberty Safeguards compared to the previous year. In addition, the Committee raised concerns about commissioning processes and the separation of responsibilities across the Clinical Commissioning Group and NHS England and noted that NHS England had yet to be represented on the Board.

Given the number of vulnerable adults in the Borough is increasing; the Committee welcomed the approach to develop Teams focussed around the family and a more holistic approach to safeguarding. The Committee also agreed that the implementation of Making Safeguarding Personal across all agencies, as well as raising public awareness of Safeguarding were important aspirations which would contribute in a positive way to the service currently provided.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

The actual cost of the operation of the Board in 2015/16 has still to be quantified and it is noted there may be some implications for the future level of support by partners for the Board's work since the Board has been placed on a statutory footing from April 2015.

Hillingdon Council Legal comments

The role and remit of the SAPB is currently under review to ensure that it will meet the requirements of the Care Act. Under current arrangements the SAPB is well placed to be compliant with new regulations and guidance as currently understood.

6. BACKGROUND PAPERS

NIL.

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Hillingdon Safer Adults Partnership Board Annual Report 2014 - 15

HILLINGDON SAFEGUARDING ADULTS PARTNERSHIP BOARD

ANNUAL REPORT 2014-15

1. INTRODUCTION

This is my last annual report as independent chair of Hillingdon Safeguarding Adults Partnership Board, and also the last annual report prior to the Care Act 2014 entering the Statute books in April 2015.

This year has seen the establishment of both the Vulnerable Persons Panel and Care Governance Board. The Vulnerable Persons Panel manages and monitors high risk cases of "self neglect", including hoarding. The Care Governance Board is part of the framework established to identify, monitor and respond to serious quality issues or identified risks to service users, within care provider services. These developments have facilitated better partnership working and improved multi-agency management of high risk cases and local care service provision.

The Safeguarding Adults Partnership Board (SAPB) has continued to oversee the implementation of the Winterbourne and Francis action plans. One Serious Case Review was completed during the year and an action plan agreed.

Services successfully managed a large increase in Deprivation of Liberty Assessments following a court judgement and the Council has begun implementation of *Making Safeguarding Personal*. This underpins the Care Act and introduces a person centred, outcome focussed way of working that will affect all agencies.

In order to prepare for Care Act implementation the Board commissioned an independent review in December 2014. The review identified many areas for development and improvement, including some changes to the Board's structure and functioning. The review identified a strong commitment to safeguarding across all agencies and operational managers, and good safeguarding practice following an alert, along with some high standards of investigation and reporting.

In this context, the Board and services represented are well placed for implementation of the Care Act in 2015 and I wish them every success.

Lynda Crellin
Outgoing chairman June 2015

2. CONTEXT

2.1 Role of SAPB and Annual Report

The Safeguarding Adults Partnership Board is a multi-agency partnership comprising statutory, independent and charitable organisations with a stakeholder interest in safeguarding adults at risk. A full list of members can be found at Appendix A with attendance details for the year.

The Board's objective is to protect and promote individual human rights, independence and improved wellbeing, so that adults at risk stay safe and are protected at all times from abuse, neglect, discrimination, or poor treatment.

The role of the Board and its members is to:

- lead the strategic development of safeguarding adults work in the borough of Hillingdon.
- agree resources for the delivery of the safeguarding strategic plan.
- monitor and ensure the effectiveness of the sub-groups in delivering their work programmes and partner agencies in discharging their safeguarding responsibilities
- ensure that arrangements across partnership agencies in Hillingdon are effective in providing a net of safety for vulnerable adults
- act as champions for safeguarding issues across their own organisations, partners and the wider community, including effective arrangements within their own organisations
- ensure best practice is consistently employed to improve outcomes for vulnerable adults.

Since November 2011, the SAPB has had an independent chairman, who also chairs the Local Safeguarding Children's Board (LSCB). The independent chairman is a member of the London and national chairs' groups SAPB.

In accordance with good practice, an annual report has been produced in previous years and presented to Council Cabinet, the Health and Wellbeing Board, and the Community Safety Partnership. From April 2015, production of an annual report will become a statutory requirement (Care Act 2014).

Through common membership, there are links to Multi Agency Public Protection arrangements (MAPPA), and the Multi Agency Risk Assessment Conference (MARAC).

2.2 Hillingdon context

Hillingdon is the second largest of London's 33 boroughs, covering 44.6 square miles.

Greater London Authority population projections estimate that in 2014 there were 292,000 people living in Hillingdon, of whom 13% were aged over 65 years of age and 6.1% over 75. Hillingdon is an ethnically diverse borough with 43% of residents from Black and Minority Ethnic groups, the largest groups being Indian, Pakistani or other Asian.

The proportion of those over 65 is slightly higher than the London average, but lower than that for England as a whole.

The population is projected to increase across all age groups, mainly due to internal migration and an increase in the birth rate and decrease in the death rate. The projected increase is larger than other North West London Boroughs. The proportion of those from black and ethnic minorities is also projected to increase, particularly in the south of the Borough.

The numbers of those with mental health needs and physical, sensory and learning disabilities are also expected to increase. Adults with learning disabilities who will be returning to the community from long stay settings (in line with Winterbourne recommendations) will contribute to this increase.

Hillingdon has 48 GP practices serving a GP registered population of 301,000 (2015).

There are 64 care homes in the Borough providing a range of services including nursing and dementia care, care for people with learning disabilities and mental health needs.

During 2014-15, Adult Social Care services provided support to 5,973 adults. Of this total 4,343 were aged over 65, 332 had mental health needs, 4,352 had a physical disability, 669 had a learning disability and 607 received support with memory and cognition.

The Multi Agency Safeguarding Hub (MASH) was launched in April 2015 with Adults Services in attendance.

2.3 London and National Context

Hillingdon, along with most other London Boroughs, has signed up to the Pan-London Safeguarding Policy and Procedures (PLP). This ensures a consistent framework for safeguarding adults, including definitions of roles and responsibilities, timescales for responding, and, in particular, cross-borough working. The procedures are currently being reviewed in terms of Care Act compliance.

Up to and including 2014-15, the SAPB has worked in accordance with the Government 'No Secrets' Policy of 2000 and the ADASS standards published in 2005.

The Care Act 2014 supersedes the 'No Secrets' guidance. It places Adult Safeguarding Boards on a statutory footing. Safeguarding within the Care Act is based on the six principles of empowerment, protection, prevention, proportionality, partnership and accountability.

Core membership of the Safeguarding Adults Partnership Board is defined in the Act (i.e. the Local Authority, Clinical Commissioning Group and Police). Boards are encouraged to have strong and explicit engagement with NHS providers, Care Quality Commission, Voluntary Sector, Housing providers, Fire and Rescue services, Prisons, Probation Service and the criminal justice system.

The statutory guidance accompanying the Care Act notes that Safeguarding Adults Partnership Boards have three statutory functions, to:

- Produce a three year strategic plan,
- Produce an annual report with an annual work plan,
- Carry out Safeguarding Adult Reviews (SARs) when required and to oversee implementation of the findings.

SAPBs should focus primarily on strategic and policy issues, and members must have sufficient seniority to speak on behalf of their agencies and to commit resources and agree actions.

'Making Safeguarding Personal' must underpin all practice, with a clear focus on the desired outcomes of the adult.

The Care Act also defines a new key role within each partner organisation of Designated Adult Safeguarding Manager (DASM).

3. BOARD IMPACT AND EFFECTIVENESS

Review of the Safeguarding Adults

In January 2015, the SAPB commissioned a review to assess its effectiveness as a Board. The review looked at all aspects of Safeguarding Adults in the Borough. The review followed the Local Government Association (LGA) peer review/challenge methodology which was originally developed by the Improvement and Development Agency (IDeA) and approved by the Association of Directors of Adult Social Services (ADASS), the Social Care Institute for Excellence (SCIE) and the NHS confederation.

The focus was on identifying opportunities for improvement and learning in 8 main areas:

1. Outcomes
2. People's Experience of Safeguarding
3. Leadership
4. Strategy
5. Commissioning
6. Service Delivery and Effective Practice
7. Performance and Resource Management
8. Local Safeguarding Adults Partnership Board.

The review also applied an additional standard of Care Act compliance.

The review identified that in all cases reviewed, the individual adult was safeguarded and that some workers and managers achieved high standards of investigation recording and oversight.

The key recommendations for the Board to be Care Act compliant are:

Recommendation 6: The Board should establish a revised Structure with seniority of members from each agency to demonstrate commitment and importance of the board and enhance its ability to operate effectively.

Recommendation 7: Resourcing of the work of the Board and infrastructure that effectively ensures delivery of core functions and the work programme should be agreed between the statutory partners and reviewed annually. This would include the setting up of the integrated safeguarding unit.

The full recommendations from the Review can be found in Appendix B.

Performance framework

An important development has been the production of a dashboard report to improve the performance and quality information available to the SAPB.
A copy of the annual dashboard figures for 2014/15 is included at Appendix C.

The Safeguarding Adults Partnership Board has spent much of 2014-15 preparing to be compliant with the Care Act. As a consequence of the Peer Review in January 2015 and with the appointment of a new independent chair the Board is now poised to confirm its forward strategy and action plan.

Links with other strategic bodies

Protocols have been developed with the Health and Wellbeing Board and the Safer Hillingdon Partnership. This Annual Report will be presented to both during Q3 2015-16.

3.6 Progress against action plan

What we planned to do – our key priorities

WHAT WE SAID WE WOULD DO	WHAT WE DID
Outcomes, peoples experience of safeguarding	
• Ensure safeguarding process fully includes the person in the process	• Hillingdon is currently implementing Making Safeguarding Personal (MSP). • Board members have been debriefed about MSP including presentation by the safeguarding lead for the London Borough of Sutton.
Leadership, strategy and commissioning	
• Implement the recommendations from the Winterbourne Report and Care Qualities Commission Review of learning disability services.	• The Winterbourne View Steering group membership was revised to ensure a stronger commissioning focus. • A discharge tracker has been set up that determines likely dates for discharge and this is monitored by the steering group. • A clinical group meets

WHAT WE SAID WE WOULD DO	WHAT WE DID
	monthly to monitor progress on discharge and alerts the steering group to any potential problems. • Agreement has been reached between the Council and Hillingdon Clinical Commissioning Group (HCCG) on a mechanism to agree joint funding of people who are discharged into community placements. • In 2014 a review of Learning Disability Services was commissioned with HCCG to inform future plans for Learning Disability Services. This will inform how local services are reshaped in light of the Winterbourne report. The review has been finalised, presented to Adult Social Care Senior Management Team and the HCCG Governing body. Recommendations and action plan agreed and in place.
• Implement recommendations from Francis Report.	• Hospital Trusts gave assurances about compliance and outstanding actions to SAPB in October 2014.
Service delivery and effective practice	
• Develop better identification and support through MASH	• MASH in Hillingdon went live in April 2015. A protocol has been activated with mental health services.
• Ensure that good MCA practice is embedded across the	• Members of the Board will undertake Mental Capacity

WHAT WE SAID WE WOULD DO	WHAT WE DID
partnership	Act training which will include Deprivation of Liberty Safeguards and best interest decisions). • Funding for this was obtained through NHS England. • 6 members of staff have been funded to undertake Best Interest Assessor training.
Performance and resource management	
• Improve care governance system	• Care Governance Board in place which meets monthly to oversee quality of local provision.
• Improve multi agency response to people who are vulnerable, particularly where self neglect/hoarding is an issue	• A Vulnerable Persons Panel is now well established and meets monthly.
Safeguarding Adults Partnership Board	
• Ensure SAPB is ready for Care Act implementation	• Peer review carried out and reported to key partners in March 2015.
• Maintain standards of quality and improve performance and identify issues	• Audit carried out as part of peer review and findings to be implemented in 2015. • The audit identified that people were safeguarded. • An action plan has been identified for the review's recommendations.
• Increase Housing staff	• 6 training sessions carried

WHAT WE SAID WE WOULD DO	WHAT WE DID
awareness of safeguarding issues in the context of the Care Act.	out, with 87 Housing staff trained.

4. WORKFORCE

Each agency has a responsibility to ensure that their staff are suitable trained in Safeguarding procedures and practice. For example, the Council has trained 172 members of staff in a variety of subjects including Mental Health and Homelessness. On the Mental Capacity Act (MCA), CNWL have rolled out MCA awareness for children's services to 126 staff members and at the Hillingdon Hospital, Safeguarding Adults awareness training is delivered monthly as part of the Statutory and Mandatory staff training programme.

Full details of the training can be found in the partner updates where reported.

5. EFFECTIVENESS OF LOCAL SAFEGUARDING ARRANGEMENTS

In response to fluctuations in the number of contacts leading to a safeguarding referral, which reached a peak in Q2, (see the Dashboard report at Appendix B) a number of workshops were held to clarify and promote better understanding about safeguarding thresholds in order to achieve a more consistent and proportionate response going forward.

In addition to the Dashboard the Council has developed a range of reports to facilitate effective performance monitoring. These include:

- monthly reports to enable Service Managers and Team Managers to keep abreast of performance in their respective service areas and within individual teams; and
- provider performance reports to facilitate operational and strategic oversight of safeguarding practice in care service provision.

To evaluate the effectiveness of safeguarding practice in the Borough, including multi-agency partnership working, 20 safeguarding cases were audited as part of the Safeguarding Adults Partnership Board review in January 2015. An action plan has been developed from the recommendations of the audit, of note the audit found that in all 20 cases the adult had been appropriately "safeguarded".

5.2 Inspections and reviews

The Council's Social Care Inspection Team reviews and monitors the quality of care being delivered by care service providers in the borough. This has

included carrying out unannounced inspections, to ensure that provider services are delivering quality care.

Monthly reports on service providers are submitted to the Council's senior management team and regular contract monitoring meetings are held with service providers.

During 2014/15, the social care inspection team carried out 113 inspections of domiciliary care services, residential, nursing homes, and supported living services.

Inspections inevitably result in an action/improvement plan for the care service provider and implementation of the action plan is subsequently monitored by the social care inspection team.

Inspections can also lead to a range of additional actions and interventions ranging from low level monitoring to intensified support involving weekly visits over a protracted period of time.

The outcome of visits and any recommendations arising are recorded with subsequent tracking of individual care homes, to ensure recommendations are actioned by them. Similarly, complaints about social care providers are tracked and followed up. In this way, the team can build up a picture of how individual care providers are meeting the needs of people in their care. The team is working on new ways to collate the overall performance of social care providers contracted to the Council.

The team is particularly important in monitoring required improvements for settings where there have been safeguarding concerns and in working with colleagues in the Care Quality Commission (CQC) on the regulatory standards providers must comply with. They also share ‘soft’ information with CQC in order to be able to follow up appropriately on concerns.

Going forward, in keeping with the spirit of the Care Act, the team will move towards a Quality Assurance model. This model will help care service providers better understand what 'good' safeguarding practice looks like, as well as helping them identify improvements to improve quality.

It is worth noting that during 2014 -15 the Care Quality Commission carried out regulatory inspections of two of the agencies represented on the Hillingdon Safeguarding Adults Partnership Board: Hillingdon Hospital Foundation Trust and Central and North West London NHS Foundation Trust.

5.3 Case Reviews

One Serious Case Review was carried out in 2013-14. All actions from the review have now been completed. Key learning points from the Serious Case Review include:

- The need for clear and timely communication between agencies at critical points: for example, when a patient is brought to Accident & Emergency by ambulance there must be a formal hand-over of concerns about the patient to A&E staff;

- Non-attendance at appointments should be followed up more rigorously;
- Agencies should remain vigilant for indicators that a carer might be in need of an carer's assessment and/or support;
- Discharge should not be the default position when contact cannot be made with a vulnerable patient - alternative means of making contact should be explored.

5.4 Priority groups and developments

Voice of the vulnerable adult

The voice of the adult is clearly captured within the Making Safeguarding Personal (MSP) framework. MSP places the adult at the centre of safeguarding establishing their views and desired outcomes from the outset.

MSP is the embodiment of "person centred, outcome focussed" practice thereby empowering the individual and their family - as far as is practicable - to identify and recognise risk and thereafter take control of their care and support to keep themselves safe.

Mental Capacity/ Deprivation of Liberty Safeguards (DoLS)

The Supreme Court judgement in the P v Cheshire West and Chester Council and P and Q v Surrey County Council in March 2014, is very significant in determining whether care/treatment arrangements for an individual lacking capacity amount to a Deprivation of Liberty.

The Court determined that for those people who do not have capacity to consent to the restrictions there are two key questions to consider in determining whether a person is deprived of their liberty:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

If the answer to the first question is yes and the second question is no, then the person is deprived of their liberty. Factors that are deemed no longer relevant are:

- The person's compliance or lack of objection
- The relative normality of their placement
- The reason or purpose of a particular placement

The DoLS Supervisory Body for Hillingdon has received 436 authorisation requests for 2014-15 compared to 15 for 2013-14.

6. COMMENTARY FROM AGENCIES

All member agencies represented on the SAPB were asked to produce a return based on the following areas:

- What is the agency role and services provided
- Regulator inspection in the reporting period and outcomes
- Safeguarding training (included in a previous section)
- Challenges in the reporting period
- Progress against safeguarding priorities
- Priorities for 2015-16
- Good news stories and good practice examples

These can be found at Appendix D.

7. SUMMARY AND PRIORITIES FOR 2015-16

7.1 Summary

On the basis of the information we have, the Board believes that services across Hillingdon are successfully supporting residents and safeguarding vulnerable adults. Responses and investigations have on the whole been speedy and proportionate, and vulnerable adults have been appropriately safeguarded.

The establishment of the Care Governance Board and the Vulnerable Persons Panel have created constructive vehicles that should enhance multi-agency communication and information sharing.

Case reviews and other information however also indicate that there are potential risk areas. Staff are not confident about using the Mental Capacity Act and there is evidence that further improvement is needed in information sharing, particularly at high risk transition points such as admission to and discharge from hospital. It is important to ensure that high standards are maintained in social care assessment and planning.

Reductions in resources across all agencies inevitably has an impact on capacity and external factors – such as High Court Judgement on DoLS – puts increased strain on those resources.

Partnership working is strong. There are, however concerns about commissioning processes, particularly the separation of responsibilities across the Clinical Commissioning Group and NHS England. This has an impact on planning, particularly for those who are mentally ill, or who have learning disabilities.

NHS England has so far not been represented on the SAPB, although it is understood that there are plans to develop co-commissioning arrangements. The Board wish to further develop relationships with GPs as critical providers and coordinators of services.

The implementation of the Care Act along with the personalisation agenda, will involve a step-change in how all professionals work with adults.

The peer review has helpfully given a steer how to best move forward into the implementation of the Care Act and the SAPB's role in that.

It is vital that all partners ensure that the SAPB is appropriately resourced to carry out its functions and to comply with its statutory responsibilities.

7.2 Priorities for 2015-16

1) Resourcing and developing the Safeguarding Adults Partnership Board
2) Implementing Making Safeguarding Personal across all safeguarding activity and across all partner agencies
3) Ensuring Care Act compliance across all agencies
4) DoLS – ensuring there is an effective model of practice to build upon including enhancing the functions of the DoLS Supervisory Body
5) Mental Capacity Act – embedding knowledge and skills across all partner agencies
6) Raising public awareness of Safeguarding

8. APPENDICES

Appendix A: Membership of the Hillingdon Safeguarding Adults Partnership Board and attendance during 2014-15

Organisation	Attendance 2014-15
London Borough of Hillingdon including Public Health Team	100%
Hillingdon Hospital	100%
Royal Brompton & Harefield Trust	100%
Hillingdon CCG	100%
CNWL	100%
Voluntary Sector	100%
Metropolitan Police	67%
London Fire Brigade	67%
Hillingdon Community Health	67%

Appendix B: Performance information

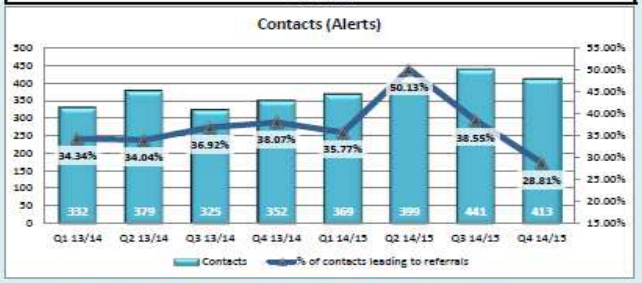
Report Author: LBH Performance Intelligence Team

Safeguarding Adults Board - Yearly Report - Draft Format

For Period: 2014/15

For further information please contact:
Paul Alexander Ext 6906

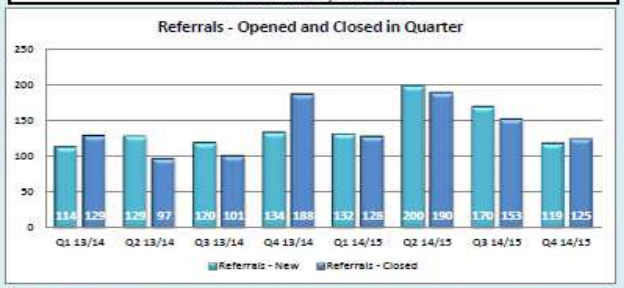
Contacts



Contact Progression	# Contacts Progressing To referral within 24 Hours	2014/15	260
		2013/14	70
	% Contacts Progressing To referral within 24 Hours	2014/15	42%
		2013/14	14%

Contacts by Source	Community Services	Independent provider agency	2014/15	9
			2013/14	1
		Other agcy NSPCC, Age Conc,Travelcare	2014/15	382
			2013/14	431
		Other Local Authority	2014/15	230
			2013/14	284
		Private Sector Home	2014/15	187
			2013/14	95
	Internal	Internal	2014/15	6
			2013/14	7
	Not Known/Recorded	Not Known/Recorded	2014/15	38
			2013/14	32
	Public (Including Relative/Friend)	Public (Including Relative/Friend)	2014/15	31
			2013/14	35
	Self referral	Self referral	2014/15	142
			2013/14	94
	Statutory Agencies	Centr Gov Agy. Prison, Customs	2014/15	53
			2013/14	11
		Legal, Police, Court, Prob,Immigr	2014/15	184
			2013/14	167
		Primary health (GP, DN etc	2014/15	5
			2013/14	2
		School/College	2014/15	323
			2013/14	187
		Secondary health, Hospital/ Hospice	2014/15	32
			2013/14	42
	Total		2014/15	1622
			2013/14	1388

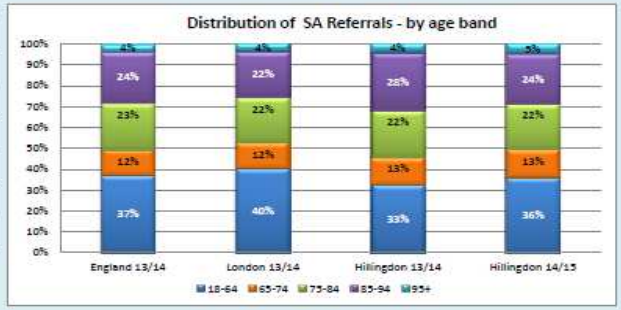
Referral Details, Outcomes



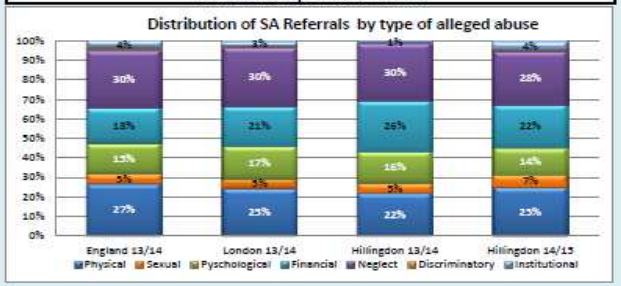
Referrals - Oppened and Closed	# Referrals Opened	2014/15	621
		2013/14	497
	# Referrals Closed	2014/15	596
		2013/14	515

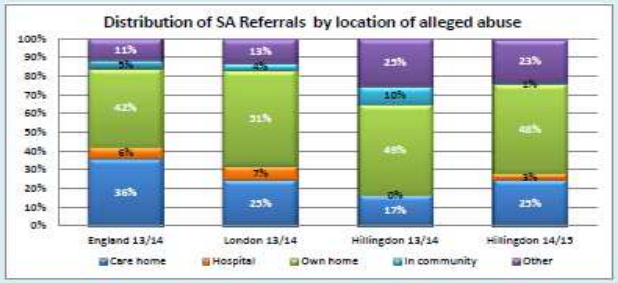
Age Bands (Referral Starts)	18 - 64	2014/15	237
		2013/14	160
	65 - 74	2014/15	85
		2013/14	63
	75 - 84	2014/15	130
		2013/14	108
	85 - 94	2014/15	143
		2013/14	134
	95+	2014/15	26
		2013/14	32

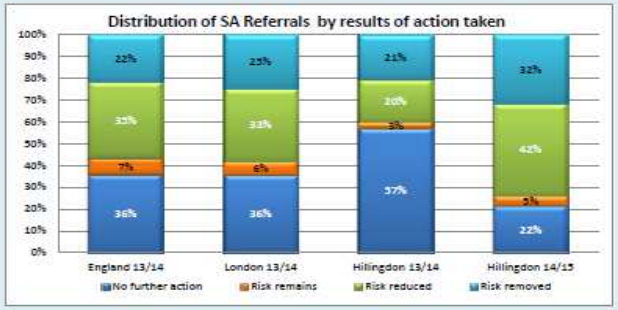
National Comparisons



National Comparisons - Contd.







Safeguarding Adults Board - Yearly Report - Draft Format

For Period: 2014/15

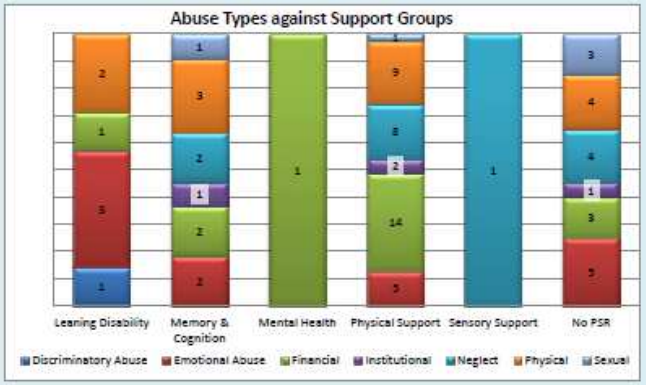
For further information please contact:
Paul Alexander Ext 6906

Closed Referrals - Outcomes and Case Profiling

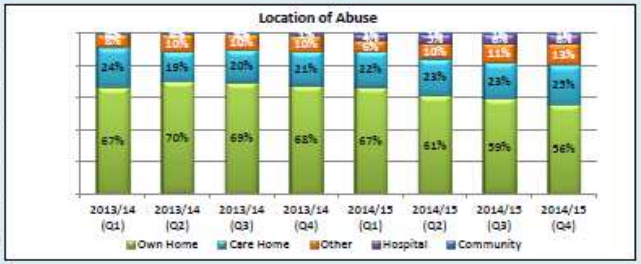
Abuse Types and Primary Support Reasons

Types of alleged abuse	Discriminatory Abuse	2014/15	3
		2013/14	3
	Psychological/Emotional Abuse	2014/15	65
		2013/14	91
	Financial and Materal Abuse	2014/15	114
		2013/14	151
	Institutional Abuse	2014/15	18
		2013/14	6
	Neglect and Acts of Omission	2014/15	131
		2013/14	178
	Physical Abuse	2014/15	118
		2013/14	131
	Sexual Abuse	2014/15	27
		2013/14	27
	Total	2014/15	476
		2013/14	587

Primary Support Reason	Learning Disability	2014/15	87
		2013/14	69
	Memory & Cognition	2014/15	65
		2013/14	55
	Physical Support	2014/15	245
		2013/14	153
	Mental Health	2014/15	22
		2013/14	10
	Social Support	2014/15	1
		2013/14	1
	Sensory Support	2014/15	7
		2013/14	7
	Total	2014/15	427
		2013/14	295



Location - Perpetrators



Location Of Abuse	Care Home	2014/15	99
		2013/14	106
	Community	2014/15	3
		2013/14	3
	Hospital	2014/15	24
		2013/14	3
	Other	2014/15	51
		2013/14	51
	Own Home	2014/15	225
		2013/14	340

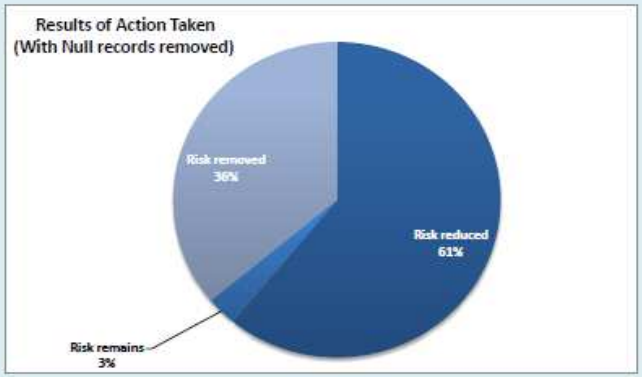
Alleged Perpetrators	Total Cases With Alleged Perpetrators	2014/15	395
		2013/14	503
	% Cases with Alleged Perpetrator Information	2014/15	66%
		2013/14	98%

Alleged Perpetrators	Health Care Worker	2014/15	48
		2013/14	42
	Friend / Neighbour	2014/15	28
		2013/14	34
	Not known	2014/15	35
		2013/14	45
	Other	2014/15	51
		2013/14	93
	Other Family Member	2014/15	97
		2013/14	111
	Other Professional	2014/15	22
		2013/14	46
	Other Vulnerable Adult	2014/15	17
		2013/14	17
	Partner	2014/15	24
		2013/14	27
	Social Care Staff	2014/15	67
		2013/14	68
	Stranger	2014/15	5
		2013/14	17
	Volunteer / Befriender	2014/15	1
		2013/14	3

Outcomes

Conclusion of cases	Substantiated fully	2014/15	139
		2013/14	165
	Substantiated partially	2014/15	68
		2013/14	48
	Inconclusive	2014/15	124
		2013/14	120
	Not substantiated	2014/15	201
		2013/14	170
	Investigation ceased	2014/15	64
		2013/14	12

Results of action taken	Risk Removed	2014/15	189
		2013/14	143
	Risk Reduced	2014/15	251
		2013/14	117
	Risk Remains	2014/15	27
		2013/14	17
	No further action (Null records)	2014/15	129
		2013/14	238



Deprivation of Liberty	Number of DOLS cases	2014/15	442
		2013/14	6

Concluded Cases	# Cases meeting LBH Criteria (Full Safeguarding Report Required)	2014/15	208
		2013/14	174
	No further action under SA process	2014/15	388
		2013/14	341

Appendix C: Recommendations from Peer Review

Recommendation 1: The Board should formally adopt MSP and oversee roll out across the Borough.

Recommendation 2: The Board should receive a report on the National Competency Framework with the view of adopting the Framework as the underpinning of workforce development plans for all partners.

Recommendation 3: Building on the disbanding of the specialist team - Consideration to be given to how the advanced practitioner role in the operational teams can assist in supporting and developing safeguarding practice.

Recommendation 4: The Board commissions the Strategic Plan and agrees the associated work programme.

Recommendation 5: The Executive Operational Group to take responsibility for developing the annual Business Plan and co-ordinating delivery of the annual work programme. The plan will capture all developments in relation to the development and maintenance of priorities to become a high performing SAPB.

Recommendation 6: The Board should establish a revised Structure with seniority of members from each agency to demonstrate commitment and importance of the board and enhance its ability to operate effectively.

Recommendation 7: Resourcing of the work of the Board and infrastructure that effectively ensures delivery of core functions and the work programme should be agreed between the statutory partners and reviewed annually. This would include the setting up of the integrated safeguarding unit.

Recommendation 8: The Board with other key strategic partnerships develops protocols/memorandums of understanding to ensure wider understanding of respective roles, responsibilities and involvement in the protection of vulnerable adults.

Appendix D: Partner Updates

Adult Social Care

Name of agency	**London Borough of Hillingdon (LBH)**
Description of service	Adult Social Services/ Safeguarding /Quality Assurance
Safeguarding training undertaken in reporting period. % of staff trained at each level.	The number of LBH staff who have accessed training in 2014 - 2015 are as follows: Mental Health & Homelessness: 10 Mental Capacity Act and Mental Health Act Interface:12 Interview & Investigation Skills (2 day workshop): 53 Chairing Safeguarding Meetings (SAMs): 13 Safeguarding Adults - eLearning: 46 Mental Capacity Act - eLearning: 38 LBH currently has 3 trained Best Interests Assessors (BIAs); all 3 BIAS attended refresher training during 2014-15. The Safeguarding Adults & Quality Assurance Manager ran 2 workshops on *Safeguarding Thresholds* in this period.
Regulator inspection in reporting period and outcomes	During 2014-15 LBH carried out the following "inspection visits" to care provider services: Residential/Nursing Homes: 64 Supported Living: 34 Domiciliary Care: 15 These figures do not include subsequent follow-up visits or spot visits.
Challenges in the reporting period	Development of performance dash boards to inform operational teams in the management of safeguarding. Workforce development, recruitment and retention.
Progress on safeguarding priorities in the reporting period	Responsibility for safeguarding was successfully repositioned as "everybody's business" within operational adult social care teams; *Making Safeguarding Personal* is being piloted within operational teams for a 6 month period; A rolling safeguarding training programme has been re-established; Improved Safeguarding Performance reporting is being developed; A full time, permanent Safeguarding Adults & Quality Assurance Manager was appointed. Development of Care Governance Board and framework for Adult Social Care.

Safeguarding priorities for 2015/6	The Peer Review style audit of safeguarding, commissioned by the Safeguarding Adults Board in January 2015, produced a number of recommendations which have been incorporated into an action plan for 2015-16. The headline objectives - some of which are a continuation of priorities for 2014-15 - are: Introduce a regular audit programme of Safeguarding cases within operational teams; Increase management oversight of safeguarding practice; Build on the role of Advanced (i.e. senior) Practitioners in order to spread expertise throughout the organisation; Implement Making Safeguarding Personal; Ensure robust Advocacy Services are available; Establish a Provider Forum; Continue with a programme of staff training; Robust performance reporting; Adapt IT system to current practice; Development of quality assurance framework.
Good news stories	The monitoring of care service provision now sits within the remit of the *Safeguarding Adults & Quality Team* - facilitating closer and more robust links with LBH's Care Governance Framework. The implementation of *Making Safeguarding Personal* within ASC has been positively received, is progressing well and with pleasing results. The results of the 6 month pilot will continue to be fed back to the SAPB.
Good practice examples	The introduction of a Police Safeguarding Clinic has facilitated regular and timely discussion between the Police and ASC and has improved partnership working significantly as a consequence.
Any other comments	The Care Act 2014 places safeguarding adults and the role of the SAPB on a statutory footing which presents a golden opportunity going forward to influence good practice. This is reflected in the future plans/strategies of the SAPB which is positive.

Central and North West London NHS Foundation Trust

Name of agency	Central and North West London NHS Trust
	The Trust provides both mental health and community services across five Boroughs. Operationally, CNWL is managed in three divisions; each headed up by a Director of Operations and supported by a Nursing and Medical Director. They are responsible for all elements of care and delivery within their respective divisions. In relation to CNWL Hillingdon services, Maria O'Brien, as the Divisional Director of Operations, has responsibility for these services and is the senior director responsible for safeguarding in Hillingdon; supported by Michelle Johnson, the Divisional Director of Nursing. Michelle Johnson, the Divisional Nursing Director, chairs the Divisional Safeguarding Group of which the Named Nurse Safeguarding Children is a member. Each of the boroughs is headed up by a Borough Director and a Clinical Director; they are a key link and member of the local adult safeguarding boards.
Description of service	Safeguarding Adults Team: CNWL have a dedicated adult safeguarding team, consisting of 6 x WTE and 2 x 0.6 WTE. These staff are split across the 3 divisions, CNWL Hillingdon falls into 'Goodall' Division. The team's primary role within Goodall Division is to provide expert advice, supervision, education and training. This team also has the capacity to gather and analyse data, carry out audits and meet the Prevent agenda. All front line staff have access to the safeguarding adults practitioners.
Regulator inspection in reporting period and outcomes	The CQC have identified 16 Essential Standards (also known as outcomes) that the Trust must meet at both a corporate and team level. Outcome 7 relates to safeguarding. **Outcome 7**: Safeguarding people who use services from abuse. People who use services - are protected from abuse, and their human rights are respected and upheld. CQC inspected CNWL in February 2015. Awaiting official report, due to be released in June 2015, some informal feedback has been given.

Challenges in the reporting period	Many of the challenges faced by front line staff can be mitigated by effective training, supervision and support systems. For example front line staff struggle to: • balance the need to recognise that people with capacity have the right to make their own decisions with a duty to care • recognise that they don't need to make the decision about whether something falls within the safeguarding agenda but instead report concerns • negotiate confidentiality agreements so the safeguarding process is as transparent as possible There have been many changes to the Safeguarding Adults agenda in the last year, including the release of the Care Act which is the biggest change in social and health care for over 60 years, it consolidates and strengthens existing legislation and further integrates health and social care service. The new criteria for DOLs following the Supreme Court judgement decision. Training helps staff to meet these challenges and is reinforced with regular reflection and learning from cases in supervision and opportunistic teaching.
Progress on safeguarding priorities in the reporting period	Priorities for 2014 – 15 Prevent: Hillingdon's safeguarding adults team have given training to over 292 members of staff regarding Prevent. They have been to team meetings and service leads meetings to give training as well as the booked training for any staff to attend. This training will be mandatory from July 2015. MCA & DOLs: It was acknowledged that staff struggle to apply the theory of MCA and DoLs to clinical practice and therefore much greater emphasis was placed on 'case studies' to embed learning in practice. Identification and targeting of teams who do not ring safeguarding adults practitioner with queries: Teams needing more awareness were recognised by looking at safeguarding adults case records. Case studies were completed with all DN teams with more emphasis on certain teams. An audit regarding staff knowledge of the safeguarding process completed. Contact details of safeguarding adults team were distributed.

Safeguarding priorities for 2015/6	**Learn from serious incidents and cases** (including SARs and domestic homicides) locally and nationally: Lessons are applied to minimise the chances of similar incidents happening in Hillingdon. **Respond to cases of self-neglect and/ or non-engagement with services**: Such cases are properly understood and responded to (including issues of capacity and/ or underlying illnesses) to keep people safe whilst respecting choice and independence. **Share the right information with the right people at the right time**: Key information is shared at the right time to enable holistic and comprehensive risk assessment and safeguarding, whilst legal requirements (such as the Data Protection Act and patient confidentiality) are complied with.
Good news stories	First session of MCA awareness for children's services was rolled out in September 2014; this has been well received by 126 staff members. CNWL has undergone many changes in the past year, one of which is that the safeguarding adults team (previously HCH) now cover CNWL mental health services for the whole division, this has been positive for staff and managers. Mental health services in Hillingdon have received a good report from CQC regarding MCA awareness and training. A recent internal audit showed our older peoples services as outstanding in this area.
Good practice examples	Safeguarding Adults practitioner attends monthly meetings with service leads, enabling her to feedback and discuss issues for staff to cascade to frontline staff. Safeguarding Adults practitioner ran surgeries for mental health staff in conjunction with the mental health law deputy manager, for advice regarding safeguarding, MCA, consent, capacity and good documentation. These were well attended and CNWL is aiming to provide more in the future.

The Hillingdon Hospital

Name of agency	The Hillingdon Hospital Foundation Trust
Description of service	The Executive Director with responsibility for Safeguarding oversees the annual work and audit programmes for safeguarding adults and progress against these is reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in October 2014. The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. The Committee is chaired by the Executive Director of the Patient Experience and Nursing. A safeguarding data report is received by the committee; this includes clinical incidents, SCR's, DoLS requests, pressure ulcers and FGM information. The Trust revised the Key Performance Indicator (KPI) for Learning Disability, which was also approved by the Safeguarding Committee. This KPI provides the Trust with substantial assurance in terms of safeguarding governance and is reviewed annually at the Safeguarding Committee.
Safeguarding training undertaken in reporting period. % of staff trained at each level.	The Trust training recording structure has been replaced by a system called WIRED, which will improve the accuracy of recording staff compliance, which also links into the Electronic Staff record (ESR). Safeguarding Adults awareness training is delivered monthly as part of the Statutory and Mandatory staff training programme and it is also part of the New Starters Induction programme to the Trust. The mandatory training session duration has been increased and includes information about meeting the needs of adults with learning disabilities and MCA & DoLS. Safeguarding Adult awareness training is now also available via e-learning, accessed via ESR. Bespoke sessions are provided within departments as requested. Training compliance for the reporting period is above 80% and is monitored on the WIRED dashboard. Training compliance has risen from 72.36% in December to 92.95% in March 2015. Enhanced awareness sessions for MCA and DoLS have

	been scheduled for 2015/16 key staff who should attend have been identified through a training needs analysis. These sessions are delivered by a Psychiatric Liaison Consultants based at Riverside and a Lawyer specialising in healthcare law and have been well evaluated.
Regulator inspection in reporting period and outcomes	Within the reporting period there was a re-audit of staff knowledge and awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The results highlighted an overall improvement compared to the audit in 2013/14, however there was a clear indication that more awareness sessions were required. Enhanced MCA and DoLs training sessions have been provided which is detailed above. We have updated the restraint policy and written a new MCA & DoLS policy. There is a new MCA and DoLS Trust policy and the restraint policy has also been updated. The Trust also audited staff, focussing on their understanding of meeting the needs of patients with a learning disability whilst in hospital, the results demonstrated that staff knew who to contact if there were concerns. There needs, however, to be continued awareness and use of the patient passport.
Progress on safeguarding priorities in the reporting period	In order to provide assurance that the Trust is listening and responding to the needs of patients with a Learning Disability, the Head of Safeguarding has attended forums where there are carers and service users present. These forums provide an opportunity to hear the views of people using our services first hand and support our aim of learning and continuously improving. The Trust is represented at the Learning Disability Partnership Board by the Head of Safeguarding, who is also a member of the multi- agency Serious Case Review (SCR) panel, where within the reporting period there has been one SCR. There is also regular attendance at the Hillingdon PREVENT Partnership Group. Safeguarding training compliance has significantly improved, which is reflected in item 3.
Safeguarding priorities for 2015/6	**Challenges for 2015-16:** • Maintaining compliance of safeguarding training above the Trust target of 80%. • Further embedding of knowledge of MCA and

	DoLS, especially in relation to recognising and understanding when restrictions might become restraint. • To re-evaluate Prevent within the Hospital based on recommendations with the Prevent Duty. **Priorities for 2015-16:** • Implement robust arrangements to put DoLS into practice, modelled on the Social Care Institute for Excellence framework. • Audit Programme: o MCA & DoLS staff knowledge and awareness o Meeting the needs of patients with learning disabilities knowledge and awareness o Application of DoLS in practice. • Continued engagement with user groups of patients with a Learning Disability and their carers and the Learning Disability team at The London Borough of Hillingdon. • Revise the Trust PREVENT strategy following the publication of the Prevent Duty in 2015. • Continued liaison with Adult Social Care and other agencies to discuss the implementation of the Care Act in April 2015.

Metropolitan Police

Name of agency	Metropolitan Police (MPS)
Description of service	Law enforcement
Safeguarding training undertaken in reporting period. % of staff trained at each level.	There was no police training during this reporting period.
Regulator inspection in reporting period and outcomes	Mayor's Office for Policing and Crime (M.O.P.C.)
Challenges in the reporting period	• Ensuring Safeguarding Adult managers remain engaged in the MASH process. • Pulling together stakeholders in the MASH to deliver

	resources previously promised. • Driving the delivery group to a successful conclusion.
Progress on safeguarding priorities in the reporting period	1.Multi Agency Safeguarding Hub ,(M.A.S.H.). go-live date 27th of April 2015.(This is imperative for the integration/development of Adult Safeguarding in the Hillingdon MASH).
Safeguarding priorities for 2015/6	1.To ensure Adult Safeguarding is an integral part of the Hillingdon MASH Process. 2.To improve joint working with adult social services and police in Safeguarding.
Good news stories	The MASH launched on 27th April was a well attended presentation informing managers & partners of the remit of the MASH. Individual presentations assisted guests with short presentations of how each contributed in the MASH process. This launch was well attended and received and viewed as a success. This is joint good news with the SCB .
Good practice examples	In January police and adult social services commenced a weekly clinic. Each Wednesday, police attend the Civic Centre and discuss with adult social workers (by appointment and pro forma) on individual cases and supply advice re criminal threshold and the necessity to report /not report and joint investigations. This joint working is believed to be unique to Hillingdon Borough.
Any other comments	A productive year with better joint working between police and partner agencies. This improvement has to increase and improve for the benefit of victims/subjects in Hillingdon Borough.

London Community Rehabilitation Company

Name of agency	**London Community Rehabilitation Company**
Description of service	The role of the CRC is to manage the majority of offenders under probation supervision. We work alongside the National Probation Service, which manages offenders who have been assessed as presenting high risk of harm to others. London CRC is one of 21 CRCs supervising offenders across England and Wales. London CRC employs around 1,200 staff and manages almost 30,000 offenders at any one time. Service delivery is currently based on geographical borough 'clusters'. The Hillingdon and Hounslow cluster is one of 15 clusters in London.

Safeguarding training undertaken in reporting period. % of staff trained at each level.	In 2013 London Probation Trust identified and trained up Safeguarding Adult Champions at each borough. During that year each champion delivered briefing sessions to wider practitioners groups at borough level. This 'train the trainer' workshop was rerun in May 2015 and the participants will be cascading the learning in similar cluster based events over the next 3 months across London to all Offender Managers. The participation levels at each cluster are being monitored and reported back to area Assistant Chief Officers. These briefings will ensure that London CRC practitioner staff knowledge remains current and new staff have undertaken training. There is a Pan London ACO Lead who coordinates and delivers meetings centrally with Safeguarding Adults Champions in each cluster to ensure best practice has been promoted, reinforced, facilitated and enhanced via a series of briefings and training events. New Safeguarding Adults procedures for London CRC were launched in March 2015. The London CRC has a safeguarding adults page on the intranet which is includes all up to date policy and guidance information.
Regulator inspection in reporting period and outcomes	N/A
Challenges in the reporting period	2014 saw a significant change in the way probation services are being delivered. In response to Government's plans to reform probation, dissolve the Probation Trusts and transfer the work to two new organisations: the National Probation Service (London Directorate) and the London Community Rehabilitation Company came into being on 1 June 2014. In December 2014 the preferred bidder for London CRC was announced and since early 2015 the London CRC has been working closely with MTCnovo to transform the way in which probation services are delivered and together develop new ways of working. This has been a time of considerable change for staff and it will continue to be so as the cohort model of service delivery is rolled out and embedded, The new operating model will introduce 'cohorts' – women, 18-25 year olds, working age males, older males and those with a chronic illness, mental illness or intellectual

	disabilities – whereby offenders are worked with based on their primary presenting need. This will allow front line staff to be better able to identify needs and issues and access the services to which they are entitled to make significant improvements to their quality of life which therefore reduces their chances of reintegration into society and increases the risk of reoffending.
Progress on safeguarding priorities in the reporting period	SA Champions training delivered. London CRC SA procedures launched. Safeguarding Adults page on service Intranet site developed - primary information source for front line practitioners and line managers.
Safeguarding priorities for 2015/6	Our priorities in 2015/16 are to ensure through an ongoing training programme, monitoring and evaluation that all front-line staff are knowledgeable in relation the Care Act 2014 and understand their responsibilities when working directly with service users who are 'adults at risk' to be aware of issues of abuse, neglect or exploitation, that they have a duty to act in a timely manner on any concern or suspicion and to ensure that the situation is assessed and investigated.

Age UK Hillingdon

Name of agency	**Age UK Hillingdon**
Description of service	Local Charity offering a wide range of services to support older people in Hillingdon
Regulator inspection in reporting period and outcomes	N/A
Challenges in the reporting period	386 staff and volunteers work for Age UK Hillingdon to support older people and all have training on safeguarding adults as part of their induction. We regularly review our policies and procedures to ensure compliance with Safeguarding and raise awareness with all staff & volunteers so that there is a clear process for reporting abuse.
Progress on safeguarding priorities in the reporting period	Age UK's Director of Services/Deputy CEO has been a member of the Safeguarding Adults Partnership Board. Review of database to include alerts and key steps taken in relation to safeguarding for individuals.
Safeguarding priorities for 2015/6	Keep up to date with new developments in Safeguarding and Disclosure and Barring. Implement the Care Bill's Safeguarding measures as

	required. Review training requirements on Mental Capacity Awareness. Review our monitoring of safeguarding issues across our range of services.
Good practice examples	Safeguarding is a standard agenda item for staff and volunteer meetings and supervision and appraisal processes. Information relating to Safeguarding and relevant contact numbers are displayed on our website and on our services brochure.

Disablement Association Hillingdon (DASH)

Name of agency	**Disablement Association Hillingdon (DASH)**
Description of service	Advice, information, advocacy and activities for people with disabilities
Safeguarding training undertaken in reporting period. % of staff trained at each level.	Staff trained in safeguarding level 1 and regular reminders in staff meetings and supervision.
Regulator inspection in reporting period and outcomes	N/a
Challenges in the reporting period	Ensuring that all PAs are DBS checked, as many people are loathe to ask friends or neighbours to undergo checks.
Progress on safeguarding priorities in the reporting period	Staff in personal budget support service encourage safer recruitment practices for clients employing PAs. Advocates available to people going through safeguarding process.
Safeguarding priorities for 2015/6	Safe Places scheme to commence in ward in Hayes and then be introduced in other parts of the borough.
Good practice examples	People attending our sports and activities are given information about keeping safe and encouraged to talk to staff if they have any concerns.

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BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Ray Puddifoot MBE
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 – Board Planner

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The Board Planner, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Chairman's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Chairman.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Chairman, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The following future Board meeting dates were agreed by Council on 15 January 2015 and will be held at the Civic Centre, Uxbridge:

- Tuesday 15 March 2016 at 2.30 pm - Committee Room 6

Board meeting dates for 2016/2017 will be considered by Council in due course as part of the authority's Programme of Meetings for the new municipal year.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

N/A

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL

APPENDIX 1

BOARD PLANNER

15 Mar 2016 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 26 February 2016 **Agenda Published:** 7 March 2016
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	HCCG Operating Plan	HCCG	
	Annual Report Board Planner & Future Agenda Items (SI)	LBH	

** SI = Standing Item*

Other possible business of the Board:

1.

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