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Health and Wellbeing Board

Date: **THURSDAY, 29 SEPTEMBER 2016**

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 Philip Corthorne MCIPD (Chairman)
Councillor David Simmonds CBE (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Richard Lewis
Councillor Douglas Mills
Councillor Raymond Puddifoot MBE
Dr Ian Goodman, (Chair - Hillingdon CCG)
Vacancy (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

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Contact: Nikki O'Halloran
Tel: 01895 250472
Email: nohalloran@hillingdon.gov.uk

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Head of Democratic Services
London Borough of Hillingdon,
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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 28 June 2016	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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)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.

Minutes

HEALTH AND WELLBEING BOARD

28 June 2016

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 David Simmonds CBE Councillor Douglas Mills Dr Ian Goodman - Hillingdon Clinical Commissioning Group Stephen Otter - Healthwatch Hillingdon (substitute) **Statutory Non Voting Board Members Present**: Tony Zaman - Statutory Director of Adult Social Services and 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) Dr Reva Gudi - Hillingdon Clinical Commissioning Group (clinician) Neil Ferrelly - Hillingdon Clinical Commissioning Group (officer) (substitute) Nigel Dicker - LBH Deputy Director Residents Services Jean Palmer OBE - LBH Deputy Chief Executive and Corporate Director of Residents Services (VOTING) **LBH Officers Present**: Kevin Byrne, Gary Collier, Glen Egan and Nikki O'Halloran **LBH Councillors Present:** Councillor Phoday Jarjussey **Press & Public: 2**
1.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Councillors Bianco, Burrows and Lewis, Mr Bob Bell (Mr Nick Hunt was present as his substitute), Mr Rob Larkman (Mr Neil Ferrelly was appointed and present as his substitute) and Ms Robyn Doran (Ms Maria O'Brien was present as her substitute). Mr Stephen Otter was present as the substitute member for Healthwatch Hillingdon.
2.	**BOARD MEMBERSHIP REVIEW** *(Agenda Item 1a)* It was noted that, to enable the Health and Wellbeing Board to maintain a complete and representative membership, the Chairman had agreed to include this additional item on the agenda.

	Following Dr Goodman's proposal, the Board agreed to appoint Mr Neil Ferrelly as the Hillingdon Clinical Commissioning Group (Officer) Co-opted Substitute Board Member. **RESOLVED: That:** **1. the current Board membership be noted; and** **2. Mr Neil Ferrelly be appointed as the Hillingdon Clinical Commissioning Group (Officer) Co-opted Substitute Board Member.**
3.	**TO APPROVE THE MINUTES OF THE MEETING ON 12 APRIL 2016** *(Agenda Item 3)* It was noted that, since the Board's last meeting, Councillors Puddifoot and Corthorne had met privately with Drs Goodman and Gudi to discuss the contraception service provision. At this meeting, it had been agreed that the Council would provide funding for the contraception service, with effect from 1 April 2016. **RESOLVED: That:** **1. it be noted that the Council would provide funding for the contraception service, with effect from 1 April 2016; and** **2. the minutes of the meeting held on 12 April 2016 be agreed as a correct record.**
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** *(Agenda Item 4)* It was confirmed that Agenda Items 5 to 13 would be considered in public. Agenda items 14 and 15 would be considered in private. It was noted that current and emerging issues could, where applicable, be included under Agenda Item 15.
5.	**HEALTH & WELLBEING STRATEGY: PERFORMANCE REPORT** *(Agenda Item 5)* It was noted that the Health and Wellbeing Strategy had a strong prevention theme and that there was a simplicity about some of the more effective activities, for example, tea dances and the Empowered Patient Programme. Work had also progressed with regard to the three Integrated Services for Long Term Conditions (cardiology, diabetes and respiratory) that had been approved in 2015/16. It was suggested that the Sustainability and Transformation Plan could offer an opportunity to revisit the Strategy to drive developments forward and improve health and social care in the Borough. **RESOLVED: That the Health and Wellbeing Board:** **1. noted the updates in the report and delivery plan (Appendix A); and** **2. noted the outcome performance indicators in the quarterly dashboard (Appendix B).**
6.	**BETTER CARE FUND: PERFORMANCE REPORT** *(Agenda Item 6)* It was noted that overall the performance of the Better Care Fund was good and that the structure highlighted activity as well financial information. Although there had been a slight overspend, there had been good performance in reaching health targets. On behalf of the Board, the Chairman thanked the officers from all of the organisations that

	had been involved. Although the last year had been challenging, it had served Hillingdon well in bringing together activities under the auspices of a pooled budget and promoting joint working. The next year, however, ran the risk of becoming stuck in additional levels of bureaucracy in order to comply with NHS reporting requirements. Officers were encouraged to continue to be ambitious in the planning of the BCF for 2017 onwards and aligning this to the work of the Sustainability and Transformation Plan (STP) with a clear focus on what should be delivered locally. It was noted that the 2016/2017 programme extended provision and that the s75 pooled funds arrangement (agreed by Cabinet on 23 June 2016) gave the Chairman and Vice Chairman delegated authority to amend the s75 agreement to include risk share arrangements for a specialist care at home service for people at end of life. **RESOLVED: That the Health and Wellbeing Board noted the contents of the report.**
7.	**HILLINGDON CCG UPDATE** *(Agenda Item 7)* The Hillingdon Clinical Commissioning Group (HCCG) had started discussions in relation to its Commissioning Intentions for 2017/2018 which would focus on a smaller number of transformation themes. It was agreed that the Commissioning Intentions now reflected more of the detail that the Board had been looking for and that information about how the services were being shaped and opportunities for market development should also be included. In addition, the document needed to demonstrate the improvements that would be delivered to residents. It was noted that a public event would be held on 13 July 2016 at Brunel University and would be used to gain service user feedback on the HCCG Commissioning Intentions. It was suggested that awareness of this event needed to be maximised and that, in future, health related information could be placed in Hillingdon People to raise awareness across the Borough. The QIPP (Quality, Innovation, Productivity, Prevention) programme had achieved £7.033m savings against the £5.5m target that had been agreed with NHS England (NHSE). Consideration was now being given to future years' QIPP savings targets. HCCG had ended 2015/16 with an in-year surplus of £7.525m (comprising £6.455m surplus on programme budgets and £1.07m surplus on running cost budgets). The additional surplus would be carried forward into 2016/17. Proposals for new models of care identified by the Shaping a Healthier Future programme included reconfiguring the way in which children's in-patient care was delivered in North West London. It was noted that the children's in-patient services at Ealing Hospital would cease and would be redistributed to the major hospital sites in North West London with the transition taking place on 30 June 2016. Although, the majority of patients would transfer to Northwick Park Hospital, it was anticipated that the change would result in an increase in the number of patients presenting at Hillingdon Accident and Emergency (the majority of which would be urgent care cases). GPs and Hillingdon Hospital were aware of the changes to the provision of children's in-patient services. To manage the expected increase in demand, Hillingdon Hospital was in the process of recruiting a paediatric consultant, a Paediatric Assessment Unit

	was being developed and the Accident and Emergency department was being enlarged (due to open in July). The Hospital was confident that the increase would be manageable in terms of physical and human resources as long as demand remained within the projected profile (although there was also a contingency in place to manage double the number of additional patients expected). However, an assessment was being undertaken to identify any impact that the changes would have on CAMHS patients presenting at Hillingdon's Accident and Emergency department. Concern was expressed that NHSE communication with regard to the transition of maternity services from Ealing Hospital had been poor. It would be important for the communication around the transition of children's in-patient services to be managed well. The Board was assured that an extensive exercise had been undertaken two years ago regarding the transport implications of changes proposed by Shaping a Healthier Future. It was noted that there had been more Ealing patients attending Hillingdon Accident and Emergency than anticipated but that there had also been a general increase in the number of non-residents attending Hillingdon Hospital. It was anticipated that the Accountable Care Partnership (ACP) would result in better integrated care for people over 65 years. The Board was advised that the CCG Annual Report and Accounts had been formally signed off by external auditors. It was noted that Ms Caroline Morison had taken over from Ms Ceri Jacob as the HCCG Chief Operating Officer. **RESOLVED: That the Health and Wellbeing Board to noted the update.**
8.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 8)* Healthwatch Hillingdon was becoming increasingly frustrated with regard to the speed at which progress was being made in relation to the delivery of the CAMHS transformation plan. It was suggested that there was a continuing need to improve the delivery around Tier 2 services. It was noted that, although the organisation was focussed primarily on provision / resources within the Borough, Healthwatch Hillingdon did work closely with other Healthwatch boroughs. The Board was advised that, so far, Healthwatch Hillingdon had not been successful in identifying the right person to appoint as Chair. Mr Steven Otter was acting as Chair in the meantime. The Healthwatch Hillingdon Board was keen to ensure that they found a Chair of the right calibre. **RESOLVED: That the Health and Wellbeing Board noted the report received.**
9.	**UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 9)* It was noted that little progress had been made with regard to identifying a suitable site for a new health centre in Yiewsley / West Drayton. Kirk House remained the only site option being explored.

	Proposals for a future health facility on the St Andrews site had not yet been discussed with the Council's Planning Service. It was suggested that pre application discussions be undertaken early to prevent any technical delays with regard to any related planning application. NHS England (NHSE) had set aside a budget of £250m in 2016/17 to be invested in primary care premises across the country. It was noted that this was less than the Council was spending on schools in the Borough and was a vastly inadequate sum. Consideration would be given to lobbying the Prime Minister to increase the amount of money being made available. The Board was aware that Hillingdon had a rising population and, as such, it was becoming increasingly important to ensure that there were more GPs with premises in the right areas. **RESOLVED: That the Health and Wellbeing Board noted the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.**
10.	**HILLINGDON SUSTAINABILITY AND TRANSFORMATION PLAN** *(Agenda Item 10)* Hillingdon Clinical Commissioning Group (HCCG) had submitted a base case to NHS England (NHSE) in April and, since then, had been working with local partners to provide a Hillingdon focus to the Sustainability and Transformation Plan (STP) process. The Hillingdon Chapter of the NWL STP now focussed on local priorities which would provide the Borough with strategic direction over the next five years. It set out nine priorities for the Board to endorse. NHSE had now advised that 30 June 2016 deadline would be for submission of a checkpoint submission that did imply formal commitment from all partners. It was noted that Hillingdon's Health and Wellbeing Board would not be able to agree the checkpoint submission until it had been through due governance process. The Hillingdon Chapter recognised that, over a five year period (2016-2021), HCCG would experience a financial gap. The Board requested that the local plan also add figures to reflect the social care funding gap over the same period to provide a systems wide analysis of the funding challenge facing health and care. Furthermore, it was important to develop a clear Hillingdon perspective which included community services. A workshop had already been held with HCCG where the Council had shared its financial pressures in relation to social care in order to identify common working efficiencies. The Board was advised that the Non-Demographic Growth made an assessment about how activity had grown historically. Other Cost Pressures included 7 day working, for which HCCG had received additional funding. With regard to population projections, consideration was given to whether or not these figures had been triangulated with the population data held by HCCG partners. It was suggested that the anticipated population increase would not be spread evenly throughout the Borough but was more likely to be concentrated in specific areas. HCCG was congratulated for putting the local plan together within challenging timescales. It was suggested that, moving forward, the Plan and reports should be

	done as a joint papers to reflect the partnership approach. **RESOLVED: That the Health and Wellbeing Board:** **1. endorsed the draft Local Hillingdon STP chapter for submission to NHS England on 30 June as part of the North West London STP, noting the work undertaken to date to develop local priorities including the input of partners, residents and clinicians;** **2. provided any commentary and feedback as to how the Board wishes to see the plan develop to further reflect partner priorities in Hillingdon;** **3. note that, as the Hillingdon Health and Wellbeing Board had not seen the North West London STP, members had not yet been able to comment on or endorse it; and** **4. receive the latest Hillingdon STP together with any NWL plans in an update at its next meeting.**
11.	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICE UPDATE** *(Agenda Item 11)* The report set out the fourth and final update in relation to the 2015/2016 CAMHS Transformation Plan. Although NHS England (NHSE) had indentified £524,623 for the development of a Community Eating Disorders Service (£149,760) and Service Transformation (£374,863) in Hillingdon, this was not recurrent funding. It was anticipated that the launch of the Eating Disorders Service on 1 July 2016 would help to reduce CAMHS waiting times. Although achieving against many key targets around waiting times, the Board was advised that the waits for routine assessments at Tier 3 CAMHS treatment were rated red, with 75% being seen within 18 weeks (against a target of 85%). It was queried whether young people were being referred to Tier 3 too early. Although good progress had been made, CAMHS was still thought to be a challenge, with the CNWL caseload having risen from around 500 in May 2014 to about 800 in June 2016 (not 700 as stated in the report). A mapping exercise had been undertaken with schools to identify and disseminate good practice. In addition, information had been shared in relation to preventative sport (it was anticipated that further discussions would be undertaken around this) and opportunities for pastoral support to reduce the number of referrals had also been investigated. It was recognised that, until the service transformation was complete, there would be challenges and that, after completion, the challenge would then be to sustain the improvements. As all boroughs were facing the same staffing challenges with regard to CAMHS, the recruitment market was competitive. However, it was noted that appointments had been made for all vacant posts in Tier 3. It was noted that there was no national definition of what CAMHS should look like. As such, it would need to be defined locally. It was anticipated that discussions would be undertaken between HCCG, Healthwatch Hillingdon and the Council to identify what information HCCG currently received from the service and where possible opportunities might lay. **RESOLVED: That the Health and Wellbeing Board:** **1. noted the progress against the implementation of the agreed 2015/16 Local Transformation Plan; and**

	2. continue to request regular performance updates against the partnership plan including detail of metrics, such as reducing waiting times, training of the workforce and of financial spend against work streams to enable progress and risks to be monitored.
12.	**TRANSFORMING CARE PARTNERSHIP PLAN FOR PEOPLE WITH LEARNING DISABILITIES, AUTISM AND CHALLENGING BEHAVIOUR** *(Agenda Item 12)* It was recognised that this was a lengthy report which set out the proposed approach to improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with learning disabilities, autism and challenging behaviour. The Plan had a similar footprint to the Sustainability and Transformation Plan (STP). It was agreed that it would be important to include unambiguous financial comments in the Plan. **RESOLVED: That the Health and Wellbeing Board endorsed the direction of travel and priorities in the North West London Transforming Care Partnership Plan noting that a final implementation plan would not be agreed until confirmation regarding any additional funding and the conditions were confirmed.**
13.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 13)* It was agreed that an update on the Sustainability and Transformation Plan would be included as an item on the agenda for the meeting on 29 September 2016. The Board was reminded that the 2017/2018 Commissioning Intentions report had also been scheduled for the September meeting. **RESOLVED: That, subject to the above amendment, the Health and Wellbeing Board agree the Board Planner.**
14.	**TO APPROVE THE PART II MINUTES OF THE MEETING ON 12 APRIL 2016** *(Agenda Item 14)* It was agreed to delete the word 'first' from the sixth paragraph of minute number 52. **RESOLVED: That the Part II minutes of the meeting held on 12 April 2016, as amended above, be agreed as a correct record.**
15.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 15)* The Board discussed a number of issues in relation to infrastructure, the Sustainability and Transformation Plan (STP), Looked After Children Health Checks and hospital provision. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 3.42 pm.

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

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BOARD MEMBERSHIP REVIEW

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 – Board Membership

1. HEADLINE INFORMATION

Summary	The Health and Wellbeing Board has been established since 1 April 2013. Board members are now asked to consider any proposed changes to its membership.
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. RECOMMENDATIONS

That the Health and Wellbeing Board notes that:

1. **the Cabinet Member for Social Services, Housing, Health and Wellbeing, Councillor Philip Corthorne, has been appointed by the Council as the Chairman of the Hillingdon Health and Wellbeing Board; and**
2. **the Deputy Leader of the Council, Councillor David Simmonds, has been appointed by the Council as the Vice Chairman of the Hillingdon Health and Wellbeing Board; and**
3. **the Council's Deputy Chief Executive and Director of Residents Services be removed from the list of co-opted voting members of the Board.**

3. INFORMATION

Supporting Information

1. The Health and Wellbeing Board was established by Council on 9 May 2013, in accordance with the Health and Social Care Act 2012, with the aim of seeking to improve the quality of life of the local population and provide high level collaboration between the

Council, the NHS and other agencies to develop and oversee the strategy and commissioning of local health services.

2. Since its inception, the Board has been Chaired by the Leader of the Council with this role enshrined with the Terms of Reference and in Article 7 of the Constitution. The Terms of Reference also stipulate that the Vice-Chairman shall be the Cabinet Member for Social Services, Housing, Health and Wellbeing. Other Statutory Members that may attend meetings are:
   - Cabinet Members from the London Borough of Hillingdon
   - A representative from the Clinical Commissioning Group covering Hillingdon
   - A representative from Healthwatch Hillingdon
   - Statutory Director of Adult Social Services
   - Statutory Director of Children's Services
   - Statutory Director of Public Health

3. It was agreed at Council on 8 September 2016 that the Chairmanship of the Hillingdon Health and Wellbeing Board will now be held by the Cabinet Member for Social Services, Housing, Health and Wellbeing and the Vice Chairmanship by the Deputy Leader of the Council.

4. In addition, Council agreed at its meeting on 8 September 2016 that the Council's Deputy Chief Executive and Director of Residents Services be removed from the list of co-opted voting members of the Board.

Board Member Vacancies

There is currently one membership vacancy on the Board:

1. Healthwatch Hillingdon - Statutory Voting Member.

The Healthwatch Hillingdon vacancy is for a voting member and any nomination would need to be agreed formally by Council. At present, no nomination has been made to fill this vacancy.

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

Section 194 of the Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board to comprise a number of Statutory Members and such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Sections 195 and 196 of the Health and Social Care Act 2012 specify the functions of the Board. These duties are to encourage persons engaged in the provision of any health or social care services "to work in an integrated manner" and to "provide advice, assistance or other support" to encourage joint working between local authorities and NHS bodies. Section 196 also specifies that the Board is to exercise the Council's functions under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 - assessment of health and social care needs in the Borough and the preparation of the Joint Health and Wellbeing Strategy.

In addition, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out how the Board should operate as a Committee of the Council. Regulation 6 provides that the existing legislation on voting rights need not apply unless the Council so directs. However, before making such a direction on voting rights, the Council is required to consult the Board. Regulation 7 makes there no requirement to have all political groups within the Council represented on the Board.

Section 49(7) of the Local Government Act 2000 requires any external members of a Council committee to adhere to the Members Code of Conduct if they have an entitlement to vote at meeting of the committee.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1

HEALTH AND WELLBEING BOARD MEMBERSHIP 2016/2017
subject to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Organisation	Name of Member	Substitute
STATUTORY MEMBERS (VOTING)		
Chairman	Councillor Corthorne	Any Elected Member
Vice-Chairman	Councillor Simmonds	Any Elected Member
Cabinet Members	Councillor Puddifoot	Any Elected Member
	Councillor D Mills	Any Elected Member
	Councillor Bianco	Any Elected Member
	Councillor Burrows	Any Elected Member
	Councillor Lewis	Any Elected Member
Healthwatch Hillingdon	**VACANCY**	Mr Stephen Otter
Clinical Commissioning Group	Dr Ian Goodman	Dr Kuldhir Johal
STATUTORY MEMBERS (NON-VOTING)		
Statutory Director of Adult Social Services	Mr Tony Zaman	Mr John Higgins
Statutory Director of Children's Services		Mr Tom Murphy
Statutory Director of Public Health	Dr Steve Hajioff	Ms Sharon Daye
CO-OPTED MEMBERS (NON-VOTING)		
The Hillingdon Hospitals NHS Foundation Trust	Mr Shane DeGaris	Mr Richard Sumray
Central and North West London NHS Foundation Trust	Ms Robyn Doran	Ms Maria O'Brien
Royal Brompton and Harefield NHS Foundation Trust	Mr Robert J Bell	Mr Nick Hunt
LBH	Mr Nigel Dicker	N/A
Clinical Commissioning Group (Officer)	Mr Rob Larkman	Mr Neil Ferrelly
Clinical Commissioning Group (Clinician)	Dr Reva Gudi	Dr Kuldhir Johal

HEALTH AND WELLBEING STRATEGY: PERFORMANCE REPORT

Relevant Board Member(s)	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).**
2) **notes the outcome performance indicators in the quarterly dashboard (Appendix B).**
3) **instructs officers to consider how best to develop Hillingdon's Joint Health and Wellbeing Strategy to take into account the Hillingdon Sustainability and Transformation plan and to come back to the Board with proposals as to how to programme and project manage delivery.**

INFORMATION

Supporting Information

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

Four broad priority areas were identified through 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.

Since the development of the Strategy further work has taken place across partners to take forwards closer working on, for example, the Better Care Fund, the accountable care partnership and on CAMHS. It is recommended, therefore, that further work be undertaken across partners to consider how best to develop the strategy to take into account delivery of Hillingdon's STP and all of its component parts. This would also need to reflect whatever performance monitoring may emerge from the North West London ST plan

Key highlights from the existing delivery plan so far Delivery Plan under each of the priority areas are detailed below:

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

1.1 **Commissioning plans for paediatric care** are being taken forward, including integrated GP/Paediatric consultant clinics, the Paediatric Assessment Unit (which opened in July 2016), the Asthma pathway, and Critical Care Level 1 for more complex sick children.

1.2 **Smoking cessation** Smoking prevalence fell from 17.5% of those aged 18+ in 2014, to 16.9% in 2015. During Q1 2016, 155 Hillingdon residents quit through the support of GP's, Pharmacies and specialist advisors. More than 60 Hillingdon pharmacists have been trained to prescribe stop smoking medication which would otherwise only be available through a GP. 45 out of 62 pharmacies deliver this service within the borough and feedback from residents has been favourable due to minimising delay in accessing specialist medication.

1.3 **Children's weight management** programmes are being delivered in several locations across the Borough for age groups from 2-13+. Additional sessions are due to start in September 2016 and January 2017.

1.4 **Adults with learning disabilities** All service user care plans continue to include evidence of support to access employment or education. Two service users have undertaken paid employment and a further 22 have improved skills though undertaking unpaid work.

2 Priority 2 - Prevention and early intervention

2.1 **Reablement** The Reablement Team received 227 referrals in Q1. 51 community referrals, representing potential hospital attendances and admissions were avoided. 102 people were discharged from Reablement with no ongoing care needs.

2.2 **NHS health checks** are available to 75,341 residents and people registered with Hillingdon GPs. The current take-up rate 66.4%. The maximum number of checks that can be delivered within current budgets and provider contracts falls slightly below the 75% take up target. Targeted promotional work has taken place to promote NHS health checks, including at Hayes Carnival.

2.3 Access to **Physical Activity** sessions for those with chronic conditions continues to be provided through the Let's Get Moving programme. The Council is also providing 'Get up and Go' sessions for residents from BME groups and running a weight action programme for staff.

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

3.1 **Early identification of people susceptible to falls, stroke, dementia and/or social isolation (BCF scheme one)** The H4ALL Health and Wellbeing Service started in April to provide support to older people living with long-term conditions at risk of escalating needs.

3.2 **Seven day working (BCF scheme four)** Councils participating in the consortium for the dynamic purchasing system tender have agreed to include a requirement in specifications for residential and nursing care home placements that there must be sufficient suitably qualified staff to do assessments, to support hospital discharges seven days a week.

3.3 **Supporting carers (BCF scheme seven)** In Q1 130 carers were provided with respite or another carer service. A new Carers' Cafe has been launched in Ruislip, providing support. A Carers' Fair was held in June and 58 new carers were identified.

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 concurs with the financial implications set out above.

Hillingdon Council Legal comments

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

BACKGROUND PAPERS

NIL.

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Appendix A Health and Wellbeing Strategy Delivery Plan Update - September 2016

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 residents' 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	Wellbeing Service, Public Health & Maternity Services	Annually	• A programme to engage over-weight pregnant women in ante-natal exercise is now open to ante and post natal women with an average attendance of 6 per week. Priority is given to women with a BMI 30+. The session is open to all and further partnership work has been developed with the Assistant Director of Operations & Head of Midwifery & Women's Care at Hillingdon Hospital. • During Q1, 18 pregnant women set a date to quit smoking, and 9 quit smoking.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• The Paediatric Business Case is now being taken forward as a commissioning plan. Work streams include: • Integrated GP Paediatric Consultant Clinics - economic modelling & logistic planning is now progressing. The aim is to test a clinic as soon as approval is agreed. • Ambulatory care pathways – the new Paediatric Assessment Unit opened in mid-July 2016.

				• Implementing the Asthma pathway - Asthma Allergy the roll out of the successful pilot. Children are seen in community/school. Practice nurses are trained in Asthma diploma, building the level of expertise and management into community. This implements the Asthma quality standards. • Critical Care Level 1 it is proposed to develop this service to provide quality care for the more complex sick child. This will enable to hospital to deliver care against London wide standards. Preparing for level 2 in the future. This will enable to hospital to care for these children close to home without transferring , to other hospitals. This programme of work is taking place with neighbouring boroughs as children attend the hospital from other areas as well as Hillingdon • Meetings of the children's health partnership were paused while CCG appointed a new Clinical Lead, who commenced in post July. This group aims to become a smaller transformation group ensuring it is action-focussed as well as strategic. Membership will be reviewed. Planned quarterly meeting to commence September. The task & finish groups continue.
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• During Q1, 469 people in total attended four tea dances. Feedback received from participants continues to be positive with older people stating that the dances encourage them to be more active, make friends and feel less lonely.

	1.1.4 Deliver a smoking cessation service including supporting the further roll out of Smoke Free Homes in Hillingdon	Public Health	Annually	• Hillingdon's Smoking prevalence (age 18+) rate is estimated at 16.9%, a reduction from 17.5% on year and less than the England average of 18% *(data obtained from Public Health Outcomes framework & HSCIC statistics on smoking 2016).* • The Smoking cessation target is 1,055 quitters. Between April to June 2016, 155 Hillingdon residents quit through the support of GP's, Pharmacies and specialist advisors. • A regular weekly clinic to support residents diagnosed with mental health conditions is being delivered at Mead House. Currently 15 patients are engaging with the service primarily on a harm reduction basis but have achieved 3 successful quits. • 6 Health promotion events have been attended to promote the availability and support to residents through stop smoking services. These included the carers forum in Northwood, Hayes carnival, life after cancer, QPR football fair day, Hillingdon Citizens Advice fair and the well being day at Brookfield health centre. • The national and well advertised campaign 'Stoptober' has been highlighted to our Healthcare professionals to ensure that they have adequate 'free' material to display in their practices in a bid to drive footfall and engagement of our residents.

				• A workshop has been organised in September to enhance the skills of Hillingdon Pharmacy / GP based stop smoking advisors to improve their current model of delivery thus leading to an increase in numbers of successful quit attempts. • Since April 2016, the format of Level 2 smoking cessation training has been modified to ensure that the advisor meets the benchmark competencies through a nationally accredited online programme (NCSCT). Successful participants will then be invited to the local authority for a face to face update which will finally accredit them with a level 2 status. This has been well received by healthcare professionals across the borough as it is convenient and accessible, reducing absence from their practice. The next update is scheduled for October and 6 health care professionals have confirmed attendance. • Currently over 60 Pharmacists have been trained to prescribe stop smoking medication which would otherwise only be available through a GP. 45 out of 62 Pharmacies deliver this service within the borough and feedback from residents has been favourable due to minimising delay in accessing this specialist medication. • Almost all Hillingdon Pharmacies provide COPD screening to patients accessing the stop smoking service.

				• Specialist advisors have been trained to deliver Nicotine Replacement Therapy directly to the patient at community clinics. GP Practices have been recommended to complete patient searches to engage with the smoking population of that surgery.
	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	Wellbeing Service/Public Health	Quarterly	• The children's weight management programme is being delivered across 3 localities and for ages 2-4, 5-7, 7-13 and 13+ with new cohorts starting in September 2016 and January 2017. • Children in Reception Year and Year 6 were weighed and measured and data was submitted to HSCIC as per the national guidance in advance of the deadline. Data will be summarised in a national report to be released in November. • The council continues to deliver the 'Walks Scheme'. In Q1 there were 356 new walkers and 891 attendances. • As part of the 'This Hillingdon Girl Can' mother and daughter physical activity programme, 29 free exercise sessions spread across the borough were delivered over a 20 week period. Over 500 people took part in the programme and more than 90% of survey respondents said taking part had improved their wellbeing.

	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The new environmental information from the GLA has been received and will form the basis of a consultation process to confirm the areas of concern throughout the borough and help identify the necessary actions needed to improve air quality and public health. It is anticipated that the process will start in September. The final Plan will be subject to a five year review as requested by the Mayor of London. • The borough will ensure that future decisions on major infrastructure projects, which can potentially threaten the improvements to local air quality which the Council is attempting to make, are highlighted within the Plan. This will include issues such as the potential expansion of Heathrow Airport, the construction of HS2 Ltd's high speed line and the implementation of the upgrading of the M4 through the borough to a Smart Motorway.
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	• All service user care plans continue to evidence the support to access employment or education opportunities. • 2 service users have had the opportunity to undertake paid employment opportunities and 22 service users had the opportunity to undertake unpaid employment to up skill in readiness for further paid work. • Examples of the unpaid opportunities have been for service users to carry out laundry tasks at Queens Walk.

				• Staff are also currently supporting 2 service users to carry out work experience within Wren- Day resource for Older people to support with catering staff at Wren with domestic tasks and meal preparation to enhance their catering skills.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• An Autism Stakeholder event took place in June 2016 and the draft Autism Plan has been updated to reflect their views. The Plan will be ready for sign off in September/October 2016. • The Autism Partnership Board is well attended by all partners.
Priority 2 - Prevention and early intervention				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
2.1 Deliver the BCF	**2.1.1** Deliver scheme three: Rapid response and integrated Intermediate Care	LBH/CCG	Quarterly	• During Q1 the Reablement Team received 227 referrals and of these 51 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, 102 people were discharged from Reablement with no on-going social care needs. • In Q1 the Rapid Response Team received 886

				referrals, 56% (500) of which came from Hillingdon Hospital, 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals. All 386 people referred from the community source received input from the Rapid Response Team.
2.2 Deliver Public Health Statutory Obligations	**2.2.1** Deliver the National NHS Health Checks Programme	Public Health	Annually	• The NHS Health Check programme aims to identify at an early stage individuals at moderate to high risk of cardiovascular disease, diabetes, stroke, kidney disease and related metabolic risk. • In 2016/17, **75,341** Hillingdon residents and people registered with Hillingdon GPs are eligible for the NHS Health Check programme. Of these, **15,068 (20%)** people should receive their First Offer (in five years) of a Check. The Check take-up rate should gradually be moving towards 75%. In 2015/16, the take-up rate was 67%, therefore Hillingdon should be aiming to carry out at least **10,146 (13.5%)** checks during 2016/17. However, it should be noted that the maximum number of NHS Health Checks that can be delivered given the current budget and provider contracts is 8,700 (11.5%). • The Quarter 1 position for 2016/17 as reported to

				Public Health England (PHE) on 29th July 2016 was: - First Offers: **2,446 (3.2%)**, an increase of **229 (10.3%)** from the Q1, 2015/16 figure; - Completed Checks: **1,624 (2.2%)**, an increase of **189 (13.2%)** from the Q1, 2015/16 figure; - Take-up rate: **66.4**% • Late data submissions from a couple of practices boosted these figures to **2,634 (3.5%)** for First Offers and **1,751 (2.3%)** for Completed Checks. This is an increase of **417 (18.9%)** First Offers and an increase of **316 (22.0%)** Checks from the Quarter 1, 2015/16 position. The take-up rate improved by **1.7%** from **64.7%** to **66.4%** for the same period. • The following targeted actions were taken during Quarter 1, 2016/17 to increase the numbers of NHS Health Checks offered and carried out: - One NHS Health Check training session held for practice and pharmacy staff; - Two visits to support practices; - NHS Health Checks were provided at Hayes & Harlington Community Centre for Hillingdon Carers at their April Café; The NHS Health Check service was promoted at Hayes Carnival and Wellbeing events at Mead House.
	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• The review and health and care needs assessment for HIV Support Services has been completed and a revised service specification tailored to meet the needs of service users living with HIV/AIDS is being

				implemented in 2016/16. • A sexual and reproductive health needs assessment (including user engagement) has been undertaken. The outputs from the needs assessment has been used to inform the development of a new model of service for an integrated sexual and reproductive health service. • The service is due to go out to tender in September 2016. It is intended that the new service model will go live on 1st May 2017. **OUTREACH:** • Men's Health Week: The Chlamydia Outreach Team are planning events for the forthcoming Men's health week (October 2016) with a focus on young men. • Fresher's Week: The Chlamydia Outreach Team are currently preparing for Fresher's Week at Brunel and Uxbridge College – both campuses. • RAF Northolt: The Chlamydia Outreach Team continue to visit new recruits briefings at RAF Northolt in collaboration with the Practice Nurse at the base. • SRE outreach: Worked in partnership with targeted schools, academies, Pupil Referral Unit (The Skills Hub) and Uxbridge College to raise awareness regarding sexual health and wellbeing and risks

				associated with substance misuse. • Early Intervention and Prevention - Partnership Working: The Team continue to in-reach into: (a) the ARCH substance misuse service; (b) Children Looked After homes; (c) YMCA hostels; (d) local bars and Club. With specific reference to bars and clubs the Outreach Team piloted the delivery of sexual health and general health and wellbeing information in a local night club for young people. The intervention yielded 44 young people who received brief advice and information and signposting to local services. • Sexual Health Outreach Nurse: The Clinic in a Box Service continues to work on a one to one basis with between 10-15 vulnerable young people – including those who are post abortion.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• No update this quarter
2.3 Prevent premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia	CCG	Quarterly	• No update this quarter

	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	• Increasing levels of physical activity in the Borough amongst those suffering from chronic conditions is being taken forward through the inclusion of the 'Let's get Moving' programme in disease care pathways. Let's Get Moving data to 31st July 2016: 470 total clients (139 final assessment attendees) 71% achieved all their goals 25% achieved some of their goals 4% failed to achieve their goals 68% achieved overall reduction in BMI 76% achieved reduction in waist measurement 67% achieved an increase in the amount of times that 30 minutes of moderate intensity (breathless) physical activity was undertaken each week. Reduction in BMI for those whose goal it was to lose weight 80% Increase in overall activity level 91% Improved fitness 73% Reduction in GP visits 64% Reduction in pain 50% Reduction in depression 43% Improved wellbeing 60% Less short of breath 55% Improved sleep 45%

				• The internal Weight Action Programme for Council staff has 28 staff registered. 16 completed the programme. The second programme has been confirmed to start in Sept. Due to an overwhelming response (over 40 staff members registered) there will be two programmes delivered over a 10 week period). • 'Get Up & Go' for residents from BME groups looking to improve their wellbeing lifestyle and take part in physical activity. In Q1 there were 8 attendees.
	2.3.3 Reduce excess winter deaths	Public Health/NHS England		• No update this quarter.
	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 worked on a joint project to improve access to preventative dental care in Hillingdon. • Two new NHS dental practices are planned for Harefield and West Drayton to ensure equity of NHS dentistry across the borough. • 3,500 school children completed forms as part of the School Oral Health Project.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Task/Metric now moved to **3.3.3 Deliver BCF scheme eight: Living well with dementia**

	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 - the mental health urgent care pathway for Adults has been operational from 2nd November 2015. Community services have been reconfigured into two hubs and the home Treatment Team now operates out of hours with two members of staff on duty. This service commenced January 2016 and the impact will be evaluated with a report expected in September/ October 2016. • Improving Access to Psychological Therapies - a Business Case was been approved to expand IAPT Services to target hard to reach groups and those with Long Term Health conditions such as Diabetes. CNWL has recruited additional staff to expand the service to ensure 15% access target is maintained 16/17. The Access and Recovery Targets continue to be met in 16/17. NHSE invited Hillingdon to submit a proposal to become an Early Implementer of the new targets set out in the National Five Year Mental Health Plan, a bid was submitted, the outcome is expected in September 2016. As part of the Hillingdon Transformation Plan The following services are all now in operation: • A CAMHs self-harm, crisis and intensive support Team. • Specialist Mental Health provision for Children and young People with Learning Disability and Challenging Behaviour Team, with an integrated pathway with LBH Disability Team. • A Community Eating Disorder Service.

				• Additional resources to reduce waiting times for treatment • 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 has been approved by Hillingdon CCG Governing Body to further enhance this service with the continuation of the Mental Health Assessment Lounge as a separate facility from Accident and Emergency department. This service is currently undergoing an evaluation for further review.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• The Vision Strategy has been signed off.
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	• Work is ongoing between the Council and partners including schools, academies and education and training providers to track the employment, education and training (EET) status of young people. This includes each Secondary provider in Hillingdon being asked to share known destination data at the end of summer term 2016. • A letter has been sent to each Hillingdon young person where the Council does not hold telephone or email contacts and home visits continue to be made in order to identify the employment, education or training status of the 16 - 19 cohort. Early indications suggest a positive upturn in identification

				rates. • Current data to 30th June 2016 shows that the number of 16-19 year olds not in employment, education or training (NEET) is 314 young people (3.7% of the cohort). The percentage of NEET in September 2015 was 5.87% representing an improvement of 2.1% in 10 months. In Hillingdon, 7,947 young people 16-19 are in further or higher education or apprenticeships or employment representing 78.8% of the cohort. • 1,702 young people's EET destinations are currently unknown. Numbers are consistent with the season level of student movement at this time of year. Destination identification work is ongoing between the Council's Participation Team and education and training providers to determine the EET status of the cohort over the coming months.

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	**3.1.1** Deliver scheme one: early identification of people susceptible to falls, stroke, dementia and/or social isolation	LBH/CCG	Annually	• As at 30th June, Connect to Support Hillingdon had 241 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. This represents an additional 39 organisations from the position at the end of March 2016. • The H4All Health and Wellbeing Service became

				operational in April, which will provide support to older people living with long-term conditions at risk of escalating needs. • By the end of Q1 approximately 340 people had been referred to the Health and Wellbeing Service from GP surgeries and 108 assessments using the Patient Activation Model (PAM) had been completed. This tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. • There were 207 emergency admissions of people aged 65 and over related to falls during Q1, which is slightly above the ceiling for the quarter of 195. The ceiling for 2016/17 is 780. • The development of a new Falls Prevention pathway working in partnership with Hillingdon Hospital / Age UK / CCG and clinical professionals is in its early stages.
	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• Training was provided for Social Care staff in the use of Coordinate My Care (CMC). Information sharing agreements are on track to be signed in Q2 which will then enable social care staff to have read and write access to this system, which should facilitate a more coordinated approach to the provision of care and support to Hillingdon residents who at the end of their life as well as supporting their Carers.
3.2 Deliver the BCF	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• It was agreed by councils participating in the consortium for the dynamic purchasing system (DPS) tender led by LB Ealing to include a

				requirement in the specifications for residential and nursing care home placements to have available suitably qualified staff to enable assessments to support hospital discharge seven days a week. October Cabinet will be asked to approve the results of the tender process. The DPS will enable the Council to comply with procurement regulations in respect of spot placements in care homes. • There was a significant drop in the number of discharges on a Saturday compared to 2015/16, e.g. 347 (2016/17) compared to 546 (2015/16). This is largely accounted for by a drop in discharges of people admitted for planned (also known as elective) procedures from 332 in 2015/16 to 171 in Q1 2016/17. There has also been a reduction in the number of Saturday discharges of people who were admitted in an emergency (non-elective admissions).
	3.2.2 Deliver scheme six: Care home and supported living market development	LBH/CCG	Quarterly	• There were 430 emergency admissions from care homes in Q1 against a ceiling of 427, which means that activity is broadly on target. • A task and finish group comprising of GP representatives, a consultant geriatrician and a representative from CNWL's community health and community mental health teams and also the third sector has met to help shape the care and wellbeing specification for the extra care sheltered housing

				schemes, including two new schemes that will open early in 2018. The service will be tendered in Q3 2016/17.
	3.2.3 Deliver scheme five: Integrated community-based care and support	LBH/CCG	Quarterly	• The use of risk stratification tools within GP practices to identify older people living with long-term conditions who could benefit from care planning as part of a more anticipatory model of care has been expanded to all practices. The intention is to extend the use of these tools to other adults during 2016/17.
	3.2.4 Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant	LBH	Quarterly	• In Q1 2016/17, 26 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 39% of the grants provided. • 64% (43) of the people receiving DFG's were owner occupiers, 33% (22) were housing association tenants, and 3% (2) were private tenants. The total DFG spend on older people (aged 60 and over) during Q1 2016/17 was £68k, which represented 30% of the spend during the quarter (£227k).
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for over 80's	LBH	Quarterly	• A total of 4,727 people were in receipt of the TeleCareLine service at the end of Q1 2016/17. • 224 residents took up the service during Q1. • 3,615 people receiving the TeleCareLine service are aged 80 years or older.

3.3 Deliver the BCF	**3.3.1** Deliver BCF scheme seven: Supporting Carers.	LBH	Quarterly	• In Q1 107 carers' assessments were completed, which is below the quarterly target of 125. • During Q1 130 Carers were provided with respite or another carer service at a cost of £230.7k. • A new Carers' Café was launched in Ruislip, thereby creating increased support opportunities for Carers in this part of the borough. • A successful Carers' Fair was delivered on 7 June 2016. 45 partner organisations held information stalls and 58 new carers were identified.
	3.3.2 Deliver BCF scheme eight: Living well with dementia			• Approximately 100 people were trained during Q1 by Alzheimer's Society to be Dementia Friends. This means that Hillingdon now has 3,500 trained Dementia Friends. • The Council's Wellbeing Service developed a '5-ways to Wellbeing' training package for people living with dementia. The next stage involves working with the Alzheimer's Society and Memory Assessment Service to identify people who may be able to benefit from the training. • Final planning consent was given for the Grassy Meadow extra care sheltered housing scheme, which includes the Dementia Resource Centre.
3.4 Implement requirements of the	**3.4.1** Implement the SEND reforms including	LBH/CCG	Quarterly	• There are 775 Education, Health and Care Plans of which 498 are transfers from previous Statements.

Children and Families Act 2014	introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service planning for children, young people and families			There are a further 973 Statements to transfer by 31 March 2018 in line with the Transfer Plan. • The Local Offer working group is overseeing delivery of the action plan. • The SEND Steering Group is overseeing improvements including readiness for Ofsted/CQC inspection. • Resource allocation systems to deliver personal budgets for children with disabilities and those with special educational needs are being piloted. A creative support planning project is underway for children with disabilities. • Disabled Go are undertaking the accessibility surveys of the 1000 chosen venues in the borough.
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 Orchard Hill College Academy Trust (OHCAT) new specialist college provision opens in September 2016 and young people have been allocated places. • OHCAT has submitted an application for a Free Special School for pupils with social, emotional and mental health difficulties on the YPA site to include sixth form provision. • Eden Academy has submitted expressions of interest to establish two new Free Special Schools; a secondary school in the north of the borough on the Grangewood school site; a primary school in the south of the borough (site options to be confirmed).

				These schools, if agreed, will provide the additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school.

Priority 4 - A positive experience of care

Objective	Task and Metric	Lead	Metric reporting frequency	Evidence of activity against task
4.1 Ensure that residents are benefitting from implementation of BCF schemes	**4.1.1** Improve service user experience e.g. how easy or difficult residents found it to access information and advice by 0.5%	LBH/CCG	Annually	• This metric will be tested by the Adult Social Care Survey undertaken in Q4 2016/17.
	4.1.2 Improve social care related quality of life by 0.2%	LBH/CCG	Annually	This metric will be tested by the Adult Social Care Survey undertaken in Q4 2016/17.
	4.1.3 Increase the overall satisfaction of people who use services with their care and support	LBH/CCG	Annually	• Subject to HWBB approval, residents will be engaged in the development of the three-year (2017 - 2020) BCF plan.
	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	• The experience of Carers will be tested in the national carers' survey being undertaken in Q3.

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	• A children and young people participation network has been established making use of existing groups e.g. special school councils, pupils attending SRPs, Merrifield House, voluntary organisations. • This will be kept under review to ensure it is an effective way of increasing participation giving young people a voice in the review and design of services.

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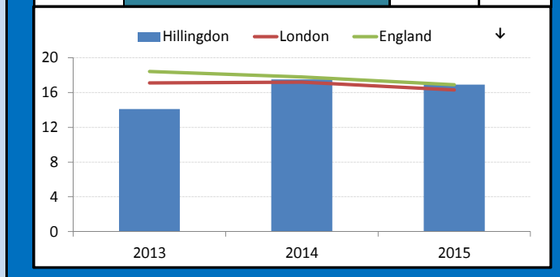
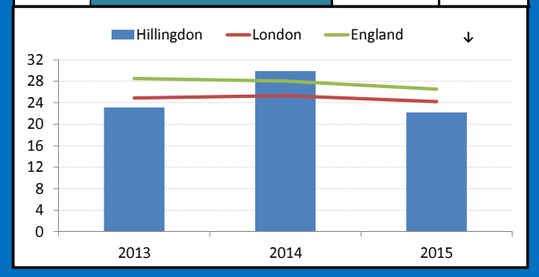
Health & Wellbeing Board - September 2016

PRIORITY ONE

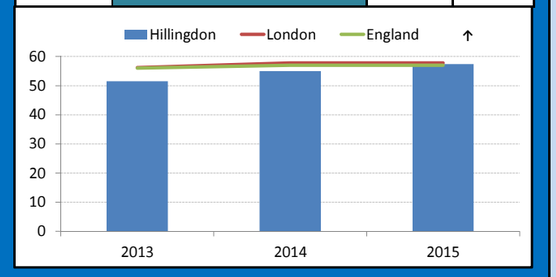
PHOF 2.14	Smoking Prevelance: age 18+	2015	16.9
		2014	17.5



PHOF 2.14	Smoking prevalence (age 18+ routine and manual)	2015	22.1
		2014	29.9



PHOF 2.13i	Proportion of active adults	2015	57.4%
		2014	55%

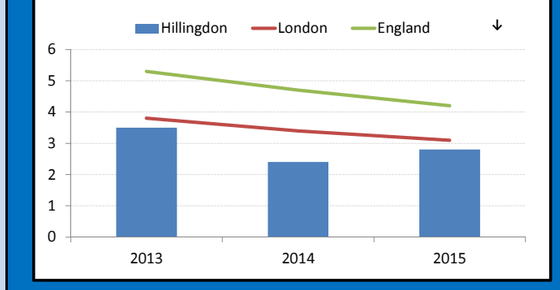


PRIORITY ONE

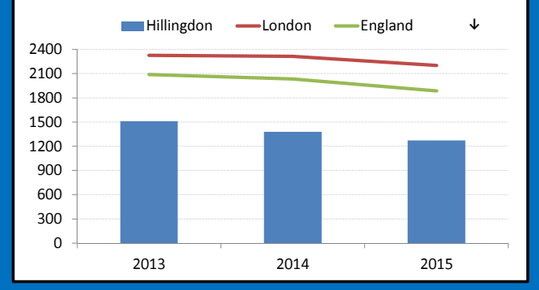
PHOF 2.13ii	Proportion of inactive adults	2015	31.20%
		2014	28.40%

PRIORITY TWO

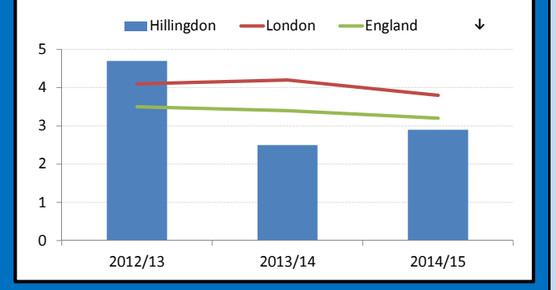
PHOF 1.05	Number of 16 - 18 year olds who are known NEET	2015	2.80%
		2014	2.40%



PHOF 3.02	Chlamydia detection rate in 15-24 year olds	2014/15	1272
		2013/14	1378



PHOF 4.12iii	Preventable sight loss (diabetic eye disease)	2014/15	2.9
		2013/14	2.5

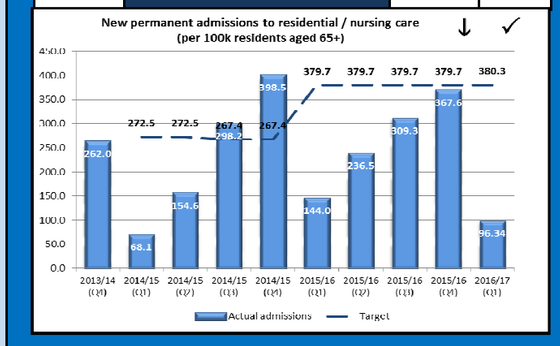


PRIORITY TWO

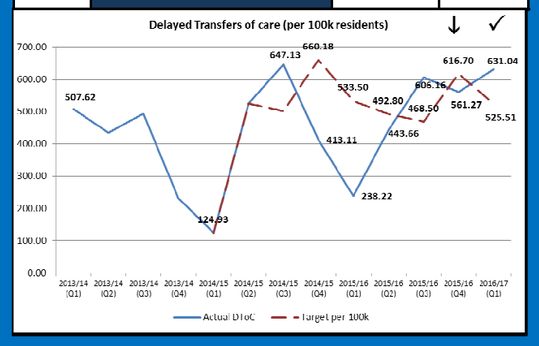
PHOF 4.02	Proportion of five year old children free from dental decay	2014/15	62.20%
PHOF 2.22iii	Cumulative % of eligible population aged 40-74 offered an NHS Health Check	2013/14-2015/16	39.40%
PHOF 2.22iv	Cumulative % of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14-2015/16	69.50%
PHOF 2.22v	Cumulative % of eligible population aged 40-74 who receive an NHS Health Check	2013/14-2015/16	27.30%
PHOF 4.12	Preventable sight loss (aged related macular degeneration)	2014/15	57.2
		2013/14	101.2
PHOF 4.12ii	Preventable sight loss (glaucoma)	2014/15	6.4
		2013/14	9
PHOF 4.12iv	Preventable sight loss (sight loss certification)	2014/15	23.6
		2013/14	30.3

BETTER CARE FUND METRICS

Perm admissions	Perm admissions per 100,000	2016/17	96.3
		2015/16 (FYr)	367.6



Delayed transfer of care (DToC)	DToC per 100,000 residents	2016/17 (Q1)	631.0
		2015/16 (Q4)	561.3



Perm admissions	Number of permanent admissions to residential / nursing care for residents aged 65+	2016/17	38
		2015/16	145
Perm admissions	Annual target for number of perm admissions	2016/17	150
		2015/16	150
Perm admissions	Target for number of permanent admissions to residential / nursinge care per 100,000 residents aged 65+	2016/17	96.3
		2015/16	367.6
Delayed transfer of care	Total number of days in quarter	2016/17 (Q1)	1447
		2015/16 (Q4)	1,287
Delayed transfer of care	DToC per 100,000 (Qtrly Outturn)	2016/17 (Q1)	631.0
		2015/16 (Q4)	561.3
Delayed transfer of care	Quarterly target for delayed discharges (total number of days)	2016/17 (Q1)	525.5
		2015/16 (Q4)	616.7

PRIORITY THREE

LBH (Local Measure)	Number of major adaptations to homes to promote safe, independent living	2015/16	478
		2014/15	223
LBH (Local Measure)	Number of people in receipt of TeleCareLine (All ages)	2016/17	4,727
		2015/16	4,674
LBH (Local Measure)	Number of people in receipt of TeleCareLine (80+)	2016/17	3,615
		2015/16	3,582
LBH (Local Measure)	Number of people in sign ups to TeleCareLine	2016/17	224
		2015/16	1,326

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

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BETTER CARE FUND: PERFORMANCE REPORT (APRIL - JUNE 2016)

Relevant Board Member(s)	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 Caroline Morison, HCCG
Papers with report	Appendix 1) BCF Monitoring report - Month 1 - 3: April - June 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (April - June 2014/15 to 2016/17) Appendix 3A) Hillingdon Hospital Discharges Before Midday (April - June 2015/16 and 2016/17)

HEADLINE INFORMATION

Summary	This report provides the Board with the first performance report on the delivery of the 2016/17 Better Care Fund plan.
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 £22,521k for 2016/17 as at month 3.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. **notes the contents of the report.**
b. **approves the reduction in the 2016/17 target for the proportion of older people still at home 91 days after discharge into Reablement from 93.8% to 90% for the reasons described in the report.**

INFORMATION

1. This is the first performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2016/17 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 the Council's Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body.

2. Hillingdon's Plan received formal approval by NHS England (NHSE) on the 21st July 2016.

3. **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 3 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 an underspend of £45k against the pooled budget of £22,521k.

- In Q1 there were 2,537 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,442. This level of activity is broadly comparable with the same period in 2015/16 when there were 2,570 admissions.

- There were 208 falls-related emergency admissions during Q1, which is slightly above the ceiling for the quarter of 195 admissions. This compares unfavourably with same period in 2015/16 when there were 186 falls-related emergency admissions.

- Delayed transfers of care - There were 1,447 delayed days during Q1 2016/17 against a ceiling of 664, which means that activity during the quarter was significantly higher than projected. The position in Q1 2015/16 was 538 delayed days.

- There were 38 permanent admissions of older people to care homes in Q1, which means that the plan for 2016/17 is on track. The 2016/17 ceiling is 150 permanent placements.

- The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q1 was 89.4% against a target of 93.8%. This target was set based on a provisional outturn for 2015/16 of 92% but the actual outturn was 88%. The sample period for this metric nationally is Q3. As the 91 days period would be completed during the winter months in Q4 this report recommends that the 2016/17 target is reduced to 90%.

- In Q1 1,353 individuals have accessed Connect to Support and completed 2,163 sessions reviewing the information & advice pages and/or details of available services and support. This reflects a lower number of people accessing the system during the same period in 2015/16 but promotional activity being undertaken in Q2 and Q3 should see an increase in usage.

- In Q1 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

Developing the 2017 to 2020 BCF Plan

4. In the 2015 Autumn Statement it was announced that each area will be required to produce a three-year BCF plan by the end of 2016/17 that will demonstrate how full integration between health and social care will be achieved by April 2020. At time of drafting the statutory guidance that will define what the Government means by 'full integration', as well as the other

requirements for the three-year plan, had not been published. However, the Council and the CCG have been working on proposals for increasing the level of ambition within the context of the Sustainability of Transformation (STP) Plan.

5. Draft proposals will be provided for Council member and CCG Governing Body consideration early in Q3 and will include:

- ***CAMHS*** - Options for a fully integrated Children and Adolescent Mental Health Service (CAMHS) that will entail a transfer of resources into prevention and wellbeing services and a subsequent reduction of treatments in specialist and highly specialist services, with a resultant reduction in the waiting times for these services, and a reduction in inpatient admissions.

- ***Intermediate Care*** - Options for a fully integrated intermediate care service that will result in a single point of access, a single accountability for the service, residents receiving the intervention of the most appropriate professional first time, a reduction of hand-offs between organisations and an improved experience of care for residents.

6. Other proposals will build on work undertaken during 2016/17 as well as looking at more integrated pathway commissioning in the following areas:

- ***Transforming Care*** - Developing an intensive intervention model to support step down from specialist (tier 4) provision and developing tailored housing options to support people with learning disabilities and/or autism;

- ***Like Minded*** - Developing a range of supported living options enabling people to transition from acute to least intensive community settings, designing and developing the model of care for Primary Care Mental Health Services and developing locally-based step-up facilities to support people in crisis.

Financial Implications

7. The Quarter 1 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £45k arising from a favourable movement on the budget for community equipment. The demand management work undertaken during the last financial year and continuing into this year to manage the community equipment budget is now delivering an improved financial outcome. There are a number of minor overspends within the LBH - Protecting Social Care funding due to staffing and some increased demand on placement budgets.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

8. The monitoring of the BCF ensures effective governance of delivery via the Health and Wellbeing Board.

9. The proposed revision of the target for the percentage of older people still at home 91 days after discharge into the Reablement Service more accurately reflects what is achievable during 2016/17.

Consultation Carried Out or Required

10. The 2015/16 BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents and the 2016/17 plan represents a logical progression of that plan and an extension in some areas, e.g. care home and home care market development. Hillingdon Hospital, CNWL and H4All have been consulted in the drafting of this report.

Policy Overview Committee comments

11. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

12. Corporate Finance has reviewed the report and notes the financial position as set out in the financial implications set out above.

Hillingdon Council Legal Comments

13. 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: September 2016	**Period covered:** April - June 2016 - Month 1 - 3
Core Group Sponsors: Caroline Morison/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 the Council's Cabinet/HCCG Governing Body.

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

A. Financials

Key components of BCF Pooled Fund 2016/17 (Revenue Funding unless classified as Capital)	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**

HCCG Commissioned Services funding (including non elective performance fund)	11,965	11,855	(110)
LBH - Protecting Social Care Revenue Funding	7,109	7,174	65
LBH - Protecting Social Care Capital Funding	3,457	3,457	0
Overall BCF Total funding	22,531	22,486	(45)

B. Plan Delivery Headlines

1. 1 This report includes the financial outturn position on each scheme within the BCF for Q1. The reported financial position at 30th June 2016 was an underspend of £45k against the budget of £22,531k.

1.2 *Emergency admissions position* - In Q1 there were 2,537 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,442. This compares favourably to Q1 2015/16 when there were 2,570 admissions.

1.3 *Falls-related emergency admissions position* - There were 207 falls-related emergency admissions during Q1, which is slightly above the ceiling for the quarter of 195. This compares unfavourably with same period in 2015/16 when there were 186 falls-related emergency admissions.

1.4 *Emergency admissions from care homes* - During Q1 there were 191 admissions to Hillingdon Hospital from care homes at a cost of £609k. In Q1 2015/16 there were 202 emergency admissions at a cost of £579k. The lower number of admissions in 2016/17 but higher cost than in the same period in 2015/16 can be explained by a longer length of stay.

1.5 *Delayed transfers of care* - There were 1,447 delayed days during Q1 2016/17 against a ceiling of 664, which means that activity was significantly higher than projected.

1.6 *Permanent admissions to care homes* - There were 38 permanent admissions of older people to care homes in Q1, which slightly exceeded the Q1 ceiling of 37.5.

1.7 *People aged 65 and over still at home 91 days after discharge from hospital to reablement* - The average for Q1 was 89.4% against an annual target for 2016/17 of 93.8%.

C. Outcomes for Residents: Performance Metrics

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

1.9 **Emergency admissions target (known as non-elective admissions)** - There were 2,537 emergency admissions in Q1 and 1,809 of these were to Hillingdon Hospital. The 2016/17 Q1 plan ceiling is 2,442 emergency admissions, which means that there has been a higher level of activity than forecast. However, the Q1 2016/17 activity is slightly lower than the same period in 2015/16, which was 2,570 admissions

1.10 **Delayed transfers of care (DTOCS) -** There were 1,447 delayed days during Q1, which was above the ceiling of 664. The Q1 position in 2015/16 was 538 delayed days. Table 2 provides a breakdown of the delayed days during Q1.

Table 2: Q1 DTOC Breakdown			
	Q1 DTOC Breakdown		
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	521	395	916
Social Care	230	97	327
Both NHS & Social Care	11	193	204
Total	**762**	**685**	**1,447**

1.11 47% (685) of the delayed days concerned people with mental health needs in non-acute beds and of these 88% (603) arose due to difficulties in securing suitable placements, which includes beds in secure rehabilitation units and care home settings for people with challenging behaviours. Nearly 88% (601) of the non-acute delayed days concerned patients in beds provided by CNWL.

1.12 Nearly 57% (434) of the 762 delayed days in an acute setting were as a result of difficulties in securing appropriate placements. This is again related to difficulties in securing providers prepared to accept people with challenging behaviours and there is work underway across partners to support existing local providers to accept people with more challenging needs and to build resilience and capacity within the market to enable it to respond to Hillingdon's ageing population.

1.13 Table 3 shows the breakdown of delayed days by NHS trust for Q1.

Table 3: Distribution of Delayed Days by NHS Trust	
Trust	**Number of Delayed Days (Q1)**
Bucks Healthcare	26
CNWL	601
Hillingdon Hospitals	388
Imperial College, London	20
Luton & Dunstable	11
North West London (Northwick Park and Ealing)	196
Royal Brompton and Harefield	5
Royal Orthopaedic Hospital	8
University College	20
West Hertfordshire	122
West London Mental Health Trust	50
TOTAL	**1,447**

1.14 In compliance with the national 2016/17 BCF plan conditions, Hillingdon has developed a DTOC action plan that is intended to address the key causes of delayed transfers locally. There has been slippage on the delivery of key tasks for Q1 and table 4 below describes the action being taken to address this.

Table 4: DTOC Action Plan Update		
Task	**Update**	**RAG Rating**
1. Complete development of a joint discharge policy and procedure.	All three actions are dependent on the completion of the proposal for the Integrated Discharge Team (IDT) by Hillingdon Hospital. HCCG will then need to consider the proposal.	**Amber**
2. Develop information for patients.		
3. Establish electronic transfer of assessment, discharge notices, withdrawal and change of circumstances notices.		

1.15 **Care home admission target** - During Q1 there were 38 permanent placements into care homes (15 nursing home and 23 residential home) against a ceiling of 37.5, which means that the level of activity was slightly higher than projected. If this was replicated throughout the remainder of 2016/17 then there would be 152 permanent placements against a ceiling of 150. 29 of these placements were of people living with dementia, 7 people with functional mental health conditions, e.g. schizophrenia, and 2 requiring extensive physical support because of their physical frailty. It should be noted that the delivery of the extra care sheltered housing schemes, Grassy Meadow and Parkview, in 2018 will provide a realistic alternative to residential care home placements for older people.

1.16 It should be noted that the new permanent admissions figure in paragraph 11.4 above is a gross figure that does not reflect the fact that there were 34 people who were in permanent care home placements also left during the period 1st April 2016 to 30th June 2016. As a result, at the end of Q1 there were 435 older people permanently living in care homes (211 in residential care and 224 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q1 and were, therefore, counted as older people.

1.17 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 207 people discharged from hospital to Reablement in Q4 2015/16, 89.4% (185) were still at home 91 days later, i.e. in Q1 2016/17. Of the 22 people who were not at home at the end of the 91 day period 11 people passed away and 11 were readmitted. The reporting period for the national metric that is used for comparison purposes is Q3 and for these residents their 91 period will be completed in Q4, e.g. during the winter months.

D. Relationship Maturity Metrics

1.18 Eight metrics were agreed by both the Health and Wellbeing Board and HCCG's Governing Body as proxy measures for the success of the 2016/17 BCF plan in developing the working relationship between the Council and the CCG. Table 5 below provides a progress update on these metrics.

Table 5: Relationship Maturity Metrics Update		
Metric		**RAG Status**
1.	The preferred integration option and procurement route for intermediate care services.	**On track (Green)** - Model options to be available for consideration in October.
2.	The preferred integration option and procurement route for end of life services.	**Some Slippage (Amber) -** Decision on Social Finance bid due in October, which will inform shape of an integrated end of life care model.

3.	The integrated brokerage and contracting model for nursing care home placements.	A revised proposal has been received that would lead to the creation of an integrated brokerage service based within the Council covering nursing home placements, homecare and Personal Health Budgets. The proposal details, including implementation timetable, are currently under discussion and approval will be sought in Q3.
4.	The model of wrap-around services for care homes and supported living schemes.	**Some slippage (Amber) -** Model (including medical support) on track to be agreed in Q3 but implementation unlikely to take place until Q4. Cross borough coverage by end of Q4 dependent on agreed model.
5.	An integrated approach to home care market development and management.	**On track (Green) -** Some initial discussions have taken place with Nicky Yiasoumi but need to link her with Mike Bibby, LBH project lead for homecare.
6.	An integrated outcomes framework for older people.	**Some slippage (Amber)** - A framework has been drafted and this will be finalised in Q3.
7.	An agreed understanding of the impact for health of the reduction by the Council in the use of residential care.	**On track (Green)** - Public Health will be working with partners to complete a Health Impact Assessment for consideration by the HWB and HCCG GB in December.
8.	The risk and benefits share arrangements following a shadow arrangement in 2016/17	**Some slippage (Amber)** - This will be drafted in Q2 and finalised as part of the process of agreeing the 2017 - 2020 BCF plan.

2. Scheme Delivery

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

Scheme 1 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	**£000's**	**£000's**
LBH - Protecting Social Care	657	660	3
HCCG Commissioned Services funding	390	390	0
Total Scheme 1	**1,047**	**1,050**	**3**

Scheme Financials

2.1 The forecast outturn is in line with HCCG contracted spend. For LBH, there is a minor adverse variance forecast on staffing costs.

Scheme Delivery

2.2 As at 30th June, Connect to Support Hillingdon had 241 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. This represents an additional 39 organisations from the position at the end of March 2016. The target for 2016/17 is to achieve an additional 100 organisations/service providers registered on the system by the end of Q4 and the Q1 performance shows that this target is on track.

2.3 From 1st April 2016 to 30th June 2016, 1,353 individuals accessed Connect to Support and completed 2,163 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 541 people and 731 sessions on the same period in 2015/16. However, more active promotion work during Q2 should see these figures increase.

2.4 During Q1 15 people completed online social care assessments and 11 were by people completing it for themselves and 4 by Carers or professionals completing on behalf of another person. 6 self-assessments have been submitted to the Council to progress and the remainder have been sent to residents at their request in order for them to decide in their own time how they wish to proceed. There have been 9 self-assessments undertaken by Carers in Q1.

2.5 The H4All Health and Wellbeing Service became operational in April with staff being seconded from the organisations within H4All, including the five Primary Care Navigators. The operational base for the service is Key House in Yiewsley but there are Wellbeing Support Officers working from GP practices and referrals during the start up phase were primarily from GP practices. From Q2 the service will start to accept referrals from a broader range of sources, including the Council. Q1 also saw the appointment of a Service Manager and a Community Development Officer with responsibility for developing the links with the voluntary and community sector.

2.6 By the end of Q1 approximately 340 people had been referred to the service from GP surgeries and 108 assessments using the Patient Activation Model (PAM) had been completed. This tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. Someone with a high PAM score will generally be sign-posted onto existing services but a person with a low score will receive more one to one support and an improved scoring following intervention from the service is a positive outcome.

2.7 There were 207 emergency admissions of people aged 65 and over related to falls during Q1, which is slightly above the ceiling for the quarter of 195. The ceiling for 2016/17 is 780. There were 186 emergency admissions during the same period in 2015/16. The total cost of the falls-related admissions in Q1 2016/17 was £675k.

2.8 In April classes specifically for people who have fallen or who are at risk of falls were set up as part of the Let's Get Moving Hillingdon programme. The purpose of the classes is to help address some of the issues that can make a person susceptible to falls, e.g. excess weight and/or high blood pressure, through physical exercise programmes. During Q1 an average of 28 older residents benefitted from these classes that are held three times a week.

2.9 As a result of a review of the tea dances on offer to older people, an online booking system will be introduced in October. This will help to ensure that priority for access is given to Hillingdon residents. Support for residents to access the system will be provided through Hillingdon's libraries.

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

Scheme 2 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	50	50	0
HCCG Commissioned Services funding	106	106	0
Total Scheme 2	**156**	**156**	**0**

Scheme Financials

2.9 The forecast outturn is in line with HCCG contracted spend. LBH spend on end of life care is forecast to be on budget. The funding included in this scheme is the Community Palliative Care Team that is included within the community health services contract held by the CCG with CNWL and also the Council's budget for specialist care at home for people at end of life.

Scheme Delivery

2.10 Training was provided for Social Care staff in the use of Coordinate My Care (CMC). Information sharing agreements are on track to be signed in Q2 which will then enable social care staff to have read and write access to this system, which should facilitate a more coordinated approach to the provision of care and support to Hillingdon residents who at the end of their life as well as supporting their Carers.

Coordinate My Care Explained

CMC is an electronic advanced care plan intended to link up the organisations and the individuals who provide care for a resident, including doctors, nurses, social care providers and emergency services, including the ambulance service, NHS 111 and the out of hours GP service. This service was developed by the Royal Marsden NHS Foundation Trust and in London is primarily used to support end of life care.

2.11 An action in the 2016/17 BCF plan is to commission an integrated specialist end of life care at home service. Pursuing this has been delayed pending the outcome of the bid to Social Finance for up to £1.5m over three years to develop an integrated end of life service in Hillingdon. Social Finance is a not for profit organisation that partners with the government, the third sector and the financial community to find better ways of tackling social problems in the UK and the results of the bid will be known in Q3. Once the result is known further consideration can be given to the procurement route for an integrated model and appropriate approvals sought from the Council and HCCG's Governing Body. A key reason for postponing development of the specialist service is to avoid adding to the level of fragmentation that already exists within end of life services. In the meantime need is being addressed through spot purchases from a local third sector provider.

Scheme Risks/Issues

2.12 This scheme is RAG rated as amber because of the slippage in delivering a single specialist care at home service for people within the last six months of life. Delaying the commissioning of this service pending the outcome of the Social Finance bid referred to in paragraph 2.11 prevents creating further fragmentation in the provision of services for people at end of life when there is an opportunity to develop and deliver a more integrated service model.

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

Scheme 3 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**
HCCG Commissioned Services funding	5,347	5,347	0
LBH - Protecting Social Care funding	2,920	3,019	99
Total Scheme 3	**8,267**	**8,286**	**99**

Scheme Financials

2.13 The forecast outturn is in line with HCCG contracted spend. For LBH, there is a forecast pressure on the spot purchase of intermediate care beds, due to increasing demand for placements.

Scheme Delivery

2.14 During Q1 the Reablement Team received 227 referrals and of these 51 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, 102 people were discharged from Reablement with no on-going social care needs.

2.15 In Q1 the Rapid Response Team received 886 referrals, 56% (500) of which came from Hillingdon Hospital, 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals. All 386 people referred from the community source received input from the Rapid Response Team.

2.16 As identified in Table 5, officers are currently working on proposals for a more integrated model for intermediate care and options will be developed for consideration and consultation in Q3.

Scheme Risks/Issues

2.17 This scheme is RAG rated as amber because of the over-spend in the provision of bed-based step-down accommodation.

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

Scheme 4 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care funding	100	100	0
Total Scheme 4	**100**	**100**	**0**

Scheme Financials

2.18 Expenditure on seven day working which relates to Mental Health Social Workers is forecast to be on budget.

Scheme Delivery

2.19 Table 6 below identifies the key deliverable under the Out of Hospital Seven day Working Standard action plan for Q1. Hillingdon was required to develop an action plan as one of the national conditions for the 2016/17 BCF plan.

Table 6: Out of Hospital Seven Day Working Action Plan Update

Task	Update	RAG Rating
A requirement for nursing homes to have suitably qualified staff available to undertake assessments in an acute setting 7-day a week included into WLA DPS tender specification.	It was agreed by councils participating in the consortium for the dynamic purchasing system (DPS) tender led by LB Ealing to include this provision in the specifications for residential and nursing care home placements. The Council's October Cabinet meeting will be asked to approve the results of the tender process. The DPS will enable the Council to comply with procurement regulations in respect of spot placements in care homes.	Completed (Green)

2.20 **Appendix 3** shows the comparison in discharge activity at Hillingdon Hospital in Q1 from 2014/15 to 2016/17. This shows a significant drop in the number of discharges on a Saturday compared to 2015/16, e.g. 347 (2016/17) compared to 546 (2015/16). This is largely accounted for by a drop in discharges of people admitted for planned (also known as elective) procedures from 332 in 2015/16 to 171 in Q1 2016/17. There has also been a reduction in the number of Saturday discharges of people who were admitted in an emergency (non-elective admissions).

2.21 **Appendix 3A** shows the comparison of discharges taking place before midday in Q1 from 2014/15 to 2016/17. Discharges taking place before midday provides a better experience of the discharge

process for residents as they are able to return home earlier in the day. Approximately 25% of all discharges occurred before midday in Q1 2016/17 and this is comparable with the previous year. There was an increase in the number of pre-midday discharges from Monday through to Thursday but a reduction on Saturday and Sunday.

Scheme Risks/Issues

2.22 The Q1 data demonstrates that although the delivery of the action plan is on track being able to impact on the pattern of discharges across the week is going to take longer to materialise, which is because all of the component parts of a seven day system in Hillingdon need to be in place for this to work consistently.

2.23 This scheme RAG rated as green on the basis that the Q1 action requirements have been delivered.

Scheme 5: Integrated Community-based Care and Support	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 5 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5,911	(110)
LBH - Protecting Social Care funding	5,405	5,368	(37)
Total Scheme 5	**11,426**	**11,279**	**(147)**

Scheme Financials

2.24 Both HCCG and LBH are currently showing an underspend for the 1st Qtr due to lower than budgeted costs for Community Equipment, which results from the success of the joint work carried out between the partners to manage the demand on this budget. For LBH, this scheme also includes the capital funding grant for Disabled Facilities, which is currently forecast to be fully spent.

Scheme Delivery

2.25 The use of risk stratification tools within GP practices to identify older people living with long-term conditions who could benefit from care planning as part of a more anticipatory model of care has been expanded to all practices. The intention is to extend the use of these tools to other adults during 2016/17.

2.26 In Q1 2016/17 26 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 39% of the grants provided. 64% (43) of the people receiving DFG's were owner occupiers, 33% (22) were housing association tenants, and 3% (2) were private tenants. The total DFG spend on older people (aged 60 and over) during Q1 2016/17 was £68k, which represented 30% of the spend during the quarter (£227k).

Scheme 6: Care Home and Supported Living Market Development	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 6 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	150	157	7
HCCG Commissioned Services funding	83	83	0
Total Scheme 6	**233**	**240**	**7**

Scheme Financials

2.23 There is forecast to be a minor staffing pressure on this budget for LBH.

Scheme Delivery

2.24 There were 430 emergency admissions from care homes in Q1 against a ceiling of 427, which means that activity is broadly on target. The annual ceiling for 2016/17 is 1,715 emergency admissions. The cost to the NHS of the admissions from care homes in Q1 was £995k.

2.25 The tender for the DPS referred to in table 6 and led by the London Borough of Ealing, resulted in seven of Hillingdon's care homes joining this electronic framework agreement, which is intended to ensure that the procurement process for spot purchases is competitive, fair and transparent. A key benefit of the DPS is that providers can join it at any time and officers will be undertaking promotional activity in October to encourage more of the local care home providers to join.

2.26 A task and finish group comprising of GP representatives, a consultant geriatrician and a representative from CNWL's community health and community mental health teams and also the third sector has met to help shape the care and wellbeing specification for the extra care sheltered housing schemes, including two new schemes that will open early in 2018. The service will be tendered in Q3 2016/17.

Risks/Issues

2.27 The limited availability of care homes in the borough willing to accept local authority and NHS placements is a significant problem. Officers will be undertaking a dialogue with providers over the coming months to discuss current and future needs as well as the impact on the care home market of the opening of the Grassy Meadow and Parkview extra care schemes in 2018.

Scheme 7: Supporting Carers	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 7 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	899	906	7
HCCG Commissioned Services funding	18	18	0
Total Scheme 7	**917**	**924**	**7**

Scheme Financials

2.27 For LBH, there is forecast to be a pressure on respite services to Carers due to increased placement cost being charged by providers.

Scheme Delivery

2.28 Work was undertaken during Q1 to ensure that all Carers' assessments undertaken are reflected in activity reporting, e.g. sole assessments, joint assessments and reviews. This identified that there were 286 assessments in Q1. On a straight line projection, this would result in 1,144 assessments being completed in 2016/17, which would represent an 8.5% (106) reduction on the 2015/16 outturn.

2.29 During Q1 130 Carers were provided with respite or another carer service at a cost of £230.7k. This compares to 106 Carers being supported at a cost of £217.4k in Q1 2015/16. The increase in the number of Carers supported and the cost of the support services reflects that the Council is now able to identify replacement care provided by homecare providers in order to meet the need of Carers, which it was not possible to do in 2015/16.

2.30 A new Carers' Café was launched in Ruislip, therefore creating increased support opportunities for Carers in this part of the borough.

2.31 A successful Carers Fair was delivered on 7th June 2016. 45 partner organisations held information stalls and 58 new carers were identified.

2.32 Following the launch of the Carers' Recognition Scheme at the end of Q4 2015/16 an event was held on the 10th May that resulted in 48 Carers who had been nominated by the people they are caring for being presented with a framed certificate by the Council's Carers' Champion, Councillor Haggar.

Scheme 8: Living Well with Dementia	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 8 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3

	£000's	£000's	£000's
LBH - Protecting Social Care	305	289	(15)
Total Scheme 8	305	289	(15)

Scheme Financials

2.33 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £15k.

Scheme Delivery

2.34 Approximately 100 people were trained during Q1 by Alzheimer's Society to be Dementia Friends. This means that Hillingdon now has 3,500 trained Dementia Friends.

Dementia Friends Explained

A Dementia Friend learns a little bit more about what it is like to live with dementia and the little ways in which it is possible to help, such as:

- Getting in touch and staying in touch with someone living with dementia
- Volunteering for an organisation that helps people with dementia.
- Telling 5 friends about the Dementia Friends initiative.
- Carrying out a personal action e.g. being more patient when out in the community

2.35 The Council's Wellbeing Service developed a '5-ways to Wellbeing' training package for people living with dementia. The next stage involves working with the Alzheimer's Society and Memory Assessment Service to identify people who may be able to benefit from the training.

2.36 **Dementia Resource Centre** - Final planning consent was given for the Grassy Meadow extra care sheltered housing scheme, including the Dementia Resource Centre included within it. Officers from Adult Social Care, Resident Services, the architects and developer for both the Grassy Meadow and Parkview extra care schemes that are due to open in 2018 visited a best practice site that has the Stirling gold standard for dementia friendly environments. The learning taken from this visit will help to inform the fitting out of the new schemes.

2.37 **Dementia training** - Tier 1, or Introduction to Dementia, training was provided by the Alzheimer's Society to staff in the Contact Centre, Hillingdon Library staff and staff from GP practices (clinical and non-clinical).

BCF Programme Management Costs

	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
BCF Programme Management	80	81	1

Total	**80**	**81**	**1**

3. Key Risks or Issues

Sustainability and Transformation Plan (STP) and the Three-year BCF Plan

3.1 The ten priorities of the Hillingdon's STP have been agreed by both the Health and Wellbeing Board and HCCG's Governing Body. The requirement to produce a three-year BCF plan provides an opportunity to demonstrate how integration between health and social care will contribute to the delivery of the broader STP priorities to make a positive difference to the lives of Hillingdon's residents.

3.2 The latest information through the BCF network suggests that the statutory guidance on the requirements for the development of the three-year BCF plan is unlikely to be published before the end of October. In view of the uncertainty about when this will actually be published, it is suggested partners continue to develop a plan that is appropriate to meet the needs of Hillingdon's population going forward. As with the development of the 2016/17 plan, the detail of this can then be adapted to suit NHSE requirements.

Delivering Change in a Complex System

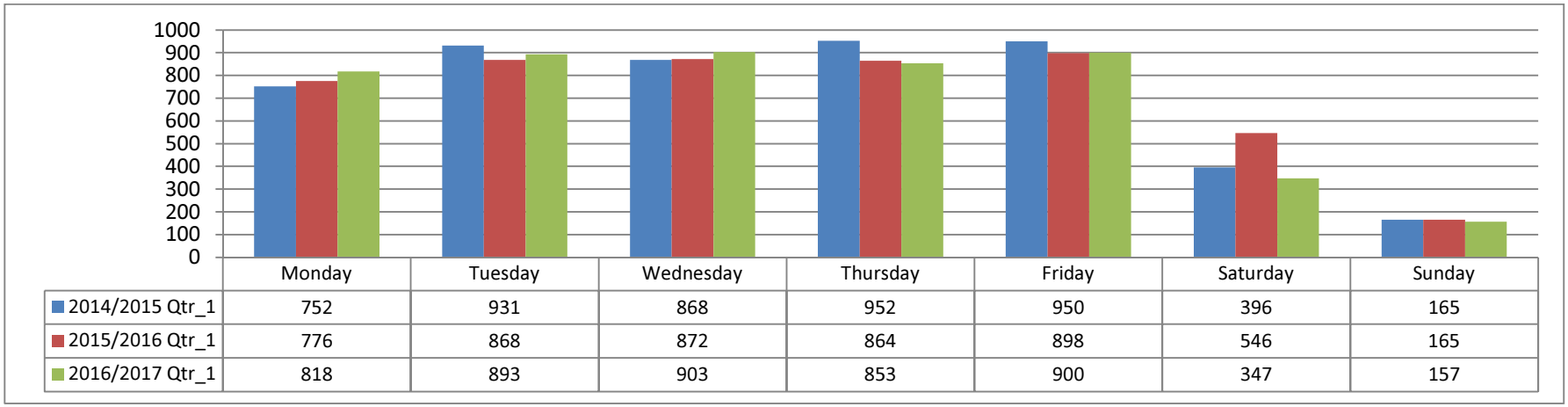
3.3 The 2015/16 BCF largely reflected work that was already in progress and for which, where additional resources were required, business cases had already been agreed. This is not the case with the 2016/17 plan and many of the schemes in the plan entail work that will require partners to make decisions about more ambitious models of integration that are unlikely to be delivered until into 2017/18 and beyond. This is due to such factors such as organisational governance processes and the logistics of delivering significant change in a complex health and care system that is under considerable pressure. Examples of some of these complexities include fragmentation within the NHS, the challenges and opportunities presented by the emerging Accountable Care Partnership (ACP) and the dynamics of the private health and care market.

DTOCs

3.4 The national conditions for 2016/17 BCF plan required the production of specific action plans to address Delayed Transfers of Care and the Out of Hospital Seven Day Working standard. The intention has been to manage delivery of these plans through existing groups but this has not delivered the required ownership and presents risks for delivery of key actions as set out in these plans. In view of the co-dependencies between the two plans, a single task and finish group is being created with senior representation from partner organisations.

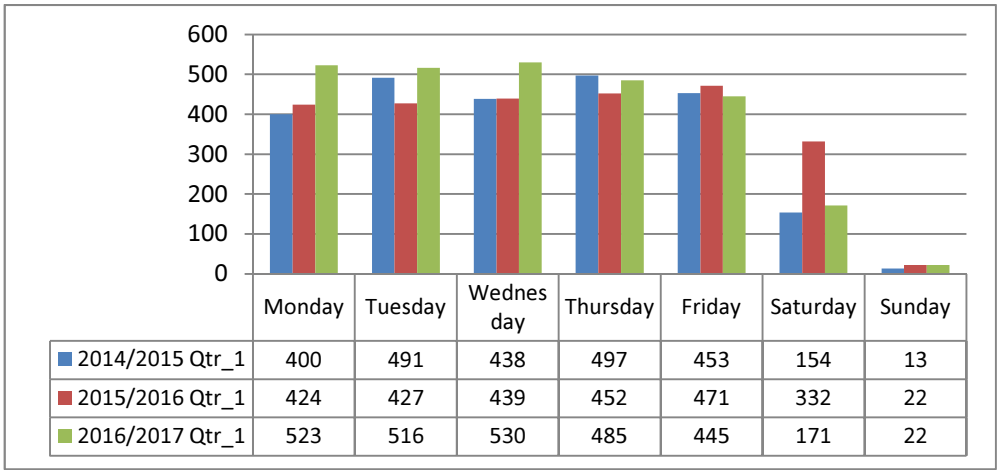
Appendix 3

Total Discharges by Day of the Week April - June 2014/15 to 2016/17



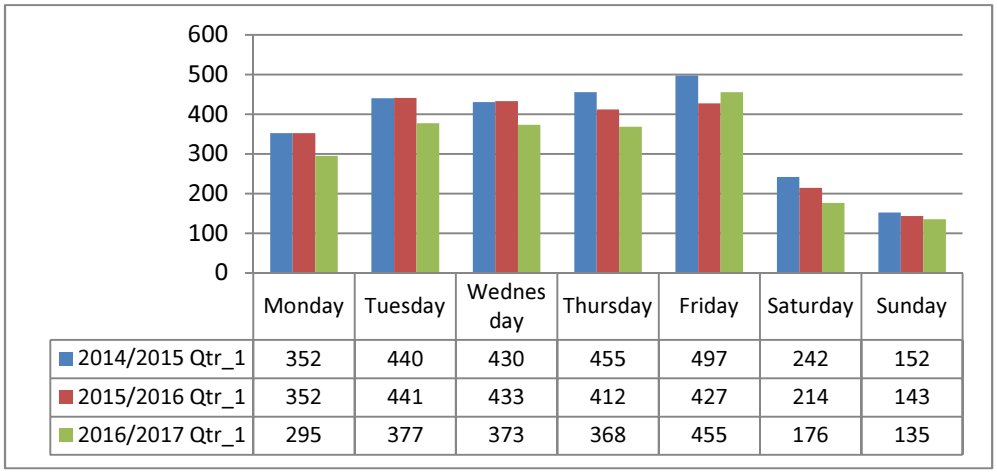
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	752	931	868	952	950	396	165
2015/2016 Qtr_1	776	868	872	864	898	546	165
2016/2017 Qtr_1	818	893	903	853	900	347	157

Discharges following Planned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	400	491	438	497	453	154	13
2015/2016 Qtr_1	424	427	439	452	471	332	22
2016/2017 Qtr_1	523	516	530	485	445	171	22

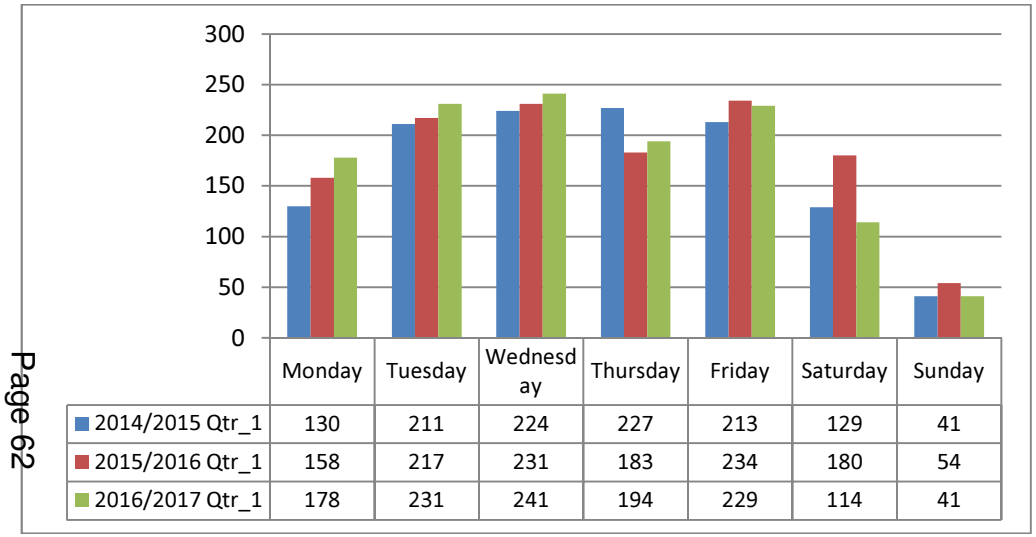
Discharges Following Unplanned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	352	440	430	455	497	242	152
2015/2016 Qtr_1	352	441	433	412	427	214	143
2016/2017 Qtr_1	295	377	373	368	455	176	135

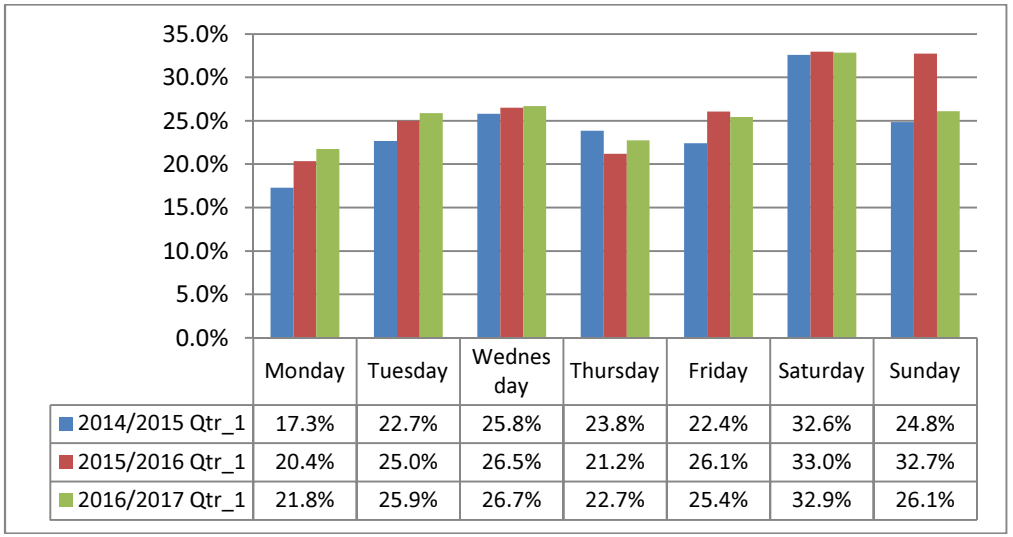
Discharges Taking Place before Midday April - June 2014/15 to 2016/17

Number of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	130	211	224	227	213	129	41
2015/2016 Qtr_1	158	217	231	183	234	180	54
2016/2017 Qtr_1	178	231	241	194	229	114	41

% of Patients Discharged Before Midday



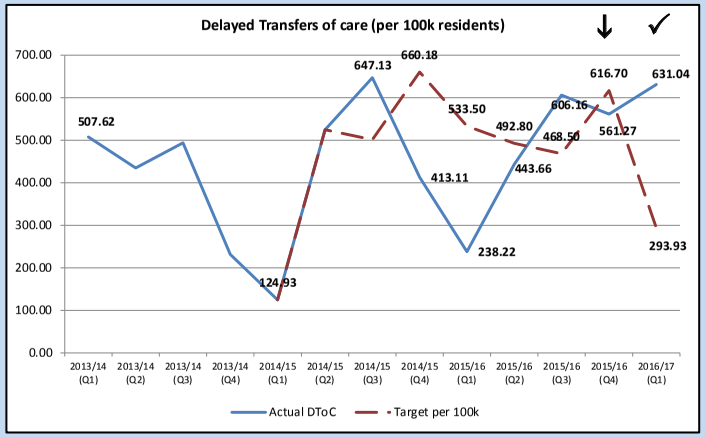
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	17.3%	22.7%	25.8%	23.8%	22.4%	32.6%	24.8%
2015/2016 Qtr_1	20.4%	25.0%	26.5%	21.2%	26.1%	33.0%	32.7%
2016/2017 Qtr_1	21.8%	25.9%	26.7%	22.7%	25.4%	32.9%	26.1%

Better Care Fund

Period: 01/04/2016 to 30/06/2016
Month Number: 4

High Level Summary

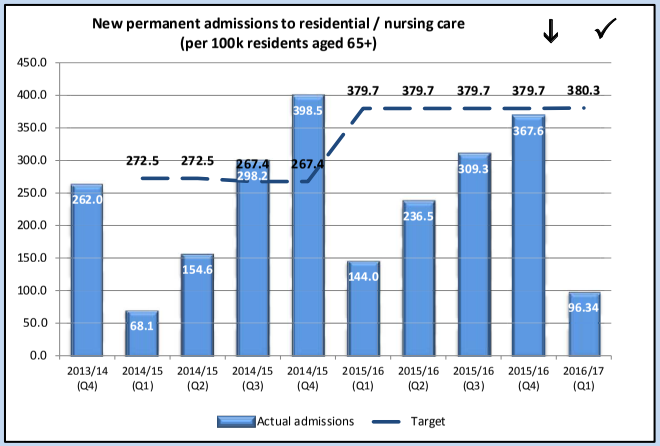
Non-Elective Admissions		Pay for performance period Q1 (Apr - Jun)	Q2 (Jul - Sept)	Q3 (Oct - Dec)	Q4 (Jan - Mar)
Non-elective admissions in to hospital (general & acute), 65+.	2015 Actual	2,570	2,468	2,560	2,612
	Req, Reduction for 2016	128	123	128	130
	Target for 2016	2,442	2,345	2,432	2,482
	Actual 2016	2,537			
	Difference from Target	+95			



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 (2014/15)	3,819	225,846	1,691.0
	2015/16 (Q1)	538	225,846	238.2
	2015/16 (Q2)	1,002	225,846	443.7
	2015/16 (Q3)	1,369	225,846	606.2
	2015/16 (Q4)	1,287	229,303	561.3
	2015/16 (Full Year)	4,196	229,303	1,829.9
	2015/16 (Target)	4,053	229,303	1,767.5
	Variance from Target	+143	229,303	62.4
	2016/17 (Q1)	1,447	229,303	631.0
	2016/17 (Q2)	0	229,303	0.0
	2016/17 (Q3)	0	229,303	0.0
	2016/17 (Q4)	0	229,303	0.0
	2016/17 (Full Year)	1,447	229,303	631.0
	2016/17 (Target)	4,117	229,303	1,795.4
	Variance from Target	- 2,670	229,303	-1,164.4

ASCOF 2B	% of clients still at home 91 days after discharge	2015-16 (Target)	2015-16 (Q4)	2016-17 (Target)	2016-17 (Q1)
		95.4%	87.5%	93.8%	89.5%

Key components of BCF funding 2016/17	Budget	Outturn	Variance
	£000's	£000's	£000's
HCCG Commissioned services funding	11,965	11,855	- 110
LBH - Protecting Social Care Funding (including Care Act New Burdens)	7,109	7,174	65
LBH - Protecting Social Care Capital Funding	3,457	3,457	0
Overall BCF Total funding	22,531	22,486	- 45



Permanent admisisons to Residential / Nursing care (residents aged 65+)	To the end of period	Number (Cum)	Residents	Per 100k
	Baseline (2014/15)	100	36,655	272.8
	2015/16 (Q1)	52	38,895	133.7
	2015/16 (Q2)	84	38,895	216.0
	2015/16 (Q3)	109	38,895	280.2
	2015/16 (Q4)	145	39,500	367.1
	2015/16 (Target)	150	39,500	379.7
	Variance from Target	-5	39,500	-12.7
	2016/17 (Q1)	38	39,500	96.2
	2016/17 (Q2)	0	39,500	0.0
	2016/17 (Q3)	0	39,500	0.0
	2016/17 (Q4)	0	39,500	0.0
	2016/17 (Target)	150	39,500	379.7
	Variance from Target	-112	39,500	-283.5

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HILLINGDON'S SUSTAINABILITY AND TRANSFORMATION PLAN

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Chief Operating Officer HCCG Kevin Byrne, Policy and Partnerships LBH
Papers with report	1. Draft Hillingdon STP chapter 2. Draft North West London STP draft submission

HEADLINE INFORMATION

Summary	Hillingdon's HWB has overseen the work being undertaken across partners to develop Hillingdon's Sustainability and Transformation Plan (STP), through reports to previous meetings. The Hillingdon STP has fed directly into the development of an overall North West London "footprint" STP for the sub-region which is reviewed by NHS England and forms the basis of the funding proposals for the Sustainability and Transformation fund. An interim submission was made at the end of June 2016 (Annex 2). The Board is now asked to agree the submission of the Hillingdon Chapter and to agree a process for consideration of the overall NWL STP which will be submitted to NHS England on 21st October.
Contribution to plans and strategies	The Hillingdon STP will directly influence local plans including: • HCCGs commissioning intentions for 2017/18 • Development of the next iteration of Hillingdon's Health and Wellbeing Strategy. • Hillingdon's Better Care Fund for 2017/18 and onwards.
Financial Cost	There are no financial implications arising directly from this report. A successful plan should, however, facilitate access to new Sustainability and Transformation funding for the local heath and care economy.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board:

1. **notes the Hillingdon chapter of the STP (Annex 1) and instructs officers to develop a delivery plan to implement the priorities identified.**

2. **notes broad support for the draft North West London STP submission dated June 2016 (Annex 2).**

3. **agrees to delegate authority on behalf of the HWB to the Director of Adults, Children's and Young People's Services in consultation with the Chairman of the Board, the Chairman of the CGG and Chairman of Healthwatch Hillingdon, to agree, in principle but subject to detailed scrutiny of financial information, the latest North West London STP submission anticipated to be available between now and 15th October, for submission to NHSE by 21st October.**

INFORMATION

Supporting Information

The Board has previously considered progress in developing the Hillingdon Chapter and the overall NWL STP. Feedback was provided to the NWL strategic planning group that Hillingdon's HWB had not approved the NWL submission as it had not been made available to the Board. In addition, concerns were raised as to the lack of democratic oversight of the governance producing the NWL STP.

Hillingdon STP Chapter

The Board has agreed ten priorities in the Hillingdon STP. The draft plan at annex one, therefore, develops these transformation themes and provides indications of how they will be taken forward, with key 2016/17 actions and anticipated outcomes by the end of the five year plan period in 2020/21. The Board also requested that the plan include data on forecast "funding gaps" anticipated by both health and social care to provide a full picture of the task at hand. This information is now included identifying a gap in funding to the CCG of approximately £40m and to social care of £18m - see also financial information below.

The Hillingdon plan builds on the significant joint effort already in place and underway. This includes work towards establishing a model of 'accountable care' where providers of services are commissioned to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative. 2017-18 will provide us with an opportunity to test the effectiveness of this approach.

In addition it also reflects the good progress on the Better Care Fund and the work on CAMHS transformation. As has been reported in the BCF paper on the agenda, work is progressing as part of the Hillingdon STP in the following areas:

- ***CAMHS*** - Options for a fully integrated Children and Adolescent Mental Health Service (CAMHS) that will entail a transfer of resources into prevention and wellbeing services and a subsequent reduction of treatments in specialist and highly specialist services, with a

resultant reduction in the waiting times for these services, and a reduction in inpatient admissions.

- ***Intermediate Care*** - Options for a fully integrated intermediate care service that will result in a single point of access, a single accountability for the service, residents receiving the intervention of the most appropriate professional first time, a reduction of hand-offs between organisations and an improved experience of care for residents.

- ***Transforming Care*** - Developing an intensive intervention model to support step down from specialist (tier 4) provision and developing tailored housing options to support people with learning disabilities and/or autism;

- ***Like Minded*** - Developing a range of supported living options enabling people to transition from acute to least intensive community settings, designing and developing the model of care for Primary Care Mental Health Services and developing locally-based step-up facilities to support people in crisis.

The Hillingdon STP has been shared in draft with NWL so as to ensure a seamless link between what is proposed in Hillingdon and that sought across the sub-region in the footprint STP.

Moving forwards it is clear that some form of project and programme management will be required to oversee the delivery of the plan both locally and at NWL level. It is not clear at present how this might happen but it is recommended that a local implementation plan be developed to take forward the transformation themes and that this is in turn replaces Hillingdon's Health and Wellbeing Strategy, and that proposals are worked up across partners for consideration by the Board.

The North West London STP

As noted Hillingdon's HWB has not yet formally been invited to comment or agree to the June 2016 submission of the NWL STP. It is therefore attached as annex 2. Since the end of June work has been underway to develop this overview further and to put more "meat on the bones" of proposals but it is not anticipated to change in terms of the scope and broad approach. Any updates available will be circulated to the Board when available.

A key part of the NWL STP is how it argues and establishes the case for accessing the ST fund support that it is anticipated is available to support transformational work across the sub-region. Overall it identifies a shortfall of £1,299m across the health and social care system by 2020/21 in NWL based on a "do nothing" scenario. It also identifies that an investment of £118m could deliver savings of approximately £508m from commissioners and providers. The hefty caveat on all this is that the figures are based on estimates and are designed to be equitable (based on same methodology across providers and boroughs) and to produce a bid for funding rather than robust business cases to warrant investment.

The NWL plan has made good progress since the June submission in developing governance proposals and addressing the concerns raised, especially from local authorities, regarding democratic accountability. Draft terms of reference are being discussed to develop a new health and care transformation group with lead member involvement alongside NHS representatives both as commissioner and providers. Cllr Corthorne is the lead member for these discussions.

The new group is also likely to include Rob Larkman and possibly Ian Goodman from Hillingdon's Health and Wellbeing Board as members.

It is expected that this group will have strong influence over how STP fund money is passported through to CCGs and allocated.

Feedback from NHSE

Initial feedback from NHSE has been positive, the NWL STP was allocated to the second wave of sites (only one area in London was identified as wave 1 – South East London).

Financial Implications

The high level estimates set out in the Hillingdon STP chapter and the initial NWL STP submission identify the funding gap arising from the option to 'do nothing' over the period 2016/21 and how using new funding through the STP provided by the government will transform services and close this gap over the next 5 financial years. The financial analysis set out in the detailed plans has been calculated at a strategic level and based upon a number of assumptions which are currently being reworked by finance officers from both Health and Local Government to ensure that financial plans can be fully evidenced.

An exercise to identify the 'Do nothing' option for the local Hillingdon STP plan , has forecast for the period 2016/2021, that the future funding gap for Health split out across the different types of provision and for Adult Social Care is initially estimated as £104 million . The table below which also includes the position for NWL as a whole sets out the forecast funding gap in more detail.

Period 2016/2021	**Hillingdon £m**	**NWL £m**
CCG	(39)	(293)
Primary Care	(2)	(15)
Social Care	(18)	(145)
Acute and Community Care	(45)	(658)
Special Commissioning	0	(188)
Total	**(104)**	**(1,299)**

The detailed assumptions underpinning these forecasts are as follows:

- For the health economy , the increased health needs of a growing and ageing population means that the forecast increase in demand and the resulting cost of delivering services will increase faster than the actual population growth. There are also financial pressures arising from inflation, increased A&E attendances, increased prescribing costs for new treatments and a range of pressures across a number of other services.

- For Adult Social Care the funding gap comprises the demographic growth for Older People, People with disabilities and mental health conditions, the impact of the National Living Wage on Home Care and Residential and Nursing Accommodation provider costs and other local pressures including the financial impact of the growth of DOLS assessments. As at June 2016, this has been estimated as £18m over the next 5 financial years. The forecast funding gap for Hillingdon does not include any financial savings over this period that ASC will need to make to deliver the council's statutory

requirement to set a balanced budget. Further work is currently underway across the NWL boroughs by finance officers to bring a more consistently and evidenced approach to calculating the each boroughs funding gap.

The NWL STP plan including the specific Hillingdon Chapter sets out how the 'Do nothing' funding gap identified above can be closed over the financial period 2016/21.

The table below sets out the forecast financial impact of the strategic proposals to close the gap as at June 2016.

	Health	**Adult Social Care**	**Total Health and Care**
	£m	£m	£m
Do Nothing funding gap as at June 2016	**(1,154)**	**(145)**	**(1,299)**
Business as usual savings (QIPP/CIPS)	569	0	569
Delivery Areas (1-5) - Investment required	(118)	0	(118)
Delivery Areas (1-5) -Savings to be delivered	446	62	508
Additional estimated full year impact of ongoing costs following transformation	(55)	(34)	(89)
ST Funding	93	54	147
Implement 2% Social Care Precept	0	63	63
Special Commissioning Services	188		188
Forecast Residual Gap as June 2016	**(31)**	**0**	**(31)**

The detailed assumptions underpinning these forecasts are as follows:

- The QIPP/CIPS savings for Hillingdon CCG have been estimated at £42.5m over the period 2016/21 and represent the status quo.

- The investment of £118m is set out in the attached NWL STP plan by Delivery Area, along with the forecast savings that will come from each planned activity delivering gross savings of £446m giving net savings of £328m within the Health and Care economy over the 5 years.

- The forecast savings for Adult Social Care assumes savings of £47.5m can be found from STP investment in the Delivery areas, including £22m from joint commissioning of services. Any residual balance is assumed to be addressed through the recurrent £147m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by 2020/21.

- Ongoing increased required annual funding of £89m has been included within the assumptions to reflect ongoing annual costs arising from transformed services.

- STP funding is the additional funding currently identified in the published indicative allocations for 2020/21 from NHS England.

- The STP plans assume that the permitted 2% social care precept is either fully implemented or funded separately by each borough.

- For Special Commissioning Services the 'solution' for closing the gap has not yet been developed, however it is assumed the gap will be closed.

- The residual gap of £31m to be addressed post 2020/21.

All the financial project estimations both in forecasting the 'do nothing ' funding gap and the draft NWL STP submission to close the funding gap are subject to further detailed analysis across local government and health.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

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, noting that the NWL STP bid outlines an approach to bridging the budget gap for Adult Social Care by 2020/21 through a combination of savings across the five STP delivery areas, implementation of the Social Care Precept and receipt of additional recurrent funding from the Department of Health.

Hillingdon's share of this budget gap is estimated at £18m and is reflected in the Council's own Medium Term Financial Forecast. Subject to acceptance of the NWL bid by Department of Health, savings identified will be fully costed and reflected in the MTFF alongside any additional funding available to support local Social Care services. Decisions regarding implementation of the Social Care Precept in Hillingdon remain the prerogative of the Council.

Hillingdon Council Legal comments

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

BACKGROUND PAPERS

NIL.

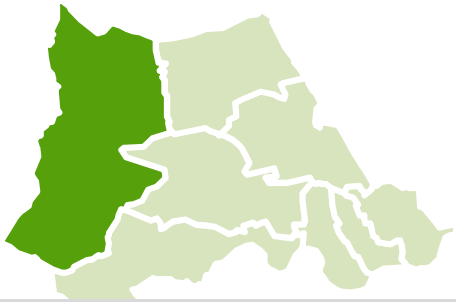
DRAFT Version 0.11

Hillingdon Executive Summary

Our five year plan for people in Hillingdon to be well and live well

This is a working document and content is not final

The Local Picture in Hillingdon



The Sustainability and Transformation Plan (STP) sets out our shared plans for the next five years to 2020/21. The STP brings together providers and commissioners of care (both local government and NHS) to deliver a genuine place based plan for the borough. The STP will act as a platform for development of new and innovative way of funding Health and Social Care in Hillingdon.

- **309,300** People (16/17 Estimate) increasing to approximately **321,000** in 2020/21
- **£347.8m** (16/17 CCG Allocation)
- **46** GP Practices and 4 GP Networks
- **302,198** registered Hillingdon CCG patients (01.07.2015)

The majority of hospital based care occurs at The Hillingdon Hospital with smaller amounts of work done at Imperial and Northwick Park Hospitals.

Our local Community & Mental Health Services are delivered by Central & North West London NHS Foundation Trust.

We work across health and local authority services to deal with our shared responsibilities including commissioning services for people with Mental Health issues and Learning Disabilities as well as services for Children.

We are also working to establish an Accountable Care Partnership (ACP) that will see even closer integration between health providers as well as the Third and Voluntary Sectors.

Hillingdon is faced with potentially significant additional environmental and health burdens through the prospect of a third runway at Heathrow as well as opportunities through new developments such as Crossrail.

Our STP is built on current local plans within Hillingdon and across NW London including (but are not limited to):

- Joint Strategic Needs Assessment
- Health and Wellbeing Strategy
- Better Care Fund Plan
- Our Digital Strategy
- Strategic Estates Plans
- Local Services Strategy
- Long Term Conditions Strategy
- End of Life Strategy
- Prevention Strategy
- Quality, Improvement, Productivity and Prevention (QIPP) Plans
- The Shaping a Healthier Future Programme
- NWL Local Services Programme
- NWL Whole Systems Integrated Care
- 2016/17 Operational Plan
- The Londonwide Strategic Commissioning Framework for Primary Care
- The NWL Primary Care Transformation Programme
- NHS Five Year Forward View
- GP Forward View

Our local STP builds on our approach of continuous dialogue with the public and partner engagement as a platform for the development of the above plans and strategies. We are currently undertaking an extended period of engagement on the local Hillingdon STP and current content and thinking is subject to further reiterations and refinement.

This executive summary is designed to feed in to the wider North West London plan and to provide an abbreviated account of the wider work underway and planned in Hillingdon and should be read with this context in mind.

The Financial Situation –Hillingdon Whole System

The most likely growth assumptions over the next five years will see approx. 21% more activity being needed to be funded and to respond to this growth.

* *Figure not inclusive of children element*

2020/21 estimates	Hillingdon £m	NWL £m
CCG	(39)	(248)
Primary Care	(2)	(15)
Social Care	(18)*	(145)
Acute and Community Care	(45)	(622)
Spec Commissioning	TBC	(188)
Total DO Nothing	***(104)***	***(1,219)***

Understanding Our Population: The Health & Wellbeing of Hillingdon

In Hillingdon our Health and Wellbeing Strategy and our Joint Strategic Needs Assessment, developed locally between the Local Authority and the CCG are the basis for our understanding of the changing needs and issues facing our population which include those shown below.

Health in summary

The health of people in Hillingdon is varied compared with the England average. The projected 2020/21 resident population is 321,000. Deprivation is lower than average, however about 20.1% (11,800) children live in poverty. Healthy life expectancy at birth for both men (65.5) and women (63.2) is similar to the England average.

Child health

At 3%, Hillingdon's low birth weight is similar to London average (3.2%) and England average (2.9%). Levels of excess weight and obesity are a growing threat to population health.

Adult health

The excess weight prevalence in adults (63.4%) is similar to the national average (64.6%). Hillingdon's utilisation of outdoor space (14.7%) is similar to the national average (17.9%). The incidence of TB in Hillingdon is (41.9 per 100,000) higher than for both London average (35.4 per 100,000) and national average (13.5 per 100,000). Cancer screening rates for breast (70.9%), cervical (66.9%) and bowel (52.1%) in Hillingdon are lower than national averages.

Reduce Childhood Obesity

Currently, excess weight in 4-5 year olds is 21% and, in 10-11 year olds is 32.6%.

In 2021:
Sustained reductions in excess weight in 4-5 year olds and 10-11 year olds in line with the national ambition.

Reduce Smoking Prevalence

Currently , the smoking prevalence in those aged over 18 in Hillingdon is 17.1%. This is similar to the England average (18%) and the London average (17%).

Smoking in pregnancy is 7.4% which is better than England (11.4%) , but worse than the London average (4.8%).

In 2021:
Reduce smoking prevalence in pregnancy due to high levels of premature births in Hillingdon.

Increase Physical Activity

Currently, 55% of Hillingdon's residents are physically active.

Hillingdon Council is working on increasing activity levels through a number of initiatives.

In 2021:
Increase physical activity rates in all age groups.

Help Improve Peoples Mental Health

Currently, prevalence of self-reported depression and anxiety in the Hillingdon GP registered population is 9.9%.

Hospital admissions for self-harm (10-24 years) was 234.7 per 100,000 population.

In 2021:
Improve pathways and response for individuals with mental health needs across the life course, including CAMHS.

Reduce Social Isolation

Currently, the proportion of people who use services and their cares who reported that they have as much social contact as they would like:
Users - 43.3%
Carers – 26.1%

In 2021:
Sustained increases in users and carers who report getting as much social contact as they would like.

Support to Manage LTCs

Currently ,working on the common risk factors for premature morbidity and mortality
- Access to weight loss programmes for those with excess weight
- Lets Get Moving exercise referral scheme for those with chronic conditions
- NHS Healthcheck offer for 40-74 year olds for early identification and treatment of cardiovascular risk factors
- Smoking cessation service

Reduce Alcohol Admissions

The new recovery orientated substance misuse service (ARCH) went live 01/08/15.
It provides a liaison service within the hospital for patients whose admission is alcohol and/or drug related.

Public Health will work with the CCG to ascertain data regarding the number of alcohol admissions who have a dual diagnosis (ie. mental health and alcohol misuse).

Make Every Contact Count

Making every contact count (MECC) is an integral part of the Hillingdon system moving forwards, with regular staff training across the borough.

In 2021:
Increase MECC training for all staff groups.

The 2021 Vision for Care & Support in Hillingdon

Below we have outlined the Hillingdon vision for how we will close the three gaps outlined within the Five Year Forward view and the STP guidance:

Health & Wellbeing

Working collaboratively across health, social care and public health we will improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long Term Conditions (including both physical and mental health LTCs) and emergent categories of LTCs such as pain, frailty and social isolation.

Our coordinated programme of work will bring together our existing plans for the BCF and our Health & Wellbeing Strategy (HWBB) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.

Care & Quality

We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services.

We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices.

We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.

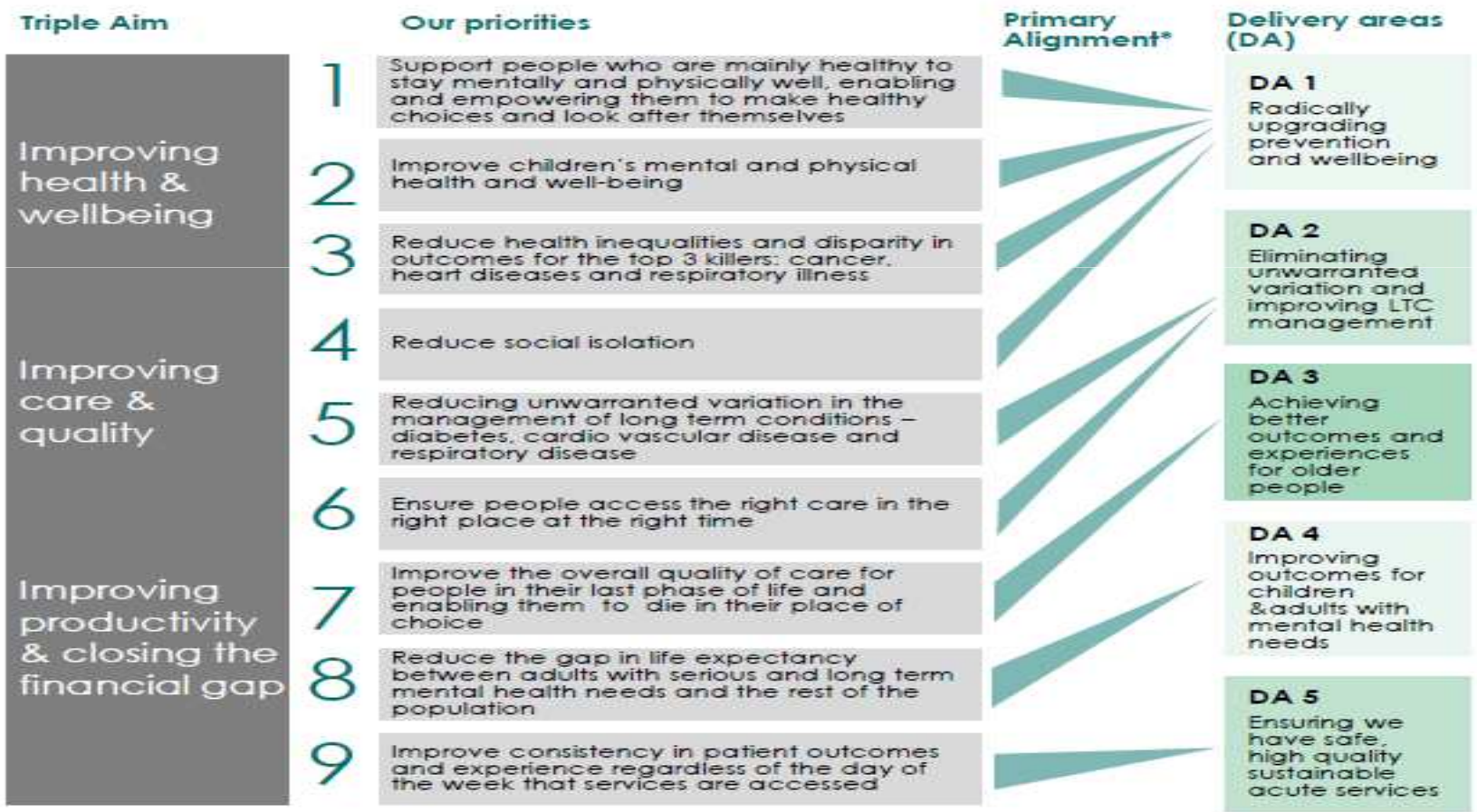
Finance & Efficiency

It is simply not viable to continue trying to respond to increasing demand for services, particularly at the expense of preventative action. We are committed to finding financial savings and ways to achieve better outcomes for individuals and their families through the better integration of services and by reducing demand through an increased focus on prevention and patient activation.

Our Local Plans for Implementation Through the 5 Delivery Areas

How are we going to achieve our priorities through the 5 key delivery areas?

The NHS and local authorities across NW London have agreed to work together to deliver a better health and care system. The STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well. A draft plan of NW London's vision for improving the health and care system has been developed and was submitted to NHS England at the end of June and include 9 Priorities grouped in 5 Delivery Areas:



What will be different for Hillingdon residents in 2021?

WORDING UNDER REVIEW

DA 1 ***Radically upgrading prevention and wellbeing***	*Our focus will be on developing processes that place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives; preventing rather than treating illness. Will are developing services that will aid earlier diagnosis – such as access to online advice and expanded medication reviews; and prevention – through the provision of our patient education workshops, wellbeing and support activities in our community. Putting people in Hillingdon in charge of their own health.*
DA 2 ***Eliminating unwarranted variation and improving LTC management***	*Healthcare services in Hillingdon are still not sufficiently joined up and do not deliver the best outcomes for patients. Services will work better together and variation in both quality of care and access to care will improve throughout the borough. Patients will receive care closer to home with more services; in addition to the existing dermatology and pain management moved into the community to create a system that will deliver better care for our patients - in a safe and effective way. We will focus upon finding ways of doing things differently: using technology to fundamentally improve services, providing highly responsive, effective and personalised care in or as close to people's homes as possible.*
DA 3 **Achieving better outcomes and experiences for older people**	*Our health and social care services will work better together to ensure local people receive better care – especially those with multiple long term conditions. The expansion of our community outreach programme will provide support for nurses and carers working to help their patients stay in the home for longer, rather than being taken into hospital. Mental health professionals and GPs will work better together with care home staff so they can help patients more effectively. We will have community based multi-disciplinary teams that could include practice and community nurses, social care workers, allied health professionals, community mental health workers, community midwives, GPs, and specialist consultants including geriatricians.*
DA 4 **Improving outcomes for children &adults with mental health needs**	*People in Hillingdon with mental health needs will have a single point of access and their requirements identified early to ensure prevention and improved wellbeing. Those with long term conditions will have psychological support in a community setting through local well-being and prevention services that are provided by primary, community and social care services working together in a coordinated way. Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives.*
DA 5 **Ensuring we have safe, high quality sustainable acute services**	*Our hospitals will operate to a very high quality without the need for extra unplanned financial support with the ability to respond more effectively to increases in demand and provide more efficient diagnosis, timely triage and consultant services and effective transfer and discharge processes.* *Patients will see care beyond general practice services including specialist primary care outpatient clinics, treatment diagnostics and urgent care. Services will be coordinated and people in Hillingdon will receive complete 'joined up' care.*

What are we doing in 2016/17 against the 5 Delivery Areas?

Our local STP builds on a number of plans and strategies currently underway. There is therefore a great deal of work already in progress across the 5 Delivery Areas, some of which is detailed below and overleaf. Our plans for 2017/18 and 2018/19 are set out over the subsequent pages.

DA 1 *Radically upgrading prevention and wellbeing*	• Mental Health and Wellbeing Programme – producing a case for change including a range of support and wellbeing options focusing on the mental health of Hillingdon residents • By the end of 2016/17 supporting 3500 patients to have a better understanding of their long terms conditions through the Empowered Patient Programme • Developing a new service model for people at risk of falls • Developing a model for strengthening medical support to care homes • Currently evaluating the effectiveness of the joint Better Care Fund schemes developed by Hillingdon Local Authority and CGG • Development of a three-year BCF plan joint with LBH by March 2017 • Sign-off and implementation of our local Prevention Strategy. • Expanding our programme of medication reviews in GP Practices to ensure effective and cost-efficient use of medicines • Consult on and agree an air quality and public health action plan • Ongoing implementation of the new Hillingdon Carers Strategy. • Understanding the impact of social isolation on the health of the Hillingdon population, identifying tools enabling early identification in a range of primary and social care settings and developing a case for change. • Implementing Patient Champions in the Urgent Care Centre • Improve access to online advice
DA 2 *Eliminating unwarranted variation and improving LTC management*	• Delivering services for patients with LTCs (Cardiology, Respiratory and Diabetes) through community based multi disciplinary integrated teams • A redesigned service for children suffering from asthma conditions • Development of an accountable care partnership for the Hillingdon population • Develop a programme to focus on management of long term conditions co-morbidities • Enhancing the effectiveness of primary care IT systems through use of clinical decision support tools to help ensure patients access the right pathways • Implementation of Hillingdon Cancer Improvement Strategy • Implement National Cancer Vanguard Programme in partnership with Royal Marsden. • Developing plans to create direct access cancer diagnostic capacity for Hillingdon GPs to support early diagnosis of cancer • Effectiveness of Long Term Condition Strategy to be captured and measured by patient outcomes data • Implement Remaining Cancer Stratified Pathways • Redesigning pathways for stroke and early supported discharge in community services, in partnership with local providers

What are we doing in 2016/17 against the 5 Delivery Areas (2)?

DA 3 *Achieving better outcomes and experiences for older people*	• Implementing a new Older People's Integrated Care service model. • Implementing Intermediate Care 'In Reach' from Community /Third Sector from October . • Reviewing Homesafe Programme (Early Supported Discharge) and expanding integrated discharge planning. • Developing the accountable care partnership to support integration between acute, community, primary care health and social care / other local providers initially focusing around older people • Publish and begin to implement the new joint End of Life Strategy from December to improve planning of, access to and integration of end of life services, including a single point of access • Early identification and support for frail patients through implementation of frailty tool linked to risk stratification and care planning . Clear methodology to collect and use patient outcomes as a service improvement mechanism. • Better engagement with voluntary and community sector via Hillingdon4All. • Embedding health and wellbeing gateway and Patient Activation Measures (PAM) to support self-management • Embedding of memory clinics and ensuring robust links to primary care. • Developing an integrated health and social care service model for Hillingdon. • Developing a range of focused programmes targeting the Care Homes population • More patients able to access consultants in community setting including a new care of the elderly consultant post in Hillingdon A&E • Integrated service model available 7 days a week • Delivery of anticipatory care planning and coordinated care through deployment of Care Connection Teams across Hillingdon (following pilot)
DA 4 *Improving outcomes for children &adults with mental health needs*	• Developing a business case for services to support those in care homes with serious mental health needs by January 2017 • Implement and deliver national and NWL strategies - Future in Mind / Like Minded from March 2017 • Implementation of all age Early Intervention Services from October 2016 • As a part of further development of Hillingdon Urgent Care pathways we will develop clear mechanism for the Crisis Resolution Home Treatment rapid response pathways • Development of a strategy for adults and children with autism • Evaluating the effectiveness of 24/7 Mental Health Single Point of Access service model • Implementing new Community Learning Disabilities Service from July 2016, including ASD, ADHD packages of care to provide enhance health planning and community based services. • Developing a Suicide Prevention Strategy following publication of audit in October 2016 • Roll out of a service for young people with eating disorders from August 2016 and embed enhanced crisis and urgent out of hours service for CAMHS • Developing CYP IAPT service in partnership with children & young people and their parents/carers • Improving perinatal mental health service provision along with the development and implementation of perinatal strategy. • Ensure that mental health support to people with LTCs and at End of Life is integral to the ACP programme
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Focus on the 4 Acute Standards and seek selective delivery of services in other settings as per the strategy. • Mainstreaming of 7 day therapy in HICU (intermediate care unit) by January 2017 • Develop dashboard to monitor outcomes and activity over 7 days • Developmental work with Bucks New University in partnership with THH, CNWL and others to ensure development of the future workforce. • CNWL leadership programme for all new Band 7 and 8a posts. • Review quality of Delayed Transfers of Care monitoring data to ensure patients receive seamless services • THH audit of Neo-natal births & babies screening programmes. • THH working with GPs and community providers to pilot new models of acute care using a networked approach. • Master-planning process for redesign of the hospital site • Develop new consultant led escalation model for enhanced care linked to optimised community intermediate care services • Pilot a nurse-led acute medical clinic, before offering the service 7 days per week • Adopt e-prescribing at Hillingdon hospital and Mount Vernon hospital. • improve access to diagnostics - to ensure cancer RTT targets continue to be met

What will we be doing in 2017/18 against the 5 Delivery Areas?

DA 1 *Radically upgrading prevention and wellbeing*	• By the end of 2017 we will have rolled out a Joint Physical Activity strategy with LBH • BCF - evaluation of the effectiveness of interventions / schemes, and assessment of impact of benefit realisation on the NHS and LA • By September 2017 we will have expanded the Empowered Patients Programme to cover a wider range of conditions • From April 2017 we will begin to implement our Prevention Strategy • Rollout of Proactive Case Finding in Primary Care to be ready by September 2017 • We will expand Personal Health Budgets in Hillingdon, putting patients in charge of their treatment options • Expand the usage of Patient Activation Measures (PAM) • Expand access to and use of online information and advice • Ongoing implementation of the Hillingdon Carers Strategy • Delivery of wellbeing training programme for schools • Implementation of the recommendations from the audit of neo-natal births & babies screening programmes
DA 2 *Eliminating unwarranted variation and improving LTC management*	• By June 2017 we will rollout our approach to tackling co-morbidities and complex needs • Rationalisation of Primary Care Contracts and investment in enhanced, at scale primary care • By June 2017 we will complete analyses to help us close the gap between those who have diagnosed and un-diagnosed LTCs • Ongoing rollout of actions from our Cancer Improvement Plan • By September 2017 we will have mobilised new AF and stroke pathways and services • Continued delivery of National Cancer Vanguard Programme • Development of psychological support for people with long-term conditions including access to Talking Therapies • Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016 • Implementation of Primary Care Model of Care
DA 3 *Achieving better outcomes and experiences for older people*	• By April 2017 we will have embedded Care Connection Teams across Hillingdon • By June 2017 we will have rolled out the accountable care partnership model of care for older people • From April 2017 we will rollout new models of care for care homes integrating Primary, Community and Secondary Care support including embedding the use of frailty tools • Implementation of post discharge follow ups in the community • Rollout of the EoL Strategy and new integrated service model • Increase access to Coordinate My Care (CMC) • By April 2017 we will achieve full integration of Co-ordinate my Care and Primary Care clinical systems
DA 4 *Improving outcomes for children &adults with mental health needs*	• Delivery of the Like Minded Programme • Improve support for patients with MH related LTCs • Implement MH support for people with a physical LTC • Expand integrated care planning to include people with MH needs • Rollout new model of Community MH Support • Rollout SPA for CYP • Implement crisis and out of hours support for CAMHS • Implementation of the strategy for adults and children with autism
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Provide medical retina services at Mount Vernon hospital to treat macular degeneration • Focus on additional 7 Day Standards • Develop ambulatory acute care for frail elderly by adopting a networked approach • Finalise Local Services Strategy for Hillingdon. • Rollout new 111 Service and Primary Care Triage Model • Improved access to consultant led paediatric services

What will we be doing in 2018/19 against the 5 Delivery Areas?

DA 1 *Radically upgrading prevention and wellbeing*	• By April 2018 we will complete evaluation and further development of Empowered Patient Programme • Bu January 2018 the Hillingdon Prevention Strategy will be fully implemented • Further implementation of Personal Health Budgets focusing on patients outside of Continuing Care • Evaluation of screening outreach programmes • Additional promotion of assistive technologies e.g. telecare and telehealth • Opening of two extra care sheltered units for older people • Expanded access to and use of online advice
DA 2 *Eliminating unwarranted variation and improving LTC management*	• By March 2019 we will complete a review and evaluation of our Cancer Improvement Plan • We will continue delivery of the National Cancer Vanguard Programme • Psychological support to people with long-term conditions will be fully embedded within Hillingdon health systems • Delivery of Primary Care Model of Care
DA 3 *Achieving better outcomes and experiences for older people*	• Enhanced progression of BHH RightCare Programme • Proactive identification and engagement at primary care level with groups at high risk of developing LTCs • Further development of the ACP Model • By March 2019 we will have evidence of closing the prevelance gaps between those with diagnosed and un-diagnosed LTCs • Evaluation and further development of programmes focussed on the care homes population • Delivery of EoL Strategy and new integrated service model • Further expanded access to Coordinate My Care (CMC) for proactive care planning • Delivery of a paperless system through the full integration of Co-ordinate my Care and primary care clinical systems
DA 4 *Improving outcomes for children &adults with mental health needs*	• Ongoing delivery of the Like Minded Programme • By January 2019 full operational delivery of the strategy for adults and children with autism • By March 2019 we will complete evaluation of support programmes for patients with MH related LTCs • Delivery of new model of Community MH Support • Delivery of Community LD Services • CYP SPA – evaluation process • Further delivery of wellbeing programme training programme for schools
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Full implementation of 7 Day Standards

Main Challenges Facing Delivery

The following is a summary of the challenges to the implementation of Hillingdon's plans for the 5 Delivery Areas

Hillingdon Health & Wellbeing Gaps

- Wider population health – development of range of interventions to prevent deterioration – management of demand by preventing or delaying the onset of ill-health
- Resilience in primary care
- Development of localised programmes enabling people managing their own conditions through easily available education, tools and support enabling them to remain as healthy as possible
- Greater presence and capacity of voluntary sector in supporting communities with their health and wellbeing resulting in less demand for primary and acute care as a result of community interventions
- Management of organisational change - health system wide consideration of Social Isolation as a Long Term Condition and its impact on both the physical and mental wellbeing of local population
- Development of new service models utilising integration of care home support with health and social care services
- Development of robust methodologies enabling effective access to information - Whole system understanding of services available allowing for referral to the most appropriate service regardless of commissioner
- Development of localised service models based on needs of local pupation at locality level - meeting the needs Individuals with mental health problems from marginalised groups including Black and Minority Ethnic (BME) communities, homeless people, older adults, those in contact with the criminal justice system and people with learning disabilities have a further elevated risk of poor health outcomes

Hillingdon Care & Quality Gaps

- Maternity services – integration of Ealing Unit
- Current capacity of the health system - the most likely growth assumptions over the next five years will see approx. 21% more activity
- Access rates to first intervention – development of new referral / care pathways
- National shortage of suitably qualified staff
- Improved pathways for vulnerable groups including looked after children and people with learning disability
- Development of an understanding about future workforce gap for new service model
- THH estates gap – chronic condition of physical infrastructure and inefficient space constrains service provision. Significant capex required
- Gap to ensure appropriate set up/step down facilities, hospital front end primary care, increased diagnostic and ambulatory care provision
- Equitable access to care and support regardless of time of day or place of residence

Hillingdon Finance & Efficiency Gaps

- High cost acute activity can only be reduced by re-orientating the entire health and care economy towards prevention and integration
- Capitol investment – estates to meet new capacity demands
- Pooled budgets and joint commissioning - Shared KPIs and performance management framework to ensure priorities are aligned / Best Value for the available funding
- Delivery of efficiencies through our existing and emerging QIPP Efficiency Schemes.
- Estate rationalisation to reduce the operational footprint and also to build on our hub strategy.
- Identification of efficiency savings through improved management of patients with LTCs and focusing on Prevention.
- Reduction in Length of Stay and Admission Rates (when clinically appropriate) as system wide contribution to reduction of overall bed usage,

Overview of the Local Services Programme for NWL

Overview of the 6 Local Services Programme Initiatives

In parallel with the development of the Sustainability & Transformation Plan (STP) work has been underway at a North West London (NWL) level to review and prioritise initiatives under the heading of the Local Services Programme (LSP) (previously the Out of Hospital Programme) that will underpin the move of care away from hospital to support the NWL STP. The Local Services Programme has identified six initiatives which are summarized below.

Initiatives	Description
Initiative 1. New Models of Local Services Care	Developing new models of care utilising technology, patient activation and empowerment, different clinical models etc. For Hillingdon this is mostly covered by the Primary Care Model of Care and Older People Model of Care (which is also aligned to the Accountable Care Partnership)
Initiative 2. Self-care	Empowering and informing patients with Long Term Conditions to enable them to take control of elements of their care, manage their condition more effectively and ultimately improve their long term outcomes. This also links to Personal Health Budgets.
Initiative 3. Wider determinants of health	Working across health and social care to jointly address wider issues that affect the health of individuals and populations including deprivation, homelessness, alcohol and substance misuse and social isolation.
Initiative 4. Rapid Response and Intermediate Care	Effectively and safely reducing the number of people who need to be admitted to hospital and are supported either to remain in their normal place of care or are supported home. This also encompasses supporting the effective and safe discharge of people following an admission to reduce their overall length of stay.
Initiative 5. Expanding Common Discharge	Improving the coordination of discharges across borough boundaries including supporting access to local services including reablement, rehabilitation, bridging care and other services.
Initiative 6. Last Phase of Life	Coordinating support for people at the end of their lives and supporting them and their carers to enable them to die in their preferred place of death with the right support provided to manage their care.

Our Local Approach To The Five Year STP Challenge

Our Local Approach To The Five Year STP Challenge

Our approach to delivering the challenges set out in this STP involves numerous activities many of which are closely related and all are inter-related. Therefore we have grouped our work into 9 Transformation Programmes and 6 Enabling Programmes that align to both the 9 North West London Priorities and the 6 Local Services Initiatives as detailed below. The Enabling Programmes by definition align with most, if not all, of the priorities and initiatives.

Hillingdon Transformation Programmes	Alignment To The 9 North West London Priorities									Alignment To The 6 Local Services Programme Initiatives					
	Prevention Priorities			Integration Priorities				Technology & Innovation Priorities		New Models of Local Services	Self-Care	Wider Determinants of Health	Rapid Response & Intermediate Care	Expanding Common Discharge	Last Phase of Life
	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6
1. Transforming Care for Older People	X		X	X	X	X			X	X	X	X	X	X	X
2. New Primary Care Model of Care	X			X	X	X		X	X	X	X	X	X		X
3. Integrating Services for People at the End of their Life			X		X	X				X			X	X	X
4. Integrated Support for People with Long Term Condition (LTCs)	X	X		X				X	X	X	X	X		X	
5.Transforimg Care for People with Cancer	X		X	X		X	X		X	X	X	X		X	X
6. Effective Support for People with a Mental Health need and those with Learning Disabilities	X		X				X	X	X	X	X	X			
7. Integrated Care for Children & Young People	X							X	X	X	X	X	X	X	X
8. Integration across Urgent & Emergency Care Services	X	X		X	X		X	X	X	X	X	X	X	X	X
9. Prevention of Disease & Ill-Health	X	X	X	X			X			X	X	X			
10. Transformation in Local Services	X				X				X	X	X	X	X	X	X

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
1. Transforming Care for Older People	• Coordinated Care for Older Peoples' Planned & Unplanned Care Needs across Care Settings • Improved Health Outcomes through focusing on LTCs and complicating factors • Integrated Health & Social Care support for those patients who need it • Reduced frequency of unplanned events	• Whole System Integrated Care Strategy • Better Care Fund	• Reduction in Non-Elective Admissions • Reduction in Zero-Length of Stay Admissions • Reduction in overall costs associated with supporting Older People	• Implement phase 1 of the Care Home Initiative • Develop Carers Support Programme • Rollout H4All Wellbeing Gateway • Integrate Unplanned Support for Older People • Develop new 'Core Offer' for Care Homes including support for EMI and people with SMI • Proactive identification of those at risk of social isolation • Embed the Memory Assessment Clinic Support • Development of capitated budget as part of ACP	• Rollout new care model via ACP focused on Older People • Rollout new core offer for Care Homes integrating Primary, Community and Secondary Care support • Embed Frailty Tool • Embed Care Connection Teams • Deliver the Like Minded Programme
2. New Primary Care Model of Care	• Increasing number of Pts managed outside of hospital setting with integration across Primary, Community & Secondary Care Services and Social Care	• Five Year Forward View	• Increase in activity managed outside of a hospital setting. • Reduction in costs across the system per capita to meet the financial gap	• Develop Primary Care Model of Care focused around Unplanned Care, Care Homes and LTCs	• Implement Primary Care Model of Care • Rationalise Primary Care Contracts and invest in Network Level Delivery
3. Integrating Services for People at the End of their Life	• Increasing number of people able to die in their preferred place of death • Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings	• End of Life Strategy • Better Care Fund	• Increase in people dying in their preferred place of death • Increase in people with anticipatory care plans • Reduction in the costs associated with managing people at End of Life	• Finalise End of Life Strategy and manage via EoL Forum • Develop integrated service model including 24/7 SPA and Out of Hours Nursing Support • Develop procurement plans around third sector services	• Rollout EoL Strategy and new integrated service model • Increase access to Coordinate My Care (CMC)

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
4. Integrated Support for People with Long Term Condition (LTCs)	• Reducing prevalence growth for core LTCs and significant progress made in closing key prevalence gaps • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Significant progress in patient activation and the numbers of patients self-managing elements of their care • Increase access to and usage of Personal Health Budgets (PHBs)	• Long Term Conditions Strategy • Dementia Action Plan • Better Care Fund • Prevention Strategy	• Reduction in prevalence growth • Reduction in prevalence gap • Reduction in unplanned events for people with LTCs • Reduction in the costs associated with supporting people with LTCs • increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan • Achieve 280 PHBs by 2020/21	• Refresh Long Term Conditions Strategy • Rollout Integrated Services for Respiratory, Cardiology (HF) and Diabetes and seek to expand to cover AF and Stroke • Rollout new Empowered Patient Programme • Develop plans around co-morbidity management and support to complex service users • Develop plans around management of MH related LTCs	• Expand usage of Patient Activation Model (PAM) • Embed AF and Stroke Services • Improve support for patients with MH related LTCs • Rollout programme for complex users • Proactive engagement with groups at high risk of developing LTCs • Expand access to and use of online advice • Implement MH support for patients with a physical LTC • Expand ICP to wider cohort
5.Transforimg Care for People with Cancer	• Holistic pathways covering both medical and non medical care pathways elements • Integrated cancer rehab • Early identification • Improved uptake rates for screening programmes • SPA survivorship service model • DA and STT diagnostics model	• Hillingdon Cancer Improvement Plan –Cancer Strategy • London Cancer Strategy	• Reduction in unplanned events • Early identification of Cancer patients in primary care/community settings • GP DA and STT community diagnostics • Pathway stratification • Treatment options close to patients homes	• Finalise rollout of Cancer Stratified Pathways • Roll out Lymphedema service model • Develop Hillingdon Cancer Board for non clinical cancer support services • Develop diagnostic capacity to meet demands and targets for Cancer pathways • Review screening programmes • Review Q Cancer Tool utilisation	• Roll out clinical protocol for the follow ups in community • Develop SPA rehab model • Implementation of DA and STT • Rollout outstanding actions from Cancer Improvement Plan
6. Effective Support for People with a Mental Health need and those with Learning Disabilities	• Reduction in inequalities associated with the care of people with one or more LD • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population	• Learning Disability Action Plan • Dementia Action Plan	• Reduction in the mortality gap • Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD • Reduction in unplanned care needs arising for people with a known mental health condition	• Rollout of 24/7 SPA for people with MH needs • Develop all age early intervention service • Review Community MH Teams • Develop and rollout MH Rapid Response Service • Implement post discharge follow ups	• Expand ICP to include people with MH Conditions • Rollout new model of Community MH Support • Rollout Community LD Service

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
7. Integrated Care for Children & Young (CYP)	• Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people	• CAMHS Action Plan • Children's Transformation Plan	• Reduction in the need for secondary care activity associated with CYP • Reduction in unplanned care needs for CYP • Reduction in the costs associated in managing CYP per capita	• Develop eating disorder support for CYP • Develop 24/7 SPA for CYP • Implement Consultant Led Acute Model with support to Primary Care & Community Services • Rollout Paediatric Asthma Programme	• Rollout SPA for CYP • Implement crisis and Out of Hours support for CAMHS • Rollout Joint Physical Activity strategy with LBH
8. Integration across Urgent & Emergency Care Services	• Coordination of support across all Urgent & Emergency Care services • Increase in the number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay	• Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care	• Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions • Reduction in Length of Stay following an unplanned admission	• Develop plans for new 111 Service and Primary Care Triage Service • Expand Urgent Care Centre capacity • Rollout Patient Education Programme • Expand Intermediate Care Services and integrate with Homesafe	• Rollout new 111 Service and Primary Care Triage Model • Expand access to and use of online advice • Embed Patient Education Programme
9. Prevention of Disease & Ill-Health	• Reduction in prevalence gap for key conditions • Reduction in the rate of growth in prevalence • Reduction in the variation in management of conditions	• Prevention Strategy	• Reduction in the prevalence gap for key conditions • Reduction in the rate of growth of prevalence • Reduction in the management of people with LTCs	• Develop Prevention Strategy • Develop Suicide Prevention Strategy • Develop plans to close Hypertension and Diabetes Prevalence Gaps • Rollout Air Quality Review with Public Health	• Rollout of Prevention Strategy • Rollout of Proactive Case Finding in Primary Care • Work to close prevalence gaps
10. Transformation in Local Services	• Reduction in the rate of growth in hospital attendances and admissions for planned care needs • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support	• Local Services Strategy	• Reduction in growth rate for planned attendances and admissions • Increase in planned care provided in non-hospital based settings • Reduction in the planned care costs per capita	• Deliver 4 Priority Acute Standards for 7 Days • Rollout 7 Day Services in HICU • Develop 7 Day Services Dashboard • Re-establish CATS and rollout to Gastro and Neuro Services • Rollout Pain and Dermatology Services to more patients	• Implement post discharge follow ups • Focus on additional 7 Day Standards

Our Enabling Programmes in Detail

HILLINGDON ENABLING PROGRAMMES					
	2020/21 OUTCOMES	UNDER-PINNING STRATEGIES	INDICATORS OF SUCCESS	KEY 16/17 ACTIONS	ACTIONS 17/18+
1. Developing the Digital Environment for the Future.	• Relevant information safely and appropriately available when needed to coordinate care for people • Clear information available to aid planning of services	• Digital Roadmap	• High utilisation of Shared Care Record across setting • Services planned using accurate and timely data • Improved outcomes for patients through shared record keeping	• Improve access to Shared Care Records • Develop plans for digitally enabled self-care • Develop plans for use of real time data in decision making	• Become paper free at the point of care • Eradicate use of fax in care services • Deliver robust Shared Care Record that is highly utilised • Real time use of data used to inform patients
2. Creating the Workforce for the Future.	• A workforce that meets the needs of the evolving health and social care market	• Workforce Plans	• A service with the capacity and capability to meet the needs of our population • Reducing sickness and absence rates • Improving skills and competences within the workforce	• Develop recruitment and retention strategy • Develop mutli-professional workforce plans • Brunel University London (BUL) with THH NHSFT and CNWL NHSFT establishing an Academic Centre for Allied Health and Healthcare Sciences • Develop plans with Buckinghamshire New University for workforce development	• Rollout recruitment and retention strategy and workforce plans
3. Delivery of our Statutory Targets	• Continued and sustained achievement of our mandatory and statutory targets	• Operating Plan	• Consistent achievement of our statutory and mandatory targets	• Robust demand and capacity study undertaken around RTT, Cancer and Diagnostic Targets • Continued focus on improvement in A&E Performance • Develop resilience plan around core measures • Development of diagnostic capacity to meet demands and targets for Cancer pathways	• Rollout resilience plans

Our Enabling Programmes in Detail

HILLINGDON ENABLING PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**INDICATORS OF SUCCESS**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
4. Medicines Optimisation	• Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Improved outcomes for people utilising medicines and a reduction in avoidable harm	• Medicines' Management Strategy	• Reducing spend per capita on medication • Reducing incidents of harm • Improving outcome for people arising from the effective use of medication	• Implement ePrescribing in acute care • Focus on reducing wastage and reducing inappropriate usage of antibiotics • Increase support to Care Homes • Undertake increased number of medication reviews	• Focus on medicines optimisation and rollout of practice level pharmacy support with medicines reviews and repeat prescriptions
5. Redefining the Provider Market	• A market capable of meeting the health and care needs of the local population within the financial constraints • A diverse market of quality providers maximising choice for local people	• Integrated Care Strategy	• Significant proportion of care delivered through integrated delivery vehicles • A high functioning, cost effective Accountable Care Partnership	• Develop and test financial assumptions around the ACP • Create Network Development Strategy • Develop Primary Care Estates Strategy • Rollout Local Estates Strategy and Rationalisation Plan • THHFT Estates Master planning for new hospital build • Joint market shaping activities with CCG and LBH for care services	• Rollout and trial ACP model and develop plans for future cohorts • Develop Network Development Strategy • Implement recommendation of THH master planning exercise • Implement the 2016/17 market shaping activities
6. Delivering the RightCare Programme	• On-going cycle of continuous, data driven and clinically led improvement based on the RightCare data and methodology	• QIPP Plans	• Achievement of financial QIPP Plans • Improving outcomes for patients	• Progress with BHH RightCare Programme for MSK, Cancer, Diabetes and Respiratory • Locally develop programme for Complex Patients and those with multiple co-morbidities	• Extend to additional specialties both across BHH and locally

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NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

V1.0

30 June 2016

DRAFT

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions.

We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.3bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
Chair, Ealing Clinical Commissioning Group and NW London STP System Leader

Carolyn Downs
Chief Executive of Brent Council

Clare Parker
Chief Officer Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs

Tracey Batten
Chief Executive of Imperial College Healthcare NHS Trust

Rob Larkman
Chief Officer Brent, Harrow and Hillingdon CCGs

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i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs have a life expectancy 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.3bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

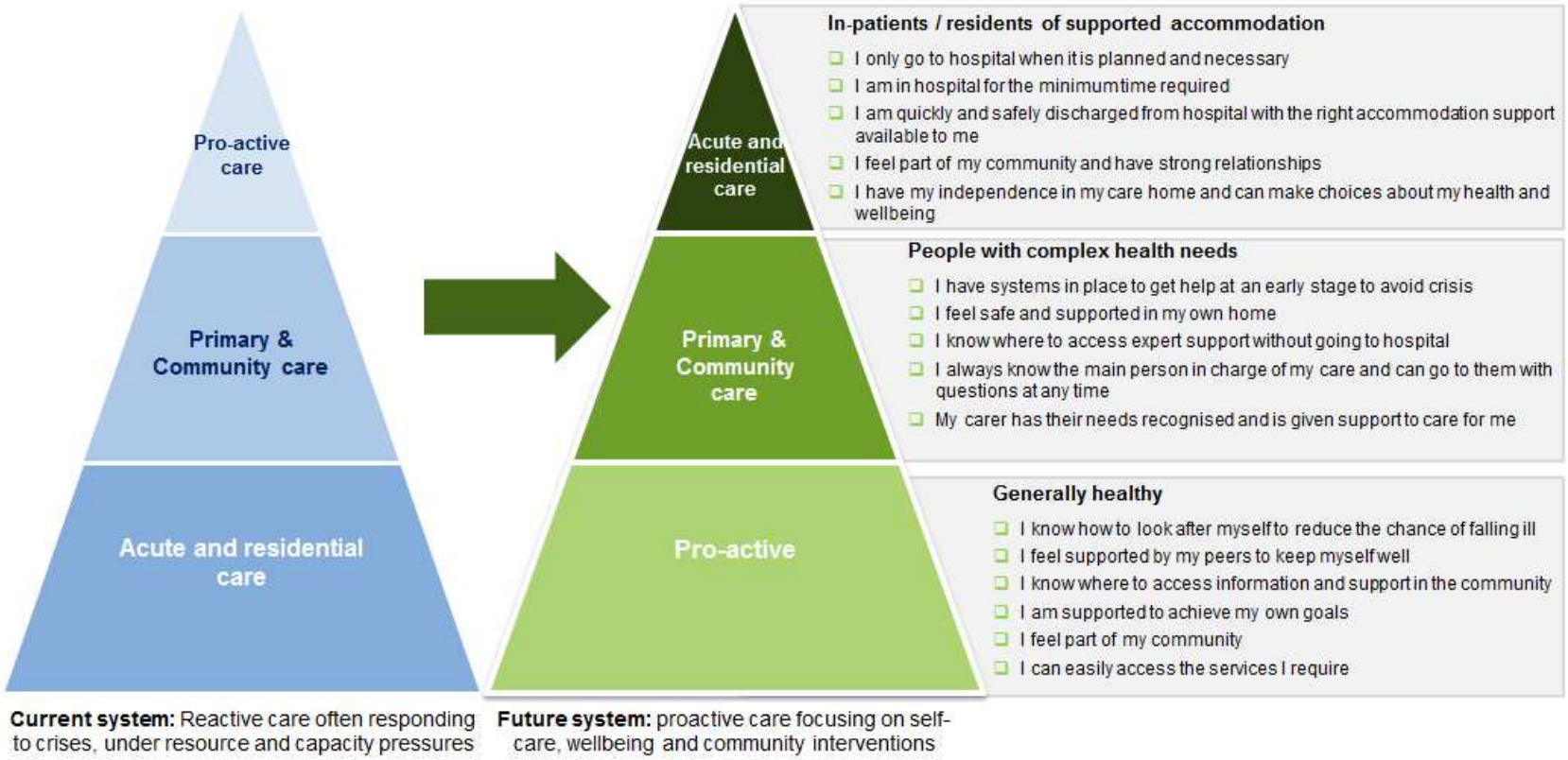
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,00	458,000	26,000	37,900	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	1%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21

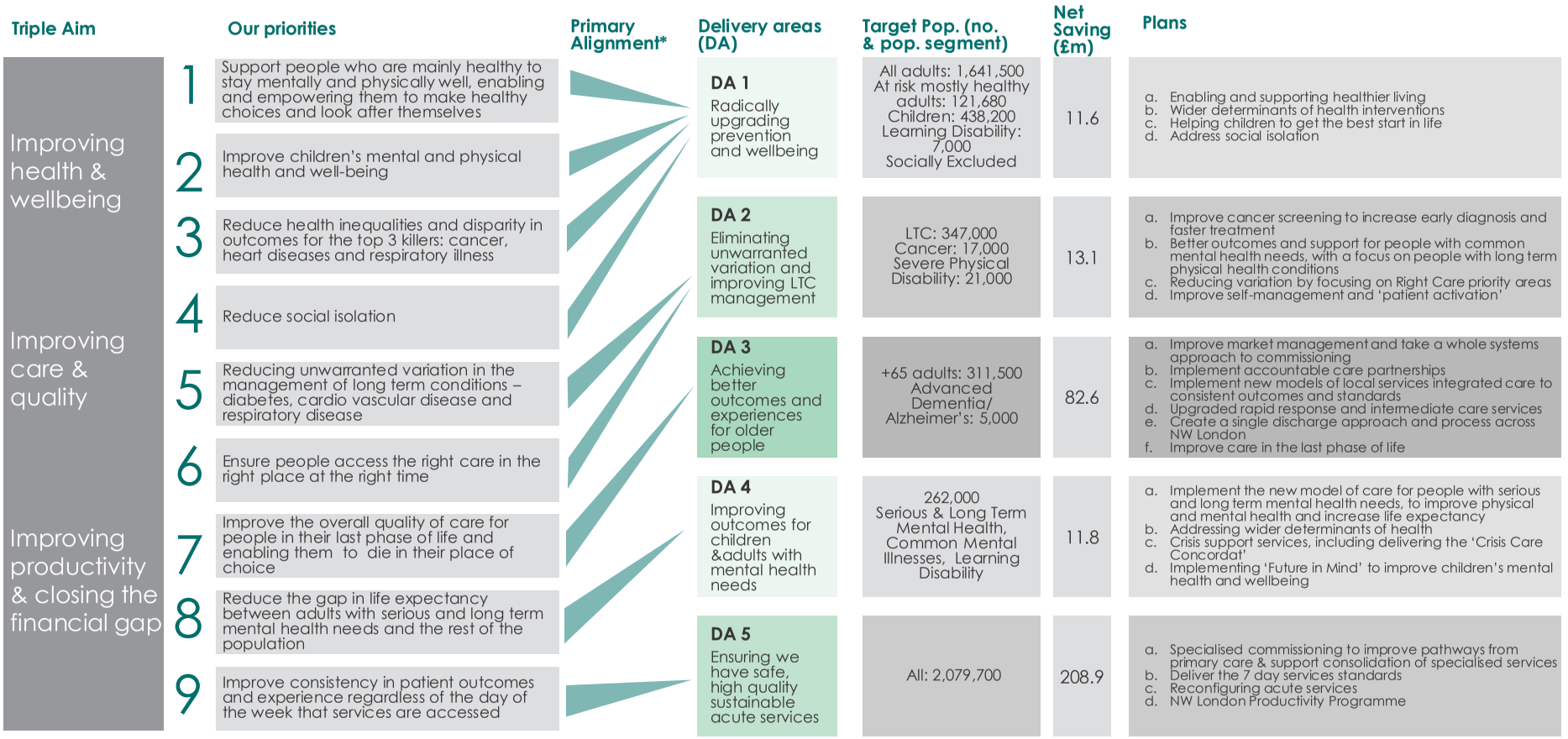


Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.



** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care. We will deliver this through primary care operating at scale through networks, federations of practices or super-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves it can benefit from specialisation and the benefits of senior clinical advice available at most parts of the day. We know from our London wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that can deliver consistently high quality, consistently well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our acute hospitals are under more strain than ever before. Some of this is due to increasing demand, and our STP sets out how we will manage demand more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. The site currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, meaning that the current clinical model cannot be financially sustainable. The vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing and for Charing Cross, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also host a GP practice and an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs.

The local government position on proposed acute changes is set out in Appendix A.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing or Hammersmith & Fulham will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

i. Executive Summary:
Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7
Delivery Area (1-5) - Investment	(118.3)	-	-	-	-	-	(118.3)	-	(118.3)
Delivery Area (1-5) - Savings	302.9	120.4	23.0	-	-	-	446.3	62.5	508.8
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0
Other	-	-	-	188.3	-	-	188.3	63.0	251.3
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**
Residual Gap (with application of business rules)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**

The solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

Additional savings have been assessed across the five STP delivery areas, and require £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings. These schemes support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.

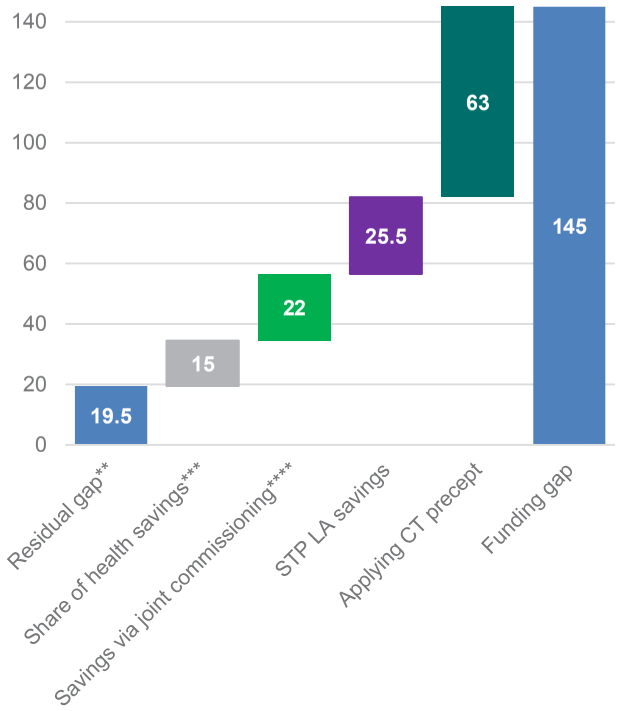
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	-	2.0	2.0	2.2
Demand management & community resilience	DA2	-	-	-	6.1
Caring for people with complex needs	DA3	-	-	-	5.1
Accommodation based care	DA3	7.7	-	7.0	2.0
Discharge	DA3	3.4	-	3.4	9.6
Mental Health	DA4	3.5	2.9	6.4	5.0
Vulnerable	DA1	3.0	3.0	6	-
Total savings through STP investments		17.6	7.9	25.5	30.0
Joint commissioning	DA3	22.0	-	22.0	TBC
Total savings		39.6	7.9	47.5	30.0

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary: 16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Increased accessibility to primary care through extended hours v. All practices will be in a federation, super practice or on a trajectory to MCP vi. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Aiming to move NW London average of 23mins/1000 people to 30mins/1000 people at pace v. Supporting sustainability, reducing unwarranted variation and preparing for Accountable Care Partnerships vi. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint bank and agency programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

i. Executive Summary:
How we will make it happen?

To deliver change at scale and pace requires the system to work differently, as both providers and commissioners. We are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. Develop a joint NW London implementation plan for each of the five high impact delivery areas
We will establish jointly led NW London programmes for each delivery area, working across the system to agree the most effective model of delivery and accountable to a new model of partnership governance. We will build on previous successful system wide implementations within Health and Local Government to develop our improvement methodology, ensuring an appropriate balance between common standards, programme management, local priorities and implementation challenges. The standard methodology includes a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. We have also developed a common project 'life cycle' with defined gateways. Models of care are developed jointly to create ownership and recognise local differences and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, seven day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures across the system
We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:
We are reviewing the total improvement resources across all providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around the delivery areas to increase effectiveness and reduce duplication
We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities
NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.
We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.
Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital
We are moving towards primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system.
By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements.
By 20/21 we will worked jointly across Health and Local Government to implement Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.3bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

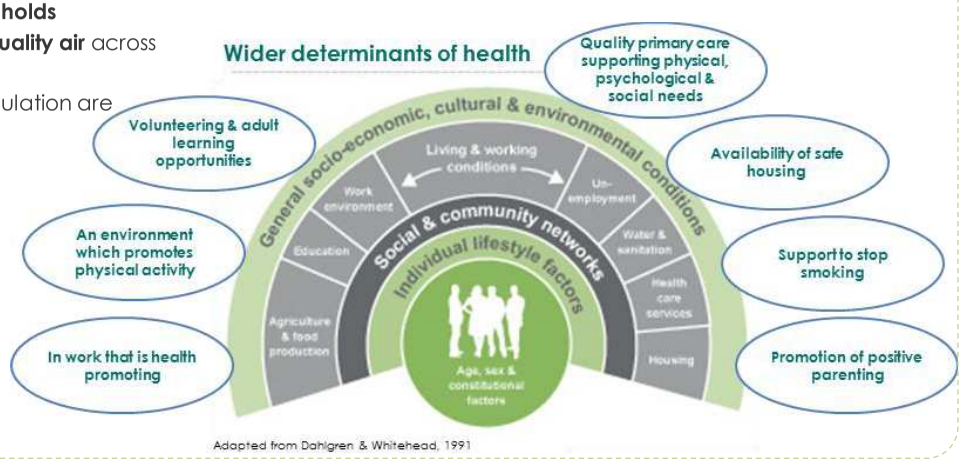
1. Case for Change:
Understanding our population

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- State primary school **children with high levels of obesity**

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Adapted from Dahlgren & Whitehead, 1991

Population Segmentation for NW London 2015–30[3]

Mostly healthy

- 1,216,000 adults in NW London are mostly healthy
- 58% of the total population
- 24% of care spend in NW London

In 2030:
- 4% more adults
- 31% more +65s

One or more long-term conditions

- 338,000 adults in NW London have 1 or more LTC
- 16% of the population
- 22% of the care spend in NW London

In 2030
- 36% more adults
- 37% more spend in NW London

Cancer

- 17,000 adults in NW London have cancer
- 0.8% of the population
- 4% of care spend in NW London

In 2030:
- 53% more adults
- 50% more spend in NW London

Serious and long term mental health needs

- 37,500 adults in NW London have serious and long term mental health needs
- 2% of population
- 7.5% of care spend

In 2030:
- 1% more adults
- 21% more spend in NW London

Learning disability

- 7,000 adults in NW London have learning disabilities
- 0.3% of the population
- 8% of care spend in NW London

In 2030:
- 29% more adults
- 35% more spend in NW London

Severe physical disability

- 21,000 adults in NW London have severe physical disabilities
- 1% of the population
- 18% of care spend in NW London

In 2030:
- 29% more adults
- 26% more spend in NW London

Advanced dementia / Alzheimer's

- 5,000 adults in NW London have advanced dementia
- 0.2% of the population
- 2% of care spend in NW London

In 2030:
- 40% more adults
- 44% more spend in NW London

Children

- 438,200 children in NW London
- 21% of the population
- 14% of care spend in NW London

In 2030
- 6% more children
- 3% more spend in NW London

Socially Excluded Groups

- Westminster has the highest recorded population of rough sleepers of any local authority in the country
- There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

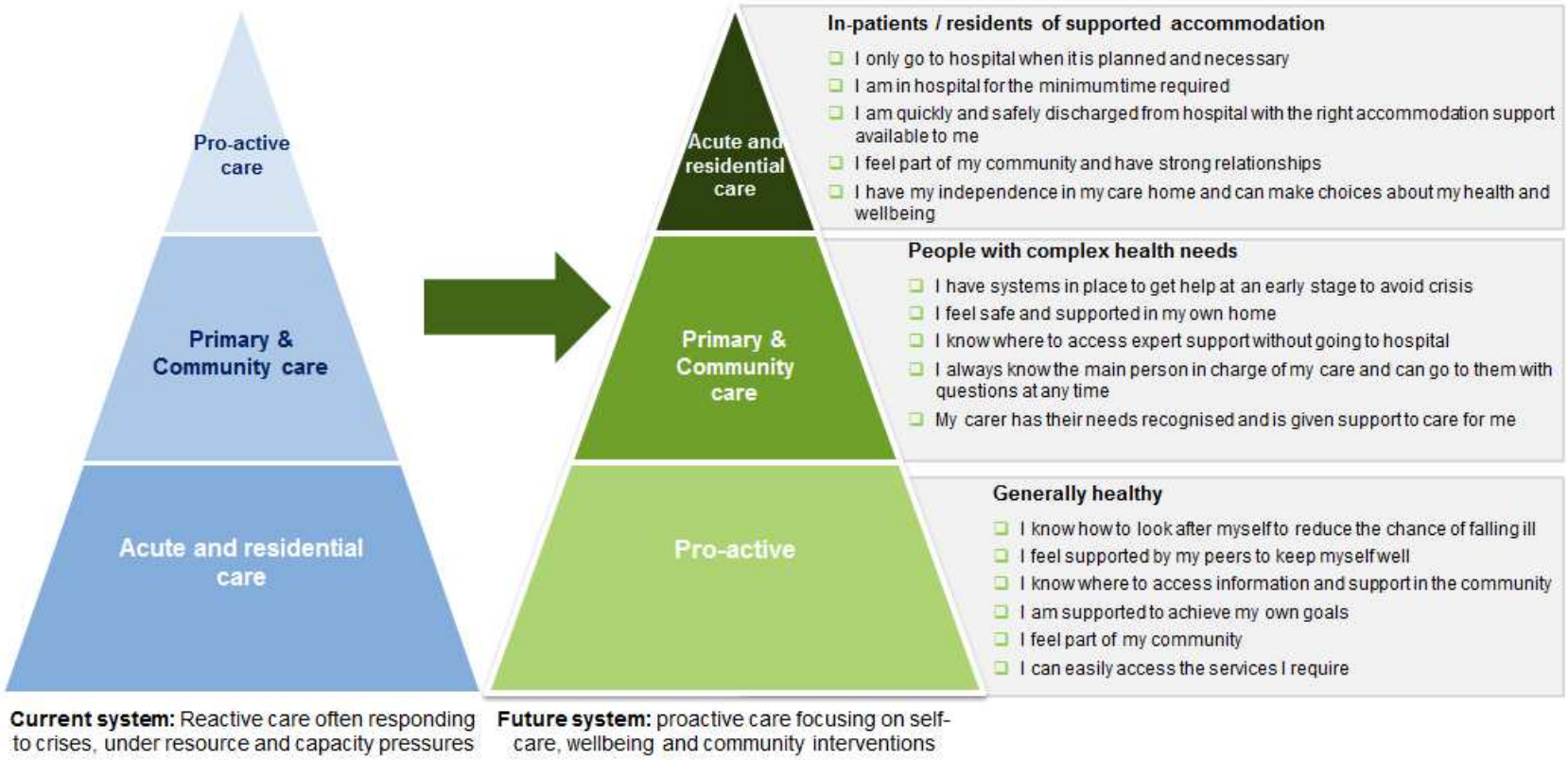
Please note that segment numbers are for adults only with the exception of the children segment

1. Case for Change:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

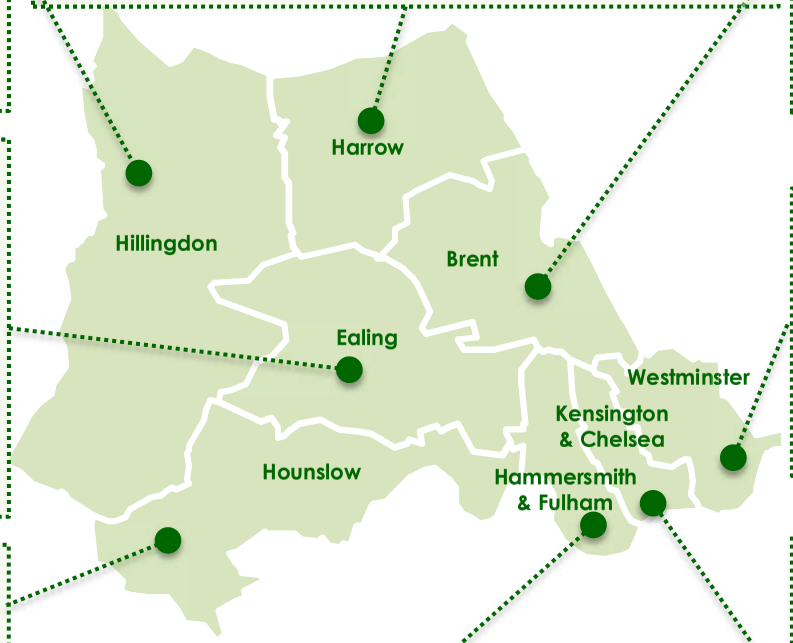
1. Case for Change:
Understanding people's needs

While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6



- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 19.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)

- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

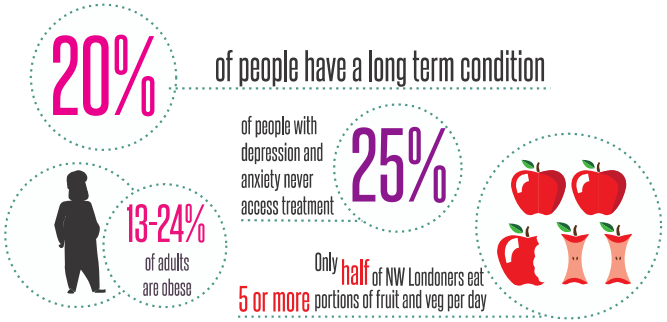
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

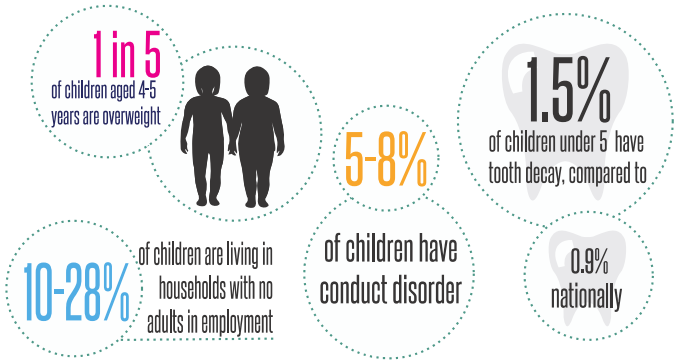
- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…





1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

Our Priorities

1 Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

2 Improve children's mental and physical health and well-being

3 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

My life is important, I am part of my community and I have opportunity, choice and control

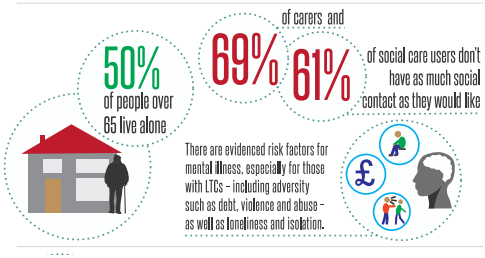
As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

My wellbeing and happiness is valued and I am supported to stay well and thrive

I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health	4 Reduce social isolation
People with long term conditions use 75% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
Over 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

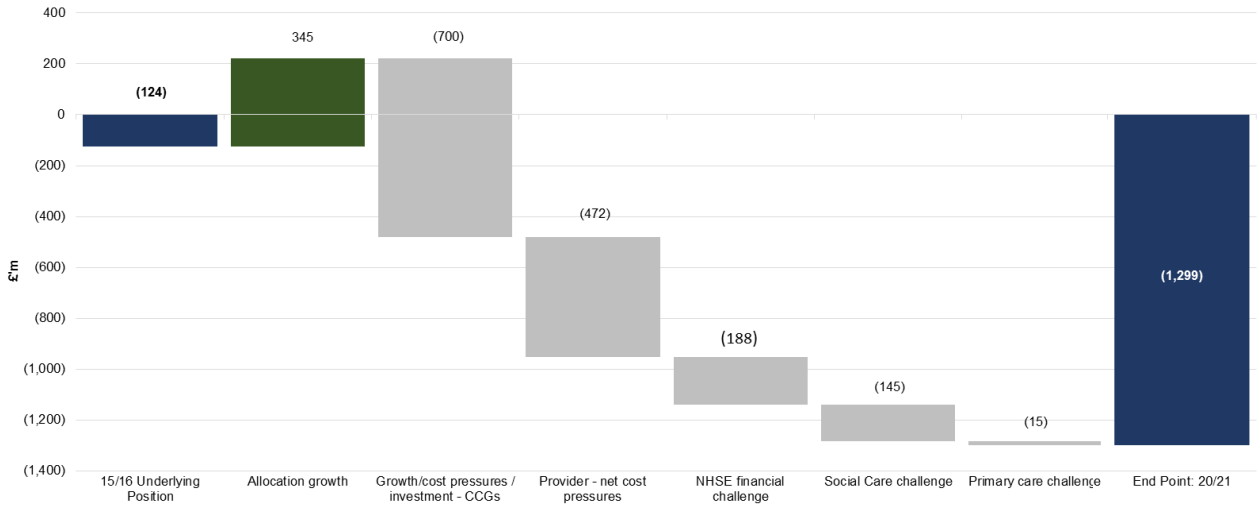


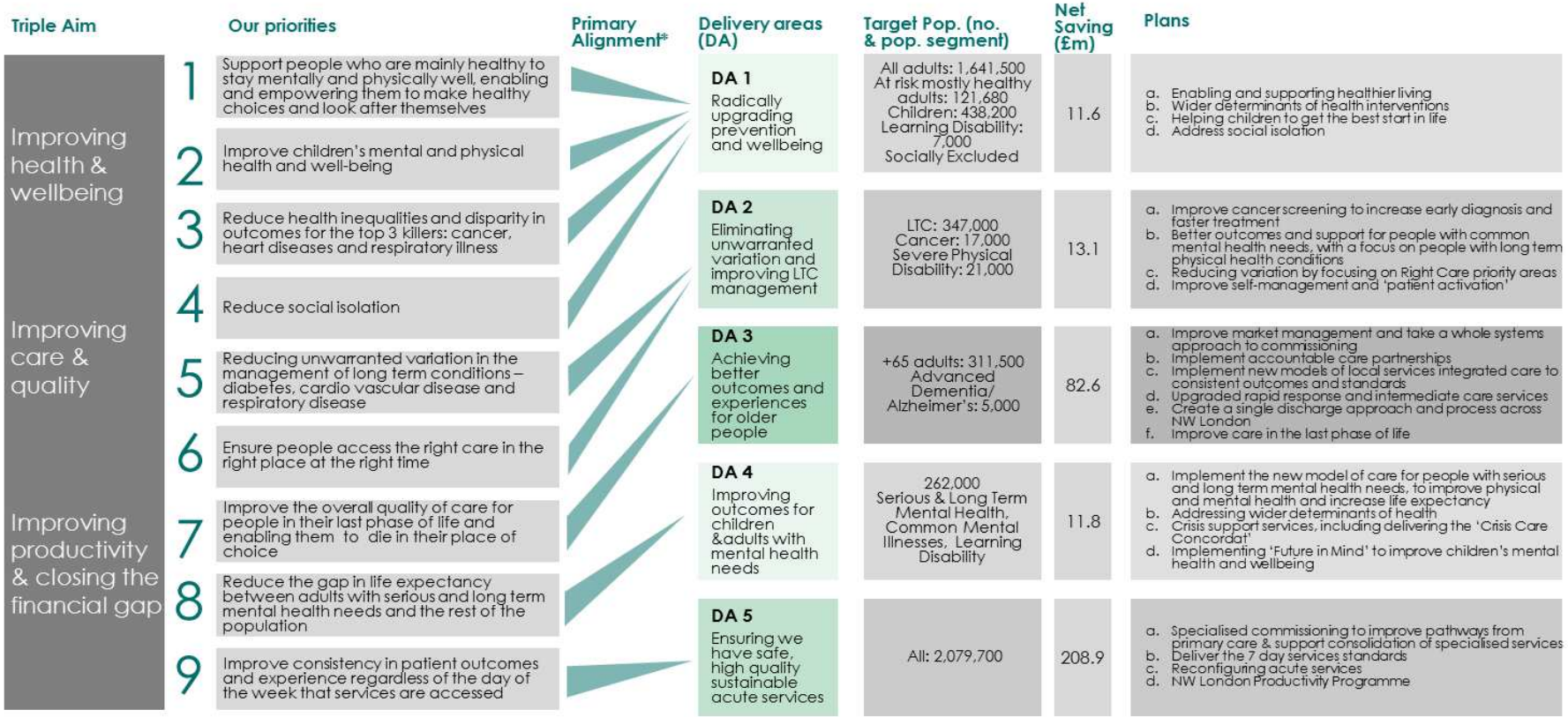
Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

£'m - Residual Gap	15/16	16/17	17/18	18/19	19/20	20/21
Providers	(190)	(304)	(374)	(462)	(544)	(659)
CCGs	60	(4)	(77)	(140)	(198)	(293)
Specialised commissioning	-	-	(44)	(90)	(138)	(188)
Primary care	-	2	(1)	(12)	(19)	(15)
Total NHS	**(130)**	**(306)**	**(496)**	**(704)**	**(899)**	**(1,154)**
Social Care	-	-	(36)	(73)	(109)	(145)
Total NWL Health and social care	**(130)**	**(306)**	**(532)**	**(776)**	**(1,007)**	**(1,299)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.



** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

2020/2021

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

Target Population:

All adults: 1,641,500

Mostly Healthy Adults at risk of developing a LTC: 121,680

All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is <u>important</u> for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. Our residents who have a learning disability are also sometimes not receiving the fully support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Targeting people at risk of developing long term conditions and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This group includes approximately 120,000 people who are currently well but are at risk of developed an LTC over the next five years[11]. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Working across the system at both NW London and London level to address the wider determinants of health, such as employment, education and housing.
- Enabling children to get the best start in life, by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].
- Focusing on social isolation as a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs. Around 200,000 people in NW London are socially isolated and it can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Enabling and supporting healthier living**	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. Establish a NW London Primary Care Cancer Board which will look at improving public messaging/advertising around preventing cancers. Launch a NW London communications and signposting campaign to more effectively guide people to support, including voluntary and community, to improve care and reduce demand on services. As part of this we will: • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Training GPs and other staff in Health Coaching and 'making every contact count' to promote healthy lifestyle choices in patients • Delivering an enhanced 111 service driven by a new Directory of Services which will signpost service users to the appropriate service • Rolling out systematic case-finding to identify and support people at risk of diabetes, dementia or heart disease, using our Whole system IT platform • Promoting a community development approach to improve health by identifying local needs and sign-posting through services, such as, information stalls, children's support sessions, health awareness sessions, debt management and maternity drop-ins • Supporting Healthy Living Pharmacies to train Champions and Leaders to deliver interventions, such as smoking cessation • Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda	0.2	2.5
B	**Wider determinants of health interventions**	The healthy living programme plans will also cover how Boroughs will tackle wider determinants of health. In 16/17, local government already plans to deliver some interventions, such as: • Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability • Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems • Bidding for funds from the joint Work and Health Unit to support social prescribing of employment and interventions for those at risk of losing their employment	As part of the healthy living programme, local government, working jointly with health partners, will take the lead on delivering key interventions by 20/21 such as: • Introducing measures reduce alcohol consumption and associated health risks, e.g. licence controls, minimum pricing and promotions bans • Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities • Partner with organisations such as London Fire Brigade to jointly tackle the wider determinants of health such as social isolation and poor quality housing	3.3	6.5
C	**Addressing social isolation**	The healthy living programme plans will also cover how Boroughs will address social isolation. In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services	As part of the healthy living programme, we will implement key interventions such as: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation.	0.5	6.6

D	**Helping children to get the best start in life**	• NW London will invest part of its PMS premium income in increasing immunisation rates for key areas of need, such as the 5-in-1 Vaccine by 1 Year
		• Implement the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services
		• Collaborate with the vanguard programme and the children's team at NHSE in the development of new care models for children and young people (C&YP)
		• Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough
			• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work
			• Establish a Connecting Care for Children GP hub in the majority of localities where children live, building on 3 Borough work to:
			  • reduce high outpatient and A&E attendance numbers among C&YP
			  • promote healthy eating and obesity screening pathways (e.g. HENRY)
			  • Co-locating dental professionals and deliver dental hygiene training
			• Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity
				TBC	TBC

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is important for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Unwarranted variation covers all services, from the early detection of cancer, the management of long term conditions, and the length of stay in hospital to the survival rates from cancer and major surgery. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1) [7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from HLP's Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. We will align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18.	Through the Royal Marsden and Partners Cancer Vanguard, develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, thereby reducing variation in acute care and ensuring patients have effective high quality cancer care wherever they are treated in NW London	TBC	TBC
B	**Better outcomes and support for people with common mental health needs** **(with an initial focus on people with long term physical health conditions)**	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC
C	**Reduce variation by focusing on 'Right Care' priority areas**	Identified and commenced work in 2016/17 in following areas: • Mobilisation of National Diabetes Prevention Programme (commencing August 2016) • Further development of diabetes mentor/champion role within communities • Extend diabetes dashboards to other LTC, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD, enabling easy navigation through device-drug-dose considerations and supporting professionals and patients in reaching appropriate decisions and achieving adherence to therapy • The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care.	• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools • Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes • Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations • Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors • Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs • Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.	2	12.4
D	**Improve self-management and 'patient activation'**	• Identify opportunities for patient activation in current LTC pathways based on best practice – application for 43,920 Patient Activation Measures (PAM) licences in 2016/17 for people who feel overwhelmed and anxious about managing their health conditions	• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be immediately referred into expert patient training • Technology in place to promote self-management and peer support for people with LTCs • Increase availability of, and access to, personal health budgets, taking an integrated personal commissioning approach • PAM tool available to every patient with an LTC to help them take more control over their own care – planned increase in PAM licences to 428,700 • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from coordinated care and continuity with a named clinician to support them with LTCs	3.4	6.1

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

2020/2021

Target Population:

311,500

Contribution to Closing the Financial Gap

£82.6m

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is important for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnership(s) • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnership(s), with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	Implement new models of local services integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes in each of the eight boroughs and across NW London • Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working • Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers	18	26.3
D	Upgrade rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want. • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

2020/2021

Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is important for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. But we know that poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact.

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially handicapped by their condition and **10% will die by their own hand**.
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before you are 18.
- The number of people with serious and long term mental health needs in NW London is double the national average
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing.

Our aim in NW London is to improve outcomes for children and adults with mental health needs, we will do this by:

- Implementing a new model of care for people with serious and long term mental health needs, which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing wider determinants of health and how they relate to and support recovery for people with mental health needs
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need
- Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home. This includes Future in Mind and Transforming Care Partnerships work.

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	**Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy**	• More support available in primary care – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community (investment of c£12-13m)
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
			• Full roll out of the new model across NW London, including:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			• **The benefit to the patient will be tailored evidence based support available closer to home**
			 
				11	16

B	**Addressing wider determinants of health, e.g. employment, housing**	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care • **The benefit to the patient will be a happier, fuller way of living**	TBC	5
C	**Crisis support services, including delivering the 'Crisis Care Concordat'**	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS) LAS, Metropolitan police and other services – meeting access targets • Round the clock mental health teams in our A&Es and support on wards, 'core 24' • Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)	• Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis • **The benefit to the patient will be care available when it is most needed**	TBC	TBC
D	**Implementing 'Future in Mind' to improve children's mental health and wellbeing**	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

2020/2021

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is important for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Consolidate acute services onto five sites (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham– see Appendix A, condition 5).
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Specialised Commissioning**	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	**Deliver the 7 day services standards**	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C	**Configuring acute services**	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites	Reduce demand for acute services through investment in the pro active out of hospital care model. Work jointly with the council at Ealing to develop the hospital in Ealing and jointly shape the delivery of health and social care delivery of services from that site, including: • a network of ambulatory care pathways; • a centre of excellence for elderly services including access to appropriate beds; • a GP practice; and • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists.	33.6	89.6

D	**NW London Productivity Programme**	Implement and embed the NW London productivity programme across all provider trusts, focusing on the following four areas:
		• **Patient Flow**: address pressure points in the system that impacts on patient flow, patient experience and performance against key targets (e.g. 4 hour wait and bed occupancy).
		• **Orthopaedics**: mobilise and commence work around establishing a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT).
		• **Procurement**: assuming no mandation of the new NHS procurement operating model, establish the necessary enablers for collaboration to take forward sector-wide transformation in procurement and implement the Carter Review recommendations across the STP footprint[8]. These include establishing line of sight of sector-wide savings opportunities through agreed baseline reporting and on-going measurement of the benefits from collaborations, sector-wide visibility of contracts and establishing governance links to enable wider benefit of existing purchasing collaboratives (e.g. Shelford Group).
		• **Bank & Agency**: reduce agency spend across NW London; initiation of a range of workforce activities such as standardised pay and sector-wide recruitment. The sector is expected to reduce agency spend by £46m and deliver net savings of £32m.
			Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together through ACPs to constantly innovate and drive efficiency. Rolling programme of pathway redesign and patient flow initiatives to ensure trusts are consistently in the top quartile of efficiency. 17/18 plans against the initial delivery areas are set out below:
			• **Patient flow:** Implement system level initiatives in areas such as: improving access to GPs, better management of increasing volumes of ambulance attendances, integrated discharge processes from hospital and best practice A&E processing of patients.
			• **Orthopaedics:** Implement orthopaedics best practice based on Getting it Right First Time. Hip and knee replacements initial area of focus with estimated savings in the region of £2.6m to £4.0m across NW London, then roll out in full.
			• **Procurement:** 2016/17 will establish baselines enabling additional quantified benefits from 2017/18 onwards. Early impact areas include utilities, waste management, agency (linked with Bank & Agency workstream) and applying the GIRFT principles to commoditised purchasing for specific clinical areas.
			• **Bank & Agency:** build on work from 2016/17 , linking with South West London to share best practice. Key areas of focus are
			  • Strengthening recruitment to reduce vacancies
			  • Optimising scheduling to reduce demand
			  • Shifting usage from agency to bank to reduce costs
			  • Reducing unit costs for agency by increasing use of framework agencies and reducing rates through volume based contracts
				4.1*	143.4

*This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas	By 2020/21, Enablers will change the landscape for health and social care:		
	Estates will…	**Digital will…**	**Workforce will…**
1. Radically upgrading prevention and wellbeing	• Deliver **Local Services Hubs** to move more services into a community setting • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improving and changing our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• Deploy our **shared care record** across all care settings to improve care, reduce clinical risk, and support transition away from hospital • **Automate clinical workflows and records** and support transfers of care through **interoperability**, delivering digital empowerment by removing the reliance on paper and improving quality • **Extend patient records to patients and carers** to help them to become more digitally empowered and involved in their own care, and supporting the shift to new channels • Provide patients with **tools for self-management and self-care**, further supporting digital empowerment and the shift to new channels • Use **dynamic data analytics** to inform care decisions and target interventions, and support integrated health and social care with whole systems intelligence	• **Targeted recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers: Estates

Context

- The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.
- Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings.
- NW London has the opportunity to work across health and local government, promoting the 'One Public Estate' to leverage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.
- Some progress has been made towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £623m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs, due by end 2016
  - The hub strategy and plans include community Mental Health services, such as IAPT
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham – see Appendix A, condition 5).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local population
  - Trusts are currently developing their site proposals, which will feed into an overall N W London ask for capital from the Treasury, contained in the strategic outline case to be submitted this summer.

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:

- Local services hubs will provide the physical location to support prevention and out-of-hospital care.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:

Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7/7 access to all residents

Delivery Area 3 - Outcomes for older people:

- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of inpatient care

Delivery Area 4 - Supporting those with mental health needs:

Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

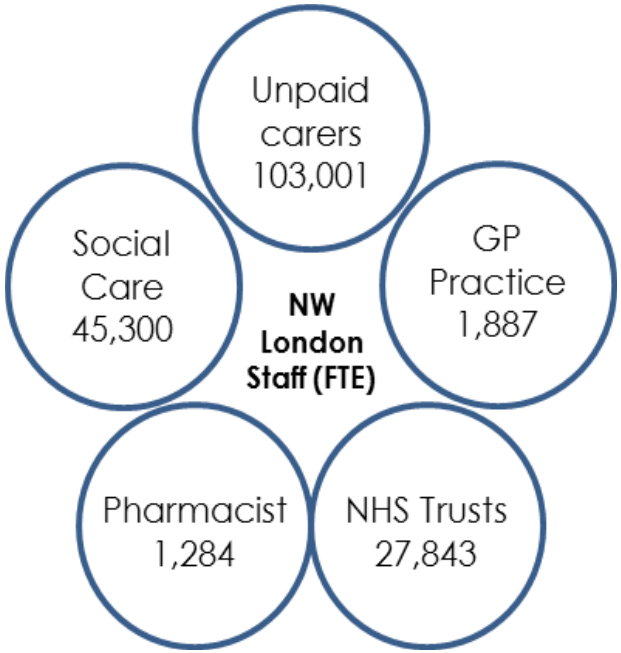
Delivery Area 5 – Providing high quality, sustainable acute services:

- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work and will be key to achieving our collective vision through delivering sustainable new models of care to deliver improved quality of care that meets our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. Carers are a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly expand work across social care[1].
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- Appropriate workforce planning and actively addressing workforce issues is instrumental in addressing the five delivery areas in the STP
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care. Nine physician associates currently work in NW London, with 32 commencing training in September. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 36 more paediatric nurses (37 more commence in September '16) and 3 consultants paediatricians (6 appointed to start in September '16, with plans to recruit 3 more).
- Building on this track record, **key enablers** will include the collaborative and partnership working between CCGs, Trusts, HEENWL and the CEPNs (Community Education Providers Network) to support workforce planning and development, and the HLP to utilise the established workforce planning infrastructure and expertise, build on strong foundations of on-going strategic workforce investment, and embed the findings outlined in HLP's London Workforce Strategic Framework.



What will be different in 2020[6]?

Our workforce strategy will address the following challenges to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Current Transformation Plans and Benefits

Addressing workforce shortages

- Through workforce planning and extensive stakeholder engagement NW London is understanding and addressing key workforce issues. For example, NW London is leading a centralised Pan-London placement management and workforce development programme for **paramedics** with an investment of over £1.5m

Improving recruitment and retention

- NW London has plans to step up recruitment. For example, by October 2016, there is planned recruitment of over 100 additional **nursing staff** and 7 additional **children's consultant medical staff** leading to more senior provision of children's care. Further initiatives include:
  - **Scale recruitment drives**; leveraging the benefits of working in NW London.
  - Development of varied and **structured career pathways** and opportunities to **taper retirement**.
  - **Skills exchange** programmes between nurses across different care settings.
- **Promoting careers in primary care** by providing student training placements across professions to introduce this setting as a viable and attractive career option.
- Supporting the **implementation of 7 Day Services** by designing a framework to support career development and retention in radiology. Addressing workforce shortages will also support the development of the Cancer Vanguard.
- A **structured rotation programme** will support 200 nurses to work across primary and secondary care (including key areas such as mental health and care of the elderly).
- NW London's trusts will work collaboratively to **reduce reliance on agency** nurses (current spend: £172m pa on bank/agency[7])

Workforce Transformation across health and social care workforce to support integrated care

- Embedding **new roles** to support the system including: Physician's Associates, Care Navigators, Clinical Pharmacists, Peer Educators (support worker that can share experiences of mental health), and Nurse Associates.
- **Hybrid roles and developing career pathways** across health and social care will be important in the long term.
- Significant investment into Dementia, Community and Neonatal Nursing, Apprentices and the bands 1-4 workforce.
- **Optimising GPs' time** by understanding how we can develop the primary care workforce (including **practice manager development**) to redeploy GP workload where possible and increase the capability to deliver the business requirements of GP networks(Day Of Care Audit).
- **Supporting self-care** through use of patient activation measurements and Health Coaching training to help staff to have motivational conversations with patients, to empower them to set and achieve health goals, take greater responsibility for their health, and grow in confidence to self-manage conditions

Leadership and Organisational Development to support future services

- **Collective, system leadership,** will be key to the success of ACPs. Leadership development will be broader than senior leadership level; empowering MDT frontline practitioners to lead and engage other professionals and take joint accountability across services will be integral to success.
- Leadership and change management programmes will foster innovation, build relationships and trust across multi-disciplinary, cross organisational teams to deliver integrated new ways of working. The **Change Academy** will use an applied learning approach and will be underpinned by improvement methodology (38 leaders supported in phase 1)
- **Commissioning for outcomes** based programmes
- Leadership development forums will include the **GP Emerging Leaders** (providing NW London-wide workshops, mentoring, and sharing of local intelligence and education) and Transformation Network
- More effective ways of working achieved through the **Streamlining London Programme** across Trusts
- Adopting a collaborative approach to embed **health and wellbeing initiatives and ambassadorship** through the Healthy Workplace Charter

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- **Health Coaching** training will help staff to have motivational conversations with patients to take greater responsibility for their health, and grow in confidence to self-manage conditions.
- To ensure carers, the largest proportion of our workforce, are supported, we will expand the programme in 2017/18, to build carers' skills around setting achievable health and wellbeing related goals for patients.
- The NW London **Healthy Workplace Charter** will embed staff health and wellbeing initiatives and ambassadorship
- Primary care and specialist community nurse workforce development

Delivery Area 2 - Reducing variation:

The framework to retain staff and support career development in radiology will help address shortages and support **implementation of 7 Day Services** and **Cancer Vanguard**. Growth in primary care and bespoke project work on LTCs prevalent in NW London such as diabetes and heart disease.

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g.: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- **Optimising GPs' time** by developing the primary care workforce (e.g. **practice manager development**) will increase capability to deliver the business requirements of GP networks
- Leadership development forums will join up practitioners, providing NW London-wide workshops, opportunities to network and share local intelligence
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs will graduate in June 2016 with an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses and thereby the cost of service
- The **Change Academy**, underpinned by improvement methodology and alignment to achieving productivity gains will support cross-boundary working and support financial sustainability of services.

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London Informatics, and has made good progress with Information Governance across care settings. All of the eight CCGs have a single IT system across their practices and six of the eight CCGs are implementing common systems across primary and community care, and have a good track record in delivery of shared records, for example, through the NW London Diagnostic Cloud.
- The NW London Care Information Exchange is under way, funded by Imperial College Healthcare charity. This technology programme gives individuals a single view of information about their care across providers and platforms, allows sharing of information, and provides tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne.
- There is good support from NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London exchange, record locator, and IG register.

Key Challenges

- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access and retain information about the patient[1]. A potential mitigation is to share care records and converge with other Local Digital Roadmaps (LDR) via universal NHS systems.
- Due to different services running multiple systems, there is a dependence on open interfaces to deliver shared records, which primary and community IT suppliers have failed to deliver. This will require continued pressure on suppliers to resolve.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is required from NHSE to define and fund interfaces nationally.
- Clinical transformation projects have in the past been very costly and taken a long time to deliver, which need to be allowed for in the LDR plans
- There is a lack of digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.

Strategic Local Digital Roadmap Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, **removing the reliance on paper** and improving quality
2. **Build a shared care record** across all care settings to deliver the **integration of health and care records** required to support new models of care, including the transition away from hospital
3. **Extend patient records to patients and carers,** to help them to become more **digitally empowered** and involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their care, further supporting **digital empowerment** and the shift to new channels of care
5. **Use dynamic data analytics** to inform care decisions, and support integrated health and social care across the system through **whole systems intelligence**

Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**, where much work has already been done
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education

3. Enablers: Digital

STP Delivery Area	Digital STP Theme	Key Impacts on Sustainability & Transformation Planning
1. Radically upgrading prevention and wellbeing	• Deliver digital empowerment • Integrate health & care records	**Enhancing self care:** • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange** to support them to become expert patients • Innovation programme to find the right **digital tools** to help people **manage their health and wellbeing**; **create online communities** of patients and carers; and to get children and young people involved in health and wellness **Embedding prevention and wellbeing into the 'whole systems' model:** • Support integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care-plans)
2. Eliminating unwarranted variation and improving LTC management	• Integrate health & care records • Whole systems intelligence • Deliver digital empowerment	**Improving LTC management** • Deliver Patient Activation Measures (PAM) tool for every patient with an LTC to promote self management and develop health literacy and expert patients • **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability and development of a share care record to deliver the **integration of health and care records and plans** • Patient engagement and self-help training for LTCs to help people manage their conditions and interventions **Reducing variation** • Integrated care dashboards and analytics to track consistency of outcomes and patient experience • Support new models of multi-disciplinary care, delivered consistently across localities, through shared care records
3. Achieving better outcomes and experiences for older people	• Deliver digital empowerment • Integrate health & care records • Whole systems intelligence	**Provision of fully integrated service delivery of care for older people** • Enable citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange**, **remote consultations** (e.g. videoconferencing) and **telehealth** • Support discharge planning and management, new models of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care • **Integrate Co-ordinate My Care** (CMC) with acute, community and primary care systems and promote its use in CCGs, where usage is currently low, through education and training and support care planning and management • **Shared information and infrastructure** to support new primary care and wellbeing hubs with mobile clinical solutions • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care dashboards have been deployed to 312 GP practices to support co-ordinated and proactive patient care, with a plan to expand to all 400 practices by 2020/21
4. Improving outcomes for people with mental health needs	• Integrate health & care records • Whole systems intelligence	**Enabling people to live full and healthy lives** • Innovation programme to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities **New model of care** • Support new care delivery models and shared care plans through **shared care records and care plans** **24/7 provision of care** • Support new models for out-of-hours care through **shared care records**, such as **24x7 crisis support services**
5. Ensuring we have safe and sustainable acute services	• Deliver digital empowerment • Integrate health & care records	**Investing in Hospitals** • Support new models for out-of-hours care through **shared care records and the NW London diagnostic cloud**, such as 24x7 on-call specialist and pan-NW London radiology reporting and interventional radiology networks in acute • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Integrated out-of-hours **discharge planning and management** through shared care records • **Dynamic analytics** to track consistency and outcomes of out-of-hours care

4. Primary care in NW London

Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. GPs are not only the first point of contact for the majority of residents, but also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

There are, nevertheless, significant challenges. These include:

- dramatic projected increases in the number of older people presenting with multiple and complex conditions, fuelling demand for GP appointments and a greater co-ordinating function within primary care – the number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26;
- 27.1% of the GP and nurse workforce is aged over 55 and 7.4% aged over 65, which represents a significant retirement bubble;
- front-line delivery pressures that are contributing to recruitment and retention challenges, whilst lowering the morale of GPs and their primary care colleagues; and
- inadequate access to primary care, contributing to a patient-reported experience of GP services significantly below the national average.

These and other challenges require fundamental changes to the design and delivery of primary care, within the context of NW London's broader system transformation across health and social care. The NW London CCGs' plan for this is described in this document.

Some other statistics: achievements and challenges

- The NW London CCGs score above the London average for 6 out of 7 facets for co-ordinated care, based largely on the achievements made through the Whole Systems Integrated Care national pioneer programme
- The NW London CCGs score above the London average for 6 out of 13 facets for accessible primary care consultations (including telephone, email, and video consultations)
- 23% of the NW London practices so far inspected by the CQC ratings are performing below the national average
- 60% of people with a long-term condition feel supported to manage their condition – below the national average of 67%.

Some of our achievements so far

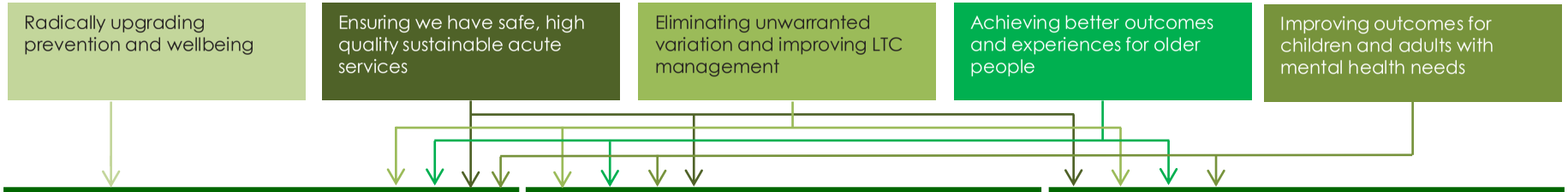
- NW London is the largest national pilot site for the Prime Minister's Challenge Fund, covering 365 practices and 1.9m people. This investment has improved patient access to general practice and supported the development of at-scale organisations in primary care. The CCGs are now working with NHS England to build on this achievement through the new Prime Minister's Access Fund investment announced in the GP Forward View.
- 280,000 patients can access web-based consultations .
- 60,000 patients can access video consultations.
- 97% of practices offer online appointment booking.
- Joint co-commissioning is embedded in NW London . Over recent months each joint committee has agreed its PMS review commissioning intentions, as a first instalment to equalising the patient offer in each CCG, and recommended estates bids to the Estates and Technology Transformation Fund
- Integrated care data dashboards have been piloted in eight practices, with a rollout plan prepared for 350 practices within 12 months. The dashboards link the past two years of patient-level data from acute, primary, community, and mental health, enabling patient journeys through the health system to be tracked and their care to be improved where appropriate.
- Contracts covering 19 services have been let at federation-level across five of the eight CCGs enabling a consistent service offering to the whole population.

Additional work already under way

- CCG self-care leads and lay partners across NW London have co-produced a self-care framework. This includes patient activation measurement that is to be piloted in approximately 200 GP practices by March 2017.
- 180 Healthy Living Pharmacies have been commissioned for 2016/17. They will train Health Champions and Healthy Living Pharmacy Leaders to support local communities with wellbeing interventions such as smoking cessation.
- Hillingdon and Ealing CCGs are providing a Minor Ailments Scheme, allowing patients to self-medicate when appropriate, reducing the impact on primary care. We plan to roll this scheme out across NW London by 2018/19.
- 32 Physician Associates places have been commissioned at Buckinghamshire New University and Brunel University, starting later in 2016.
- The Clinical Pharmacists in General Practice pilot is underway at 23 GP practices in NW London .
- The CCGs plan to make seven collective technology bids to the Estates and Technology Transformation Fund. These will cover areas including digitally-enabled patients, videoconferencing, integrated telecoms and patient management systems, and care home pilots.
- On-going work on local implementation of the 10 Point Plan for workforce includes: a recruitment evening session at Northwick Park Hospital for Foundation Year Doctors, the national thunderclap campaigns organised by HEE, and Joint work with the Foundation School and Medical School to attract new GP Trainers into local training programmes.

4. The future of primary care in NW London

NW London has a clear set of primary care outcomes that the CCGs will support providers to deliver over the next five years. These are shown below, along with how they map onto the five delivery areas to illustrate the crucial role that primary care has in delivering the NW London STP.



Proactive care	
Co-design	- primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
Developing assets and resources for improving health and wellbeing	- primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community
Personal conversations focused on an individual's health goals	- where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	- primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
Patients not currently accessing primary care services	- primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Accessible care	
Patient choice	- patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs
Contacting the practice	- patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations)
Routine opening hours	- patients can access pre-bookable routine appointments with a primary health care professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	- patients can access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
Same-day access	- patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network
Urgent and emergency care	- patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately
Continuity of care	- all patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate

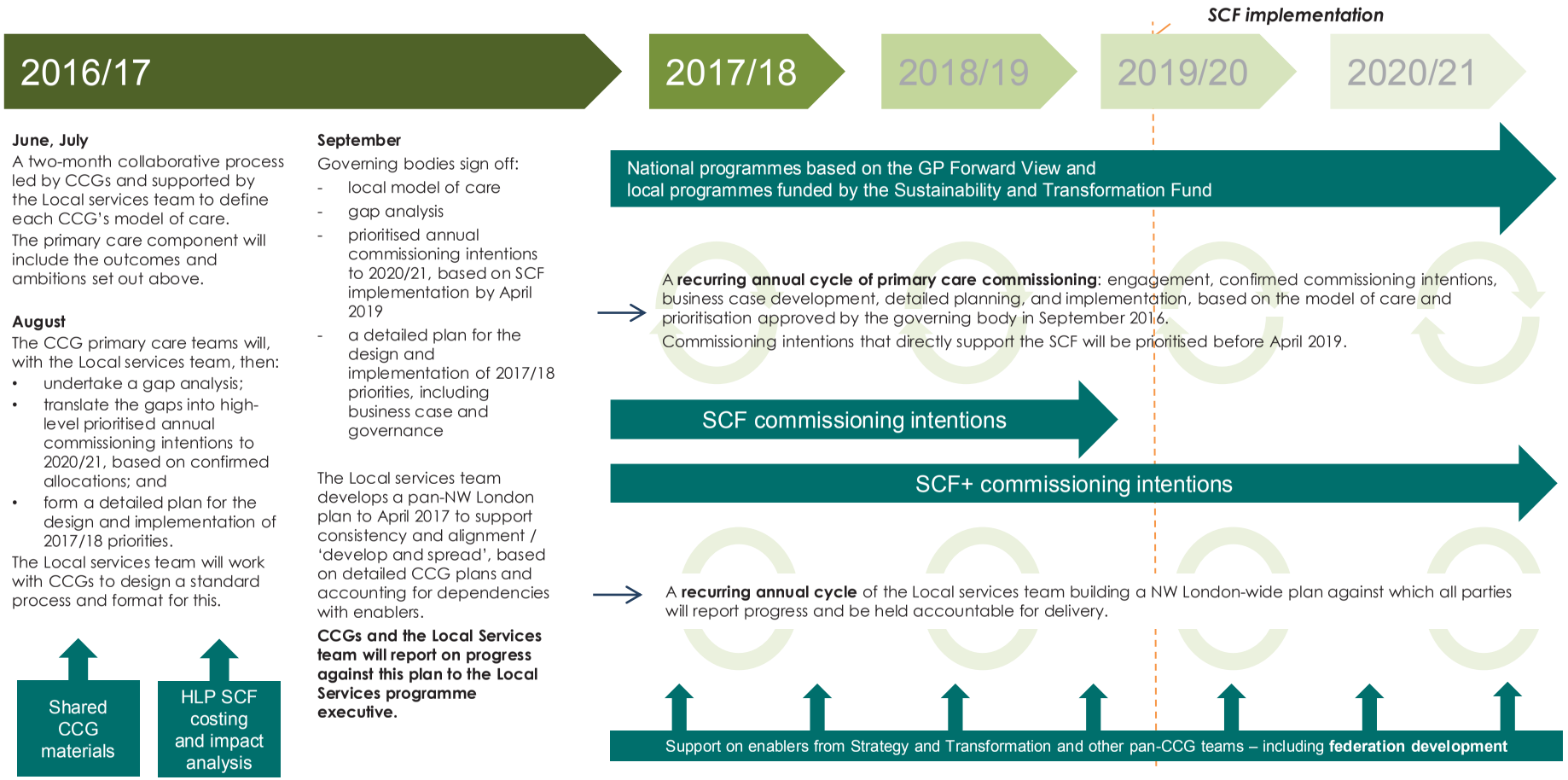
Co-ordinated care	
Case finding and review	- practices identify patients, through whole systems data analytics, who would benefit from coordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis
Named professional	- patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	- each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in their care
Patients supported to manage their health and wellbeing	- primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing, including through health coaching, future digital tools and other forms of education
Multi-disciplinary working	- patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. Care will be coordinated via shared electronic care records.

4. Delivering the ambitions of the primary care strategy

Following the NW London-wide development of ambitions and outcomes for primary care, the CCGs are now working with primary care providers to agree how this will be delivered in each borough in a way that meets the needs of their local populations. The draft process is shown below. This will be the basis of the design and delivery of annual commissioning intentions each year until 2020/21, with delivery of the SCF achieved by the end of 2018/19.

This will ensure that the increases to the NW London primary care medical allocations (shown in the table below) are invested in a way that delivers maximum benefits to patients, alongside the national programmes – such as the Prime Minister's Access Fund, from which NW London might be able to access approximately £12m in 2016/17 – announced in the GP Forward View.

NW London CCGs	2016/17	+£19.3m	2017/18	+£11.8m	2018/19	+£11.5m	2019/20	+£15.6m	2020/21
	£279.97m		£299.26m		£311.03m		£322.50m		£338.07m



5. Finance:
Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that at an STP level there is a surplus of £50.5m and there is a small, £31m gap to delivering the business rules (i.e. including 1% surpluses).

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care	
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**	**note 1**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7	**note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	(4.0)	-	(4.0)	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	15.6	8.0	23.6	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	(5.4)	-	(5.4)	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	18.5	-	18.5	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	(52.3)	-	(52.3)	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	134.9	33.1	168.0	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	(11.0)	-	(11.0)	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	22.8	6.4	29.2	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	(45.6)	-	(45.6)	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	254.5	15.0	269.5	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)	**note 4**
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0	**note 4**
Other	-	-	-	188.3	-	-	188.3	63.0	251.3	
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**	
Residual Gap (see note)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**	
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**	
				note 5				**note 3**		

Note: The financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since April '16 STP due to changes in the underlying position of organisations and social care, inclusion of 1% gap requirement on Trusts, NHSE spec comm gap for the Royal Brompton, removal of 16/17 CIP and the inclusion of Primary Care.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable)

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

The key financial challenge that remains at 2020/21 is the deficit at the Ealing site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging. This deficit could be eliminated if acute services changes were accelerated, generating a further improvement in the sector position of £62m.

The key risk to achieving sector balance is the delivery of the savings, both business as usual and the delivery areas. There will be a robust process of business case development to validate the figures that have been identified so far and the next section of the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered.

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

5. Finance:
Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a 1% surplus for the NHS.

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

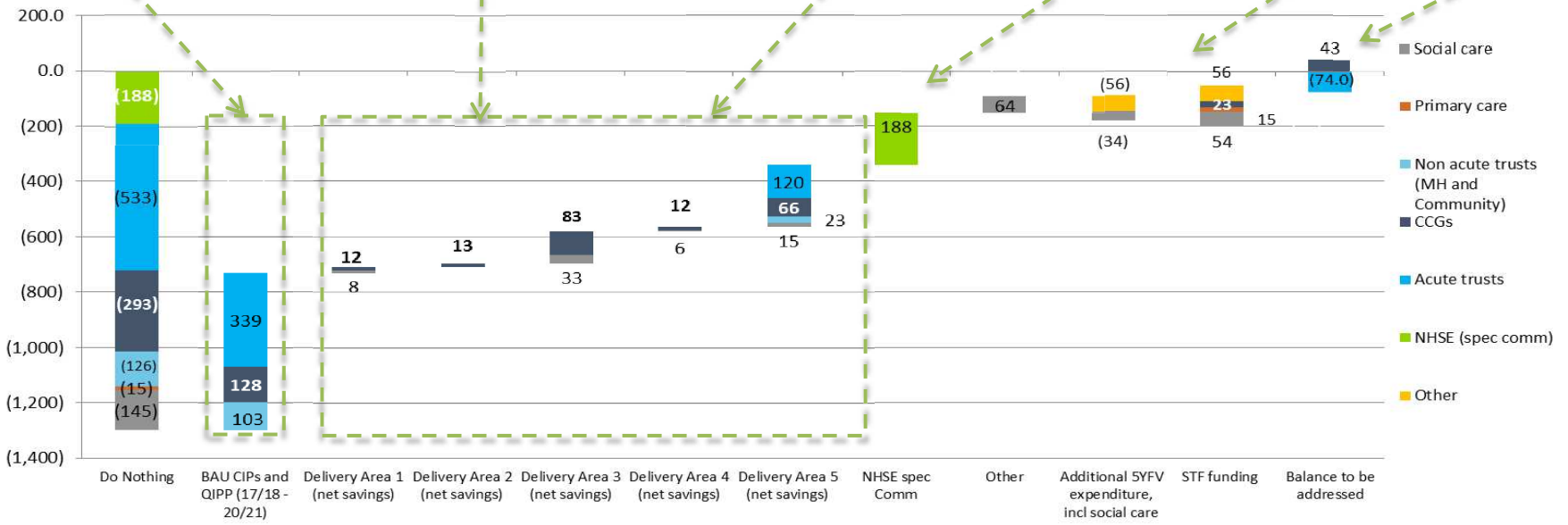
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

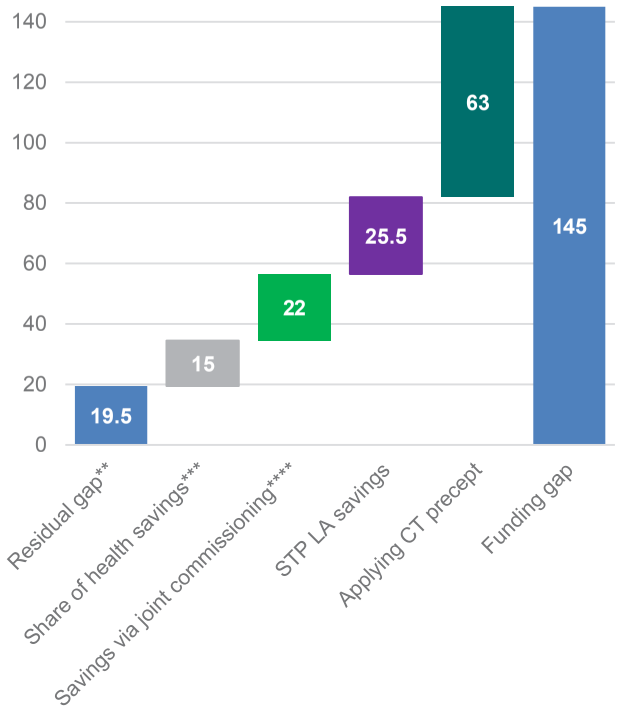
Balance to be addressed Remaining gap of £31m to be addressed – post 20/21.



5. Finance:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	-	2.0	2.0	2.2
Demand management & community resilience	DA2	-	-	-	6.1
Caring for people with complex needs	DA3	-	-	-	5.1
Accommodation based care	DA3	7.7	-	7.0	2.0
Discharge	DA3	3.4	-	3.4	9.6
Mental Health	DA4	3.5	2.9	6.4	5.0
Vulnerable	DA1	3.0	3.0	6	-
Total savings through STP investments		17.6	7.9	25.5	30.0
Joint commissioning	DA3	22.0	-	22.0	TBC
Total savings		39.6	7.9	47.5	30.0

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

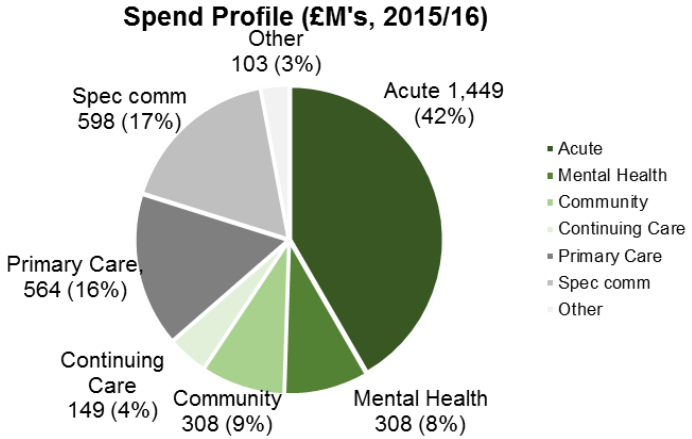
NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

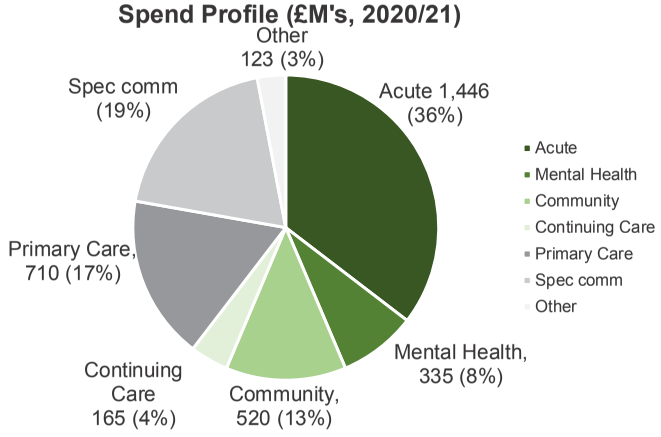
5. Finance:
STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. This is set out below, and shows our expectation of where we expect to invest the funding recurrently from 2020/21.

	16/17	17/18	18/19	19/20	20/21	
	£m	£m	£m	£m	£m	
Sustainability funding	-	112.4	82.3	61.6	0.0	
Investment in prevention and social care	-	21.0	25.0	30.0	34.0	£53.5m
Social care funding gap	-	-	-	-	19.5	
Seven day services	3.0	4.0	7.0	12.0	20.0	
Mental health transformation and invetment in services - integrated care models	0.0	10.0	10.0	13.0	20.7	
Federation and primary care development	5.0	10.0	10.0	5.0	0.0	£55.7m
Support new payment models design and implementation	3.0	10.0	10.0	5.0	0.0	
Digital roadmap	-	3.0	10.0	10.0	15.0	
Improvement resources	2.0	2.0	2.0	0.0	0.0	
Additional investment in primary care services	0.0	1.0	12.0	19.0	14.8	
Uncommitted funding	0.0	0.0	0.0	0.0	23.0	
TOTAL	**13.0**	**172.4**	**156.3**	**136.6**	**147.0**	

The charts below show how the delivery of the STP will change the commissioner expenditure profile over the next 5 years as we move from a reactive system to a proactive care model. Acute spend by CCGs reduces from 42% to 36% of total spend, while primary and community care spend increases from 25% to 30%. Mental health spend stays the same as a percentage of the total but the expenditure increases and the way in which the money is spent shifts towards community based rather than acute based interventions, enabling increased demand to be managed. Some increased mental health spend is also included within the main primary care and community expenditure totals.





5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £783m (funded by £573m from internal resources, £37m from disposals and £173m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period and the subsequent five years. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

Table 1: Do Something Capital

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	**747.9**
Disposals and contingency	-	(330.0)	-	-	**(330.0)**
Total Net Capital Requirements	**75.2**	**(82.6)**	**219.2**	**206.1**	**417.9**
Post 20/21					
Gross Capital Expenditure	252.5	1,116.0	4.5	97.1	**1,470.1**
Disposals and contingency	29.0	(681.2)	23.0	-	**(629.2)**
Total Net Capital Requirements	**281.5**	**434.8**	**27.5**	**97.1**	**840.9**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: Projected costs, land sale receipts and affordability, particularly in the second five year period, are indicative and subject to detailed business case processes

Other Additional Capital – there are additional capital cases of £303m made up of: (1) £141m for LNWH for additional investment in NPH and CMH including, ICT and EPR and other IT; (2) £53m for backlog maintenance for THH relating to the tower; (3) £79m for CNWL for strategic developments; and (4) ETTF IT Digital roadmap of £31m.

To address the sustainability challenge at Ealing hospital would require the acceleration of the capital developments and approvals process (within the 'Outer NWL'. If that were achieved the capital profile would change, with the estimated position shown below :

Table 2: Accelerated timeline

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Total Net Capital Requirements	**249.9**	**(82.6)**	**219.2**	**206.1**	**592.6**
Post 20/21					
Total Net Capital Requirements	**106.8**	**434.8**	**27.5**	**97.1**	**666.1**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: The table shows the re-phasing without any assumed inflation saving (estimated to be c. £30m)

The funding for above capital ask will be a mixture of loans and PDC, which will modelled within individual business cases.

6. How we will deliver our plan:
Our NW London Delivery Architecture

To deliver this change at scale and pace will require the system, us, to work differently, as both providers and commissioners. At its heart, this requires shared commitment to an agreed vision, a credible set of plans and the right resources aligned to those plans. We know this both from the literature but more critically through our own experiences and track record of delivery change. Therefore we are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. **Agree a joint NW London implementation plan for each of the 5 high impact delivery areas**
2. **Shift funding and resources to the implementation of the five delivery areas, recognising funding pressures across the system and ensure we use all our assets**
3. **Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities**
4. **Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital**

1. Develop a joint NW London implementation plan for each of the 5 high impact delivery areas

We will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We have built upon previous successful system wide implementations to develop our standard NW London improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges. This has been codified in the common project lifecycle, described below, with common steps and defined gateways:

Critical success factors of the standard methodology include a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. Models of care are developed jointly to create ownership and recognise local differences, and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, 7 day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures and complementary skills across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

- We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
- We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
- We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

To further support the alignment of resources we are mapping and reviewing the total improvement resources across all providers and commissioners, including the AHSN, to realign them around the delivery areas to increase effectiveness and reduce duplication. The diagram on the next page also indicates where the various delivery areas are being supported:

NW London Collaboration of CCGs Strategy & Transformation Team *Commissioner* ~ 80-100 staff	**West London Alliance Local Government** Work in progress to allocate key L G staff	**Academic Health Sciences Network (Imperial College Health Partners)** AHSN ~ 8 staff	**Provider Transformation/ Productivity (CIP)/ Integration Teams** *Providers* ~ 90 staff
DA1 a) Enabling and supporting healthier living			Business as usual CIP
	DA1 b) Wider determinants of health interventions		DA2 c) Delivering 'Right Care' priorities
	DA1 c) Helping children get the best start in life		DA4 c) Crisis support and Crisis Concordat
DA1 d) Addressing social isolation			DA5 a) Specialised Commissioning
DA2 a) Improving cancer screening			DA2 a) Improving cancer screening
DA2 b) Better outcomes and support for people with common MH			DA5 b) Delivering the '7 day standards'
DA2 d) Improving self management and patient activation			DA5 c) Configuring acute services
DA3 a) Improving market management and whole systems approach			DA5 d) NW London provider productivity programme
DA3 b) Implementing Accountable Care Partnerships (ACPs) by 2018/19			
DA3 c) Implement new models of local services			
DA3 d) Upgrade rapid response/IC services			
DA3 e) Creating a single discharge process			
			DA3 f) Improving last phase of life
DA4 a) New model of care for people with serious and long term mental health needs			
DA4 b) Addressing wider determinants of health			
DA4 d) Implement Future in Mind			
DA5 b) Delivering the '7 day standards'			
DA5 c) Configuring acute services			

Over time, we are seeking further alignment and integration between these teams, to avoid duplication and align the relevant people and skills to the most appropriate programmes of work

6. How we will deliver our plan:
Our NW London Delivery Architecture

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

- We are moving towards federated primary care primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system
- By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements
- By 20/21 we will have implemented Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

Latest progress with the provider productivity programme

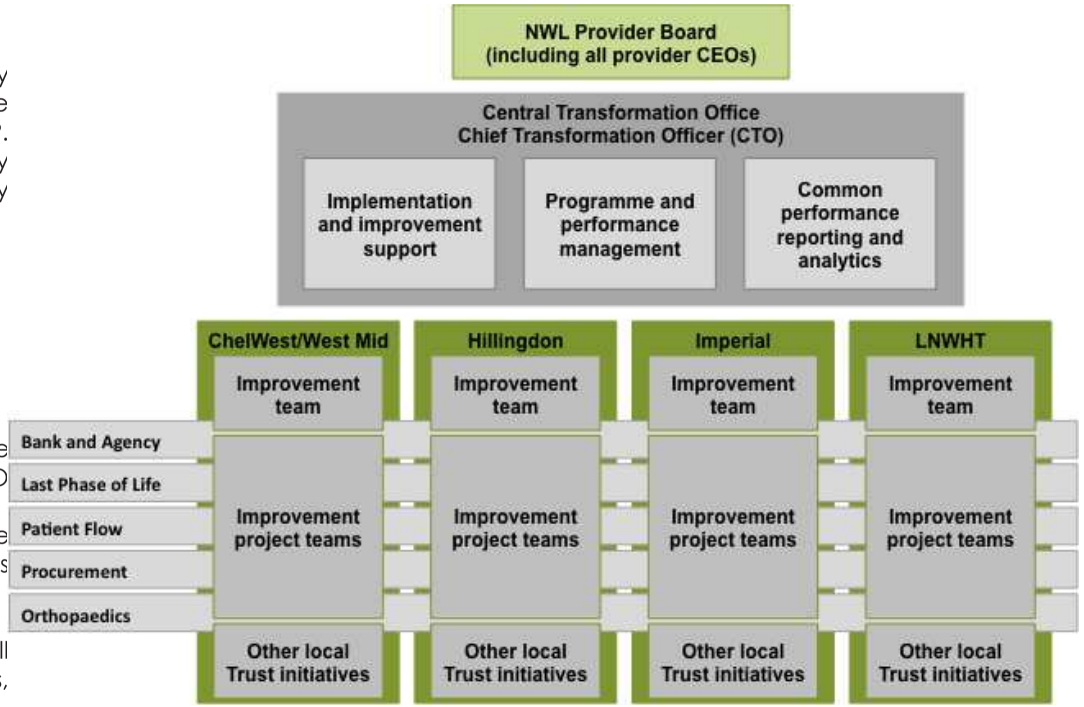
Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review. These opportunities are detailed in the STP. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery the priority projects of:

- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.
To achieve this providers are working together to:

- Recruit a sector transformation director to lead the programme, with analytics funded by CCGs and PMO provided by ICHP.
- Programme directors are now in place for all but one programmes, programme directors and project managers funded by acute trusts.

As a result savings are expected in year from procurement, all trusts expecting to deliver their bank and agency targets, planning for a pan NW London bank by the end of the year.



6. How we will deliver our plan:
Risks and actions to take in the short term

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	Development of a dashboard and trajectory, and regular monitoring of progress through joint governance Adoption of learning from vanguard and other areas	Access to learning from vanguards and other STPs
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	On-going quality surveillance to reduce risk	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	Support development of federations Early investment in primary care through joint commissioning Identification and support to vulnerable practices Digital solutions to reduce primary care workloads	Clarity about future of and funding for GMS and PMS core contracts
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	Development of joint market management strategy On-going support to homes to address quality issues	
Can't get people to own their responsibilities for their own health	Self care and empowerment	Development of a 'People's Charter' Work with local government to engage residents in the conversation	National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints	Finance and estates	Submit a business case for capital in summer 2016 Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment.	Support for retention of land receipts for reinvestment, and potential devolution asks.
We are unable to access the capital required to increase capacity at the receiving hospitals quickly enough to address the sustainability issues at Ealing hospital	Finance and estates	Submit a business case for capital in summer 2016 that sets out the clinical and financial rationale to accelerate the timeline	Support for an accelerated timeline for the capital business cases
We are unable to recruit or retain workforce to support the old model while training and transforming to the new model of care	People and workforce	Development of workforce strategy, close working with HEENWL	

6. How we will deliver our plan:
Risks and actions to take in the short term

Risks	Category	Proposed mitigations	Support from NHSE
There is resistance to change from existing staff	People and workforce	OD support and training for front line staff Wide staff engagement in development of new models to secure buy in	
Providers are unable to deliver the level of CIPs required to balance their financial positions	Finance and sustainability	Establishment of new sector wide improvement approach to support the delivery of savings	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	Establishing a new political relationship and reflecting this in enhanced joint governance, taking a 'whole systems view' to investment and market management	
BI systems aren't in place to enable shifts of activity through integrated care	Information and technology	Work within new national standards on data sharing to support the delivery of integrated services and systems.	NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality
Lack of interoperability in our primary and community IT systems, EMIS and SystmOne, which prevents shared care records which support integrated care	Information and technology	Keep pressure up on supplier to deliver open interfaces.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	Work closely with partners to understand the 'Brexit' implications and provide staff with support to ensure they feel valued and secure.	Early clarity of impact Political messaging to staff

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
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Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
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Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	25-26	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
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Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	29-31	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
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7. References

Section	Slides	References
Enablers: Workforce	35-36	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
Enablers: Digital	37-38	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

NHS Brent Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

NHS Harrow Clinical Commissioning Group

NHS Hillingdon Clinical Commissioning Group

NHS Hounslow Clinical Commissioning Group

NHS West London Clinical Commissioning Group

Brent

Harrow Council London

Hillingdon London

London Borough of Hounslow

The Royal Borough of Kensington and Chelsea

City of Westminster

West London Mental Health NHS Trust

Central and North West London NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

London North West Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Hounslow and Richmond Community Healthcare NHS Trust

The Royal Marsden NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust

London Ambulance Service NHS Trust

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

NHS Health Education North West London

NHS England

NHS National Institute for Health Research Clinical Research Network North West London

Imperial College Health Partners

wla West London Alliance

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NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

APPENDICES

List of appendices

Appendix A: Local Government statement

Joint Statement from the eight boroughs on Health and Care Collaboration in North West London

All eight boroughs in NW London welcome the opportunity to improve the outcomes for local people and communities

- Local Government and Health partners in North West London (NWL) are committed to working together to design a sustainable health and care system that improves outcomes for our communities
- We recognise the huge financial and demographic challenges facing public services over the next five years and acknowledge our duty to work together as system leaders to create a sustainable health and care system, whilst retaining our rights as sovereign organisations to help our communities get the outcomes they need
- We support person-centred health and care that enables increased numbers of older people and those with disabilities to access clinical and social care in community settings whenever appropriate
- We welcome joint working with the NHS to prevent health problems occurring and to improve the wellbeing of local people. We are committed to working together to deliver integrated health and social care systems that provide the highest quality out-of-hospital services for residents
- The councils covering North West London will work closely with NHS partners to implement work in these areas, building on our strong track record of partnership delivery

In order to deliver the ambitions of the STP, all eight boroughs also agree that the following conditions must be reflected in the STP document itself:

1. Explicit reference to how the NHS will help to close the £145m social care funding gap, through investment in prevention and integration services
2. Explicit reference to the need to map and invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government
3. Explicit reference to plans to significantly expand pooled budgets and joint commissioning for delivery of integrated and out of hospital care, especially for older peoples services, to support the development of the local and NW London market
4. Explicit reference to a devolution proposition around local retention of capital receipts from estates and joint commissioning of all out of hospital care, with resources allocated to deliver it. This in no way infers any assumptions about acute reconfiguration
5. There will be no substantive changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met
6. A commitment from NHS partners to review with local authority partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes
7. A commitment to work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety and quality concerns and expected demand pressures

Any changes to this agreement will be subject to joint review based on agreed criteria with local authority partners and communities.

Concerns still remain around the government's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in north west London or downgrade the status of Ealing or Charing Cross hospitals, including A&E services

We recognise that there is significant work still to do to develop a genuinely joint approach and reach agreement on any hospital changes in these areas. At the same time, the boroughs recognise the significant opportunity to work together to invest in better care for local residents

To move forward, our boroughs ask that NHS partners commit to work jointly to:

- develop an agreed approach to the delivery of the commitments, following the 30 June checkpoint
- develop an acceptable set of review criteria for any changes
- strengthen the supporting data and evidence base, and understand the financial risks and benefits and overall business case across health and care by October 2016
- agree a 'review point' in 2018 to review the agreed criteria
- co-produce the final plan with leaders, clinicians and the public from June through to October 2016

Appendix B: Leadership and governance

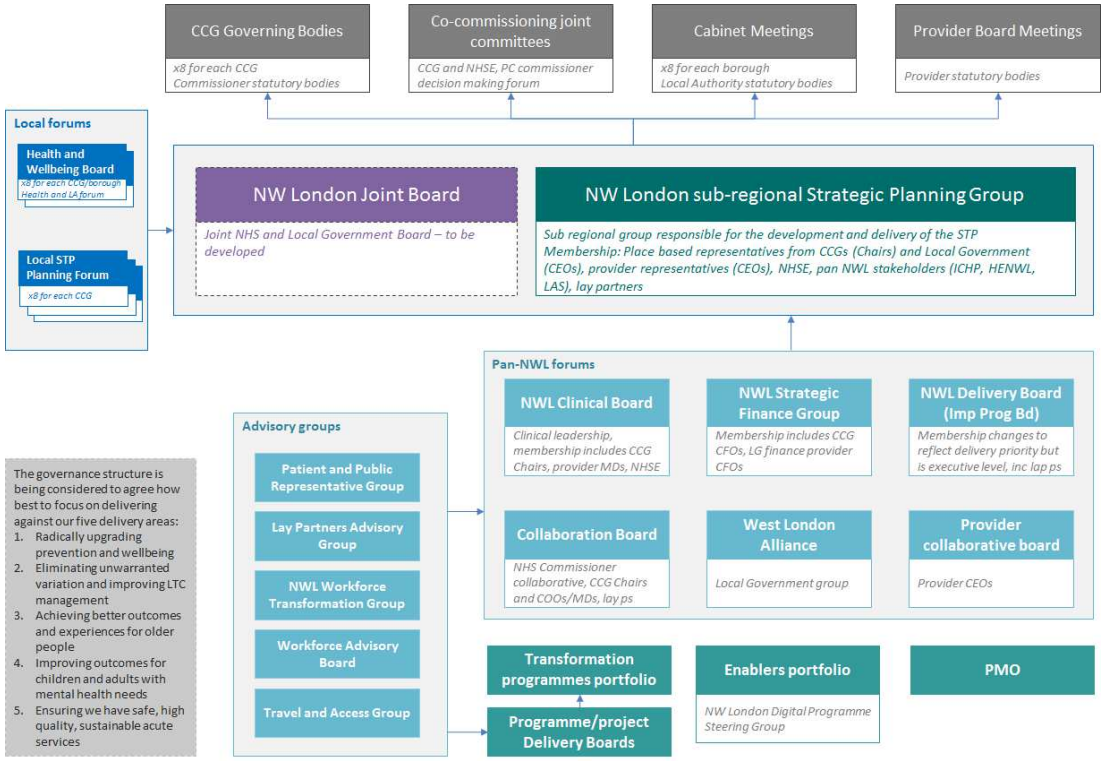
NW London has meaningful leadership and robust governance to drive transformational change

There is a history of collaboration at a sub-regional level in NW London across both health and local authorities. To help us work most effectively we have in place a robust governance structure and leadership arrangements.

NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership.

With the development of the STP, we have strengthened our ways of working. NHS and Local Government partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy. We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government STP partners for each of the five delivery areas and three enablers. Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

Incorporating the individual's voice, clinical expertise and our managerial functions, we are operating in the following structure to develop and implement the STP:



STP Leadership Team

The STP is led by the appointed STP System Leadership Team, which meets weekly and includes representation from all of the key stakeholder groups in our system:

Dr Mohini Parmar *System Leader*
(Ealing CCG Chair)

Carolyn Downs *Local Authority Lead*
(Chief Executive, Brent Council)

Clare Parker *Joint NHS Commissioner SRO*
(Chief Officer CWHHE CCGs)

Dr Tracey Batten *Provider Lead*
(Chief Executive, Imperial College Healthcare Trust)

Rob Larkman *Joint NHS Commissioner SRO*
(Chief Officer BHH CCGs)

Matt Hannant *STP Programme Director*
(CCG Director of Strategy & Transformation)

Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
1. How are you going to prevent ill health and moderate demand for healthcare?	**Priority 1:** Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-22	• 5 of the 8 boroughs in NW London are part of the Diabetes Prevention Programme Pilot • PMS review - move to equitable provision of preventive screening and immunisation, targeting prevalence across CCGs potentially depending upon commissioning intentions • 6 of 19 primary care hubs up and running in NW London • Model of care work and federations - based on principle of commissioning for the whole population in order to address health inequalities • Risk stratification enabling care planning for high risk individuals • Patient activation measurement tool rolled out across NW London
2. How are you engaging people, communities and NHS staff?	**Priority 1:** Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves **Priority 4:** Reduce social isolation	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-11 **Enabler:** Workforce (Pages 35-36) **Enabler:** Digital (Pages 37-38) **Appendix C:** Co-production, communications and engagement with service users, partners and staff (Pages 5-6)	• Embedding co-production throughout our transformation, supported by the Lay Partner Advisory Group • Expert Patient Programmes in some CCGs • Federation commitment to engaging people and communities e.g. all practices have a Patient Participation Group • All CCGs signed up to healthy workplace charter • Change Academy has supported 4 multi-disciplinary teams to date as part of Phase 1 • Mental Health engagement events in collaboration with West London Collaborative
3. How will you support, invest in and improve general practice?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA3:** Achieving better outcomes and experiences for older people **DA5:** Ensuring we have safe, high quality sustainable acute services	**DA3:** Pages 25-26 **DA5:** Pages 29-31	• Established federations to increase GP accessibility • Improvements to maternity and children's care across NW London by consolidating inpatient and emergency services onto 5 sites • 1.9m people have access to weekend primary care appointments • NW London CCGs score above London average for accessible and coordinated care dimensions • Primary care is working at scale – all eight CCGs have federation population coverage of above 75%
4. How will you implement new care models that address local challenges?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 7**: Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice **Priority 5**: Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**DA3:** Achieving better outcomes and experiences for older people **DA2:** Eliminating unwarranted variation and improving Long Term Condition management	**DA3:** Pages 25-26 **DA2:** Pages 23-24	• Joint commissioning of services (in particular rapid response) across health and social care • Whole Systems approach developed and in practice to segment the population and develop tailored services • Development of local models of care for urgent care, including 111 • There are urgent care centres at all A&Es in NW London • As part of the reconfiguration of paediatric services, a new model of care and paediatric assessment units have been developed
5. How will you achieve and maintain performance against core standards?	**Priority 3:** Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Performance is managed through a range of forums between providers and commissioners including quality meetings which feed into CCGs, Finance and Performance meetings and Contract meetings

Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
6. How will you achieve our 2020 ambitions on key clinical priorities?	**Priority 2:** Improve children's mental and physical health and well-being **Priority 8:** Reduce the gap in life expectancy between adults with severe and long-term mental illness and the rest of the population **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA1:** Radically upgrading prevention and wellbeing **DA4:** Improving outcomes for children &adults with mental health needs **DA5:** Ensuring we have safe, high quality sustainable acute service	**DA1:** Pages 21-22 **DA4:** Pages 27-28 **DA5:** Pages 29-31	• Single point of access' and rapid response home treatment teams for urgent mental health needs launched across all 8 Boroughs Urgent care centres across NW London all operate to the same specification • Maternity – after the transition of maternity services at Ealing, there has been an improvement in: - midwife to birth ratio from 1:31 to 1:30 - midwife vacancy level from 8.1% to 7.2% - consultant ward presence from 108 hours to 122 hours • Signed up all North West London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of their staff. • launch of young people's eating disorder services. Providing quicker access for this vulnerable population
7. How will you improve quality and safety?	**Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Launched seven day services programme • Implemented single discharge process • Psychiatric liaison in all A&Es and Urgent Care Centres (UCCs) in NW London • Maternity & Paediatrics – agreed quality standards which are tracked monthly across NW London • Mental health Crisis Care Concordat signed • Agreed clarifications on 7 Day Services standards on radiology
8. How will you deploy technology to accelerate change?	Underpins all priorities		**Enabler:** Digital (Pages 37-38)	• NW London Diagnostic cloud • Roll out of Electronic Prescribing Service (EPS2), Summary Care Record • Patient Online functionality available at all practices • Integrated Care data dashboards being piloted • In primary care 280,000 patients have access to web-based consultations and 60,000 patients have access to video consultations
9. How will you develop the workforce you need to deliver?	Underpins all priorities		**Enabler:** Workforce (Pages 35-36)	• Joint working with Health Education England (HEE NW London) • Care Coordinator and Care Navigator role developed, trained and in post (increasing numbers in the existing workforce) • Health and Social Care Coordinator role development (enhanced clinical skills) • CEPNs established across NW London which are improving ways of working across different parts of health and social care • PA programme in Hillingdon mobilised
10. How will you achieve and maintain financial balance?	Underpins all priorities		**Finance** (Pages 42-47)	• NW London financial strategy being implemented for the past few years • The Shaping a Healthier Future programme, by creating new unified clinical pathways and providing higher quality care across the system

Appendix D: Further information about our Mental Health and Wellbeing Transformation

LikeMinded
WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

Appendix D: The current picture

In North West London we have had a shared whole systems mental health programme (across health and social care) since 2012 reflecting a commitment to improving mental health and wellbeing for the 2 million residents of North West London. Since 2015 we have been working under the banner of Like Minded – with a Case for Change endorsed across all Health and Wellbeing Boards, and CCGs setting out our challenges and common ambition for change.

The programme coproduced the following 3 statements to articulate the overall vision our population. These statements are supported by a number of principles. Critically the Strategy, vision and principles describe the outcomes and experience we want to change – rather than focus on services.

My wellbeing and happiness is valued and I am supported to stay well and thrive

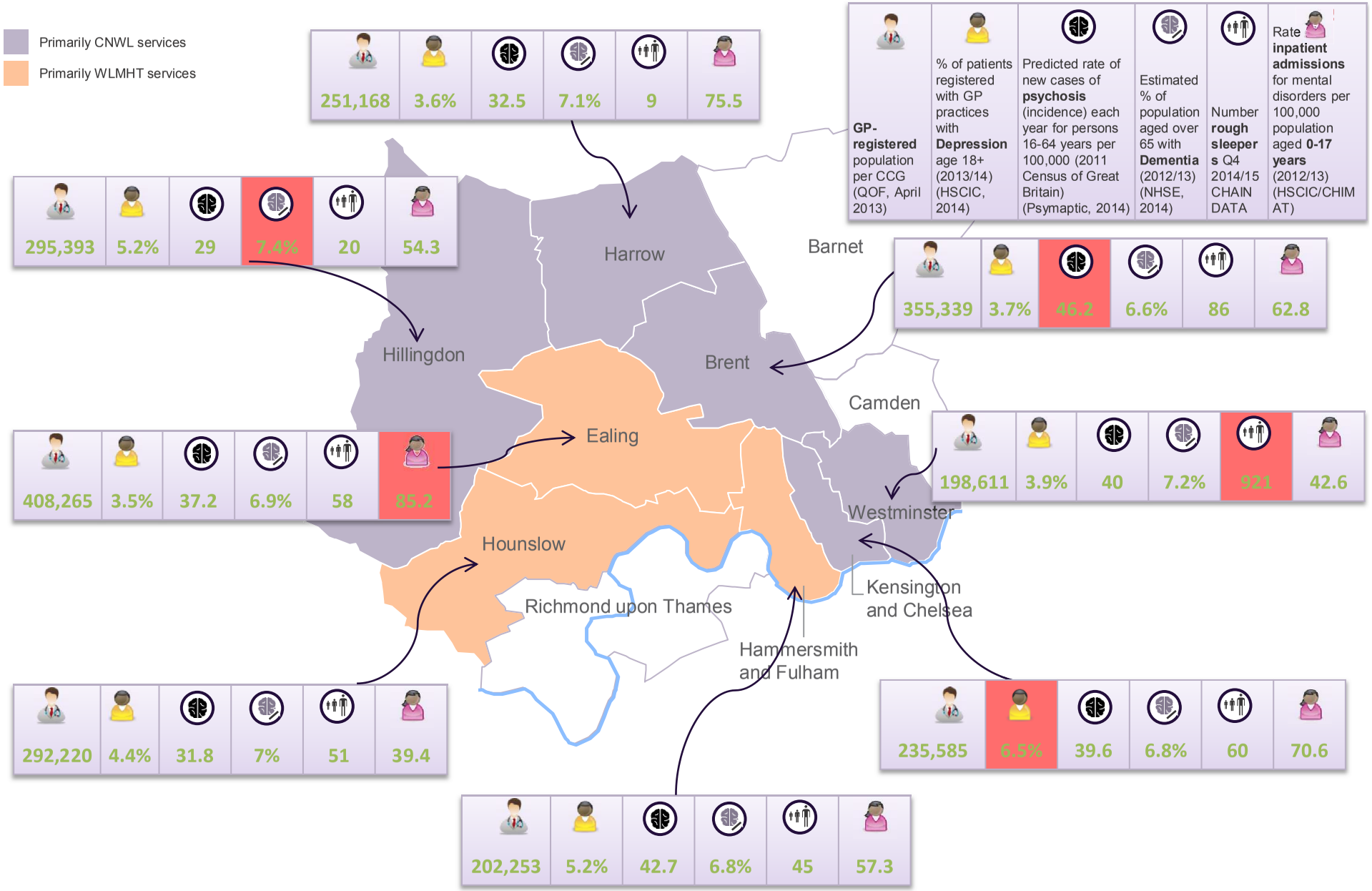
As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

Core principles

- My life is important, I am part of my community and I have opportunity, choice and control.
- My wellbeing and mental health is valued equally to my physical health
- I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing
- My care is seamless across different services, and in the most appropriate setting
- I feel valued and supported to stay well for the whole of my life

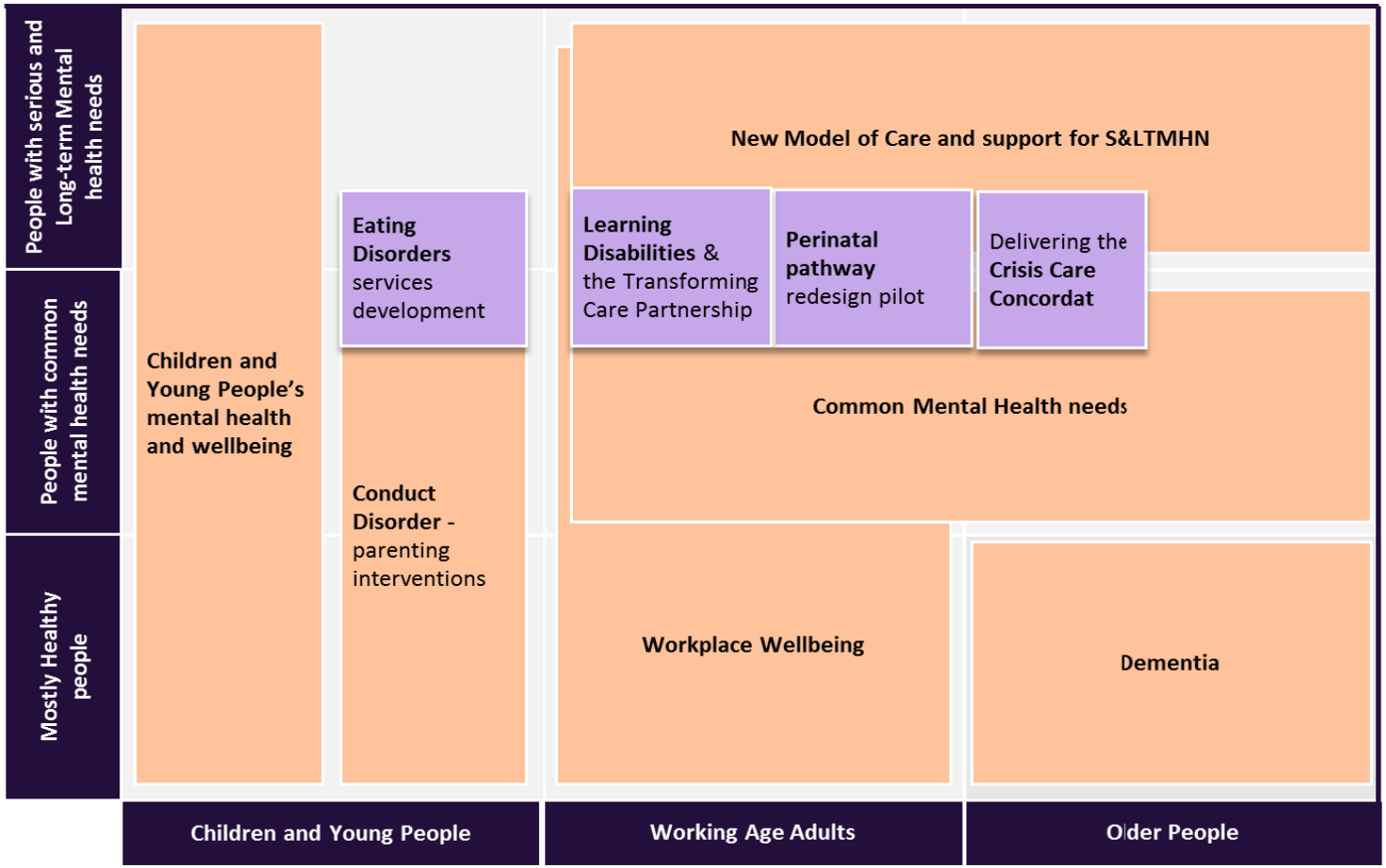
Appendix D: Case for change: there is still much we can do to improve outcomes and reduce variation



Appendix D: We use an approach across the life course, aiming to reducing mental health inequalities

In approaching mental health transformation in North West London we have considered an approach across the life course aimed at reducing mental health inequalities. Whilst we know that people are not defined by their diagnosis (we acknowledge that comorbidity is the norm) or demographics, this is a useful framework to prioritise and focus within an area of vast need.

We recognise that learning disabilities and mental health needs are not the same thing – but our work since 14/15 to address needs of our population who have both learning disabilities and mental health needs provided a spring board for wider work on learning disabilities under the Transforming Care Partnership Programme.



Appendix D: As a transformation programme with a wide remit we embed in NW London the sense that mental health is everyone's business

The Like Minded Strategy is a 'whole systems', all ages strategy. Throughout the programme we recognise the critical role that services and initiatives across the system have in supporting mental health and wellbeing. Our combined work across NWL naturally builds on the local transformation and co-production work within each Borough, and on work led by local mental health providers – CNWL and WLMHT. As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business – through supporting our own workforce to remain healthy, as much as focusing on supporting the mental wellbeing and recovery of our service users, carers and wider population.

As we have approached mental health transformation in North West London one key commitment has been to co-production – not just with service users and carers, but through a cross-system leadership approach in health, social care and the voluntary and community sector. Our work to date lends itself to a 'place based approach' - with no health without mental health we have to work with a wide range of partners and recognise the impact of mental illness on all statutory services and broader societal outcomes, such as employment and educational attainment.

The whole programme is focused on delivering the ambitions for Parity of Esteem, all transformation work rooted in a holistic approach to meeting the needs of the public.

We work closely with service users and carers, clinicians, professionals and experts across the system in health, social care, voluntary sector and public health and have held workshop events in specific areas, including children & young people, socially excluded groups, and mental ill health prevention.

We are not starting from scratch – our 24/7 urgent care pathway has been the critical development over the last year and unlocks the gateway to wider services for adults with serious and long term needs:

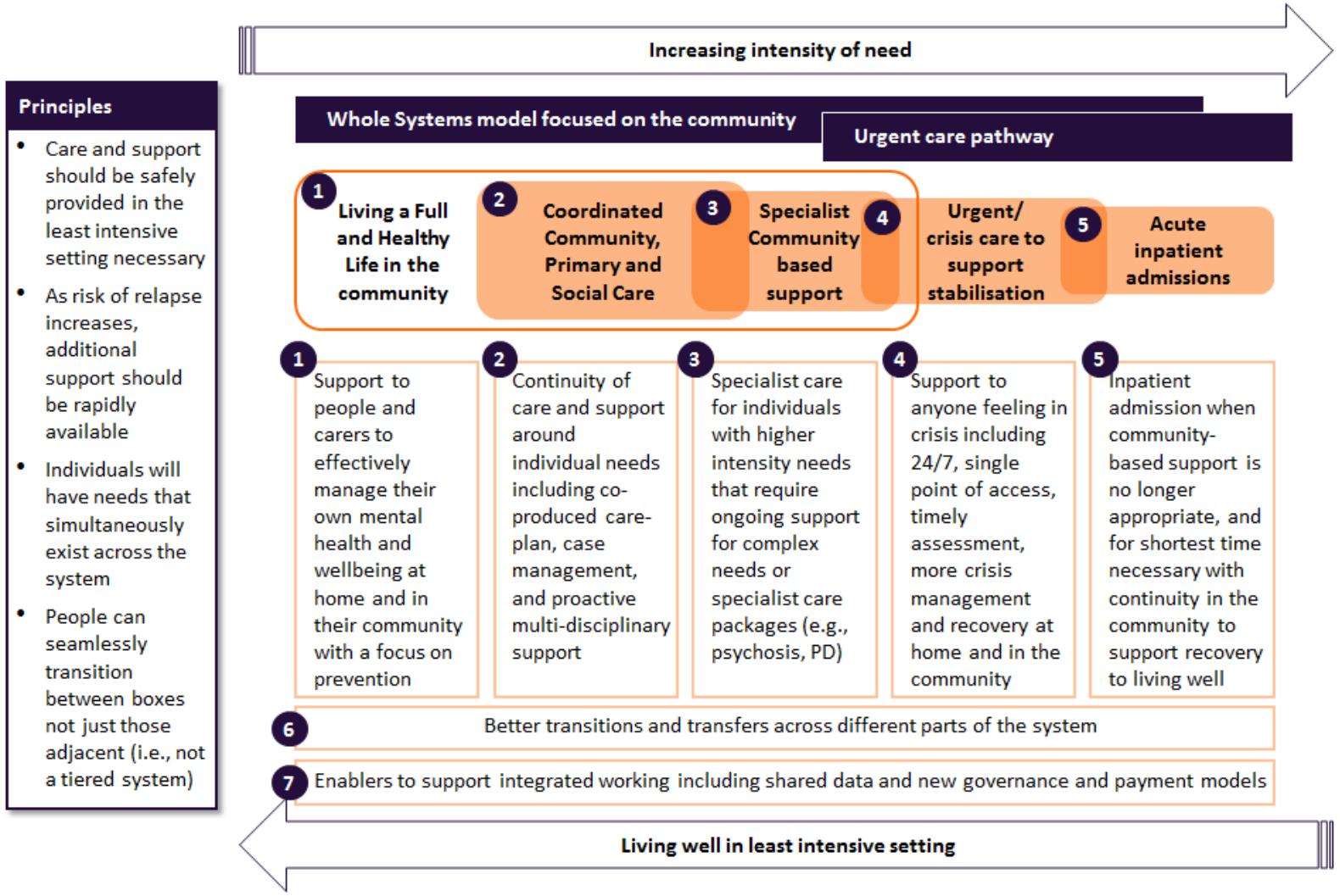
The 24/7 crisis line is the best anti-anxiety drug for GPs –we know we can get the right specialist support quickly for patients in the community

Appendix D: Like Minded new Model of Care and Support for people with Serious and Long Term Mental Health Needs (SLTMHN)

Like Minded has put much focus on the development of a model of care and support for people living with and experiencing SLTMHNs, as shown below. This model of care has been developed in conjunction with service users, CCGs, Trusts, and local authorities.

The model of care is designed to ensure care and support takes place in the least intensive setting possible, maximising independence and wellbeing.

Local business cases for the implementation of the model are still in development with the intention of these being agreed by governing bodies in September 2016.



HILLINGDON CCG UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Joan Veysey; Judy Mace, Mark Eaton, Jonathan Tymms
Papers with report	Update Paper

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • Operating plan ratings 15/16 • Children's services at Hillingdon Hospital • Finance • Update on QIPP 16/17 • Update on integration
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital (local services) strategy • Financial strategy • Shaping a Healthier Future
Financial Cost	Not applicable to this paper.
Relevant Policy Overview & Scrutiny Committee	External Services Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board note 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 Operating plan ratings 15/16

NHS England published the performance ratings for CCGs on Thursday 21st July. The ratings consisted of four levels, 'outstanding,' 'good,' 'requires improvement' and 'inadequate' against five domains, 'well-led,' 'delegated functions,' 'finance,' 'performance' and 'planning'. Across the country 10 CCGs were rated 'outstanding', a further 82 'good' and 91 were found to 'require improvement'. At the same time, NHS England is taking action with each of the 26 CCGs rated as 'inadequate.'

Hillingdon CCG's ratings were as follows:

Well-led	Delegated functions	Finance	Performance	Planning	Headline rating
Good	Good	Requires improvement	Requires improvement	Good	Requires improvement

Whilst achieving a rating of good for three of the five domains our headline rating was impacted by the financial domain rating which has been assessed based on a wholly technical accounting issue that NHS England is clear does not make a material difference to the good running of the CCG. Hillingdon CCG is disappointed to have missed out on a better rating because of this.

The CCG has written to NHS England to highlight that the rating of 'requires improvement' for finance does not feel congruent with Hillingdon's performance (delivery of a surplus beyond our planned target). A response from Anne Rainsberry (Regional Director, London) stated that this was due to a national decision that where continuing healthcare risk pool contributions had been accounted for as Unadjusted Audit Differences it would not be appropriate to rate a CCG as 'Good' for finance. The letter goes on to state that in the view of NHS England, the CCG's financial performance in 2015/16 was sound and acknowledges the major achievement of the CCG in achieving financial turnaround in the years since inception.

3.2 Update on Transition of Children's Services

The transition of Children's inpatient and A&E service from Ealing Hospital occurred safely on 30 June 2016. There have been no serious incidents reported and robust operational management arrangements are in place to provide significant programme oversight as the new model of care continues to embed.

Since transition the levels of activity at A&Es and inpatient wards at all sites has remained within the levels predicted by the activity model, which was used to determine how many additional staff and beds were needed at each site. This means that all sites had sufficient additional resource to manage the increased demand caused by the closure of A&E and inpatient services at Ealing Hospital.

The Ealing UCC remains open and the number of children attending all UCCs in NWL has remained steady. The transfer pathways from Ealing Urgent Care Centre (UCC) to other hospital sites are working well and continue to embed. The number of London Ambulance Service and Patient Transport Service transfers from Ealing Hospital is significantly lower than expected. Ealing children who attend Hillingdon Hospital and require follow up outpatient treatment are being repatriated to Ealing, meaning they receive treatment closer to where they live and ensuring that there is not additional pressure on the Hillingdon outpatient service.

The new Paediatric Assessment Unit (PAU) and children's A&E at Hillingdon Hospital, which opened in July, are expected to have a positive impact on A&E performance once they are embedded, as will the resident consultant model which will come into effect in September 2016.

To support the transition seven new paediatric consultant posts were created at Hillingdon, all of which have been appointed to. The new consultants are due to start in September 2016. These new consultant posts ensure there is a consultant paediatrician on site at Hillingdon 24/7, including the weekends, and will cover inpatients, outpatients, the PAU and subspecialties.

Significant capital investment has been put into the major acute hospitals across NW London in order to improve the environment in which children will be seen and treated. This includes:

- Refurbishment and expansion of the Paediatric Accident and Emergency at Hillingdon, which now provides a better environment and facilities for children and their families, including bigger bed bays with chair-beds for parents. It is decorated throughout with child-friendly graphics based on the Hillingdon trail which depicts local landmarks. These graphics were designed with input from children.
- Opening a 4 bedded Paediatric Assessment Unit for children who require a short stay to avoid them being admitted to the ward unnecessarily.

To ensure the ongoing monitoring of paediatrics, data from the paediatric dashboard will be built into the Integrated Performance Report (IPR) and monitored through the CCG Quality and Safety Committee.

The remaining priorities for Hillingdon Hospital are to:

- Transition to their consultant resident model in September 2016 which will help to deliver an improved clinical service for children.
- Open four additional inpatient beds which are scheduled for September 2016. Due to seasonal activity levels these beds are not required before October 2016.
- Develop an improvement plan and trajectory for paediatric A&E performance.
- Work with the CCG to ensure winter readiness
- Future planned developments include transferring paediatric services into community working alongside GPs and developing a Critical Care Level 1 service.

Work is also underway to re-establish the Children's Health Partnership Group which included members from the local health, education and social care partnership and was suspended in January 2016. This group is now being revised and refreshed as the Strategic Transformation Group; with the aim of being an action and change management group, with task and finish groups reporting to the Strategic Group. Key work streams include: vulnerable children and young people including SEND, Maternity, Acute Services and Emotional Health and Wellbeing. The first meeting is planned for October 2016.

3.3 Financial position

Overall, at month 4, the CCG is achieving its YTD planned surplus of £1.2m. The CCG is reporting to achieve its £3.6m planned surplus by Year End.

Whilst the CCG continues to report achievement of its planned YTD and FOT financial targets, there are a number of risks within the CCG's financial position which mainly relate to over-

performance on the CCG's main Acute Contracts and also significant financial pressures in its Continuing Care budgets.

The over-performance on the contracts with THH relates to higher than planned increases in Accident & Emergency activity and also OP referrals in a number of specialties. Whilst elective activity is down on plan spend is significantly above plan, likewise emergency activity has reduced from last year but costs have increased due to an increase in the acuity of patients at THH.

There is also significant over performance at London North West Hospitals (mainly stroke related activity), Imperial (Non-Elective and Maternity) and the Royal Brompton.

Continuing Care costs are currently projected to increase by £3m (20%) compared to last year. Part of this increase in overall cost (c£900k) relates to the recently announced national increase in Funded Nursing Care reimbursement. In addition there have been significant increases in activity and placements relating to Palliative Care, Elderly and also Section 117s.

As a consequence of these emerging financial risks the CCG is currently in the process of developing an action to mitigate these pressures to ensure it achieves its financial targets for the year. These include:

- increasing the resource available to assess and review continuing health care packages
- working with THH to understand the difference in performance and spend
- continuing dialogue with the Royal Brompton on the causes of the over performance
- addressing out of area over performance collectively across Brent, Hillingdon and Harrow

Overall Position- Executive Summary Month 4 YTD and FOT

Table 1

EXECUTIVE SUMMARY		Year to Date Position (Month 4)					Forecast Outturn Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)	Month 03 YTD Variance (£000)	Month 02 YTD Variance (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Commissioning of Healthcare-Programme									
Acute Contracts	207,180	68,662	71,076	(2,414)	(1,544)	(325)	212,301	(5,121)	(996)
Acute Reserves	1,893	1,411	0	1,411	1,466	123	406	1,487	0
Other Acute Commissioning	12,684	3,597	3,380	217	87	63	11,949	735	225
Mental Health Commissioning	24,836	8,122	8,100	22	11	80	24,689	147	88
Continuing Care	16,266	5,354	6,196	(842)	(261)	(123)	18,944	(2,678)	(24)
Community	31,116	10,310	10,189	121	95	11	30,785	331	27
Prescribing	35,784	11,933	11,985	(51)	7	4	35,895	(111)	0
Primary Care	6,215	1,787	1,724	63	114	74	6,003	212	0
Sub-total	**335,974**	**111,177**	**112,649**	**(1,472)**	**(25)**	**(94)**	**340,972**	**(4,998)**	**(680)**
Corporate & Estates	4,399	1,466	1,455	11	25	65	4,301	98	0
TOTAL	**340,373**	**112,643**	**114,104**	**(1,461)**	**(0)**	**(28)**	**345,273**	**(4,900)**	**(680)**
Reserves & Contingency									
Contingency	2,289	763	0	763	0	0	0	2,289	0
Uncommitted Reserves	4,149	0	0	0	0	0	4,149	0	0
2015/16 Anticipated Creditor Balance	0	0	0	0	0	0	(1,399)	1,399	0
Other Balance Sheet Gains	0	0	(393)	393	0	0	(393)	393	0
RESERVES Total:	**6,438**	**763**	**(393)**	**1,156**	**0**	**0**	**2,357**	**4,081**	**0**
Total 2016-17 Programme Budgets	**346,811**	**113,406**	**113,711**	**(305)**	**(0)**	**(28)**	**347,630**	**(819)**	**(680)**
Planned Surplus/(Deficit)	3,616	1,205	0	1,205	**904**	**603**	**0**	**3,616**	**0**
Total Programme Budgets	**350,427**	**114,611**	**113,711**	**900**	**904**	**574**	**347,630**	**2,797**	**(680)**
RUNNING COSTS									
Running Costs	**6,279**	**2,107**	**1,803**	**305**	**0**	**28**	**5,460**	**819**	**0**
CCG Total	**356,706**	**116,719**	**115,514**	**1,205**	**904**	**603**	**353,090**	**3,616**	**(680)**

Year To Date Position- Acute Contracts and Continuing Care

Table 2

ACUTE CONTRACTS		YTD Month 4		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
In Sector SLAs				
Chelsea And Westminster Hospital NHS Foundation Trust	2,353	783	783	0
Imperial College Healthcare NHS Trust	12,066	3,998	4,294	(296)
London North West Hospitals	16,594	5,482	5,977	(496)
Royal Brompton And Harefield NHS Foundation Trust	6,442	2,147	2,628	(481)
The Hillingdon Hospitals NHS Foundation Trust	131,788	43,688	45,559	(1,871)
The Hillingdon Hospitals NHS Foundation Trust - Transitional Support	3,300	1,100	0	1,100
Sub-total - In Sector SLAs	**172,543**	**57,198**	**59,241**	**(2,043)**
Out of Sector SLAs				
Sub-total - Out of Sector SLAs	**32,359**	**10,705**	**11,090**	**(385)**
BMI Headquarters	2,228	743	711	32
Specsavers Limited	51	17	34	(18)
Sub-total - Acute SLAs	**207,180**	**68,662**	**71,076**	**(2,414)**

Continuing Care		YTD Month 4		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
Mental Health AMI (Under 65) - Residential	59	20	19	0
Mental Health AMI (Under 65) - Domiciliary	0	0	3	(3)
Mental Health EMI (Over 65) - Residential	2,865	955	945	10
Mental Health EMI (Over 65) - Domiciliary	277	92	112	(19)
Physical Disabilities (Under 65) - Residential	2,015	672	841	(169)
Physical Disabilities (Under 65) - Domiciliary	2,201	734	593	141
Elderly Frail (Over 65) - Residential	951	317	448	(131)
Elderly Frail (Over 65) - Domiciliary	92	31	60	(30)
Palliative Care - Residential	381	127	203	(76)
Palliative Care - Domiciliary	424	141	227	(86)
Sub-total - CHC Adult Fully Funded	**9,265**	**3,088**	**3,451**	**(362)**
Sub-total - Funded Nursing Care	**2,095**	**698**	**960**	**(262)**
Sub-total - CHC Children	**1,263**	**421**	**529**	**(108)**
Sub-total - CHC Other	**661**	**152**	**256**	**(103)**
Sub-total - CHC Adult Joint Funded	**2,982**	**994**	**1,000**	**(6)**
Total - Continuing Care	**16,266**	**5,354**	**6,196**	**(842)**

FOT Position- Acute Contracts and Continuing Care

Table 3

ACUTE CONTRACTS	YTD Month 4		Forecast Outturn Position	
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)
In Sector SLAs				
Chelsea And Westminster Hospital NHS Foundation Trust	783	0	2,353	0
Imperial College Healthcare NHS Trust	4,294	(296)	12,820	(754)
London North West Hospitals	5,977	(496)	17,461	(867)
Royal Brompton And Harefield NHS Foundation Trust	2,628	(481)	7,400	(958)
The Hillingdon Hospitals NHS Foundation Trust	45,559	(1,871)	137,245	(5,457)
The Hillingdon Hospitals NHS Foundation Trust - Transitional Support	0	1,100	0	3,300
Sub-total - In Sector SLAs	**59,241**	**(2,043)**	**177,278**	**(4,735)**
Out of Sector SLAs				
Sub-total - Out of Sector SLAs	**11,090**	**(385)**	**32,761**	**(402)**
BMI Headquarters	711	32	2,157	70
Specsavers Limited	34	(18)	105	(54)
Sub-total - Acute SLAs	**71,076**	**(2,414)**	**212,301**	**(5,121)**

Continuing Care	YTD Month 4		Forecast Outturn Position	
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)
Mental Health AMI (Under 65) - Residential	19	0	58	1
Mental Health AMI (Under 65) - Domiciliary	3	(3)	3	(3)
Mental Health EMI (Over 65) - Residential	945	10	2,801	64
Mental Health EMI (Over 65) - Domiciliary	112	(19)	362	(85)
Physical Disabilities (Under 65) - Residential	841	(169)	2,474	(459)
Physical Disabilities (Under 65) - Domiciliary	593	141	1,717	484
Elderly Frail (Over 65) - Residential	448	(131)	1,345	(394)
Elderly Frail (Over 65) - Domiciliary	60	(30)	181	(89)
Palliative Care - Residential	203	(76)	608	(227)
Palliative Care - Domiciliary	227	(86)	754	(330)
Sub-total - CHC Adult Fully Funded	**3,451**	**(362)**	**10,303**	**(1,038)**
Sub-total - Funded Nursing Care	**960**	**(262)**	**2,928**	**(833)**
Sub-total - CHC Children	**529**	**(108)**	**1,740**	**(477)**
Sub-total - CHC Other	**256**	**(103)**	**972**	**(312)**
Sub-total - CHC Adult Joint Funded	**1,000**	**(6)**	**3,000**	**(18)**
Total - Continuing Care	**6,196**	**(842)**	**18,944**	**(2,678)**

3.4 Update on QIPP 16/17

The 16/17 Net QIPP Target is £8.673m. Current FOT as at M4 is (£680k) giving a FOT of £7.993m, a reduction of £70k since M3.

The key areas of focus are:

- **MSK** – Discussions with THH around the QIPP for 16/17 have not progressed quickly despite the funding provided in the Transition Support process. Work with THH is on-going and further options will need to be explored to bring performance back in line and develop a way to progress into 17-18 onwards.

- **Intermediate Care** – The appointment of a Care of the Elderly Consultant will improve performance in this area. Discussions with THH are centred on a blended tariff for Homesafe and Rapid Response Service for all patients with a zero length of stay that will significantly improve the financial performance of this area.

- **Long Term Conditions** – The LTC Projects (Respiratory, Cardiology and Diabetes) have slipped largely due to lack of progress on discussions between providers. We are therefore establishing an Operational Delivery Group across all three areas to focus on accelerating these project areas.

Significant actions we are taking to secure the current 16/17 QIPP include:
- Implementing a 'quick win' project for Cancer including tariff changes given that all outpatient activity is being charged as first appointments.
- Attempting to accelerate our LTC QIPP Schemes as well as focusing on new schemes for 17/18 around LTCs and Prevention.
- Seeking to agree to have a clinical advice and triage service for Gastroenterology and Neurology with THH.
- Seeking to agree to increase the number of patients ambulated which will increase the overall QIPP.

Other significant areas of stretch for QIPP we are exploring are:
- Agreeing a new Paediatric Assessment Unit Tariff which will offset the large zero length of stay (ZLOS) tariffs we are being charged. Expected benefit: £170k+ in 16/17.
- Agreeing a new CDU Tariff for the Chairs that will come into use from December. Expected benefit: £100k in 16/17.
- Agreeing a new blended Tariff for Homesafe & Rapid Response Service for patients admitted with a ZLOS. Expected benefit £100k+ in 16/17.
- Agreeing a reduction in costs for GP Out of Hour Services for opted out Practices. Expected benefit £50k+.
- Further savings arising from NHS111. Expected additional £50k for 16/17 from December onwards.

The above areas will also generate ~£500k of the 17/18 QIPP target.

3.5 Update on integration

The Hillingdon vision for Accountable Care is that by April 1st 2017, Hillingdon will have a formally constituted ACP Joint Alliance ready to receive an outcome based capitated contract

from the CCG for delivering integrated care for people over 65 years. This will enable the testing and refinement of the commissioning approach and assurance of the provider capability to deliver the new ways of working required. Since the June update to the HWBB, HCCG has been working with the ACP Shadow Board to develop the finance, contracting and governance arrangements that will need to be in place from April 2017.

Heads of Terms have now been agreed between HCCG and ACP Provider Parties outlining how the ACP and HCCG will work to develop an initial contracting and payment model to commence from Financial Year 2017/18. The likely contractual model will be an Alliance Contract model underpinned by individual NHS Standard Contracts with each Provider Party for the population segment of over-65. The aim is to draft an Alliance Agreement by October 2016, which will require a number of key contractual and financial issues to be agreed by respective provider boards.

A new Joint CCG/ACP finance and business development group has been convened to progress these discussions and fully develop the capitated payment model, risk and gain share arrangements, scope of service and length of contract agreement.

The shadow ACP providers have continued to test and evaluate elements of the care model that will deliver improved outcomes for people in Hillingdon. This includes a primary care focused model with access to multi-disciplinary care connection teams, supporting GPs to provide coordinated care for their local populations. Piloting use of the third sector offering signposting, patient activation to support self-care and peer support via the Hillingdon Health and Wellbeing Gateway commenced in April 2016. Community consultant geriatricians will be introduced from October 2016 providing specialist support to reduce pressure of unplanned attendances and admissions to acute hospital. This work has informed the development of a specification and outcomes for the integrated service for people over 65 years, which will be agreed by HCCG Governing Body and delivered from April 2017.

Whole systems integrated care for people over 65 is a key element of the Hillingdon STP, to enable high quality, coordinated care, improved health outcomes and financial sustainability. The Hillingdon STP will provide the opportunity to ensure benefits from new health care models funded through an outcome based capitated payment model are aligned with HWB ambition to explore further integration of health and care via the Better Care Fund 3 year plan from 2017.

4. FINANCIAL IMPLICATIONS

None in relation to this update paper.

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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HILLINGDON CCG'S 2017/18 COMMISSIONING INTENTIONS

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Chief Operating Officer
Papers with report	Draft Hillingdon CCG Commissioning Intentions (CIs)

HEADLINE INFORMATION

Summary	This report sets out an overview of the HCCG's plans to commission high quality health care to improve the health outcomes for Hillingdon patients in 2017/18 and to set the scene for transforming these services over future years. The Commissioning Intentions (CIs) have been shared early with partners and matched against the priorities in Hillingdon's Sustainability and Transformation Plan and include budget summaries. The final iteration of commissioning intentions will be signed off at the Governing Body meeting on 7th October.
Contribution to plans and strategies	The CIs will be an important part of delivering against the Hillingdon STP which is integral to the North West London STP and based on the NHS five year forward view. The CIs are developed based on the borough's Joint Strategic Needs Assessment (JSNA) and consistent with the Joint Health and Wellbeing Strategy (JHWS).
Financial Cost	There are no direct financial implications arising directly from this report.
Ward(s) affected	All

RECOMMENDATION

That the Board considers and notes Hillingdon CCG's commissioning intentions for 2017-18.

INFORMATION

Supporting Information

All CCGs are required to prepare CIs for each financial year. The CI plan must set out how the CCG proposes to exercise its functions in that period. Each CCG is required to provide a copy of the commissioning plan to the Borough's Health and Wellbeing Board, to ensure that the CIs are kept up to date, and that they are routinely discussed by the Health and Wellbeing Board.

The identification and prioritisation of the CIs are based on:

- The health needs of the Hillingdon population
- Input from residents and service users
- Delivery of the sustainability and transformation plan which addresses the need for the health and care system to improve health and wellbeing, improve care and quality and improved productivity and close the financial gap between growth in demand and growth in resource

The prime purpose of the CIs is to advise providers of potential changes in direction and to set the parameters within which subsequent specific commissioning decisions will be taken. This is set against the backdrop of a clear strategic vision for improved health across the borough. The CIs, as such, are a key part of the annual commissioning cycle.

Hillingdon's HWB had provided feedback in relation to last year's CIs (2016/17) that it would have been helpful to see how proposed changes impacted directly on local people and that the absence of budgetary information made commenting difficult.

Section 4 (page 18) sets out how the CI's have been developed having listened to the voice of local people. Section 6b includes what the intentions mean for the population served and in Section 7, success measures are identified against each theme.

This year's intentions are built around the agreed 10 priorities of Hillingdon's Sustainability and Transformation Plan together with the 6 enabling themes (section 3f, page 15) together with indicative expenditure against each theme (page 17) and the indicative efficiency savings (section 7, page 33 onwards). The CIs point towards a need for the HCCG to meet a funding gap of approximately £40m to 2020/21, which is also reflected in the STP work.

In Hillingdon we are continuing to work towards establishing a model of 'accountable care' where we commission providers of services to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative. 2017-18 will provide us with an opportunity to test the effectiveness of this approach with our local providers.

Financial Implications
The CIs set out the current financial position of HCCG (section 3d page 10), identifying the need to find savings of approximately £40m by 2020/21.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?
The CIs will be developed into contracting plans and form the foundation of STP delivery in 17/18.

Consultation Carried Out or Required
The consultation undertaken to develop the CIs is set out in section 4 page 18.

Policy Overview Committee comments
None at this stage.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments TBC
Corporate Finance has reviewed this report and concurs with the financial implications set out above

Hillingdon Council Legal comments
The Borough Solicitor confirms that there are no other specific legal implications arising from this report. TBC

BACKGROUND PAPERS

HCCG Commissioning Intentions 2017-18.

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NHS
Hillingdon
Clinical Commissioning Group

Commissioning Intentions 2017-18

October 2016

[DRAFT - FOR CIRCULATION]

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. This document aims to set out how we will achieve these requirements in 2017-18.

**The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of health care are commissioned by the London Borough of Hillingdon (LBH) and, particularly for Primary Care, other bodies 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 share responsibility for commissioning GP Based Services in Hillingdon) and this relationship continues to evolve.*

Section 1b: Aim of the Commissioning Intentions

The aim of these Commissioning Intentions is to provide an overview of Hillingdon CCG's plans to purchase (commission) high quality health care to improve the health outcomes for Hillingdon patients for the Financial Year 2017-18 (FY17/18) and to set the scene for how we envisage services transforming over future years.

To develop these Commissioning Intentions we have talked to a wide range of local people including patients, carers and the wider public along with our providers of healthcare services and our members in General Practice. We have also drawn on a wide range of sources of information and feedback.

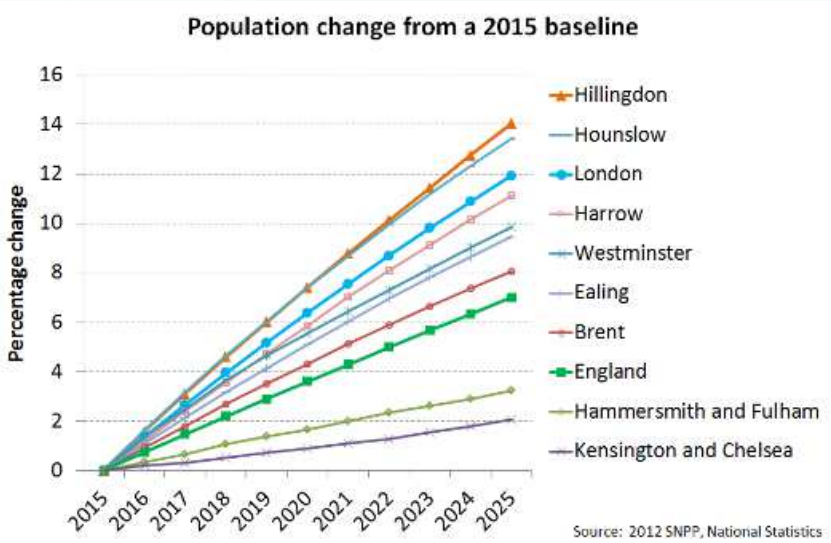
In Hillingdon we are continuing to work towards establishing a model of 'accountable care' where we commission providers of services to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative. 2017-18 will provide us with an opportunity to test the effectiveness of this approach with our local providers.

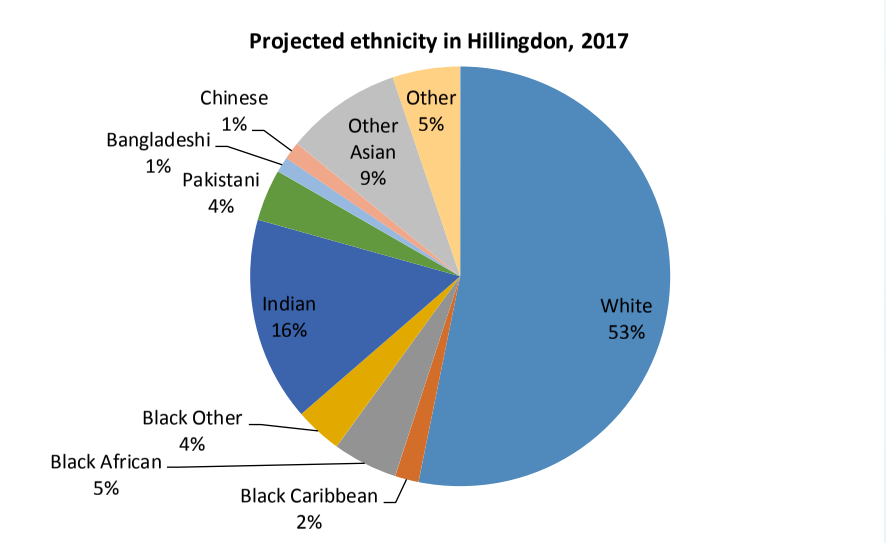
The Commissioning Intentions for 2017-18 is a living document that will evolve over time based on further engagement activities with the public, partners and providers. This document should also be read in conjunction with the Commissioning Intentions stated for NHS England (NHSE) and for the North West London Collaborative of CCGs.

Section 2: The Health Landscape in Hillingdon

Section 2a: Demographics

Hillingdon is the second largest London borough by area, located 14 miles from central London with the 12th largest population. Based on the Office for National Statistics (ONS) sub-national population projections, the Hillingdon population in 2017 is projected to be 309,300 with 23,100 (7.5%) aged 0-4 years, 40,100 (13.0%) aged 5-14 years, 205,600 (66.5%) aged 15-64 years, 21,400 (6.9%) aged 65-74 and 19,100 (6.2%) aged over 75. 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. A growth of just over 18,300 residents is projected by 2021, with children aged 5-14 years and adults aged 65-74 years projected to have the highest growth rates. Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG and will be above both the average for London and England.





Hillingdon is an ethnically diverse borough with 46.9% of residents in 2017 projected to be from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021.

Section 2b: Health profile

Lifestyle & Risk Factors

- **Excess weight** prevalence in adults (63.4%) is similar to the national average (64.6%) but higher than London (58.4%).
- Percentage of adults achieving at least 150 minutes of **physical activity** per week (55.0%) is similar to London (57.8%) and England (57.0%).
- **Smoking** prevalence in adults (17.1%) is similar to London (17.0%) and England (18.0%).
- **Alcohol**-related hospital admissions (553 per 100,000) are similar to London (526 per 100,000) but lower than the national average (641 per 100,000).
- **Social isolation.** The percentage of adult social care users who have as much social contact as they would like is 43%, compared to 42% in London and 45% in England.
- Percentage of over 65 year olds receiving **winter fuel payments** (99%) is higher than the national average (97%) and London (97%).

Child Health

- **Infant mortality** (3.6 per 1,000) is similar to London (3.8 per 1,000) and England (4.0 per 1,000).
- **Low birth weight** of term babies (3.0%) is similar to London (3.2%) and England (2.9%).
- It is estimated that approximately 12,000 children aged 0-19 years in Hillingdon are living with a **longstanding illness** or **mild disability,** and just over 50 are living with a **severe disability.**
- **Unplanned hospitalisations for asthma, diabetes and epilepsy** in children aged 0-19 years, which should not normally require hospitalisation, is 315 per 100,000 (221 admissions). This is lower than the national average (327 per 100,000).
- Estimates for Hillingdon suggest that around 4000 5-16 year olds will have a **mental health disorder**, about 60% of whom are boys, and prevalence increases with age.
- **Mental health** hospital admissions in children aged 0-17 years (82.4 per 100,000) is similar to the national average (87.4 per 100,000) but lower than London (94.2 per 100,000).

Adult Health

- Injuries due to **falls** in people aged 65 and over (2,205 per 100,000) is similar to London (2,253 per 100,000) and England (2,125 per 100,000).
- **Hip fractures** in people aged 65 and over (506 per 100,000) is similar to London (517 per 100,000) and England (571 per 100,000).
- **Emergency hospitalisations for people with specific long-term conditions**, which should not normally require hospitalisation, is 889 per 100,000 (2,228 admissions). This is higher than the national average (809 per 100,000).
- **Cancer screening** rates for breast (70.9%), cervical (66.9%) and bowel (52.1%) are lower than national averages. The number of patients diagnosed with **cancer** via an emergency presentation is 82 per 100,000 which is not significantly different to the England average (90 per 100,000).
- **Diabetes** prevalence in GP registered adults (6.7%) is higher than London (6.1%) and England (6.4%). There are an estimated 15,803 people over 17 years of age with a diagnosis of diabetes in Hillingdon. There are an estimated further 3,539 people who remain undiagnosed. If current trends in population change and obesity persist the total prevalence of diabetes is expected to rise to 8.4% by 2020.
- **Coronary heart disease** (CHD) prevalence in GP registered adults (2.3%) is higher than London (2.1%) but lower than England (3.2%). There are an estimated 6,878 people with a diagnosis of CHD in Hillingdon. However, the modelled prevalence estimate of underlying CHD in Hillingdon is higher (3.7%) suggesting approximately a further 4,096 people with CHD in Hillingdon are undiagnosed. The admission rate for CHD in Hillingdon is 632.8 for every 100,000 people in the population (1,347 admissions). CHD admission rates have been relatively unchanged over the last 10 years.
- **COPD** prevalence in GP registered adults (1.2%) is higher than London (1.1%) but lower than England (1.8%), with a slight increase trend over the last decade. The modelled prevalence estimate of underlying COPD in Hillingdon is higher (2.8%) suggesting under-diagnosis. The COPD admission rate in Hillingdon is 1.7 per 1,000 people (482 admissions) with a mean length of hospital stay of 4.1 days. COPD admission rates have remained relatively unchanged over the last 10 years but there is a gradually decreasing trend in length of hospital stay.
- **Dementia** prevalence in people aged 65 and over (4.2%) is similar to the national average (4.3%) but lower than London (4.5%).
- Prevalence of self-reported **depression** and **anxiety** in the GP registered population is 9.9% which is lower than London (12%) and England (12%).
- **Intentional self-harm** emergency hospital admissions (124.5 per 100,000) for Adults are lower than the national average (191.4 per 100,000).

Section 3: Strategic Context: The Sustainability & Transformation Plan (STP)

In developing our local Commissioning Intentions, Hillingdon CCG (HCCG) not only needs to consider our local challenges but the needs and challenges in the wider context of North West London and nationally. This chapter starts by exploring the national context and the North West London response to these challenges before outlining the local challenges.

Section 3a: The National Strategic Context

The national strategic context is laid out in the NHS document "The Five Year Forward View" most notably the fact that without changes to the way healthcare services are delivered and the resulting financial efficiencies the NHS will need an additional £30 billion a year by 2020/21. Some of the options discussed in this comprehensive document as to how the NHS can respond to the national and local challenges are outlined below:

- 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.

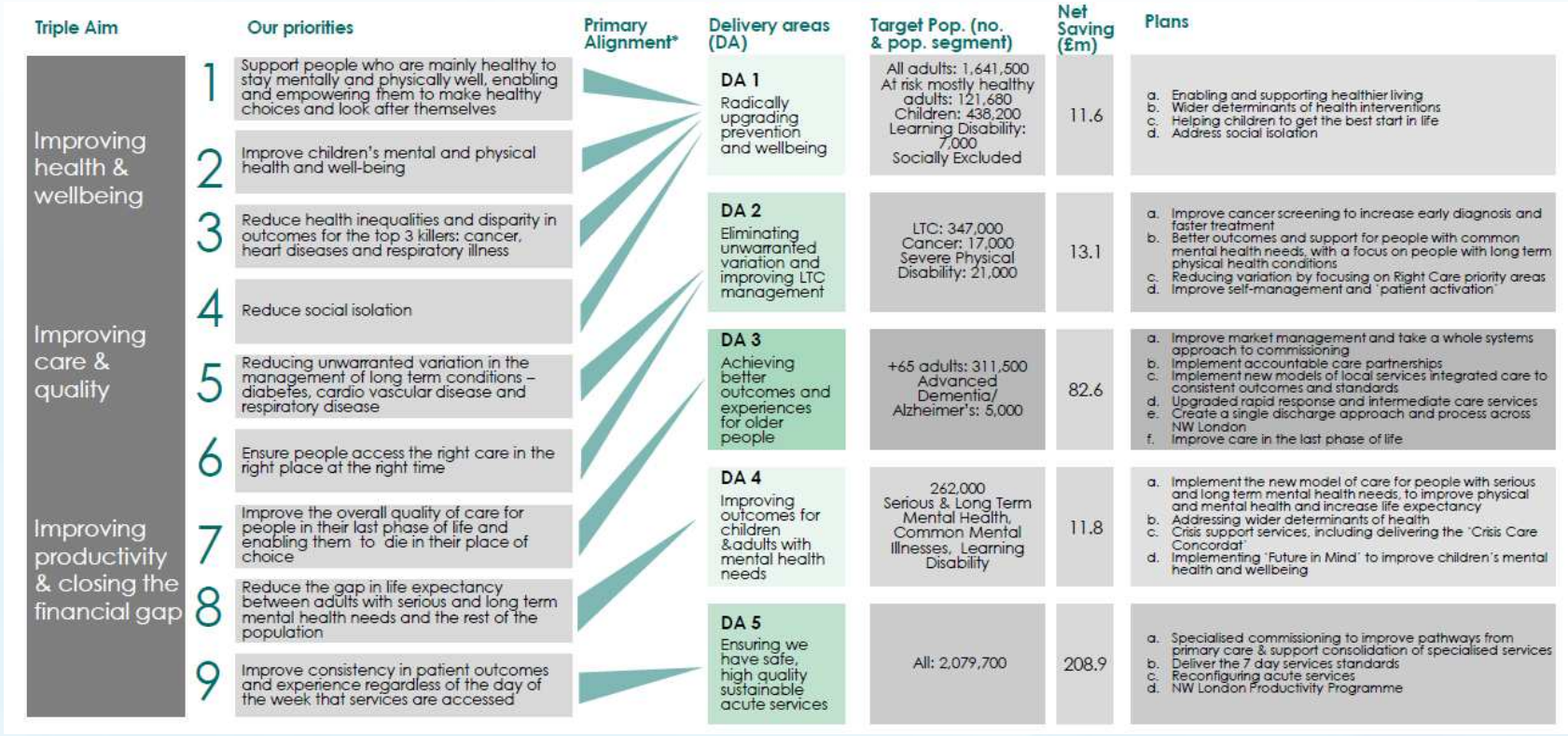
- The NHS will provide more support for frail older people living in **care homes**.

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

Section 3b: The North West London Sustainability & Transformation Plan (STP)

NHS England have asked for CCGs to work across borders and with the public and providers to develop their response to the Five Year Forward View via Sustainability & Transformation Plans (STPs). For Hillingdon CCG we are collaborating with the other seven CCGs in North West London (NWL) to produce our STP and are also working locally across our network of partners and providers locally to ensure the STP reflects our local needs as well as NWL priorities.

In setting out the requirement for CCGs to respond NHS England identified three gaps (collectively called the Triple Aim) that need to be tackled: Health & Wellbeing Gap, Care & Quality Gap and the Efficiency & Finance Gap. The North West London CCGs have agreed nine local priorities that collectively will deliver the Triple Aim. These are grouped into five delivery areas and ultimately in to 22 Improvement Areas. This is summarised in the diagram below along with the indicative numbers associated with North West London.



Section 3c: The Local Digital Roadmap (LDR) for North West London (NWL)

The NWL LDR is key to supporting the identified STP priorities, harnessing technology to accelerate change as the NWL care community moves towards greater digital maturity in delivering clinical services – creating digitally connected citizens and care professionals. The main components of the LDR strategy are:

1. **Automate clinical workflows and records,** particularly in secondary care settings (primary care is already largely paper-light) to **remove the reliance on paper** within care settings and **support transfers of care through interoperability**, replacing paper correspondence between care settings

2. **Build a shared care record across all care settings**, again through interoperability, to deliver the **integration of health and care records** required to support emerging and new models of care, including the transition away from hospital care to new settings in the community and at home

3. **Extend patient records to patients and carers**, to help them to become more **digitally empowered** and take an active role in their own care, and supporting the shift to new channels of care

4. Provide people with **tools for self-management and self-care**, further supporting **digital empowerment** and the shift away from traditional care to new channels

5. Using **dynamic data analytics** to inform care decisions and support **integrated health and social care through whole systems intelligence**

To ensure the elements of the LDR deliver to best effect we need a continued focus on some of the underpinning principles of high quality IT including:

- Improved accuracy, timeliness and quality of data entered into clinical and non-clinical systems
- Ensuring data is safe and secure, further embedding role-based processes for access and as much as possible ensuring that access is systematised
- Identification and mitigation of issues of non-compatibility across software packages
- Maximisation of the opportunities presented by mobile working to reduce the need for double-entry and increase time for patient-facing activity

There is also a need to address how data is transmitted. In the last 5 years there has been a huge increase in the amount of data being transmitted to and from services. To allow for this growth to continue we will have to address the limits being imposed by the current service provider (N3). Working with partners across the system and ensuring that we align our commissioning and contracting intentions to these priorities will accelerate and strengthen the systematic use of data and information to deliver high quality, timely, secure and person-centred care.

Section 3d: The North West London 'Transforming Care Partnership Plan' (TCP)

The North West London (NWL) 'Transforming Care Partnership Plan' (TCP) focuses on improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with learning disabilities, autism and challenging behaviour. This covers such things as:

- **Community Support:** including the utilisation of more skilled staff to manage more people with complex/challenging behaviour. This will specifically focus on accommodation and behavioural support for this cohort, informed by the market development work that we will undertake within NWL.
- **Crisis Care Pathways:** available 24 hours a day, 7 days a week, that ensure people with a learning disability and their families and carers receive care that meets their needs in times of crisis including when the crisis occurs outside of the standard working hours.
- **Community Forensic Pathway:** Development of a North West London service for people who have a forensic history and present a high risk of offending to provide the specialised psychological support required. This also includes people with Asperger's syndrome.

The overarching outcomes of the TCP are to:

- Reduce the reliance on inpatient services and strengthen support in the community.
- Improve quality of life for people in inpatient and community settings.
- Build up the community capacity to support the most complex individuals in a community setting and avoid inappropriate hospital admissions.

This is with view to:

- Supporting a universal level for positive access to, and effective response from, mainstream services.
- Targeted work with individuals and services enabling others to provide person centred support to people with learning disabilities and their families/ carers.
- Responding positively and effectively to crisis presentation and urgent demands.
- The quality assurance and development of strategic services in support of commissioners.
- Specialist direct clinical therapeutic support for people with both behavioural and health support needs.

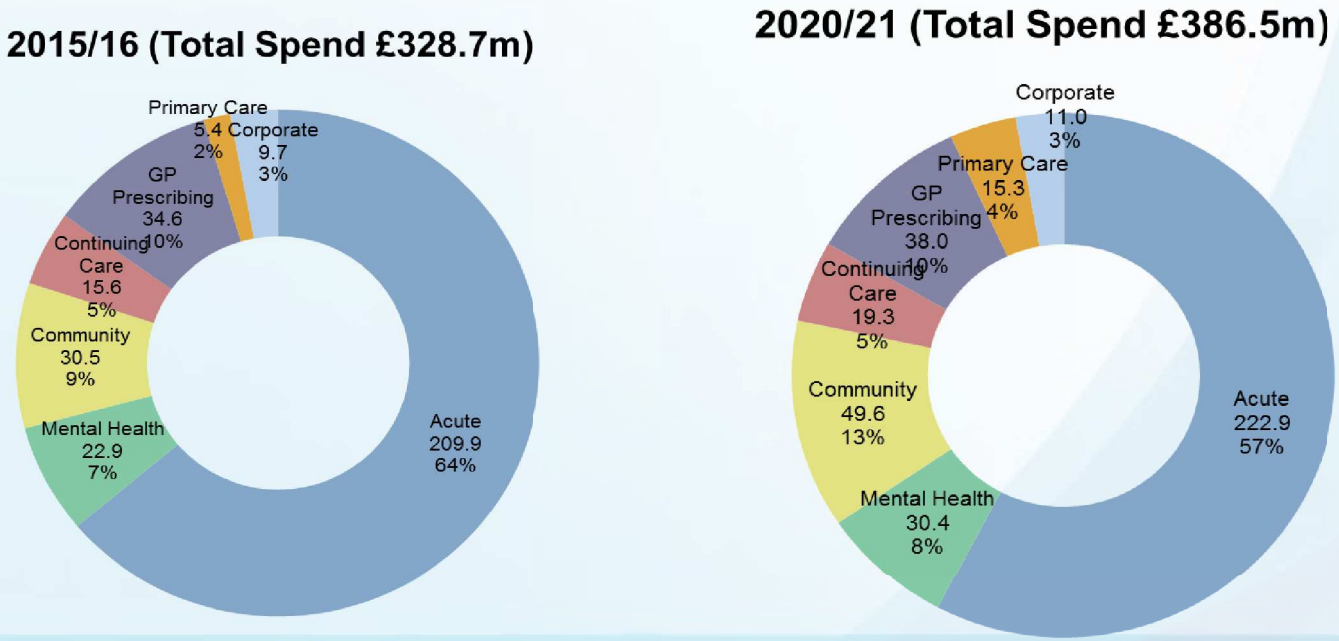
Hillingdon's TCP Local Annexe can be found at:
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/tcp_local_annex_hillingdon.pdf

Section 3e: The Local Financial Challenge

Between 2016/17 and 2020/21 it is expected that demand for services will increase by ~21%. This is made up of the expected growth in the population (called demographic growth) of ~7.4% and the growth in the prevalence of disease and ill-health through such things as increasing rates of diabetes (called non-demographic growth) of ~13.2%.

If we compare the expected growth in demand with the financial allocations we expect from NHS England over the next five years (this being the amount of money available to Hillingdon CCG to spend on healthcare services) we predict that Hillingdon CCG will develop a gap of ~£40m between now and 2020/21. It is therefore essential that our plans include a range of approaches to address this gap including preventing people becoming ill in the first place (through encouraging healthier lifestyles) as well as ensuring that the services we commission are truly delivering the outcomes we expect, in a way that provides best use of resource – integrating where appropriate, reducing duplication and improving coordination. In addition to the budgets we hold as a CCG substantial commissioning budgets are held by NHS England for specialist commissioning and primary care. The numbers in this document do not include the impact of those budgets if responsibility for them were to transfer to the CCG.

The following diagrams show how expenditure is likely to change based on projected allocations to the CCG over the period to 2020/21:



As mentioned, the growth in allocated funding for the CCG is expected to be less than the costs associated with the growth in demand.

An indication of the settings where savings might be realised is given in the table below:

NET QIPP SAVINGS						
	16/17	17/18	18/19	19/20	20/21	Total
	£'000	£'000	£'000	£'000	£'000	£'000
QIPP						
Acute	(8,977)	(9,118)	(8,602)	(8,520)	(8,765)	(43,982)
MH	(483)	(300)	(567)	(583)	(596)	(2,528)
Community	(1,354)	(714)	(293)	(618)	(574)	(3,552)
CHC	(495)	(305)	(174)	(304)	(182)	(1,459)
Primary Care	(1,500)	(1,650)	(1,574)	(1,512)	(1,444)	(7,680)
Reprovision Costs	4,163	2,950	3,700	3,100	2,750	16,663
Total	**(8,646)**	**(9,137)**	**(7,509)**	**(8,436)**	**(8,811)**	**(42,539)**

This is further broken down by the POD (Point of Delivery) as shown below:

	16/17	17/18	18/19	19/20	20/21	Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	Activity
Acute QIPP PODs							
A&E	(173)	(544)	(453)	(453)	(453)	(2,075)	(18,135)
Non-Elective Spells	(4,329)	(4,647)	(5,083)	(4,503)	(5,056)	(23,617)	(11,787)
Elective Spells	(75)	(1,001)	(1,001)	(1,001)	(1,001)	(4,079)	(3,299)
1st Outpatient attendances	(787)	(581)	(533)	(432)	(605)	(2,938)	(17,995)
All Subsequent Outpatient attendances	(1,298)	(1,276)	(1,203)	(1,102)	(1,124)	(6,004)	(58,586)
Other	(2,315)	(1,069)	(329)	(1,029)	(526)	(5,267)	(8,995)
Total	**(8,977)**	**(9,118)**	**(8,601)**	**(8,520)**	**(8,765)**	**(43,981)**	

Section 3f: Responding to Local Challenges

The previous section outlined the financial challenge faced by the CCG in the forthcoming years. To enable the CCG and our partners to continue to be able to deliver high quality, accessible services then we will need to change the way that patients are identified, supported, informed and involved including through the ways described below:

1. Proactively identifying people at risk of developing disease and ill-health and supporting them to avoid developing Long Term Conditions.
2. Managing people with Long Term Conditions to keep them stable and healthy for longer and therefore reducing the need for hospital based services.
3. Ensuring that people with an urgent or unplanned need are treated in the most appropriate setting which may not be at hospital.
4. Working across health and social care boundaries to provide truly integrated services for children, people with a mental health need and older people.
5. Moving services out of hospital into lower cost settings where appropriate.

To support the changes in our services outlined above we intend to test a new way of commissioning our providers that enables staff from different services and organisations to work together, delivering care that is centred on the patient without different funding streams, organisational targets and incentives getting in the way. In 17/18 we will test this approach on the delivery of care for older people.

Over the next 5 years we will commission increasingly integrated care delivery and in particular will look to have consultants working with colleagues in the community and providing services in community settings.

Taking into account the North West London (NWL) Sustainability & Transformation Plan (STP) and what we wish to do locally Hillingdon CCG has built the 17/18 Commissioning Intentions around 10 Transformation Themes and 6 Enabling Themes. The full list of the Transformation and Enabling Themes are detailed below and are expanded upon in Section 7:

Transformation Themes	
T1. New Model of Care for Older People	T6. Supporting People with Serious Mental Illness and those with Learning Disabilities
T2. New Primary Care Model of Care	T7. Integrated Care for Children & Young People
T3. Integrating Services for People at the End of their Life	T8. Integration across the Urgent & Emergency Care System
T4. Integrated Support for People with Long Term Condition (LTCs)	T9. Prevention of Disease & Ill-Health
T5. Transforming Care for People with Cancer	T10. Transformation in Local Services
Enabling Themes	
E1. Developing the Digital Environment	E4. Delivering Our Statutory Targets Reliably
E2. Creating the Workforce for the Future	E5. Medicines Management
E3. Delivering Our Strategic Estates Priorities	E6. Redefining the Provider Market

These Themes (Transformation & Enabling) are aligned to the 22 Improvement Areas stated within the NWL STP as shown in the table below:

NWL STP Improvement Area	Main Alignment To The Hillingdon CCG Transformation & Enabling Themes
1. Enabling & Supporting Healthier Living	All 10 Transformation Themes
2. Wider Determinants of Health Interventions	(T4) (T9)
3. Helping Children To Get The Best Start In Life	(T7)
4. Address Social Isolation	(T1) (T4) (T5) (T9)
5. Improve Cancer Screening To Increase Early Diagnosis & Faster Treatment	(T5)
6. Better Outcomes & Support For People With Common Mental Health Needs, With A Focus On People With Long Term Physical Health Conditions	(T4)
7. Reducing Variation By Focusing On RightCare Priority Areas	(T2)(T4)(T5)(T9)(T10)
8. Improve Self-Management & "Patient Activation"	(T4)
9. Improve Market Management & Take A Whole Systems Approach To Commissioning	(T10)(E6)
10. Implement Accountable Care Partnerships	(E6)
11. Implement New Models of Local Services Integrated Care To Achieve Consistent Outcomes & Standards	(T1)(T2)(T3)(T8)(E4)(E5)
12. Upgrade Rapid Response & Intermediate Care Services	(T1)(T8)
13. Create A Single Discharge Approach & Process Across North West London	(T1)(T8)(T10)
14. Improve Care In The Last Phase Of Life	(T3)
15. Implement The New Model Of Care For People With Serious & Long Term Mental Health Needs To Improve Physical & Mental Health & Increase Life Expectancy	(T6)(E5)
16. Address The Wider Determinants Of Health	(T1)(T4)(T9)
17. Deliver Crisis Support Services Including Delivering The 'Crisis Care Concordat'	(T6)(T8)
18. Implementing "Future In Mind" To Improve Children's Mental Health & Wellbeing	(T4)(T7)
19. Specialised Commissioning To Improve Pathways From Primary Care & Support Consolidation Of Specialised Services	(T2)(T10)(E5)
20. Deliver The 7 Day Services Standards	(T10)(E4)
21. Reconfigure Acute Services	(T8)(T10)(E4)
22. Deliver The North West London Productivity Programme	All Transformation & Enabling Themes

The savings (QIPP Efficiencies) that are needed to be delivered are aligned to all of the 10 Transformation Themes and several of the Enabling Themes. Indicative efficiencies are stated for each year from 2016/17 to 2020/21 in Section 7. The reason for these figures being indicative is that it is difficult to fully disaggregate the expenditure for (say) Urgent & Emergency Care from the expenditure on Children & Young People as there is a significant overlap between the two. Both the QIPP targets stated in Section 7 and the estimated expenditure against each Theme stated below are therefore meant as an estimate and are both subject to change.

Section 4: Listening to the Voice of Local People

Section 4a: Overview

Throughout 2015/16 and into 2016/17 a variety of engagement activities undertaken by the CCG and with partner organisations have provided opportunities for dialogue with local people about what they want from local health services. This feedback helps the CCG to shape our priorities and helps us design solutions that meet the needs of the population we serve.

In addition to engaging with the public we also engage with our local GPs, Public Health colleagues, providers such as our local acute (hospital) services providers and community and mental health providers as well as patients, carers and our third/voluntary sector partners. This on-going programme of engagement enables us both to obtain feedback on current services as well as seeking feedback on the changes needed for the future.

Based on the extensive engagement programme over the last 18 months we have summarised some of the main pieces of feedback received. This is presented to give a summary of the many hundreds of individual pieces of feedback and suggestions we have received that have been used to shape the detail of the Commissioning Intentions presented later in this document.

"You Said"	What Hillingdon CCG has done to date	What Hillingdon CCG will be doing in 2017/18
We need improved awareness and easier access to mental health services for both adults but also specifically for children and young people.	We have created a Single Point of Access to provide support for Adults with a mental health need and have developed a plan for Children and Young People that will be enacted through the rest of 16/17 and into 17/18. We have also worked hard to improve support for people of all ages with an urgent need and will continue to do so.	We will be rolling out an integrated service for Children and Young People (CYP) with a mental health need. This will be done in collaboration with our partners in the London Borough of Hillingdon. We will be focusing on people with a dual diagnosis covering both a physical need and a mental health need and improving support for people with low level mental health needs that are often associated with lifestyle factors and long term conditions.
We want to more integrated support for children and improved support for children as they move into adult services	We are rolling out improvements for children and young people including establishing a Consultant led team in our local A&E and a Paediatric Assessment Unit. We are working on plans with our partners at the London Borough of Hillingdon to jointly commission integrated services for children covering both those with physical and those with mental health needs.	We will be seeking to provide improved support in the community with more joint working between GPs and Consultants to support children and will be working with partners to improve the transition from children's services into adult services to make the care needed as seamless as possible.

We are concerned that children's issues are not being addressed in schools	We are working with the council who provide school nursing services on this matter. Our local hospital are providing services for children with asthma and allergies and diabetes, part of this care is being delivered via schools. We are keen to develop these models further, this includes working with CAMHS to support emotional health in schools such as anxiety, body image and self-harm.	Schools have their own budgets to provide care in schools the CCG will continue to find ways of delivering service's both through and with schools in partnership with the London Borough of Hillingdon who provide the bulk of school based services.
We need a 'one stop' approach to Urgent Care that includes support in the community	We have been working with other CCGs in North West London to develop an Integrated Urgent Care Service covering the NHS 111 Service, Urgent Care Centres (UCC), A&E Departments, GP Services and the London Ambulance Service (including the 999 Service). Locally we have extended the scope of services offered by our UCC and improved links between both the hospital and the UCC with GP Practices.	The new Integrated Urgent Care Service will see much greater integration between NHS 111, 999, GP Services (including Out of Hours) and our UCC. We will continue to extend the scope of our UCC to enable it to take more patients who would otherwise need to be treated in the A&E Department. We will also be seeking to introduce a virtual Walk in Centre at the UCC to treat people attending with low level needs.
Improve waiting times for wheelchair services	We have procured a new service with our partners at Harrow CCG and this has been established. Lead times have dropped and we are receiving generally positive feedback.	We will full establish a patient and carer forum with the new provider and will seek to iron out any residual issues. However, the new service does offer a number of enhancements including a much reduced waiting time for the majority of patients and improved access.

Section 4b: Major Recent Engagement Events

We held two heath conferences during 2015/16 collectively involving over 320 local people and a further two during the first part of 2016/17 involving very similar numbers. As well as introducing the CCG and talking about some of the changes to health services locally there were facilitated interactive sessions with members of the public, representatives of community groups, third sector, public health partners and clinicians to set the scene on commissioning and ask for some thoughts on priorities. Other groups and events where we have engaged include:

Faith Groups

Workshops were held to discuss health issues and raise awareness of long term conditions such as tuberculosis amongst community/faith groups providing information to diverse groups as well as encouraging dialogue and signposting to local services. Members were involved from 11 different faith organisations including Harlington Baptists Church, Hayes Islamic Education and Cultural Centre, Quba Islamic and Education Centre, Sant Nirankari Mission (Hindu organisation), Desi Radio and Punjabi, Hillingdon Asian Women's Group, The Community Voice, REAP (Refugees in Effective and Active Partnership), Healthwatch Hillingdon and P3 – People Potential Possibilities (who provide youth services).

Children & Young People

A series of engagement activities were undertaken with young people between the ages of 5 and 18 throughout Hillingdon borough between February and July 2016. They focused upon Children and Young People's Mental Health Services including the experiences of young people and how these could be used to inform targeted and universal mental health and wellbeing services in Hillingdon. Over 350 young people participated and we gained valuable feedback and insight into how we should shape our services for 2017/18 onwards which is included within this document.

Fundamental Health Event

Working in partnership with The London Borough of Hillingdon we launched 'Fundamental Health' - a mental health and wellbeing event for 11 to 18 year olds themed around the national 'Five Ways to Wellbeing' Initiative. The aim of the event was to raise awareness about mental health and wellbeing, reduce stigma and give young people the opportunity to share their thoughts and experiences about mental health and wellbeing services.
This provided us with a platform for developing our transformation programme for mental health and learning disabilities.

Network Meetings with our Member Practices (GPs)

As a membership organisation we also take seriously our responsibility to work with and help member GP practices and wider primary care to quality assure current standards. We work closely with NHS England and strive to continually improve the range and quality of services we offer. The CCG's geographic area is divided into three localities. Monthly locality meetings involving our 46 GP Practices are held for the purpose of discussing current services, service changes and feedback on changes for the future. All of this feeds into our Commissioning Intentions.

Website

In addition to events outlined above we frequently use our website to describe our priorities and strategic intentions – giving people opportunities to share their views on an ongoing basis.

Hillingdon CCG sees engagement of the public and our partners and providers as essential to both helping shape services for the future and to aid understanding of how and why decisions are taken. Our extensive programme of engagement will continue into 2017/18.

Section 5: Our Local Quality Priorities

Section 5a: Our Vision for Quality: 'Improving quality creating consistency'

We believe that the people of Hillingdon are entitled to a high quality and safe experience in any of the healthcare services commissioned by Hillingdon CCG. We will continue to listen to our patients and carers and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

Our quality duty is a statutory obligation and we consider we are well placed to assure people about the quality of the health services they commission. This is because we are:

- A clinically led commissioning organisation
- Have in-depth knowledge about local health services and communities
- Receive and analyse feedback from local people using local healthcare services
- Are dedicated to placing quality at the heart of commissioning activities
- Work in close partnership with other commissioners

We will ensure learning from our quality and safety assurance processes is triangulated from a variety of sources to inform what high quality, safe and effective care looks like across the Borough of Hillingdon.

From our engagement sessions we have learnt that the following are key priorities for our patients and carers:

Key priority for our patients and carers	What We Will Do
Provide Seamless Services Across Providers	We will continue to foster partnership working across organisations both through our on-going Clinical Quality Review Group structure and through the development of our Accountable Care Partnership. The development of the Sustainability & Transformation Plan for North West London has also given us the opportunity to work with partners to understand how we can improve services. Lastly, we will continue to progress the existing integrated care services we have already introduced and those we are planning including for people at End of Life and those for people with various Long Term Conditions.
Improve partnership working across health and social care services	We will continue to share ideas and discuss opportunities with our social care partners and have various forums for this to occur within. We are exploring additional opportunities for joint working and joint commissioning with a focus on Children and Young People as well as services provided for older people.
Rapidly reduce the variation in care received across and within providers	This is a major reason for the work we have done to date to integrate services for people with Long Term Conditions (which include Diabetes, Respiratory Diseases and Cardiology). We will extend this work and will also be working with Primary Care Colleagues to develop a new Model of Care for Primary Care and a joint Prevention Strategy that will focus on both primary prevention (preventing disease and ill-health) and improving outcomes for people with Long Term Conditions once diagnosed.
Be open and transparent and be honest when things do not go as planned	We continue to undertake audits and to manage complaints we receive robustly. We monitor provider quality through our Clinical Quality Groups and constantly review whether we are seeking sufficient and appropriate assurance of the quality they are receiving, something we obtain through direct and indirect patient feedback as well as a range of quality indicators.
Ensure care is delivered with compassion and that it is personalised to the needs of each person	We will monitor and review the trends and themes from our provider patient experience teams which includes; complaints, friends and family test results and patient surveys. Any concerns in relation to these will be explored via the Clinical Quality Review Group.
Ensure providers continue to have a safe and skilled workforce that feel valued in their work	We will continue to monitor the providers' safer staffing reports and their staff surveys via the Clinical Quality Review Groups and seek assurances and actions when there are concerns raised in relation to the workforce.

Section 5b: Our Quality Principles

The CCG Quality and Safety team apply the following principles to all of the work done within the CCG:

- Apply systematic approaches to monitoring and improving quality with the patient at the centre and with them in the line of sight.
- Proactively address any organisational barriers which hinder quality of care.
- Foster an open and transparent culture across the local health system.
- Maintain a systematic approach to proactive and early identification of service quality failures.
- Ensure there are robust links between commissioning priorities, the strategy and transformation plans and quality.
- Prioritise our quality assurance and improvement efforts developing an integrated approach with social care to reflect the Better Care Fund changes.
- Drive effective engagement with key stakeholders across BHH to achieve the delivery of robust measurable outcomes that reflect *"what matters most to patients".*
- Build work streams to define robust integrated quality & safety indicators that will deliver agreed Place Based outcomes.
- Ensure evidence based guidance & learning from assurance processes across Health and Social Care underpin & inform the design of outcomes to support place based care.
- Ensure "I statements" from patient's, families and carers engagement events are reflected in indicators and outcomes when redesigning services and measures.
- Ensure that governance and assurance mechanisms are appropriate to support "Place based" commissioning between the local authority and the CCG including: integrated pathways, integrated contractual monitoring (CQRG), integrated assurance visits, shared quality improvement plans.
- Embed the application of Quality Impact Assessment methodologies across Local Authority and CCG **QIPP (Quality, Innovation, Productivity and Prevention**) & financial plans including commissioned providers.

Everything we do is focused on delivering high quality care for the population we serve and these Commissioning Intentions have been written to align with our vision, priorities and principles.

Section 5c: Safeguarding

Hillingdon CCG has comprehensive and robust roles, systems and processes in place to protect and safeguard vulnerable children and adults. There are safeguarding strategy and policies available via the CCG website for further information. The CCGs' quality governance roles and committees oversee reporting and monitoring of compliance with safeguarding requirements.

We will:

- Continue to be active members of key Hillingdon Safeguarding Adults Boards and Safeguarding Children's Boards.
- Continue to work together with Quality and Safety colleagues to ensure valuable learning and triangulation of data is effectively utilised alongside Safeguarding alerts and concerns.
- Work in close affiliation to the Continuing Healthcare team who manage and support some of the most vulnerable people in the community.
- Have joint meetings, alignment of complaints, serious incident and Never Event data, and feedback from quality assurance processes such as Clinical Quality Assurance Visits, CQG meetings etc. This will involve the coproduction of systems and processes to enable the timely sharing of such information.

Our Safeguarding Priorities	What We Will Do
Listening to children & young people and adults at risk	• Work with children's services to review the needs of all Hillingdon's children and young people especially those with additional needs; children looked after and those involved with the youth offending services. • Make Safeguarding Personal (MSP), ensuring that the adult at risk is involved in the process throughout (nothing about me, without me) • Ensure that decisions are made in a person's best interest following a mental capacity assessment.
Safeguarding Education and Training (Adults & Children)	• Continue to monitor and challenge the Providers of contracted services to comply with safeguarding responsibilities and achieve targets. Safeguarding Children and Adults training should also include Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Violence and Abuse, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) and an introduction to the PREVENT agenda concerning radicalisation. • Increase the number of staff trained and training levels, to be monitored through contractual arrangements to assure compliance. • Audit key providers in their functions and implement the actions recommended.
Safeguarding Medicals	• Work with the commissioner and providers community and acute to secure safeguarding arrangements.
PREVENT	• Continue to ensure training is rolled out to staff that is commensurable to their level of responsibility. • Improve support to vulnerable children and adults including those at risk of radicalisation.
Domestic Violence and	• Monitor compliance with Nice Guidance 2016 to ensure that staff are trained and that victims and families at risk are identified,

abuse	assessed and referred for appropriate care. • Monitor number of victims identified by all providers.
Work with the sector to provide an evidence and needs base for CSE	• Develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM).
Information Sharing	• Continue to highlight responsibilities and importance of information sharing and support the CCG and providers to share information appropriately. Adhere to the Multi agency Safeguarding information sharing guidance.
Young Offenders, Looked After Children and Children with Disabilities and Additional Needs	• Work with children's services to ensure their health needs are identified and met, working with the providers to ensure they understand their responsibilities.
Reduce the incidence of Pressure Ulcers	• Reduce harm to patients and achieve an incremental reduction in pressure ulcers along with further work to prevent pressure ulcers.
Ensure adults at risk are protected from avoidable harm	• Ensure a positive experience of care in a safe environment. • Prioritise "Best Interest" of Adults at Risk.

Section 6: 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) but also includes services delivered by Carers, Voluntary and Third Sector partners in a variety of domestic and other settings and collectively these organisations and partners along with services commissioned by NHS England and our Local Authority (The London Borough of Hillingdon) form '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 2017/18.

Section 6a: The Current Provider Market

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 minority 'opted out' which places the responsibility for provision with the CCG. More recently the networks have been exploring setting up a single GP federation for Hillingdon and a joint COO and clinical lead have been appointed to help facilitate this.

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 other Clinical Commissioning Groups who are party to the same contract with CNWL. 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.

Hospital Based 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 and the transition of Paediatric Services at Ealing Hospital that occurred in July 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.

In addition to being the leads on the contracts for THH and RBH, Hillingdon CCG is also an associate commissioner on the contracts for other acute trusts where our patients are treated.

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.

Carers

We must not forget the valuable contribution made by carers of all types who support individuals of all ages and greatly add to their quality of life and the outcomes they experience.

Section 6b: Our Intentions for 2017-18

This section provides a high level overview of our Commissioning Intentions for 2017-18 in respect to the Provider Market. This lists on the left what we intend to do and on the right the expected benefits to the population we serve.

General Intentions (Applicable to all Providers)	
• We expect all providers to make full use of eReferrals and aim to eliminate any referrals issued via other means. No referrals should be made by fax.	**What does this mean for the population we serve?** • Referrals sent immediately and with less chance of being 'lost' • Improved data sharing between clinicians enabling care to be better coordinated. • Improve quality of care provided from different healthcare organisations and more assurance that the CCG is commissioning high quality services.
• We expect all NHS providers to utilise EMIS compatible systems to access, update and use a full Shared Care Record that is integrated across Health and Social Care to improve patient care. This goes beyond the limited expectations set out for the Summary Care Record (SCR).	
• We will implement a schedule of clinical and quality audits guided by anomalous activity, CQC reports, patient feedback or other sources.	

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 build on the work done in 2016-17 and progress to testing an ACP approach in 2017-18. Through this process we will expect providers involved in the ACP to contribute to the delivery of the three main NHS challenges (Health & Wellbeing, Care & Quality & Finance & Efficiency) and also address how membership of the ACP can flex and change if needed over time.	**What does this mean for the population we serve?** • A joined up, integrated and coordinated health care system across all health care providers in Hillingdon including voluntary and third sector providers. • Improved coordination of services across health and social care. • A coordinated and capable urgent care system that will improve access to information to enable clinicians to make timely and appropriate decisions.
• In line with the Commissioning Standards for Urgent & Emergency Care (UEC) we will be seeking to redesign our Urgent & Unplanned Care Services and improve the coordination of care between the various elements including the NHS 111, Urgent Care Centre, GP Out of Hours and A&E based services.	
• Greater integration across care settings will need to be supported by the evolution of a shared care record across health and social care and work on this will continue into 17/18 and on-going delivery of our Better Care Fund (BCF) plan.	
• 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/federation and will work with them to design, shape and deliver a new Model of Care for Primary Care that sees them playing an essential role in supporting our Out of Hospital Strategy and an increasingly important role in supporting patients with Long Term Conditions to self-manage elements of their care.	**What does this mean for the population we serve?** • Improved access to Primary Care particularly for those with complex needs and a reduction in the variation of care received by people with Long Term Conditions. • Better coordination between Primary and Secondary (hospital) care and improved sharing of appropriate information to enable clinicians to make appropriate and timely decisions.
• The new Model of Care will include current commissioned services including the Integrated Care Programme (ICP) and a new approach to the Primary Care Contracts (PCCs) and various other contracts we hold with practices as well as new services focused on supporting Older People and those with Long Term Conditions.	
• We will continue with our local delivery plan for the strategic commissioning framework for primary care (as set out by NHS England) that focusses on accessible, proactive and coordinated care	
• 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 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.	**What does this mean for the population we serve?** • Services redesigned to meet the future needs of our population and which are integrated fully with other provider organisations. • More services delivered closer to home.
• We will work with our main Community Provider (CNWL) on how they can support our need to move more activity out of hospital and to align Community Services to the emerging Primary Care Model of Care and Older People Model of Care and to embed and expand the existing work around supporting people with Long Term Conditions.	
• We will continue to work closely with CNWL on the delivery of the efficiencies within the contract and also additional, opportunistic, efficiencies.	
Mental Health	
• We will continue to work collaboratively with the main provider of Mental Health Services CNWL to develop cost effective high quality services in the Borough, evaluating the impact on the whole Mental Health system of the Business Cases approved in 2015/16.	**What does this mean for the population we serve?** • Improved access to Mental Health Services for people of all ages whether they have a need that is unplanned or planned. • Improved outcomes for the investment we make in Mental Health services.
• We expect to see a positive impact of additional investment in perinatal services in line with the 5 year Implementation Plan.	
• We expect Talking Therapy Services to achieve the Access and Recovery Targets within existing resources, Early Intervention in Psychosis Services to meet national targets and agreed outcome measures and the full implementation of the Hillingdon Dementia Action Plan.	
• We will continue to roll out the 5 year CAMHS Transformation Programme and will expect to see a reduction in local waiting times and the number of admissions to Out Of Area (OOA) Tier 4 services.	
• We will work in partnership with key stakeholders to develop a fully integrated Children and Young Peoples Mental health Service from wellbeing and prevention to specialist interventions	
• We will expect to see evidence of a reduction in psychiatric admissions via A&E and to see a positive impact of additional investment in Learning Disability Services.	
• We anticipate the local development of Employment support services embedded in both Talking Therapies and Primary Care plus Services in line with the Trailblazer Employment initiative.	
• In conjunction with the Local Authority we expect to see the development of a comprehensive Rehabilitation Pathway.	

• We will work in partnership to expand the Primary Care Plus service to full coverage across the Borough.	
• We will expect to see a positive impact on reducing Bed numbers following investment in the Urgent Care Business Case.	
• We will work in partnership to develop a Personality Disorder Pathway.	
• We will work in partnership to implement the Like Minded 5 Year Vision for services for people with Serious and Long Term Mental Health problems, Common Mental Health problems, Primary Care, Wellbeing and Health Promotion.	
• We will work in partnership to lay the foundations to ensure we are best placed to achieve the vision for the delivery of services over the coming years to 2020/21 as set out in the Five Year Forward View for Mental Health.	
Hospital Based Acute Care	
• We will work with our main acute provider (THH) to consistently achieve our Operating Plan priorities around A&E Performance, Referral to Treatment (RTT) Targets and those associated with Cancer and Diagnostics.	**What does this mean for the population we serve?** • Continued delivery of our access and quality targets. • Improved access to services delivered both 7 days per week and, where appropriate, "Out of Hospital" and nearer to patients' homes. • Improved access to clinical information across organisations to improve clinical decision making and ultimately improve outcomes for patients.
• We will seek to move more activity out of hospital where possible and to transform our local pathways so that patients who do not need to be treated in hospital are treated in a more appropriate setting.	
• We will work to embed our existing Integrated Services for people with Long Term Conditions and seek new opportunities to improve outcomes for people living with LTCs, for example extending access to Talking Therapy IAPT services for people with LTCs such as Diabetes, COPD and Cancer as set out in the Hillingdon CCG Cancer Improvement Plan.	
• We will focus attention on the Community Assessment & Treatment Services (CATS) delivered by THH to ensure they continue to deliver our Out of Hospital aspirations and will focus on developing new CATS for Gastroenterology and Neurology Services.	
• 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.	

Carers, 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 ACO where appropriate. • We will assess the impact of the Health & Wellbeing Service delivered by Hillingdon for All (H4All) and determine whether this will continue to be funded. • We will seek to achieve all of our obligations to carers as defined in the Care Act 2014 and to support young carers (those under 18) in collaboration with our Local Authority colleagues.	**What does this mean for the population we serve?** • Improved support to carers. • Improved coordination of support across health care and the third sector which will lead to improvements in wellbeing as well as health.
Service for Children and Young People:	
• We will continue to work with the Local Authority to deliver our obligations as defined in the Children & Family Act 2014 integrating services and co-producing redesign with children young people their families and carers as part of our five year plan. This will involve proactively working with children and young people and ensuring that their voice is clearly heard in the design of services to support them.	**What does this mean for the population we serve?** • Improved integration in the support of Children and Young People across health providers and across health and social care which will ultimately lead to improved outcomes.

Section 7: 2017-18 Commissioning Intentions

As stated in Section 3 our Commissioning Intentions for 2017-18 are focused on the delivery of 10 Cross-Cutting Transformation Themes supported by 6 Enabling Themes and this section provides a breakdown of our intentions for each of these and how they will contribute to our priorities and objectives including an indicative QIPP efficiency (saving) associated with each Transformation Theme and one of the Enabling Themes.

<table>
<tr><th colspan="7">1. New Model of Care for Older People (16/17 spend ~ £97m)</th></tr>
<tr><td rowspan="2">Key Information</td><td>CCG Team</td><td>16/17 Post-Risk Net QIPP</td><td>17/18 Pre-Risk Net QIPP</td><td>18/19 Pre-Risk Net QIPP</td><td>19/20 Pre-Risk Net QIPP</td><td>20/21 Pre-Risk Net QIPP</td></tr>
<tr><td>Dr Kuldhir Johal (CRO)
Joan Veysey (SRO)</td><td>£1,107,256</td><td>£1,500,000</td><td>£1,000,000</td><td>£1,000,000</td><td>£750,000
(Total 17/18-20/21: £4.25m)</td></tr>
<tr><th colspan="2">2020/21 Outcomes</th><th colspan="2">Commissioning Intentions 17/18</th><th colspan="3">Indicative Commissioning Intentions Beyond 17/18</th></tr>
<tr><td colspan="2">By 2020/21 we will be delivering the following outcomes:

• Coordinated Care for Older Peoples' Planned & Unplanned Care Needs across Care Settings
• Improved Health Outcomes and reducing Unplanned Care needs through focusing on LTCs and age related complicating factors such as frailty
• Integrated Health & Social Care support for those patients who need it
• Empowering people to plan for their own care
• A diverse market of quality care providers maximising choice for local people who have complex needs covering both older people and other vulnerable groups</td><td colspan="2">We will:

• Develop a Carers Support Programme
• Rollout the H4All Wellbeing Service
• Integrate Unplanned Support for Older People
• Develop new 'Core Offer' for Care Homes and extra care sheltered housing, including support for the EMI and people with SMI and Dementia with Challenging Behaviours
• Embed the Memory Assessment Clinic Support Programme
• Improve coordination between health and social care around support from Continuing Health Care (CHC)
• The CCG will commit to the Dementia Action Alliance and will expect all relevant partners to do so as well
• Continue to develop and embed the integrated model of care for older people including self-care (PAM)
• Implement an integrated, shared care record across health and social care</td><td colspan="3">We will:

• Progress the next phase of an integrated system for older people including transition to capitated payment and outcome based commissioning.
• Commission a single integrated system of care via a full capitated budget for this population cohort age over 65 years.</td></tr>
<tr><th colspan="2">Measuring Success</th><th colspan="2">Supporting the Integration Agenda</th><th colspan="3">Supporting Strategies & Assurance</th></tr>
<tr><td colspan="2">Delivery of this Transformation Theme will realise:

• Reduction in Non-Elective Admissions for people aged >65 years old
• Reduction in Zero-Length of Stay Admissions for people aged >65 years old
• Reduction in overall costs associated with supporting Older People</td><td colspan="2">The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:

• Joint projects with regard to Care Homes, extra care Sheltered Housing and Home Care between LBH and HCCG
• Specifying and commissioning of a framework of services for older people as part of the development of the ACO</td><td colspan="3">The work for this Transformation Theme is underpinned by the following strategies:

• Whole System Integrated Care Strategy
• Better Care Fund
• Local Digital Roadmap

The delivery of this Transformation Theme will be managed and monitored via the Older People's Delivery Group which in turn reports to the Hillingdon CCG Transformation Group.</td></tr>
</table>

2. New Primary Care Model of Care (16/17 spend ~ £69m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr Steven Shapiro (CRO) Rigo Pizzaro (SRO)	**£171,250**	**£750,000**	**£750,000**	**£1,000,000**	**£1,000,000 (Total 17/18-20/21: £3.5m)**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18

By 2020/21 we will be delivering the following outcomes:
 	
• Increasing number of Pts managed outside of hospital setting with integration across Primary, Community & Secondary Care Services and Social Care
• Improved access to routine and unplanned services in primary care during the week and weekends
• Reduced variation in service and patient outcomes in primary care
• Sustainable primary care
	We will:
	
	• Develop and Implement the first phase of the Primary Care Model of Care focused around Unplanned Care, Care Homes, LTCs and enhanced access
	• Rationalise Primary Care Contracts and invest in Network/Federation Level Delivery
	• Exploit existing investment in EMIS Web Clinical Services to support new services and delivery models within Networks & Hubs
		We will:
		
		• Link the Primary Care Models of Care to the CCG Hub Strategy
		• Deliver Phase 2 of the Primary Care Model of Care including:
		  ○ Embedding Mental Health Support in Primary Care
		  ○ Improving Acute Flows (and reducing demand for acute services)

Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Increase in activity managed outside of a hospital setting. • Reduction in costs across the system per capita to meet the financial gap • Co-ordinated care for people with long-term conditions including primary prevention for sections of the population developing risk profiles; and secondary prevention for people with multi-morbidities to reduce hospital admissions	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Primary Care Model of Care is a key element in the delivery of integrated services across Community and Acute Services and is key to the delivery of Out of Hospital Targets.	**The work for this Transformation Theme is underpinned by the following strategies:** • Five Year GP Forward View • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

3. Integrating Services for People at the End of their Life (16/17 spend ~ £11.8m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr Kuldhir Johal (CRO) **Vittorio Graziani (SRO)**	**£75,000**	**£300,000**	**£400,000**	**£500,000**	**£500,000** **(Total 17/18-20/21: £1.7m)**

2020/21 Outcomes

By 2020/21 we will be delivering the following outcomes:

- Increasing number of people able to die in their preferred place of death
- Reducing number of admissions for people in the last 30 days of their life
- Improve access by clinicians and professionals supporting people at End of Life to anticipatory care plans
- Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings

Commissioning Intentions 17/18

We will:

- Rollout the End of Life Strategy and manage via the EoL Forum
- Develop an integrated service model including 24/7 SPA and Out of Hours Nursing Support
- Develop and rollout procurement plans around third sector services
- Increase usage of Coordinate My Care (CMC) and use of the Shared Care Record
- Improve support from the CHC Fast Track programme for eligible patients
- Seek to integrate health care and social care services for people at the end of their lives to improve the quality of care received and the support to families and carers

Indicative Commissioning Intentions Beyond 17/18

We will:

- Embed the principles of the Single Point of Access (SPA) and continue to increase the number of people who die in their preferred place of death
- Increase the percentage of people in the last phase of life with an Anticipatory Care Plan to greater than 60% of those in their last 12 months of life (measured via CMC usage)

Measuring Success

Delivery of this Transformation Theme will realise:

- Increase in people dying in their preferred place of death
- Increase in people with anticipatory care plans
- Reduction in the costs associated with managing people at End of Life

Supporting the Integration Agenda

The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:

- This supports the integration agenda through the integrated service model that will add a 24/7 SPA and Out of Hours Nursing Support to the existing support spanning primary, community and secondary care plus the services commissioned by the CCG from the third and voluntary sector
- In addition, increasing access to Coordinate My Care (CMC) and the use of the Shared Care Record will support a more coordinated and integrated approach to supporting people at the end of their life
- We will also seek to develop a joint model with Social Care that integrates the health and social care needs of people at the end of their life

Supporting Strategies & Assurance

The work for this Transformation Theme is underpinned by the following strategies:

- Hillingdon Joint End of Life Strategy
- Better Care Fund
- Local Digital Roadmap

The delivery of this Transformation Theme will be managed and monitored via the **End of Life Forum** which in turn reports to the **Hillingdon CCG Project Management Office**.

4. Integrated Support for people with Long Term Conditions (16/17 spend ~ £100m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr N Bharakhada (CRO) Rigo Pizarro (SRO)	£370,943	£1,500,000	£2,000,000	£2,500,000	£3,250,000 (Total 17/18-20/21: £9.25m)

2020/21 Outcomes

By 2020/21 we will be delivering the following outcomes:

- Improved outcomes and support for people with multiple LTCs and complex needs
- Reducing unplanned care needs arising associated with LTCs
- Reduced variation in care received by people with LTCs with a particular focus on variation in Primary Care
- Increasing focus on improved outcomes through preventative measures (primary, secondary and tertiary prevention)

Commissioning Intentions 17/18

We will:

- Refresh the Long Term Conditions Strategy
- Rollout Integrated Services for Respiratory, Cardiology (HF) and Diabetes and seek to expand to cover AF and Stroke
- Rollout an expanded Empowered Patient Programme and increase usage of Patient Activation (PAM)
- Improve support for people with multiple co-morbidities
- Seek to reduce the number of Outpatient Follow Ups and Procedures associated with key LTCs
- Develop plans around management of MH related LTCs
- Introduce new AF and Stroke ESD Services
- Pursue the opportunities identified in the RightCare methodology focusing initially on supporting people with Diabetes, MSK needs, Cancer & Respiratory diseases
- Ensure timely access to CHC support and improve the efficiency and value for money obtained via the CHC budget
- Improve advice and support to carers of people with an LTC
- Review rehabilitation services and also rationalise hospital based Health Psychology at THH
- Introduce an integrated, shared care record across health and social care and explore the use of apps and technology

Indicative Commissioning Intentions Beyond 17/18

We will:

- Progress the next phase of the Integrated Services for Respiratory, Cardiology and Diabetes
- Rollout the Complex Patient Programme to a wider cohort of people
- Focus on improving the support to those who currently need to call 111 or 999 on a regular basis
- Embed the concept of Mental Health Support for people with Physical LTCs to ensure their MH needs are met on a consistent and on-going basis
- Ensure that Care Planning and PAM become the norm for people with LTCs

Measuring Success

Delivery of this Transformation Theme will realise:

- Reduction in unplanned events for people with LTCs
- Reduction in the costs associated with supporting people with LTCs
- Increase in people with an LTC who self-manage elements of their care
- Increase in people with an LTC who have an anticipatory care plan
- Improved Quality of Life measures e.g. PAM
- Improved support for Carers
- Reduction in number of home visits, general practice appointments
- Medicines Optimisation

Supporting the Integration Agenda

The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:

- The Integrated Services for Diabetes, Respiratory & Cardiology already combine the expertise of Acute/Secondary Care and Community Services and will be expanded to have much better integration with Primary Care.

Supporting Strategies & Assurance

The work for this Transformation Theme is underpinned by the following strategies:

- Long Term Conditions Strategy
- Dementia Action Plan
- Better Care Fund
- Local Digital Roadmap

The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

5. Transforming Care for People with Cancer (16/17 spend ~ £12.7m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr S Vaughn-Smith (CRO) Vittorio Graziani (SRO)	**£25,000**	**£250,000**	**£500,000**	**£500,000**	**£500,000 (Total 17/18-20/21: £1.75m)**

2020/21 Outcomes

By 2020/21 we will be delivering the following outcomes:

- Increasing rates of cancer prevented and increasing survival rates
- Reduction in the rates of reoccurrence
- Reduction in variation rates in the quality of care
- Patients and their families better informed, empowered and involved in decisions around their care
- Improved health, wellbeing and quality of life for patients after treatment and at the end of life
- Reducing number of patients identified as having Cancer following a non-elective presentation

Commissioning Intentions 17/18

We will:

- Develop access to psychological support for people with Cancer
- Develop a digital care support menu jointly with our partners at the London Borough of Hillingdon
- Establish a Local Cancer Board and Clinical Working Group with a detailed dashboard to enable effective decision making
- Fully implement stratified care pathways for priority cancers
- Develop localised programmes for delivery of lung and prostate screening
- Implement a Patient & Carer Engagement Group to help deliver the actions from the National Cancer Patient Experience Survey
- Work with partners to improve access to and support to our BME community suffering with Cancer
- Achieve the 28 day standard for cancer diagnosis in three site-specific areas: Breast, Urology and Lung
- Promote awareness of the Cancer Decision Support Tools within EMIS

Indicative Commissioning Intentions Beyond 17/18

We will:

- Finalise rollout of Cancer Stratified Pathways across all Cancers
- Embed Cancer Support (including proactive case finding and screening) into the Primary Care Model of Care
- Implement a clear policy on DNA follow ups
- Significantly improve the coding of Cancer within Primary Care
- Continue the rolling education programme in partnership with Cancer Research UK
- Enhance diagnostic capacity to meet expected prevalence growth rates
- Develop enhanced support to people living with Cancer
- Explore the use of a Shared Care Record across the London Cancer Network

Measuring Success

Delivery of this Transformation Theme will realise:

- Reduction in the prevalence gap around Patients identified with Cancer in Primary Care
- Reduction in the number of patients identified with Cancer following a non-elective presentation
- Increase in life expectancy at 5 years following successful treatment of patients

Supporting the Integration Agenda

The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:

- Cancer by its very nature is a cross-cutting issue affecting all aspects of health care provision including Mental Health, Hospital Based Care and Primary Care. The Cancer Improvement Plan being developed by the CCG will ensure that support is coordinated across the entire Cancer pathway from screening/prevention through to survivability and end of life. This will ensure that support from third sector and voluntary organisations as well as the support from social care are fully integrated with services provided via NHS providers.

Supporting Strategies & Assurance

The work for this Transformation Theme is underpinned by the following strategies:

- National Cancer Strategy
- London Cancer Strategy
- NWL Sustainability and Tr Plan
- NWL TCTS Transformation Plan
- Hillingdon Cancer Improvement Plan

The delivery of this Transformation Theme will be managed and monitored via the **Cancer Clinical Working Group** which in turn reports to the **Long Term Conditions Transformation Group**. Non clinical elements of the service will be coordinated through development of **Local Cancer Board**, while clinical elements will be managed by the **Cancer Board** which is led by clinicians at THH.

6. Transforming Support for people with Serious Mental Health Needs and those with Learning Disabilities (16/17 spend ~ £30.5m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr S Vaughn-Smith (CRO) Joan Veysey (SRO)	**£399,700**	**£1,000,000**	**£500,000**	**£500,000**	**£500,000 (Total 17/18-20/21: £2.5m)**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Reduction in inequalities associated with the care of people with one or more LD • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population • Full Implementation of Five Year Forward plan for Mental Health	We will: • Support people in crisis by fully embedding Urgent Care, OOH, SPA and rapid response functions • Develop all age early intervention service and packages of care for first episode psychosis • Expand ICP to include people with dementia and MH Conditions • Develop new models of care for people with severe mental illness and learning disabilities in the community • Implement NWL Like-Minded Strategies covering severe mental illness, common mental health, primary care and wellbeing and promotion to ensure sustainability • Further develop an integrated 5 year plan for CAMHS including Tier 4 • Improve support to carers where needed and appropriate • CNWL as our main provider must implement the Shared Care Record and ensure EMIS compatibility following the migration to SystmOne	We will: • Implement Like-Minded Business Cases • Implement the recommendations from CAMHS OOH, Urgent Care and Like-Minded evaluations • Review 16/17 CAMHS investment and business cases • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health • Progress delivery of Transforming carte for people with LD • Progress delivery of 5 year CAMHS transformation plan • Progress delivery of Like Minded plans Specifically: • Implement Like-Minded Business Cases • Implement the recommendations from Adult and CAMHS OOH, Urgent Care and Like-Minded evaluations • Progress to an integrated CAMHS model • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • People with SMI (Severe Mental Illness) to receive complete list of physical health check to achieve reduction in the mortality gap • Access to community mental health services and IAPT from BME groups, crude rates per 100,000 population • Unplanned readmissions of mental health patient within 30days of inpatient admission. • Percentage of service users in adult mental health services in employment. • Reduction in Psychiatric admissions via A+E	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Expanding the Integrated Care Programme to include people with Mental Health Conditions will bring better coordination between physical and mental health services • Like Minded strategy to develop enhanced primary care mental service, services for severe and common mental health problems and wellbeing and prevention	**The work for this Transformation Theme is underpinned by the following strategies:** • Learning Disability Transforming Care Programme • Dementia Action Plan • Mental Health Transformation Plan • CAMHS Transformation Plan The delivery of this Transformation Theme will be managed and monitored via the **Mental Health Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

7. Integrated Care for Children & Young People (CYP) (16/17 spend ~ £26m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr Sujata Chadha (CRO) Joan Veysey (SRO)	£627,900	£700,000	£500,000	£500,000	£500,000 (Total 17/18-20/21: £2.2m)

2020/21 Outcomes

By 2020/21 we will be delivering the following outcomes:

- Coordination of support for children and young people across all health and social care services
- Improved outcomes for children and young people with one or more LTCs
- Reduction in the risk of harm to children and young people

Commissioning Intentions 17/18

We will:

- Embed eating disorder support for CYP working with CAMHS commissioners and develop a 24/7 SPA for CYP
- Implement Consultant Led Acute Model/s with support to Primary Care & Integrated Community Service, including increasing skills of professionals, families/carers and children and young people to stay well and self-manage remaining healthy
- Implement new pathways to manage acutely sick children in community
- Rollout the Paediatric Asthma Programme
- Rollout Joint Physical Activity strategy with LBH
- Implement Critical Care Level 1 within THH
- Focus on improving the support available to Young Carers
- Continue to support CYP with a CHC need to access appropriate support and services
- Carry out a rapid early review of health service needs for young offenders and LAC including Care leavers
- Implement an integrated, shared care record across health and social care and explore the use of apps and technology
- Work with Maternity providers to improve children's life chances: by working with all partners to improve antenatal booking, smoking cessation during pregnancy, improving breast feeding and weight management before and during pregnancy
- Introduce Community clinics at local tariff where appropriate

Indicative Commissioning Intentions Beyond 17/18

We will:

- Review the service needs of all vulnerable children and young people working with children and their families/carers LBH, THH and third sector and other providers
- Review the service needs of all vulnerable children and young people working with LBH, THH and third sector and other providers
- Develop integrated services for Children & Young People aged 18-25 who remain in education and have a Health, Education and Care Plan
- Provide education programmes for professionals, families and children and young people, to self-manage their care: preventing hospital use
- Integrate services where relevant to children and their families for thee with complex care needs.
- Develop a fully integrated model of care for children and young people with additional needs
- Reduce reliance on unplanned care system for CYP.

Measuring Success

Delivery of this Transformation Theme will realise:

- Reduction in the need for secondary care activity associated with CYP:
- Reduction in GP referrals to secondary care
- Reduction in unplanned care needs for CYP
- Reduction in the costs associated in managing CYP per capita

Supporting the Integration Agenda

The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:

- Support to CYP is jointly commissioned across Health & Social Care and we will work increasingly closely with our Social Care and Local Authority colleagues to develop joint plans.
- We will also continue to work closely with NHS England around support to CAMHS patients with CAMHS commissioners

Supporting Strategies & Assurance

The work for this Transformation Theme is underpinned by the following strategies:

- CAMHS Action Plan
- Children's Transformation Plan
- The children's JSNA May 2016
- The Children & Family Act 2014
- Local Digital Roadmap

The delivery of this Transformation Theme will be managed and monitored via the **Children's Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

8. Integration Across the Urgent & Emergency Care System (16/17 spend ~ £26m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr Mitch Garsin (CRO) **Rashesh Mehta (SRO)**	**£1,451,651**	**£2,000,000**	**£1,000,000**	**£1,000,000**	**£750,000** **(Total 17/18-20/21: £4.75m)**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Coordinated support across all Urgent & Emergency Care services • Increased number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay	We will: • Develop and procure a new NHS 111 Service and Primary Care Triage Service • Expand our Urgent Care Centre capacity and implement a Virtual Walk in Centre at the UCC for people with low level needs • Rollout the Patient Education Programme and continue to increase the effectiveness of our UCC based Health Connectors • Expand Intermediate Care Services and integrate with Homesafe with the aim of closing 20 or more beds • Expand access to and use of online advice for people with an unplanned need • Commission a new Directory of Service (DoS) • Change the focus of DTOCs to also include those who are Medically Fit For Discharge (MFFD) and rollout a joint approach to reducing LoS with the Local Authority and CHC • Reduce the number of alcohol related presentations a THH • Improve the support to those with alcohol addiction that has caused a long term medical condition • Introduce 'follow up' nurse support to reduce readmission rates following a non-elective presentation at THH • Deliver the Ambulance Handover Time targets consistently	We will : • Commission a fully Integrated Urgent and Emergency Care system • Improve the effectiveness of our NHS 111 Service • Reduce demand at the door of A&E and the UCC through improved access in Primary Care, Education and through our support to people with LTCs • Integrate IT system across the UEC system to ensure professionals have access to essential medical records for people • Expand and update the DoS in line with national standards • Link the Urgent Care System with the Primary Care Model of Care and the CCG Hub Strategy

Measuring Success	Supporting the Integration Agenda	Supporting Strategies & Assurance
Delivery of this Transformation Theme will realise: • Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions and a Reduction in Length of Stay following an unplanned admission	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Multidisciplinary Integrated Discharge Team and A&E Delivery Board are examples of Integration across health and social care associated with Unplanned Care • The development of the Older Peoples' Model of Care and the Primary Care Model of Care will both enhance integration further across the UEC System as will the development of a truly Integrated Urgent Care (IUC) System	**The work for this Transformation Theme is underpinned by the following strategies:** • Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **A&E Delivery Group Group** which in turn reports to the **Hillingdon CCG Governing Body**

9. Prevention of Disease & Ill-Health (16/17 spend ~ £25m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr N Bharakhada (CRO) Rigo Pizarro (SRO)	£95,451	£200,000	£350,000	£700,000	£1,300,000 (Total 17/18-20/21: £2.55m)

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Reduced prevalence gap for key conditions meaning that more people are identified as having conditions such as Diabetes and Hypertension • Reduced rate of growth in prevalence to improve long term outcomes and slow the growth in demand for health related services • Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcome	We will: • Develop and rollout a Prevention Strategy as well as a Suicide Prevention Strategy • Develop plans to close the Hypertension and Diabetes Prevalence Gaps and identify further prevalence gaps to address in later years • Rollout an Air Quality Review with Public Health to understand why Hillingdon is an outlier for Respiratory related activity • Rollout of Proactive Case Finding in Primary Care as part of the Primary Care Model of Care • Expand access to and use of online advice and contribute to raising the awareness of the public around prevention of long term conditions • Utilise data from the JSNA, NHS RightCare and other external parties to support the development of the Prevention Strategy • Explore the use of apps and technology to help people stay well and prevent exascerbations	We will: • Close the prevalence gaps for Hypertension and Diabetes by more than 30% • Expand the range of conditions for which proactive case finding can be utilised to identify those at risk of developing disease and ill-health • Expand the range of conditions where the NHS can use prevention techniques to reduce complications and co-morbidities for those people who already have a long-term condition **Note:** much of the longer term impact of this Transformation Theme will be delivered via (T4) and (T5) with respect to Secondary and Tertiary Prevention.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap for key conditions including Hypertension and Diabetes • Reduction in the rate of growth of prevalence • Reduction in the costs of managing people with LTCs	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Prevention is a shared issue between the NHS and the Local Authority. Although the development and rollout of the Prevention Strategy for the CCG will be very much focused on the NHS elements of prevention we will be working closely with our Local Authority colleagues (particularly public health and the health and wellbeing teams) to develop this strategy and roll it out.	**The work for this Transformation Theme is underpinned by the following strategies:** • Hillingdon CCG Prevention Strategy The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

10. Transformation in Local Services (16/17 spend ~ £77.5m)

Key Information	CCG Team	16/17 Post-Risk Net QIPP	17/18 Pre-Risk Net QIPP	18/19 Pre-Risk Net QIPP	19/20 Pre-Risk Net QIPP	20/21 Pre-Risk Net QIPP
	Dr N Bharakhada (CRO) Kamran Bhatti (SRO)	**£2,748,284**	**£2,000,000**	**£1,500,000**	**£1,200,000**	**£1,000,000 (Total 17/18-20/21: £5.7m)**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Reduced rate of growth in hospital attendances and admissions for people with planned care needs • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support	We will: • Deliver the 4 Priority Acute Standards for 7 Day Services • Rollout 7 Day Services in HICU and develop a 7 Day Dashboard • Procure a Community MSK CATS services • Reduce activity to NWL averages within the THH and RBH contracts for key specialties focusing on OPD and OPPROC • Re-establish existing CATS and rollout to Gastro and Neuro Services and rationalise Physiotherapy support across Hillingdon • Implement post discharge follow up calls to reduce readmissions • Introduce an integrated, shared care record across health and social care • Undertake a resilience review of the RTT target for Hillingdon • Adoption and integration of NHS RightCare programme recommendations for key specialties • Support delivery of the Referral to Treatment waiting times in line with NHS guidance • Rollout NWL Referral Criteria to the Top 20 priority specialities and monitor impact • Introduce a Referral Management process for the Top 6 referring practices in Hillingdon and improve decision support for all practices • Proactively engage in the negotiations for the contracts where HCCG are significant associates to obtain improved efficiency • Implement a Placement Efficiency Programme for patients with a physical need	We will: • Restructure and improve the effectiveness of Clinical Working Groups (CWGs) to empower them to take more control of clinical decision making across providers • Focus on additional 7 Day Standards in line with NWL and HCCG priorities • Reduce Length of Stay to the NWL Average wherever this exceeds the average by more tha 10% • Increase the scope of services delivered Out of Hospital and closer to patients' homes as well as the amount of activity delivered Out of Hospital • Rollout NWL Referral Criteria to the next 20 specialities whilst continuing to monitor impact on the Top 40 specialties and the rate of growth • Reduce Internally Generated Demand to NWL average rates where applicable whilst ensuring the policy is applied where clinically appropriate to reduce delay and burden on primary care
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in growth rate for planned attendances and admissions • Increase in planned care provided in non-hospital based settings • Reduction in the planned care costs per capita	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The move to drive more activity out of hospital will contribute to the integration across secondary, community and primary care services and this will be combined with an increasing focus on self-care and patient activation	**The work for this Transformation Theme is underpinned by the following strategies:** • Local Services Strategy • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **System Delivery Group** which in turn reports to the **Hillingdon CCG Governing Body**.

Enabling Themes

The following pages provide the detail of each of the Enabling Themes.

1. Developing The Digital Environment			
Key Information	**CCG Team**	**Indicative QIPP Targets**	
	Dr Kuldhir Johal (CRO) **Mike Davies (SRO)**	**None**	
2020/21 Outcomes	**Commissioning Intentions 17/18**	**Indicative Commissioning Intentions Beyond 17/18**	
By 2020/21 we will be delivering the following outcomes: • Effective and efficient integrated care services enabled by shared health and care records • Relevant information safely and appropriately available when needed to coordinate care for people • Clear information available to aid planning of services	We will: • Improve access to and use of the Shared Care Records • Develop plans for digitally enabled self-care and the use of real time data in decision making for both clinicians and patients • Eradicate use of fax in care services	We will: • Encourage secondary care to move towards paperless operation at the point of care • Complete development of a shared care record across all care settings including social care, facilitating integrated out of hospital care • Extend patient records (from all settings) to patients and carers, and provide them with digital self-care and management tools such as apps, to help them become more involved in understanding and managing their own care • Use dynamic analytics to inform care decisions and support integrated health and social care across the system through whole system intelligence	
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**	
Delivery of this Enabling Theme will realise: • High utilisation of Shared Care Record across settings by the right people • Services planned using accurate and timely data • Improved outcomes for patients through shared record keeping	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The Shared Care Record will facilitate integrated working across settings and across providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Local Digital Roadmap • Hillingdon IT Strategy The delivery of this Enabling Theme will be managed and monitored via the **IT Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.	

2. Creating the Workforce for the Future

Key Information	CCG Team	Indicative QIPP Targets
	Dr Steven Shapiro (CRO) Rigo Pizarro (SRO)	None

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • A primary care workforce that is sufficient to sustain general practice. • An expanded primary care workforce that is competent and confident to work in new models of care delivery and new provider structures. • A supported workforce environment that promotes Hillingdon as an attractive place to work. •	We will: • Increase the mentorship and student placement capacity in general practice • Ensure supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes • Continue to provide staff forums, training and education opportunities • Develop cross-organisational working within the GP Federation and the ACP • Develop new workforce roles and competency frameworks with HENWL and HEIs • Develop a plan for IT Skills within the workforce along with the requisite tools and enthusiasm for utilising them to improve care	We will: • Establish multi-disciplinary, multi-organisational and multi-HEI packages of properly tariffed student placements • Create targeted, multi-organisational pipeline of new staff recruitment • Develop a CEPN (Community Education Provider Network) function sitting with the ACO provider for multi-disciplinary forums, training and education • Develop more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care • Continue to properly evaluate and develop new workforce roles and competency frameworks with HENWL and HEIs
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • The workforce required to sustain general practice and help deliver any new models of care or provider structures. • The skills and consistency required to care manage multi-morbidity and increasingly complex patients. • A supported environment in which staff want to stay and work.	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The practice of multi-organisational student placements, staff recruitment including apprenticeships, staff training and working patterns contribute to significant integration across health care settings, • The development of a more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care will further integrate how care is provided for people.	**The work for this Enabling Theme is underpinned by the following strategies:** • BHH and Hillingdon Workforce Plans 2015-7 • HENWL Training Plan 2016-7 The delivery of this Enabling Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

3. Delivering Our Strategic Estates Priorities

Key Information	CCG Team	Indicative QIPP Targets
	Dr Reva Gudi (CRO) **Sue Hardy (SRO)**	**None**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • An estate portfolio that meets the needs of our Transformation Themes.	We will: • Deliver Local Estate Strategy for Hillingdon to support the delivery of the Five Year Forward View and 'One Public Estate' vision • Deliver a Primary Care Investment Plan which analyses the suitability of the current estate and sets out how the estate will need to change to meet the needs of the new model of care • Deliver local services hub business cases for the North and Centre of the Borough • Maximise utilisation of existing estate and reduce void costs • Deliver a temporary solution for Yiewsley Health Centre whilst continuing to find a long term solution for the site	We will: • Deliver a local service Hub in North of Hillingdon by 2020/21 • Deliver a local service Hub in the Uxbridge and West Drayton area by 2020/21 • Deliver a solution for Yiewsley Health Centre by 2019/20
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • A service with the capacity and capability to meet the needs of our population	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Local services hubs provide physical locations to support patients with a variety of needs through the provision of varying services across primary, community and secondary care with the opportunity to integrate certain elements of services delivered by the Local Authority. • The provision of high quality premises and estate will both contribute to the improvement in the quality of care as well as improved financial performance allowing more funds to be released to support further integrated working elsewhere.	**The work for this Enabling Theme is underpinned by the following strategies:** • Strategic Estates Plan The delivery of this Enabling Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Hillingdon CCG Transformation Group**.

4. Delivering Our Statutory Targets Reliably

Key Information	CCG Team	Indicative QIPP Targets
	Dr Reva Gudi (CRO) **Joan Veysey (SRO Mental Health)** **Kamran Bhatti (SRO RTT)** **Rashesh Mehta (SRO A&E)**	**None**

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Achievement of NHS Targets for Referral to Treatment (RTT), A&E and Cancer Waits and Diagnostics as well as our other statutory targets associated with Mental Health	We will: • Continue to achieve the 92% RTT target for Incomplete Pathways for Hillingdon CCG Registered population • Undertake a full capacity and demand modelling exercise with THH supported by initial work undertaken as part of 16/17 CQUIN to understand the resilience of our RTT system • Return performance of THH to the expected standard of 95% for 4 hr waits in A&E • Explore in detail the impact of Cancer Breach Sharing Standards and continue to achieve Cancer Wait Targets whilst undertaking an end to end review to ensure continued resilience based on projected prevalence growth in Cancer. • Continue to achieve the statutory targets for mental health	The plans beyond 17/18 will be dependent upon national statutory targets and any changes that are made centrally.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Achievement of our Statutory Targets	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • As delivery of our statutory targets normally requires integrated working across multiple providers such as Cancer which will involve Primary Care and a mix of secondary care providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon CCG Operating Plan The delivery of this Enabling Theme will be managed and monitored via the **Hillingdon Systems Resilience Group** which in turn reports to the **Hillingdon CCG Governing Body**.

5. Medicines Management

Key Information	CCG Team	Indicative QIPP Targets
	Dr Mayur Nanuvati (CRO) Tarvinder Kalsi (SRO)	(QIPP 16/17) £1,572,566, (QIPP 17/18) £1,200,000, (QIPP 18/19) £1,000,000, (QIPP 19/20) £1,000,000 (QIPP 20/21) £750,000 Annual Spend 16/17 c£33m (QIPP Total 17/18-20/21: £3.95m)

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Improved outcomes for people utilising medicines and a reduction in avoidable harm	We will: • Increase support to Care Homes • Focus on medicines optimisation and rollout of practice level pharmaceutical support with medicines reviews • Undertake domiciliary medication reviews by specialist pharmacists for the frail and elderly • Undertake domiciliary medication review of newly discharged patients by specialised pharmacists • Review and streamline repeat prescription processes in practices • Focus on reducing wastage and reducing inappropriate usage of antibiotics • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Increase use of EPS2 and also implement EPS Release 4 and ePrescribing in THH	We will: • Carry on monitoring and supporting practices in ensuring high quality, cost effective prescribing is being carried out without compromising patient care • Support in improving Quality and safety of medicines use • Support in the reduction of Medicines waste • Support in Improving patient experience • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Link medicines management within the primary care models of care • Support as an enabler in the transformation themes where appropriate.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Reducing spend per capita on medication • Quality and safety of medicines use is improved • Reducing incidents of harm • Improving outcome for people arising from the effective use of medication • Patient experience is improved with their medicines • Medication waste is reduced • Cost savings achieved • National and local guidance is implemented • Reduction in polypharmacy • Partnership working with relevant stakeholder to improve patient care	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Medication is an issue that spans the entire healthcare sector and also links into areas such as Care Homes, Social Care and the support provided by Carers. As such, medication and medicines management is by its very nature an issue of integration.	**The work for this Enabling Theme is underpinned by the following strategies:** • Medicines Management Plan The delivery of this Enabling Theme will be managed and monitored via the **Hillingdon Medicines Management Committee** which in turn reports to the **Hillingdon CCG Governing Body**.

6. Redefining the Provider Market

Key Information	CCG Team	Indicative QIPP Targets
	Dr Ian Goodman (CRO) Joan Veysey (SRO)	As defined within the Transformation Themes

2020/21 Outcomes	Commissioning Intentions 17/18	Indicative Commissioning Intentions Beyond 17/18
By 2020/21 we will be delivering the following outcomes: • A market capable of meeting the health needs of the local population within the financial constraints • Payment and risk share arrangements that incentivises innovation, quality and sustainability.	We will: • Develop a shadow outcome based commissioning model for older people via an ACO (locally referred to as an Accountable Care Partnership or ACP) and seek to identify further cohorts to work with • Create a GP Network Development Strategy • Rollout the Local Strategic Estates Strategy and Rationalisation Plan	We will: • Enhance and drive forward the 3 year BCF plan with LBH to deliver longer term alignment and integration across Health and social care • Deliver a transformation in Primary Care support through our Primary Care Model of Care • Commission outcomes based services for further population groups including Adult Mental Health and Children • Work with LBH to shape the market and re commission services currently delivered in institutional or Tier 4 care settings for people with complex needs. • Further develop the concept, scope and impact of our ACP • Further develop the scope of our capitated payment model and impact of ACP providers.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Significant proportion of care delivered through integrated delivery vehicles • A high functioning, cost effective Accountable Care Partnership • Established GP networks and federation capable of delivering services in out of hospital settings.	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The reshaping of our Provider Market and our work on our Better Care Fund (BCF) Programme is already driving improvements in integrated care across health and social care and will continue to do so. In particular the ACP brings together all health partners and third sector organisations into a single commissioned provider and naturally therefore delivers on our integration agenda for health.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon BCF • New Care Models for Primary Care & Older People • Local Service Plan • Hillingdon Strategic Estates Plan The delivery of this Enabling Theme will be managed and monitored via the BCF Officers' Group, the ACP Commissioning Group and GP Co-Commissioning Board. These groups are overseen by the CCG's Governing Body and the Health & Wellbeing Board collectively.

Section 8: 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
CATS	Community Assessment & Treatment Service	CAATS	Clinical Advice & Triage Service		
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	HICU	Hawthorne Intermediate Care Unit		
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	IUC	Integrated Urgent Care		
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS/LES	Local Incentive Scheme Locally Enhanced Service	LoS	Length of Stay
LAS	London Ambulance Service	LAC	Looked After Children	LTC	Long Term Condition
LD	Learning Disability	LBH	London Borough of	LNWH	London North West Hospitals NHS

			Hillingdon		Foundation Trust
MH	Mental Health	MMT	Medicines Management Team	MSK	Musculo-Skeletal
MIU	Minor Injuries Unit	MDT	Multi-Disciplinary Team	MFFD	Medically Fit For Discharge
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		PCC	Primary Care Contract		
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 or Summary Care Record	STARRS	Short-Term Assessment, Rehabilitation & Reablement Service

STP	Sustainability & Transformation Plan				
TB	Tuberculosis	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				

HEALTHWATCH HILLINGDON UPDATE

Relevant Board Member(s)	Stephen Otter, Acting Chair
Organisation	Healthwatch Hillingdon
Report author	Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon
Papers with report	Appendix A

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 & 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

2.1. The body of this report to The London Borough of 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. ANNUAL REPORT 2015-16

Healthwatch Hillingdon formally submits its Annual Report 2015-16, published on 30th June 2016, to the Health and Wellbeing Board. Appendix 1

As mandated, the report was made available to the public through our website http://bit.ly/2957ZcD , by email and by post.

4. GOVERNANCE

During this period Board Members who were appointed on 17th April 2013 stood for reappointment. The following were duly appointed for a further 3 year term.

- Richard Eason
- Baj Mathur
- Kay Ollivierre
- Stephen Otter

A subsequent recruitment process was undertaken and we are pleased to announce that this has resulted in the appointment of a Chair and 2 Board Members.

These appointments will be ratified at the Healthwatch Hillingdon Board meeting of 28 September 2016 and communicated to the Health and Wellbeing Board at this meeting.

5. 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 first quarter.

Fertility Services

We have been gathering evidence from Hillingdon women and their families on their experience of accessing NHS-funded fertility services. In addition to highlighting this work in our annual report, we also published a separate report.

In our report "IVF: **I**s **V**ariation **F**air?", we illustrate how the impacts of infertility can have far reaching effects on couples and their families. We question the equity of access to IVF and the cost-effectiveness of the service. We conclude with a recommendation, that consideration should be given to commissioning fertility services to national standards, at a set national cost, with universal quality standards.

In response, the National Clinical Director for Maternity Review and Women's Health, at NHS England, recognises that there is a clear variation in the prices CCGs pay and that there is some work to be done to improve IVF services. He acknowledges that NHS England and the Department of Health are currently considering national options and that our report informs their thinking on the options being considered.

To read the report: http://bit.ly/2cbU7KW

Wheel Chair Service

A number of complaints were received from residents about the wheelchair service in quarter 4 of last year. As the service is provided across Hillingdon and Harrow we have liaised with Healthwatch Harrow to compile evidence of resident's experiences. This has been submitted to HCCG, as the lead commissioner of the service, who are now working with the provider to improve outcomes for residents.

Domiciliary Care

Following allegations made against a domiciliary care agency on the Channel 4 program 'Dispatches', Healthwatch worked very closely with the family, Social Service colleagues, and the Care Quality Committee, as a thorough investigation was undertaken.

5.1 **Information, Advice and Support**

During this quarter we recorded a total of 177 enquires relevant to our function. 131 of these were from residents in receipt of our signposting service.

Table A gives a breakdown of the number and type of enquiry we have received.

Type of enquiry	Number	% of enquiries
Refer to a health or care service	26	20
Refer to a voluntary sector service	20	15
Requesting information / advice	25	19
Requesting help / assistance	8	6
General Enquiry	52	40

Table A

Table B shows the source of these enquiries.

Source of enquires	Number	% of source
shopper	84	64
event	2	2
referral	3	2
promo	0	0
advert	0	0
website	1	1
known	8	6
other	5	4
unknown	28	21

Table B

Access to our service through the shop remains the main point of contact for our information, advice and support service.

We have given individuals advice, and given them information about, or signposted them 107 times to a cross section of statutory and voluntary sector services. On occasions this

can be to more than one provider and we continue to see a varied range of reasons for people contacting us.

Mrs P asked us for help. After speaking to her we found out she was over 65 and looks after her husband with dementia. She was struggling with a number of things including some DIY. We were able to signpost her to Age UK, Hillingdon Carers and Alzheimer's Society for a range of solutions.

3 family members of Mr F came into see us as they were becoming concerned about Mr F living alone. We were able to discuss the options available and advise them how to contact social services to arrange for Mr F to be assessed.

Concerns and complaints

Healthwatch Hillingdon recorded 46 experiences, concerns and complaints in this quarter. The areas by organisational function are broken down in Table C.

Concern/complaint Category	Number	% of recorded
CCG	3	7
Primary care: GP	16	35
Primary care: Pharmacy	0	0
Primary care: Optician	1	2
Primary care: Dental	1	2
Hospitals	12	26
Mental Health Services	3	7
Community Health	1	2
Social Care	5	11
Care Agency	0	0
Care Home	3	7
Patient Transport	0	0
Community Wheel Chair Service	1	2

Table C

Referring to Advocacy

12 referrals were made during this period to support residents. 8 to VoiceAbility (independent NHS Complaints Advocacy), 1 to AvMA and 3 to LBH Safeguarding.

Overview

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

GP Access

We continue to work with NHS England and the Hillingdon Clinical Commissioning Group (HCCG) to facilitate the registration of residents who have been refused registration at a GP practice. The large majority of these patients have been in UB3, UB4 and UB7, where there remain particular pressures. Each patient has been registered but we continue to express our concern at the process that residents are being subjected to.

Heathrow Villages remains an area outside of any GP practice catchment area and Healthwatch are strategically involved in ongoing discussions with local practices to address this. Healthwatch joined local residents in a meeting held by HCCG in Harmondsworth which gave the opportunity for those residents to express their concerns directly with the Chair and Chief Operating Officer. We also supported residents in a direct meeting with NHS England.

In April and June we presented to the External Services Scrutiny Committee and raised our concerns on the provision of general practice in the south of the borough. Data shows that the area has one of the lowest ratios in London, of clinical staff per 1000 patients. With planned building programmes, such as those on the Nestles Avenue site, we would suggest that this is a subject the Health and Wellbeing Board should consider monitoring closely.

5.2 Strategic Working NHS Sustainability and Transformation Plans

The Health and Wellbeing Board will be fully sighted on the Sustainability and Transformation Plans (STP).

As a member of the STP Partners Group we have expressed our concern to the Hillingdon CCG Governing Body on a number of points.

It was particularly disappointing that the initial STP Base Case submission to NHS England on the 16th May 2016 was submitted by the NWL STP team without final sight from the Hillingdon Partners Group and that the Hillingdon chapter was not truly reflected in the NWL STP submission.

We were also equally disappointed that the 'checkpoint' submission of the 30 June 2016, submitted by the NWL STP team, did not include the Hillingdon Chapter as an appendix.

The CCG held a public engagement STP event on Wednesday May 18th 2016, which was well attended by Healthwatch Hillingdon Board members and other Healthwatch representatives. Board members also attended the NWL STP workshop on Wednesday 8th June 2016.

Engagement has been stated as extensive. We have formally questioned this and raised our concern about the public engagement in the STP. We have been advised that thorough stakeholder engagement will take place before a formal sign-off of the Hillingdon plan in October 2016.

Quality Accounts

In May 2016 Healthwatch Hillingdon made our formal statutory responses to the Quality Accounts of:

- The Hillingdon Hospitals NHS FT
- Central North West London NHS FT
- Royal Brompton & Harefield NHS FT

Full details of these responses are available to download from our website.

Hillingdon Hospital Strategic Lay Persons Group

Healthwatch Hillingdon are supporting Hillingdon Hospital in the development of a Strategic Lay Persons Group. Working with Non-Executive Director, Lis Paice, we are helping to identify and recruit members and will be providing representation training and support to the group.

Through this group Hillingdon Residents will get the opportunity to use their lived experience of care at a strategic level, to support the Trust and influence planned service improvements at their inception.

5.3 Engagement Overview

Healthwatch Hillingdon took part in 9 engagement events. Our participation helped to raise awareness of Healthwatch Hillingdon as we disseminated our promotional material and informed the general public of the work carried out by Healthwatch.

The Carers Fair in June provided an opportunity to connect with the voluntary sector and to tell them about Healthwatch and to learn more about the services that are available to local residents. We made links with a number of organisations including Asphaleia Action and Community Cancer Centre who are keen to work with us. We also effectively engaged with the general public, predominantly carers, by telling them about Healthwatch and gathering their experiences of health and social care services.

At the Disability Assembly we joined Council and Hillingdon Hospital colleagues to outline the new Accessibility Standards and run a workshop for residents to inform providers of how best to meet their communication and access needs.

<u>Promotion</u>

We have run a number of ‘drop in clinics’ at both Yeading and Botwell Libraries this quarter, which has given residents the opportunity to get to know more about the services we offer, tell us about their experience of care and get involved in our volunteering opportunities.

We have also replenished our marketing materials at several GP surgeries, libraries, Citizen Advice Bureau and at other venues regularly accessed by the public. We have also placed posters and leaflets in children centres, community centres, churches and many voluntary organisations and NHS funded services in Hillingdon.

<u>Volunteering</u>

We currently have a core team of volunteers assisting us both in the office and at engagement events. Volunteer recruitment for our Hospital Discharge & Maternity Care projects remain ongoing, but to date we have recruited 8 volunteers who are awaiting training to undertake patient engagement work.

To celebrate ‘Volunteers’ Week and to say thank you to our amazing volunteers and as a way recognising their volunteering contributions, we organised a thank you lunch.

Our Enter and View Team also committed 115 hours to the PLACE Assessments of the care environment at Hillingdon Hospital and Central North West London services in Hillingdon.

Use of Media

Through our volunteers we have again been able to focus on a number of initiatives. We are currently looking to produce a paper copy of our bi-monthly newsletter, which has previously only been sent out electronically.

Our website has received visits from over 16,000 individual IP addresses in the first 3 months. Our twitter account is being vibrantly supported by a volunteer and has reached 943 followers, with May peaking at over 21,000 impressions. We have also filmed some short clips which will soon be published on our You Tube account following editing.

We have also seen front page coverage in the Evening Standard and Uxbridge Gazette, with stories published on NHS Sustainability and Transformation Plans, Fertility and Maternity.

6 PROJECT UPDATES

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

Healthwatch Hillingdon continues to monitor the delivery of the transformation plan through our seat on the Children & Young Peoples Emotional Health & Wellbeing Steering Group.

We are pleased to note the development of the LD CAMHS service and the work which has been undertaken in schools. It was also pleasing to see the new service helping children and young people suffering from eating disorders being launched across north west London in June 2016.

In June 2016 the steering group agreed to review the draft 16/17 plan for resubmission to the Health Wellbeing Board. Work has since proceeded to refresh this plan and the developments have been well received.

At the June Healthwatch Board it was agreed that CAMHS was not currently an operational project and as such all reporting to the Healthwatch Board will be on our strategic involvement.

6.2 Maternity Care and Hospital Discharge

Both projects have progressed during the first quarter under the control of their respective project leads. The engagement programmes are underway and now on track. In the first phase of the projects engagement will take place mainly in the hospital. Experiences will be captured and the person's permission sought to be able to go back to them in the future to recap on their experience after our first contact. For discharge this will be about 8-12 weeks after discharge to gauge the care at home. For maternity, post the birth of their child to look at the birth and post-natal experience.

In the responses to date over 80% of those interviewed have agreed for us to contact them again in the future. It is expected that each project will engage with around 150 people.

7 ENTER AND VIEW ACTIVITY

PLACE Assessments

During May 2016, 8 Assessors committed to 115 hours of volunteering to complete 3.5 days of assessments at Hillingdon Hospital and the Central North West London FT's Woodlands and Riverside sites in Hillingdon.

At Riverside assessors highlighted what they saw as a major safety issue. This was immediately reported to senior management and swift action was taken by the Trust to carry out repairs. Healthwatch was invited by CNWL to inspect the repairs as part of the assurance process.

8 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 2016/17

*Targets are not set for these KPIs as measure is determined by reactive factors.

KPI no.	Description	Relevant Strategic Priority	Monthly Target 2016-17	Q1			Q2			Q3			Q4		
				2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017
1	Hours contributed by volunteers	SP4	550	692	550	**637**	732	625		583	462		637	729	
2	People directly engaged	SP1 SP4	350		354	**434**		333			250			354	
3	New enquiries from the public	SP1 SP5	175	124	232	**177**	126	402		96	241		98	227	
4	Referrals to complaints or advocacy services	SP5	N/A*	19	9	**12**	15	14		18	7		12	7	
5	Commissioner / Provider meetings	SP3 SP4 SP5 SP7	70	68	49	**93**	68	60		87	54		112	72	
6	Consumer group meetings / events	SP1 SP7	10	62	22	**16**	48	25		42	10		89	22	
7	Statutory reviews of service providers	SP5 SP4	N/A*	0	0	**0**	0	0		0	1		0	0	
8	Non-statutory reviews of service providers	SP5 SP4	N/A*	5	7	**3**	2	4		4	3		2	7	

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Appendix

healthwatch Hillingdon

Annual Report 2015/16

A catalyst for change

Contents

Message from our Chairman

Welcome to the third Annual Report from Healthwatch Hillingdon. I am delighted to be able to report that we have continued our excellent progress during 2015/16 in helping to achieve real improvements in local health and social care services, although there is much still to be done.

Our aim is to give Hillingdon residents a voice to influence local change and also to continue to highlight those services which fail to meet expectations.

I am particularly pleased that we are able to highlight a number of areas where the organisations who run our local Health and care services have acted upon our representations and made improvements to services as a result. One of our main duties is to listen to residents of Hillingdon so that we understand the things that are most important to you and the extent to which services are currently meeting your needs or expectations. We use this information to illustrate where patients and service users want to see changes, provide as much evidence as we can to support the need for improvement and we then monitor progress being made by the appropriate agency. We are not always successful in obtaining the changes wanted by residents but we will continue to represent your views and needs.

Examples of areas where HW has been instrumental in achieving change are set out in the report and I will not repeat them here, but one area that does warrant special mention is services for children and young people with mental health issues. This is a very common problem for many families in the borough and we have been able to show that local services are often quite poor and our young people haven't been getting the support they need in their formative years.

This is also a national issue but we do believe that local services can be improved and we are still waiting to see tangible improvements in Health outcomes for young people in our area and we will continue to watch for progress.

Our overriding priority for the future is to continue our successful work in helping to obtain local improvements in services. In addition to following up issues in any service, we are doing some work in two specific areas.

First of all, in maternity Hillingdon is having to increase its activity considerably due to maternity units in other parts of North West London closing down. We are therefore

looking at the experience of Mothers using Maternity in Hillingdon to obtain a view about the quality of service. We will also be looking at the experience of people who are discharged from hospital, particularly older people, to see what improvements may be needed.

We shall also continue to examine bigger changes being proposed to the way in which health and care services are delivered in order to protect resident's interests.

Finally, I would like to offer a huge thank you to Graham Hawkes and his team as well as Board Members for their hard work, effort and support which has resulted in a successful year for Healthwatch and a final year for me, as my term has now closed.

Jeff Maslen
Chairman
Healthwatch Hillingdon

Message from our Chief Executive

I hope you will agree as you read our 2015-16 Annual Report that the Healthwatch Hillingdon team should be proud of their achievements and pleased with the outcomes of their work.

As we prepared the annual report what really struck me this year was how much the team had achieved. Sometimes it is not until you take time out of your busy daily schedule to look back, that you really appreciate just how far you have progressed.

It has been a positive year and I thank everybody who has contributed to Healthwatch Hillingdon. For the residents who have spoken to us, the volunteers whose valuable time is so appreciated, my dedicated staff for their hard work and the Board for all their support again this year. It has been a real team effort.

As Jeff steps down as Chairman, I would like to express my sincere gratitude to him and acknowledge his contributions during his term of office.

As Chairman, and founding member of the Board, Jeff has been at Healthwatch Hillingdon from its inception. Through his leadership, dedication and effort over the last 3 years, Healthwatch Hillingdon has developed into a strong, well respected organisation within Hillingdon and the wider Healthwatch Network.

Jeff should be proud in the knowledge that he leaves us on a firm foundation. He will be deeply missed and I wish him all the best for the future.

Vice Chair, Stephen Otter, becomes the Acting Chair whilst Jeff's replacement is recruited. I look forward to continuing to work closely with Stephen in the months ahead.

Board Member, Turkay Mahmoud, also stepped down from the Board at the end of his term in March. I am really grateful for all his help and support over the last 3 years and I am so pleased he has decided to continue his Enter & View work as a volunteer.

Success can be measured in many different ways and as you read our report you will determine for yourself whether by your standards this has been a successful year for Healthwatch Hillingdon.

Although it is important for us to meet our performance targets, success for me is all about how we have served our residents.

> **"Success is all about how we have served our residents"**

I am so pleased that this report outlines the many ways in which we have helped people and made a real difference in their lives. With contacts to our information, advice and signposting service more than doubling, to 1100 people in the last year, we really hope this rise continues and we have the opportunity to help so many more.

One of the most pleasing aspects of our work this year is the focus we have continued to bring upon children's mental health in the borough. With £2.5 million[1] being invested in 4 new services over the next 5 years, this has been a real 'catalyst for change'.

> **" With £2.5 million being invested in 4 new services over the next 5 years, this has been a real 'catalyst for change' "**

We have come a long way since I sat down with 5 parents nearly 3 years ago and they told me about how Hillingdon's services were letting their children down. We have more work to do and I certainly will not rest until I know the new investment has improved services and the mental wellbeing of children in our borough.

As we look to the future I know we will have to work hard to surpass this year's achievements. One thing I can promise you, is the team will continue to focus on our residents and give their best to help in every situation.

Finally, I would like to ask for your help. Our work has proved that armed with the evidence of your lived experience of care, we can improve services.

We need to hear from you, your family and your neighbours. Tell us your story. Together we can make a difference in our communities.

Graham Hawkes
Chief Executive Officer
Healthwatch Hillingdon

1. https://www.england.nhs.uk/wp-content/uploads/2015/07/annex-4-transformation-plan-guidance-ccg.pdf

Forward-Councillor Philip Corthorne

I'm delighted to be able to congratulate Healthwatch Hillingdon once again for the work it has undertaken on behalf of our residents over the last year and as set out in this annual report.

Our partnership working has gone from strength to strength and Healthwatch Hillingdon has proven itself as a valuable partner and as an integral part of our Health and Wellbeing Board, representing the voice of consumers as we seek to improve health and social care standards.

I offer particular thanks to Healthwatch's outgoing chairman, Jeff Maslen, who has steered Healthwatch expertly through its start up to the established partner it is today. In addition, I am grateful for the Healthwatch team and all the volunteers, trustees and residents who have helped to deliver the impressive programme set out in this report.

As ever the future holds uncertainty, we are working together on a five year Sustainability and Transformation plan which promises much, but crucially, needs to deliver benefits locally. During this unprecedented period of change and it is reassuring to know that we have the "consumer voice" at the heart of our plans.

Cllr Philip Corthorne MCIPD
Cabinet Member for Social Services, Housing, Health and Wellbeing
London Borough of Hillingdon

HILLINGDON
LONDON

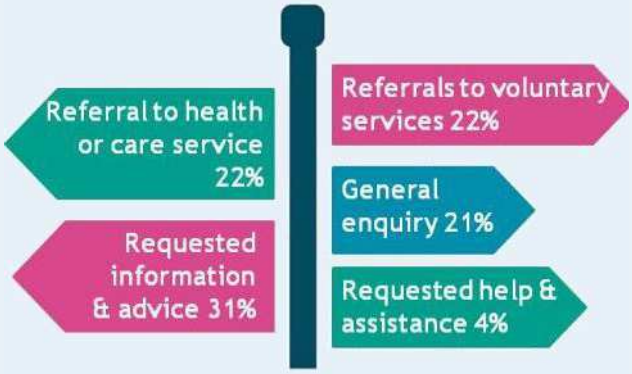
The year at a glance

Listening to people who use health and social care

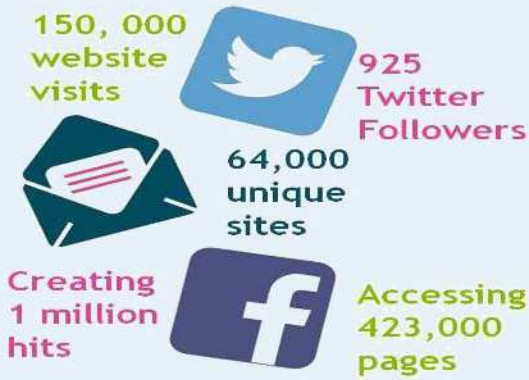
Top 5 concerns & complaints

Engagement and Feedback

Giving people advice and information



Contacts & Enquiries



Use of Media

Representation

Our People - Volunteering

Who we are

Healthwatch Hillingdon is completely separate from the NHS and the local authority.

We represent the views of everyone who uses health and social care services in the London Borough of Hillingdon. We make sure that these views are gathered, analysed and acted upon, making services better now and in the future.

We exist to make health and social care services work for the people who use them.

We monitor local services to ensure they reflect the needs of the community, and where necessary, use statutory powers to hold those services to account.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

As part of a network of local Healthwatch from every local authority area in England, we are also uniquely placed to raise issues nationally through Healthwatch England.

Our vision

Our vision is to become the influential and effective voice of the public.

We want to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

And, give adults, young people, children and communities a greater say in - and the power to challenge - how health and social care services are run in Hillingdon.

This vision is founded on the strong belief that services work best when they are designed around the needs and experiences of the people who use them.

Our priorities

The focus of our work for 2015-16 was established after undergoing an in-depth analysis of the data and intelligence gathered from our residents during the previous year.

A number of areas were highlighted for consideration by the Board and the final priorities were agreed and set out in the published work-plan, presented to the Health and Wellbeing Board in October.

The key area for 2015-16 was the continuation of our work on Childrens & Adolescent Mental Health and Wellbeing - which is given comprehensive attention later in this report. It was also agreed to look at Discharge from Hillingdon Hospital for the over 65s and Maternity Care following the closure of Ealing Hospital's Maternity Unit. Although started, the conclusion of these projects are planned for later in 2016.

Full details of the Healthwatch Hillingdon Work Plan 2015-2017 can be viewed at http://bit.ly/20QJAcy

Our Shop

The Healthwatch Hillingdon shop in Uxbridge continues to be a major focal point for our work and we must again sincerely thank the Pavilions Shopping Centre for making this possible.

We are able to provide our signposting service and give information, advice and support to our residents from an easily accessible central location.

Being directly open to the public, Monday to Friday has enabled us to talk to hundreds of residents and has been a rich source of information about the services provided in Hillingdon.

The shop also provides the added value of being able to offer other organisations within Hillingdon a venue to deliver their services.

This year we have supported REAP (Refugees in Effective and Active Partnership), the Pukaar Hillingdon EACH Domestic Violence Counselling Service and The Hillingdon Learning Disability Team provide weekly sessions. The space has also been used by Hillingdon Social Services and VoiceAbility as a place to meet clients.

> **"When the National Childbirth Trust approached us about their Little Bundles Program, it was a real pleasure to be able to support such a great cause"**

Late last year the shop came to the rescue of another local organisation in an unexpected way.

The Hillingdon branch of the National Childbirth Trust approached us about their Little Bundles Program, and asked us if we knew anybody who could help them with storage. It was a real pleasure to be able to support such a great cause by offering them use of our basement.

Hillingdon Little Bundles Program
Brook Grange
National Childbirth Trust Hillingdon

"We set up Little Bundles in September 2015 with the aim to help new and expecting mums that find themselves in financial hardship, and are unable to provide the essentials for their baby. The program is run entirely by volunteers and relies on donations from parents and

local businesses. We are always in need of things like moses baskets, baby carriers, toiletries, and other baby essentials - things most parents take for granted.

Of course with all of the generous donations, we need a permanent storage solution to keep these items clean, dry and safe. We were so greatful that Healthwatch Hillingdon have been kind enough to help us in the interim with temporary storage in their basement.

I think the entire program can be summed up by a message I received from one of our referring midwives: "Thank you for your support you should be here when the ladies receive the packs. Thank you for giving me that pleasure."

“We were so greatful that Healthwatch Hillingdon have been kind enough to help us”

Listening to people who use health and care services

Gathering experiences and understanding people's needs

To gather the experiences and views of our residents we use a number of methods to promote awareness of Healthwatch Hillingdon. We carry out a wide ranging engagement programme to try to reach a broad cross-section of our communities, encouraging as many people as possible to share their views with us.

Promotion and Communication

To advertise and encourage people to talk to us we have promotional materials in GP practices, hospitals and libraries. Our details are in every edition of Hillingdon People and we regularly have articles published in the local paper, where we call for people's experiences on specific conditions and issues.

Social media has become an excellent way to raise our profile and reach members of the public.

Engaging

Staff and volunteers listen to our residents at events, workshops, presentations, meetings and numerous outreach activities.

- In our focus on mental health and emotional wellbeing, children and their parents told us their stories and how they felt that they were being let down and wanted things to change.
- Our regular presence at Hillingdon, Mount Vernon and Harefield Hospitals in the early part of the year enabled us to speak directly to people using those hospitals.
- Working closely with the Boroughs' Older Peoples, Disability and Carers Forums has given us an in depth view of the services these residents receive. As a result, we have heard positive reviews of patient transport and have been able to support the deaf community to access GP and hospital appointments.
- By presenting on Healthwatch Hillingdon at individual groups gives us an opportunity to hear about specific issues. Our visit to The Parkinson's Group led to a number of people contacting us and a resident receiving access to a crucial drug they were being denied.

- With the threat of a third runway, residents from The Heathrow Villages remain disadvantaged. Through our engagement with them, we continue

to hear their concerns about having no local GP, dentist, or chemist. Working with NHS England we have supported a number of residents to register with GPs in other parts of the borough.

We also submitted a response to the Government Airports Commission consultation on the possible effects on Hillingdon residents of another runway at Heathrow.

Jane Taylor - Chair of The Harmondsworth and Sipson Residents Association

"HASRA has often questioned if our community's proximity to Heathrow Airport is to the detriment to our health and is concerned that the requirements of air passengers and hotel guests are often perceived to supersede those of the residents.

Aircraft noise has recently been highlighted in the media as a possible reason for the onset of depression. High levels of air pollution are thought to be responsible for increased incidents of heart disease and breathing ailments. On top of this, many long term village residents have lived through decades of stress, being under the constant threat of having their homes demolished.

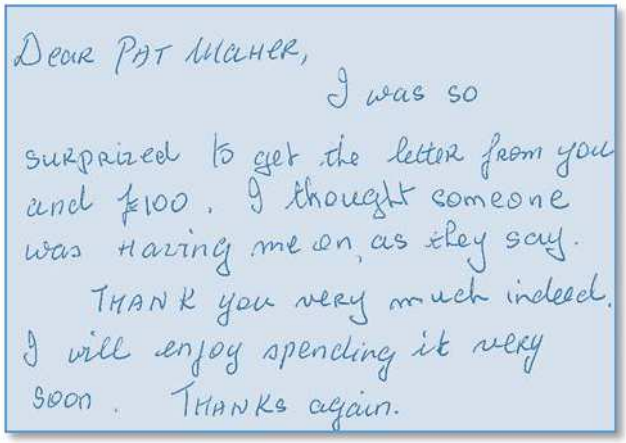
Life expectancy in the south of the borough is quoted as seven years lower than for those who live in the north. Seven years is a significant number. With such a discrepancy, what are health professionals doing to understand this difference. Surely if this gap is to be closed, health service provision for the south of the borough should be considered a high priority within local resources and the needs of the south targeted.

HASRA would like to thank Healthwatch Hillingdon for listening to our residents and acknowledges the significant support we have received from Healthwatch in raising the profile of our unique circumstances. We hope to continue this partnership with a view to achieving a more appropriate investment in the south of the borough to improve our health and well-being leading to the probability we can enjoy a life comparable to those living in the north of the London Borough of Hillingdon."

- Supporting the Council's engagement team at the Older Peoples, Disability and Carers forums has led to us regularly hearing from almost 300 residents.

  One of the work-streams of the Disability Assembly early in the year was non emergency patient transport. In addition to holding a workshop, we carried out a survey in conjunction with Hillingdon CCG and Hillingdon Hospital, with participants being entered into a prize draw. The Mayor of Hillingdon, Cllr George Cooper,

drew out Mrs G from Hayes as the lucky winner



Dear Pat Maher,

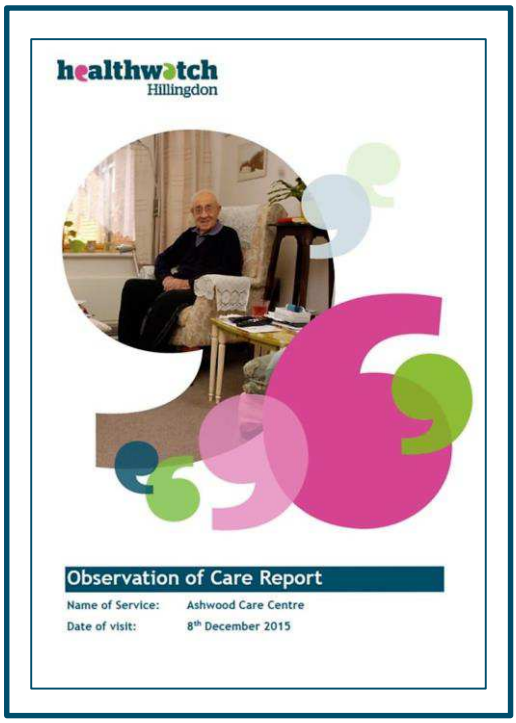
I was so surprised to get the letter from you and £100. I thought someone was having me on, as they say.

Thank you very much indeed. I will enjoy spending it very soon. Thanks again.

Importantly, over 90% of the 138 people who completed the survey, or attended the Disability Assembly recommended the service.

What we've learnt from visiting services

Our Enter & View Representatives and PLACE Assessors visited services on 15 occassions during the year.



healthwatch Hillingdon

Observation of Care Report

Name of Service: Ashwood Care Centre

Date of visit: 8th December 2015

We work very closely with colleagues within the Local Authority Contracts Monitoring Team and Care Quality Commission, to inform their inspection schedule. Our own enter and view activity is therefore very small. In December, we visited Ashwood Care Centre, Hayes, at the request of the Manager, to observe their lunchtime service to residents and make recommendations on how this could be improved.

We also joined Central and Northwest London NHS FT to view the care at the Heathrow Detention Centres at Harmondsworth early in the year, and visited the wards at the Riverside Inpatient Unit in Hillingdon, as part of an internal quality audit.

Patient-led assessments of the care environment (PLACE) looks at patient privacy, the quality of food and how hospitals and clinics maintain and clean the areas were they provide care.

Our team of 10 PLACE Assessors have carried out over 300 hours of assessment during the year. Their work is helping organisations understand how well they are meeting the needs of their patients.

At Hillingdon and Mount Vernon Hospitals, for example, a number of areas were identified and improvements are starting to be put in place:

- The introduction of earing loops at reception desks
- Privacy in reception areas
- Secure storage of personal possessions
- Ensuring there are handrails in corridors and on approaches to bathrooms and toilets
- Dementia friendly floors, signage and door colours

FOCUS - reaching out to residents through local media

Working with the local media is an important way for Healthwatch Hillingdon to highlight issues that affect our communities and to encourage people to share their experiences about local health and social care services.

This year we featured regularly in the local print media, highlighting local concerns and calling for peoples experiences on fertility treatment, maternity services, young people's mental health services and much more.

Here are some of the examples of how the use of local media has enabled us to represent our residents and gather information.

Children's mental health

'Frightening' truth of Hillingdon's youth mental health services (11.08.15)

Around our work on children's mental health and in line with our published report '***See & Heard – Why not now?***' which outlined how a lack of early intervention, lack of funding and fragmented services impacted upon children's emotional wellbeing, we spoke to the local media and highlighted the struggles faced by young people and their families with accessing mental health services in Hillingdon. We called for local people to share their experiences of accessing mental health services in Hillingdon.

http://bit.ly/1Jc72v1

Adult Mental Health

Hillingdon adult mental health services to get a re-vamp (29.02.16)

At the CNWL launch of the new model of care for community mental health services which aims to offer an 'improved experience' for both mental health service users and professionals; we shared our comment's with the local press on such as positive development in mental health services for the borough as a real opportunity to improve outcomes for local residents.

http://bit.ly/28Te5O7

Mental Health

NHS Trust apologies for 'inadequate' mental health services in Hillingdon (29.07.15)

In light of the findings of the Care Quality Commission's inspection report on Hillingdon's mental health services, which concluded that some of the mental health services in Hillingdon were 'inadequate', we were asked to share our views on the report's findings. Through the work we had carried out on children mental health services, we were able to echo some of the CQC reports findings about delayed treatments and long waiting lists. As this had been expressed to us by the parents and young people we had spoken to.

http://bit.ly/28Rcveu

Maternity Care Services

Hillingdon health watchdog concerned for vulnerable mums-to-be in light of national report (07.03.16)

In light of the findings from the national maternity report which proposed that mums-to-be should be given a personal budget of £3000 each to design their own personalised maternity care plan, we highlighted the need for vulnerable and disadvantaged women to receive adequate advice and support to enable them to make informed choices and called for local women to share their experiences of using maternity services in Hillingdon.

We are following this up with a focused project to listen to women's experiences on maternity care services in Hillingdon.

http://bit.ly/292SbUz

Contraception

Concern over contraceptive coil removal across Hillingdon GPs (14.12.15)

Following a decision made by Hillingdon Health & Wellbeing Board to decommission (stop) the service providing the contraceptive coil to local women across general practice, which raised concerns about teenage pregnancy rates, we were contacted by the local press to give our comments. We asked for women affected by the changes to come forward and share their views and experiences.

http://bit.ly/28UUw7L

Fertility treatment

West London Patients suffer mounting 'stress' over IVF postcode lottery (05.02.16)

We challenged the inequalities faced by IVF patients in Hillingdon who were suffering the strain of a 'postcode lottery', by only being allowed one treatment cycle on the NHS, compared to three cycles on offer in other boroughs.

We called for women to share their experience of IVF treatment in Hillingdon and used Facebook and Twitter to engage with local women to gather their experiences.

http://bit.ly/28PJn4s

NEWS
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www.getwestlondon.co.uk

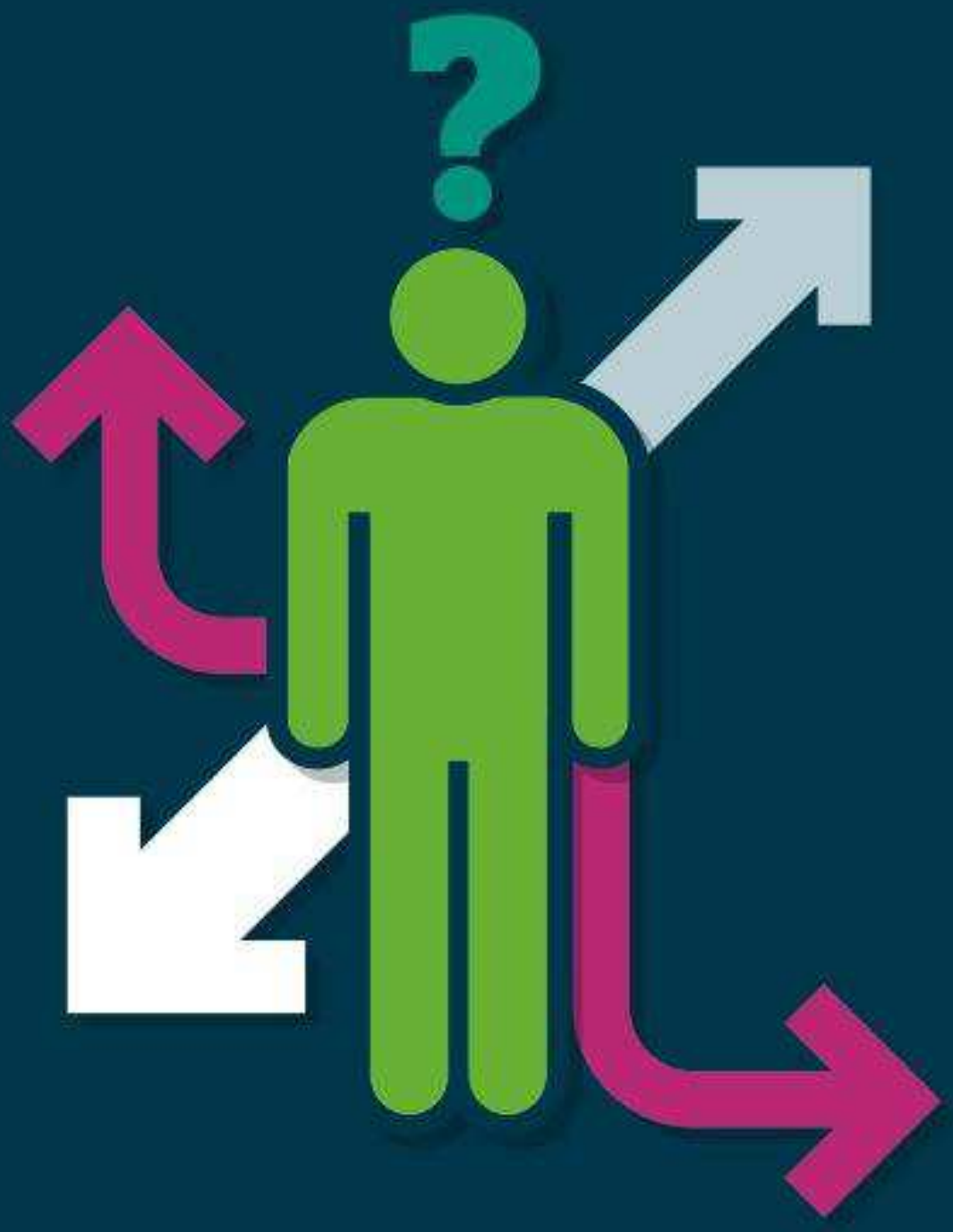
Children 'failed' by mental health care

Borough services have reached 'breaking point'

By Will Ackermann

MENTAL health services in Hillingdon are failing young people and have reached 'breaking point', according to the authors of a damning report.

Giving people advice and information



Helping people get what they need from local health and care services

At Healthwatch Hillingdon we provide a comprehensive information, advice and signposting service to our residents, through a number of different ways:

- Our shop within The Pavilions Shopping Centre
- Stalls at events and fairs across the borough
- Our website and social media
- Taking telephone enquiries and receiving emails

The shop is used as a main information hub. We have a wide ranging array of leaflets and posters to inform residents.

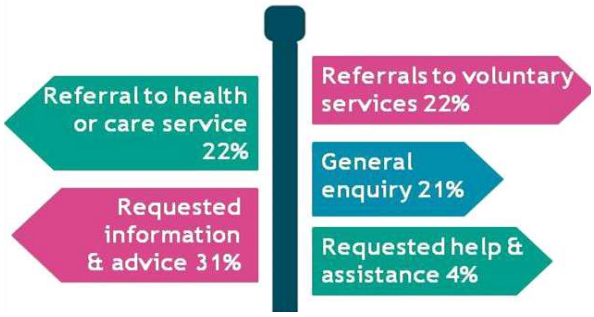
Our website also features similar information and has been visited over 150,000 times this year.

We signpost people to NHS, Care and Voluntary Sector Organisations.

Where possible we look to empower people by providing them with the information and advice to make their own choices.

Where required, we intervene for residents and on a few occasions have provided intensive one to one support.

1102 residents contacted our information, advice and signposting service in 2015/16



The reasons that people contact us are very varied. They range from simple enquiries, to some very complex issues. Our experienced team have an excellent knowledge of health and social care and the services that are provided locally.

As these examples show, this means that when approached we can offer residents advice and support that best meets their needs:

- A deaf and mute gentleman had been sent an appointment for an eye clinic. He wanted to change the appointment but could not contact the department, as telephone was the only method, and both he and his wife were deaf and mute and they did not know another person who could help them.

  We contacted outpatient appointments on the gentleman's behalf and rescheduled the appointment.

  We also raised this with the hospital and are working with them to ensure that methods of communication for people who are sensory impaired are appropriate to their disability.

  On 37 occassions this year we have refered residents to other independant services that provide

advocacy support. The majority of these were to VoiceAbility for people needing help to make a complaint. We have however refered 4 people who alleged clinical negligence to Action against Medical Accidents (AvMA).

Top 5 areas of concern or complaint

- A number of people contacted us to tell us that their NHS dentists had told them they no longer provided treatment for NHS patients and they would have to pay privately. Where people gave us their permission, we contacted NHS England and reinstated NHS treatment for those patients.

  We have also shared these experiences with Healthwatch England and the Federation of London Local Dental Committees.

- Mr B, contacted Healthwatch with a request for help.

  Mr B is frail, elderly and has chronic respitory and cardiovascular conditions. He was referred to Charing Cross Hospital, part of Imperial College Healthcare NHS Trust. His GP advised him that he would need patient transport. Mr B attempted, without success, over a 2 month period to arrange transport to Charing Cross Hospital including 1 missed appointment.

  Our intervention with Imperial College Healthcare NHS Trust resulted in Mr B being assigned patient transport and he was able to attend his next appointment.

  Additionally, Healthwatch Hillingdon raised a number of concerns with the NHS Trust regarding their patient transport policy. In response to these concerns, the patient transport policy was revised to improve equality of access for all patients who go to Imperial College Healthcare NHS Trust.

> **'The previous methodology for assessing if a patient is eligible for patient transport was primarily based on mobility and how the patient currently managed their daily activities… Our revised assessment involves a new series of specific questions that assess a patient's medical need…. rather than the previous set of questions that may not have identified all of the patients that truly needed patient transport'**
>
> Imperial College Healthcare NHS Trust'

- After we visited the local Parkinson's Group, Mrs P contacted us about access to a medication called apomorphine. She had been informed by Imperial College Hospital Trust (ICHT) this treatment for Parkinsons was no longer available.

On enquiry we discovered that the Trust had decided to withdraw this costly treatment to patients as it was not a directly commissioned service. We challenged this decision and the outcome was that ICHT re-instated access to apomorphine for Mrs P and all NWL residents, whilst a permanent solution is found with commissioners.

- During changes to the Wheelchair Service in Hillingdon we received a high volume of calls from residents.

  Many people contacted us after receiving a letter about the changes, to advise they had already returned their wheelchair and some family members rang us to advise the person being written to was deceased. We raised this immediately and a public apology was issued to those relatives by the Chief Executive Officer of Central NorthWest London NHS FT.

Will came to the shop to tell us about his experience of the new service

When the new provider took over we helped residents during the transition and in the period the new service was imbedding, to ensure they were fully informed about the new service.

- A number of residents contacted us because they had been unable to register at a GP surgery.

  On investigation we found that the majority of these residents had been registered for a number of years with other GP surgeries in Hillingdon, but as a result of the relocation of a GP practice, they were now looking to move to another local surgery.

  On contacting the surgeries, all confirmed that without exception their policy was to only register a patient who had photographic identification.

  As this was contrary to current UK law and NHS England guidance, Healthwatch Hillingdon challenged this policy and supported all local residents who had contacted us to register with a GP.

  As a result, a GP Access Forum was started by Hillingdon CCG and we are working closely with them and NHS England to address similar problems across the borough.

  To date everybody who has contacted Healthwatch has been registered with a GP.

How we have made a difference

"Just sending you a very BIG thank you, had a phone call off (CNWL) and met with them the following day, and L now has a permanent care coordinator and the consultant she wanted. Thank you" *Mr T*

"A note to say 'thank you' for your valuable support during our traumatic experience relating to my mother's numerous hospitalisations this year.

Your support was extremely valuable and important and a catalyst to ensuring our mother's treatment vs recovery at Hillingdon Hospital was effectively carried out. Without your involvement, we strongly believe the outcome would have been detrimental.

Your involvement was a 'life saver' for our mother." *Ms W*

"Thank you very much for the information regarding (nursing home), as well as the time that you and your organisation have spent with our family. It is greatly appreciated.

We had a meeting with Hillingdon Social Services after seeing you on Wednesday. The objective was to complete an assessment of Mum to determine `Mum's future level of care that she needs….

……. we will keep you informed of progress. Once again thank you and your organisation for all the advice and time given to us." *Mr S*

"Thank you again for being so helpful and understanding, it's made me very glad I contacted your service!" *Ms J*

"Healthwatch are fantastic they made sure I get a British Sign Language (BSL) interpreter when I go to the doctor, instead of taking my (school age) son." *Lady at Disability Assembly via BSL interpreter.*

"I attended the national maternity review as per your advice. I tried to put forward my experience to them. Hope it brings a change. It was really helpful. Thank you."- *Ms E*

"When I rang you I was not expecting anything. You were the 4th organisation I had contacted. The others did not even try to help but you were excellent. Thank you so much for helping me register with a GP." *Mr C*

"Thank you for all the help you are doing for me." *H*

"But again I am glad I contacted you and followed up and acted on your advice." *Ms J*

"I'm really grateful for your help. Not sure we would have got this without your involvement." *Ms W*

"Yes I am happy with all the help I can get right now, thanks for what you guys are doing." *Mr P*

Working with other organisations

Healthwatch Hillingdon has very strong operational relationships locally with NHS, Council and Voluntary Sector organisations.

As the 'stakeholder statements' demonstrate later in this chapter, we are seen as independent, an equal partner and a valued "critical friend" within health and social care.

These important relationships enable us to have considerable strategic input into the shaping of local commissioning and the delivery of services.

This year Healthwatch HIllingdon attended 235 health and social care meetings and 79 voluntary sector and community meetings, covering a wide rang of subjects.

Our involvement enables us to fulfil our duties professionally, keeping us well-informed on all matters and gives us the opportunity to challenge and seek assurances on behalf of our residents. It also ensures that the lived experience of our patients and public are clearly heard and are influencing decisions and improving health and social care in Hillingdon.

In practice our strong relationships ensure that whatever element of our work we are engaged in, we are able to directly communicate with all organisations at any level.

- Working with Hillingdon Clinical Commissioning Group is a key relationship. We have an independent seat on the Governing Body, all their strategic meetings, and across a range of work streams. This strong avenue of communication has allowed us to regularly raise quality issues and challenge commissioning decisions. High on the agenda this year has been our work on children's mental health, access to GP services, Continuing Health Care, fertility treatment, Co-commissioning and the transfer of services from Ealing to Hillingdon Hospital.
- At the Health and Wellbeing Board (HWB) we have used our statutory membership to champion our concerns on the boroughs provision of Childrens and Adolescent Mental Health. We were the only Healthwatch in NWL asked by a HWB to sign off their Childrens and Adolescent Mental Health Transformation Plan, before its successful submission to NHS England, and later in the year the Better Care Fund. This is testament to our valued contribution to the HWB.
- We meet with Hillingdon Social Services to input into a number of areas, such as, discharge from hospital, care homes, domiciliary

care and SEND (special educational needs and disability)

- We work in similar ways with both The Hillingdon Hospitals NHS FT and Central West London NHS FT.

  Through observation and the sharing of information we work together to gain a wider understanding of service quality and how their patient's experience the services each oranisation provides.

  Healthwatch has a duty to respond each year to the Trusts Quality Statements and we now work very closely with each Trust throughout the year to make sure that quality is continually addressed and those areas which require the most focus are seen as a priority.

  We support both Trusts by providing volunteer PLACE Assessors to carrying out inspections of the care environment and this is resulting in improvements to their condition, cleanliness and to the provision of food.

  This year we have worked closely with both Trusts on major strategic changes.

  Hillingdon Hospital have seen maternity services transfer to them from Ealing hospital and they have also been preparing for the transfer of children's paediactric services in 2016.

  At Central West London NHS FT there has been a reconfiguration of the way in which mental health services are delivered in Hillingdon with a greater emphasis on providing services in the community.

  Throughout these changes we have made sure residents have been kept fully informed and supported.

- We represent Hillingdon at regional meetings for change programmes which are being planned and implemented across North West London. Such as:

  Shaping a Healthier Future - the reconfiguration of acute and community services

  Like Minded - the reconfiguration of mental health services

  Sustainability and Transformation Plans - health and social care working together to build services around the needs of the local populations

- Healthwatch Hillingdon continues to develop strong relationships with our local voluntary sector and community groups.

  We work closely with Age UK, DASH, Hillingdon Carers and MIND, supporting residents together, through the sharing of information and signposting to each others services.

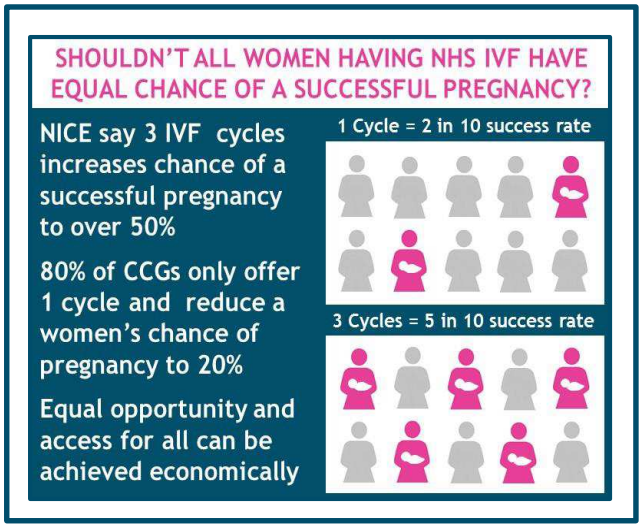
  Our work on children's mental health saw us work very closely with Hillingdon Carers, Link Counselling, P3 Navigators and local schools on our CAMHS report.

- Our role on the NWL CCG's Policy Development Group (PDG) is to ensure that access to certain NHS treatments is both fair and equitable.

As reported in our last 2 annual reports, Healthwatch Hillingdon has been working to remove weight restriction in the access to knee replacement operations. We are pleased to acknowledge that this was finally implemented across the whole of NWL this year.

We have also pressed the case for changes to the referral criteria for inguinal hernias. Our intervention led to a recommendation by the PDG that the referral policy should be changed to reflect the standpoints of the Royal College of Surgeons and NICE. This is a major step forward for the safety and quality of care for hernia patients across NWL.

- During 2015-16 we have continued to hear from many Hillingdon women and couples about the unfairness they face in accessing fertility treatment on the NHS.



We are disappointed that to date we have been unable to change policy. Based on the feedback we have gathered and our work in this area over the past 3 years we believe that NHS England and the Department of Health undertakes a national review of the access to fertility services for NHS patients and consumers.

- Our strong relationship with Healthwatch England continues to go from strength to strength.

  Our regular attendance at the London Healthwatch Network meetings provides a valuable opportunity to share intelligence and good practice with others in the London Healthwatch network and to help influence the work of Healthwatch England at the national level.

  We would particularly like to thank Healthwatch England's policy team for their work with us on Children & Young People's Mental Health and the National Maternity Review, which is presented later in our report; And for the work with us and NHS England on strengthening the CCG conflict of interest national guidance and NHS Continuing Health Care advocacy, which follows:

CCG conflict of interest guidance

Healthwatch Hillingdon continues to make significant contribution at the national level by working in partnership with Healthwatch England and NHS England to bring about improvements.
In our annual report last year, we highlighted our concerns around the potential conflicts of interests in the joint co-commissioning of GP services by CCGs.

We are pleased to report this year that NHS England and Healthwatch England have responded positively to these concerns and have actively involved Healthwatch Hillingdon in

the development of more robust conflict of interest guidance to CCGs.

> **"We view this as a really positive step, which demonstrates our ability to deliver impact and outcomes at both the local and national level"**

We believe that the revised conflict of interest national guidance goes a long way to address many of the concerns highlighted in our last annual report.

We view this as a really positive step, which demonstrates our ability to deliver impact and outcomes at both the local and national level.

NHS Continuing Health Care

Last year we also highlighted the need to improve access to NHS Continuing Health Care (CHC). We have seen a steady and welcomed improvement in this area, although more can and should be done.

Through this work we became aware of a gap in the provision of advocacy support for those people who could most benefit from NHS CHC. This resulted in us stepping in to provide direct support for local residents.

> "Just a brief note to say thank you for attending yesterday's meeting on behalf of Healthwatch Hillingdon, it made it a friendlier place and was much appreciated"

We highlighted this gap to both our local CCGs and NHS England. We were pleased with the positive responses we received and their willingness to work with us, in partnership with Healthwatch England to address this issue.

This work will take some time to deliver outcomes and improvements. In the meantime, as this year, we will continue to step in and provide appropriate support for local residents in the NHS CHC process.

- Healthwatch Hillingdon regularly shares anonymised feedback and intelligence on providers with the Care Quality Commission (CQC).

  We hold regular quarterly meetings with the CQC where we discuss common concerns and areas of improvement with the regulator. Healthwatch Hillingdon values our growing relationship with the CQC and we look forward to strengthening this relationship in the year ahead.

Our reports and recommendations

Healthwatch Hillingdon's strategic input enables us to use the information collected from residents, to make regular recommendations to commissioners and providers on how they could improve the quality and safety of services. Our input is recorded in the minutes of meetings and this means that recommendations do not always have to be formally submitted by letter, or in a report.

Following the transfer of maternity services from Ealing we wrote to the Shaping a Healthier Future Clinical Board outlining a number of recommendations. The response was positive and a commitment has been made to improve

the consultant presence in maternities to meet the Royal College's standards.

This will potentially result in helping to ensure that the clinical outcomes for mothers and new born babies will be improved for 29,000 mothers per year across NWL.

Our 'Seen & heard?' report, published following our engagement with young children and their familes outlined a number of recommendations on how childrens mental health and emotional wellbeing could be improved in the borough. Full details of the impact of this report and how recomendations were received are outlined in "Our Work in Focus"

Involving local people in our work

There have been a number of ways we have directly involved residents in Healthwatch work, or supported them in other opportunities.

Our Board members are not only involved in the governance of the organisation but regularly attend meetings as Healthwatch representatives, including the Health and Wellbeing Board.

Our Enter and View representatives and PLACE Assessors are all active members of our volunteering team and undertake visits to NHS and care facilities.

Through active promotion of local events in our newsletter and direct contact with residents by telephone and email we make sure that residents attend important events and conditions specific focus groups where their imput is invaluable.

Safeguarding Boards

Through an advertising campaign we were able to help recruit lay members to both the Children's and Adult's Safeguarding Boards in Hillingdon. This is enabling local people to use their expertise on these important boards and it was a way for us to support the Local Authority who were having difficulty recruiting to these volunteer posts.

> **"Just to say a big thank you for all your help in this process. I have recruited KP for the children board and MN for the SAB. Both were really keen and I think will contribute a lot to the board. I couldn't have done it without your help, so thank you."**
>
> Andrea Nixon, Business & Development Manager LSCB and SAPB, London Borough of Hillingdon

National Maternity Review

In addition to sharing the experiences of over 150 mothers of maternity services at Hillingdon Hospital with the National Maternity Review (Cumberlege Review), we also supported two families to attend the Maternity Review's "listening event" into serious injury during birth. This gave those local families the opportunity to share their recent experiences directly with the national review team.

Stakeholder statements

Hillingdon Clinical Commissioning Group
Caroline Morison,
Chief Operating Officer

NHS Hillingdon Clinical Commissioning Group

"Healthwatch Hillingdon is a key partner for Hillingdon CCG. They provide a valuable contribution to a number of our formal committees, including our Governing Body and Quality Safety Risk Committee, supporting us in the identification of local priorities as well as the development and delivery of plans to address them. Healthwatch Hillingdon is also a member of our Conflict of Interest Panel, working with us to manage potential conflicts of interest arising from Primary Care Co-Commissioning robustly and transparently.

In addition, we value the role that Healthwatch Hillingdon plays in ensuring that ongoing, consistent feedback from the residents of Hillingdon is incorporated into the way that our services are commissioned and delivered. In 15/16 that has included input to access to community and primary care services, including the development of integrated care for older people, GP access and end of life care. Healthwatch have supported us with the development of mental health transformation programs, specifically focusing on urgent care, talking therapies, perinatal care, dementia and improved coproduction with children and young people with mental health needs. Healthwatch Hillingdon also contributes to shaping services outside Hillingdon including attending the North West London Policy Development Group.

'Future of Health and Care in Hillingdon Event'

Hillingdon CCG looks forward to continuing to work in partnership with Healthwatch Hillingdon, shaping our services in a way that best meets the needs of Hillingdon residents."

The Hillingdon Hospitals NHS FT
Shane Degaris,
Chief Executive Officer

The Hillingdon Hospitals NHS NHS Foundation Trust

"The Trust has continued to work in close partnership with Healthwatch Hillingdon and appreciates the valuable contribution they provide to the organisation. Representatives from Healthwatch Hillingdon have regularly attended focus groups and committees and have attended meetings of the Trust Board, Council of Governors and People in Partnership. Healthwatch Hillingdon is

an active member of our Experience and Engagement Group which oversees the delivery of the Trust-wide plan for improving patient experience.

Healthwatch Hillingdon has direct access to the Chief Executive and meets bi-monthly with the Chief Executive and Director of Nursing to provide feedback from patients and local residents who are in receipt of services provided by the Trust

Healthwatch Hillingdon and Healthwatch Ealing attend a quarterly quality meeting, to check progress and gain insights into how the Trust is performing against a number of quality indicators. The Trust has benefitted from the involvement of Healthwatch Hillingdon in Executive appointments at the Trust and we continue to work closely with Healthwatch Hillingdon on the consultation for the priorities for the quality report, PLACE inspections and follow up actions.

The Trust undertakes regular engagement with local people by attending community events and forums. The Trust has attended several events with Healthwatch Hillingdon providing opportunity to work together to improve services for the local community.

In the coming year the Trust will be supporting Healthwatch Hillingdon on two projects which will be looking at the patient experience on maternity and discharge into the community.

Central & North West NHS Foundation Trust
Maria O'Brien,
Divisional Director of Operations

"CNWL deliver a significant number of health services in Hillingdon including inpatient and community based mental health services as well as adult and children's physical health community services such as district nursing, rehabilitation, rapid response, health visiting and school nursing. It is therefore essential that we work with local organisations to improve services and respond effectively to feedback from our service users and patients.

Our relationship with Healthwatch Hillingdon is an important element of this feedback and as a critical friend to the organisation, it is important that we are able to work in partnership to address any concerns, improve existing services or redesign them completely to meet the changing needs of our local patients.

We have a longstanding and established working relationship with Healtwatch with regular meetings in place between

Healthwatch senior officers and the CNWL Mental Health and Community Borough Directors and Divisional Director of Operations. We recognise the valuable contribution that they make through our regular dialogue, visits to our clinical areas and joint working on specific service related projects.

Throughout the year, we have worked with Healthwatch across a variety of areas including:

- Informing and developing our 2016/17 Trust-wide Quality Priorities
- Involvement in the co-production of a new model of care for our mental health community services

Launch of new model of care for adult community mental health services in Hillingdon

- Developing a joint CAMHs strategy alongside Hillingdon Clinical Commissioning Group and London Borough of Hillingdon
- In-patient PLACE inspection teams

We look forward to our continued joint working during the forthcoming year and welcome their ongoing challenge function to support our drive for continuous quality improvement.

The Community Voice,
Joan Davis, Chairman

The Community Voice
MONITORING THE NHS IN NW LONDON AND SW HERTS

Healthwatch Hillingdon has much to be proud of. It has excellent premises ideally situated in a major mall in Uxbridge, where its is highly visible to shoppers. Its open frontage invites casual visitors, who can help themselves to the many NHS leaflets on display. More importantly, there is always a member of staff ready to answer questions and to give advice.

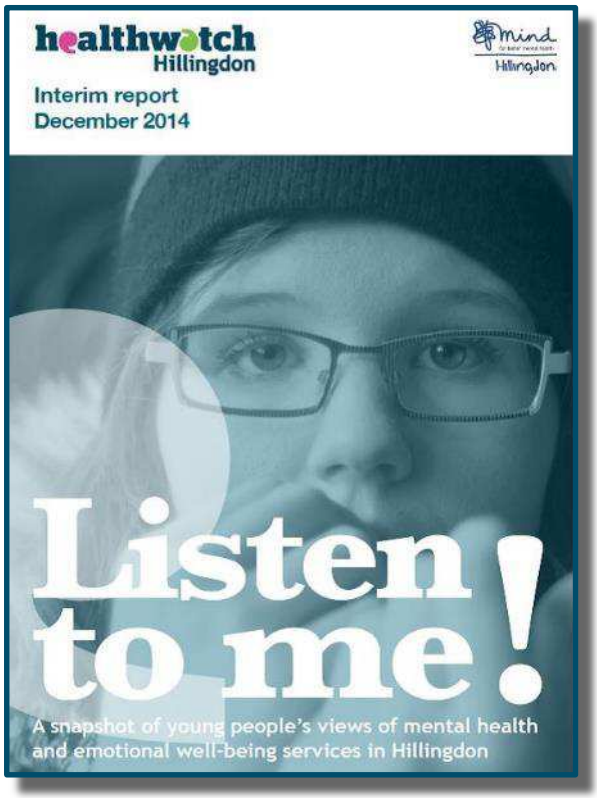
Healthwatch Hillingdon is an active participant in many local NHS committees. It stoutly defends the interests of local patients and is vocal on their behalf. It also monitors all levels of NHS services and engages with the public at every opportunity.

The high standards of Hillingdon Healthwatch are sadly not echoed universally elsewhere. Some of its sister organisations could learn much from the exemplary model that it provides.

Our work in focus

Our work in focus: Children and Young People's Mental Wellbeing

Being a catalyst for change



Introduction

As we reported in last year's annual report, in December 2014 Healthwatch Hillingdon and Hillingdon Mind published 'Listen to Me', an interim report that highlighted the struggles of children and young people with mental health problems in Hillingdon and the effects these have on them and their families.

We outlined how uncertain funding, a lack of early intervention and fragmented services were compounding issues and called for a joint approach, from all stakeholders, to improve services.

In Hillingdon, 'Listen to Me' inspired a renewed commitment to improve services for children experiencing mental health problems.

Hillingdon Clinical Commissioning Group (CCG) and the London Borough of Hillingdon formed a new Children & Young People's Mental Health and Wellbeing group to oversee improvements to services and started to develop a Joint Social Emotional Wellbeing and Mental Health Strategy 2015-2018. This incorporated a number of the recommendations made in our 'Listen to Me!' report.

Nationally, Healthwatch England used the report to directly influence the Government's Children and Young People's Mental Health Taskforce, which was undertaking a major review of children's mental health.

Continued Engagement

The interim report was published due to the scale of the problem we had found. It was very important that we built on this report and to do so we set out a 5 month intensive programme of engagement with young people, their families and care professionals. Our ambition was to gain a

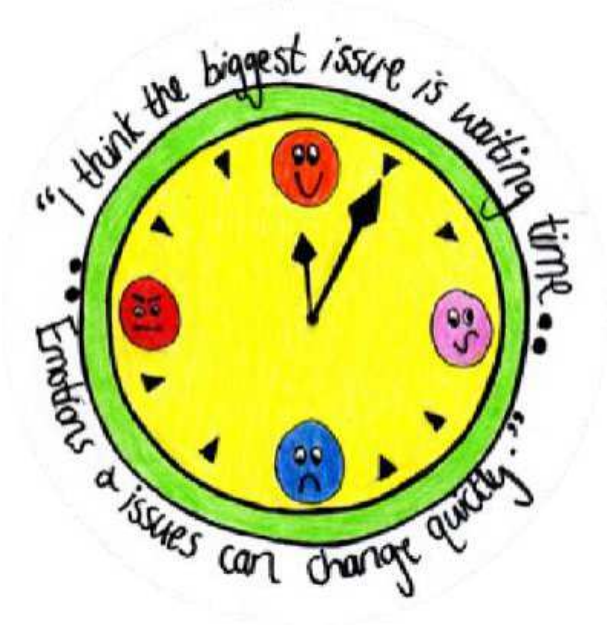
better understanding of services. We wanted to produce a comprehensive report, which not only gave a rich evidence base of the lived experience of children, young people, parents and carers, but ensured that these experiences influenced and shaped future plans, by offering practical solutions on how services could be improved.

Sustained Challenge

As our engagement continued, we took every opportunity to bring focus upon children's mental health.

At the Children & Young People's Mental Health Group we looked for the membership of the group to be expanded, to include schools and the voluntary sector.

We maintained a sustained challenge at the Hillingdon CCG Governing Body and the Health and Wellbeing Board.



This led to the Hillingdon CCG commissioning Public Health to complete a Children's Mental Health Needs Assessment, and providing funding for:

- Reducing the waiting list for the Tier 3 CAMHS (Children's and Young Peoples Mental Health Service)
- Learning Disability CAMHS
- Out-of-Hours CAMHS intervention at Hillingdon's A&E department
- Perinatal Mental Health Services.

Already prepared to act

The Children and Young People's Mental Health Taskforce completed their review and in March 2015 published a report called 'Future in mind – Promoting, protecting and improving our children and young people's mental health and wellbeing.'

The Taskforce echoed much of what we had said in our interim report and reinforced the recommendations we had made.

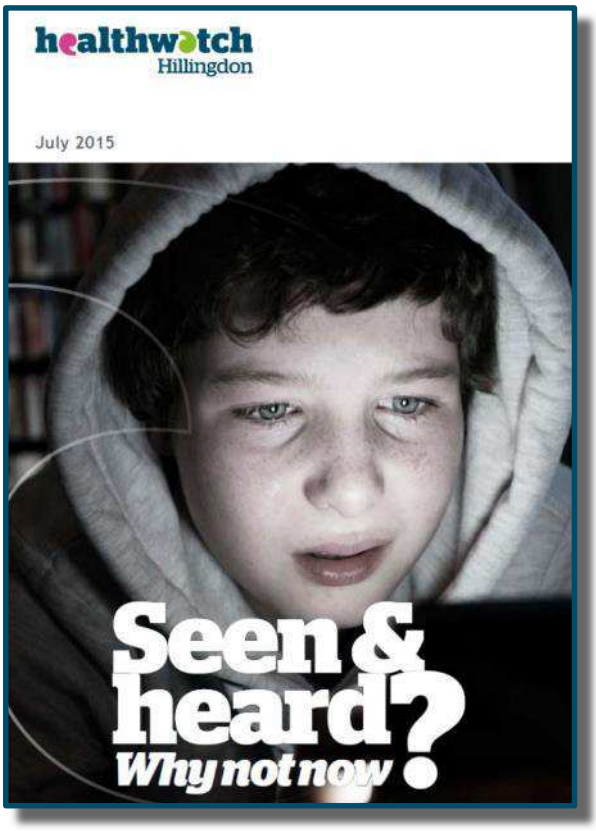
It called for long-term whole system solutions, collective working and the development of clearly defined transformation plans to address the

shortfalls in children's mental health provision.

Due to the Healthwatch Hillingdon work on children and young people's mental wellbeing, these were steps we had already taken in Hillingdon. Partners were in a position of strength that could now be built upon.

Comprehensive Report

In July 2015, pre-empted by a publicity campaign in the local media and the release of a short promotional animation, we published our eagerly awaited second report, 'Seen & Heard – Why not now?'



The report featured some uncomfortable hard hitting stories, which gave real insight into Hillingdon's mental health and wellbeing services from the children, young people and their families who have faced the struggles of emotional and mental health.

As planned, in addition to containing a rich evidence base, we outlined 10 key principles that formed a 'blueprint' for commissioners to provide better support and services in Hillingdon.

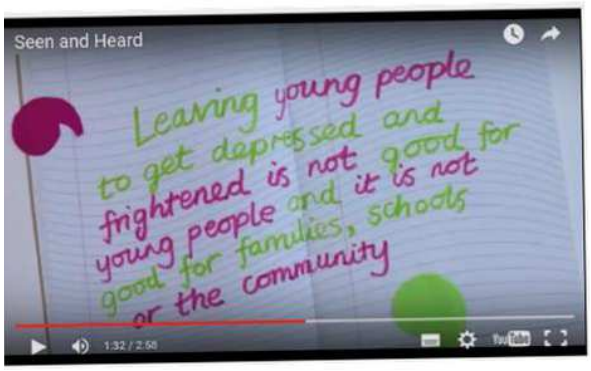
Transformation Plans

Healthwatch Hillingdon had a pivotal role in the formulation of Hillingdon's Children and Young People's Mental Health and Wellbeing Transformation Plan. 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 framed much of the contents of the plan.

The information in our reports has been referenced in the Children's Mental Health Needs Assessment completed by Hillingdon's Public Health team. It was also pleasing to note that Hillingdon was the only borough in North West London to complete a needs assessment to inform

their transformation plan and this was directly as a result of Healthwatch Hillingdon's request in our Listen to Me! report for this to be commissioned.

Our work was also 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.



Seen and Head Animation
www.youtube.com/watch?v=NjdqrL1JNpk

We continued to collaborate with partners to develop Hillingdon's transformation plan and in recognition of all our work were invited by the Health and Wellbeing Board to countersign the plan, with the CCG and the Council, before it was submitted to NHS England for approval, as part of a joint North West London plan.

We did not want to see the momentum for change in Hillingdon slow whilst the plan was being assured by NHS England. Being conscious that every region across the country would be looking to recruit specialist CAMHS staff once transformation funding was announced, we formally asked the CCG Governing Body to consider funding the recruitment of CAMHS staff in advance of the announcement. We also raised concerns with them about the slow progress in the development of the pan North West London Eating Disorder Service and asked for firm timelines to be set in delivering this new service.

NHS England announced in November 2015 that North West London had been successful in its bid and Hillingdon was awarded £524,623[3], recurrent for 5 years, to deliver the transformation plan.

3. https://www.england.nhs.uk/wp-content/uploads/2015/07/annex-4-transformation-plan-guidance-ccg.pdf

Delivering The Plan

We continued to work with and challenged partners on the delivery of the transformation plan, to ensure services were being appropriately planned to meet the needs of Hillingdon's residents and that children and their families/carers are involved in the process.

As before, we took every opportunity to raise the profile of children's mental health.

In December 2015 we presented on our CAMHS work and the 'Seen & Heard – Why not now?' report to The Children and Young People's Mental Health Coalition (CYPMHC) at the Mental Health Foundation. They were very complimentary about our work and specifically admired the Healthwatch role in signing off the Hillingdon Transformation Plan at the Health and Wellbeing Board.

Through this presentation we facilitated the CYPMHC attending the Hillingdon Children and Young People's Mental Health and Wellbeing Board, to inform on the work being carried out in schools by Place2Be.

We also presented on our CAMHS work at the National Service Change Conference in March 2016. Facilitated by Healthwatch England and the Leadership Centre, the conference focussed on how the public sector can work together during service change programmes.

Progress on plan?

We acknowledge that progress has been made in the implementation of the plan.

Our expectation is high and we have been increasingly frustrated by the speed at which progress is being achieved.

New services have commenced for community eating disorder, self harm, crisis and intensive support and challenging behaviour, which will take time to imbed.

We have seen a reduction in waiting times for accessing CAMHS Tier 3, but until we see the implementation of initiatives to offer early help and prevention, system pressures will remain and those young people who do not meet Tier 3 thresholds, will struggle to find support.

Children and Young People have been engaged by partners in redesign and training will commence in April 2016 following the completion of a training needs assessment.

As we had anticipated the recruitment of staff has been a real challenge and with Trusts across the country advertising for professionals, this has also had an adverse effect of staff retention.

Engagement with schools has also proved to be problematic. Especially with the independence of academies.

We understand the challenges involved and appreciate the efforts being taken by partners but it is disappointing that almost all of the work-streams within the plan were RAG rated amber at the end of March 2016.

What next?

As work continues into the new financial year, it is recognised by all partners that there are 6 areas which require immediate focus and further development:

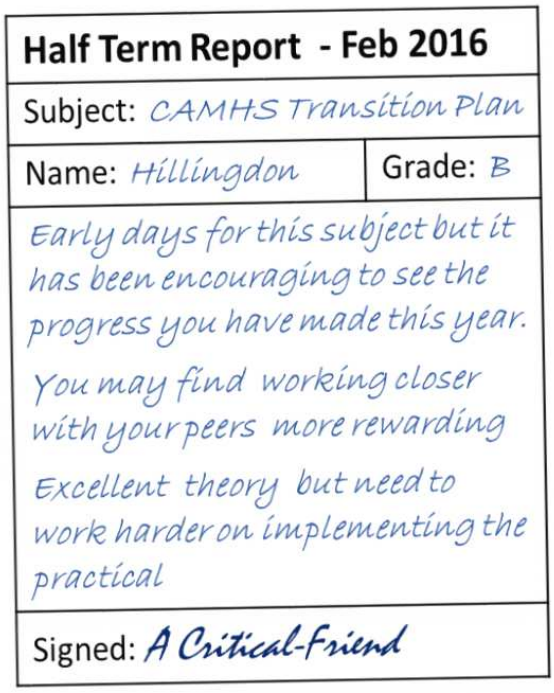
- No counselling service for under 13's
- Recruitment & retention of NHS staff
- School based counselling services

- Raise participation of CYP in redesign
- Increase Tier 2 capacity
- Transition to adult services

Healthwatch Hillingdon's task will be to continue to monitor, and challenge, the development in these areas and ensure the new services deliver the desired outcomes.

We have come a long way since we sat down with 5 parents nearly 3 years ago and they told us about how Hillingdon's services were letting their children down.

We know we have more work to do and Healthwatch Hillingdon will certainly not rest until we know the new investment in Hillingdon has improved services, and the mental wellbeing of children in our borough.

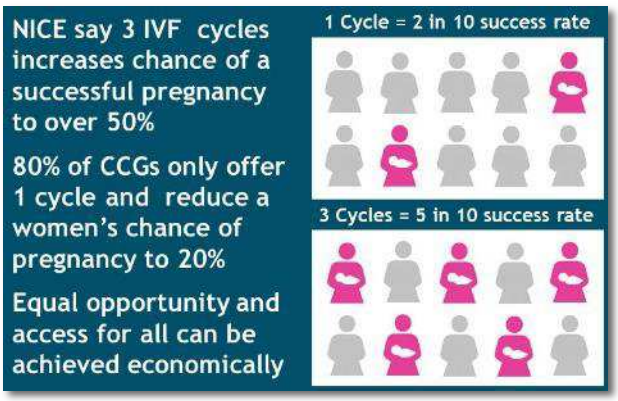


Our work in focus: Access to Fertility Treatment

Shouldn't all women having NHS IVF have equal chance of a successful pregnancy?

Introduction

Over the past 3 years Healthwatch Hillingdon has heard from Hillingdon women and couples who have expressed their views on the unfairness that they face in access to NHS-funded fertility services including in vitro fertilisation (IVF). These people, in our view, represent seldom heard members of our community.

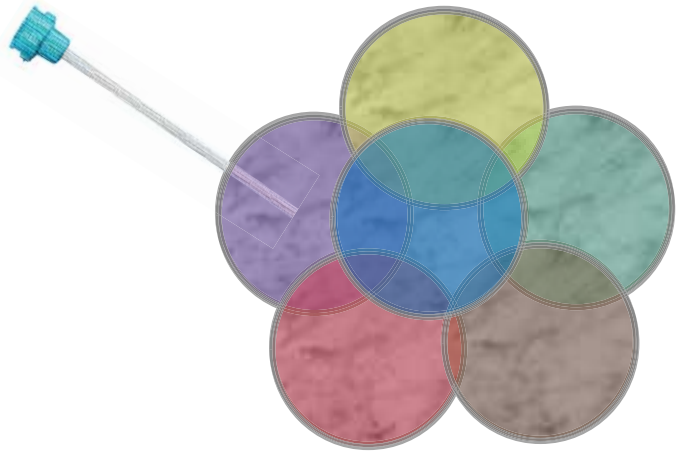


The facts about fertility

- Most couples seek medical advice after 1-2 years of trying to conceive.
- Fertility issues are second to pregnancy, as the most common reason for women to visit their GP.
- If left untreated, infertility can result in stress, depression, emotional distress and breakdown in relationships.
- The chances of IVF success fall sharply after the age of 42.
- The National Institute of Clinical Excellence (NICE) recommends that women under 40, who have been trying to get pregnant for 2 years, should be offered 3 full cycles of IVF.[4]
- For women aged between 40 and 42, who have been trying for 2 or more years, and have not previously received IVF, NICE recommends 1 full cycle of treatment.

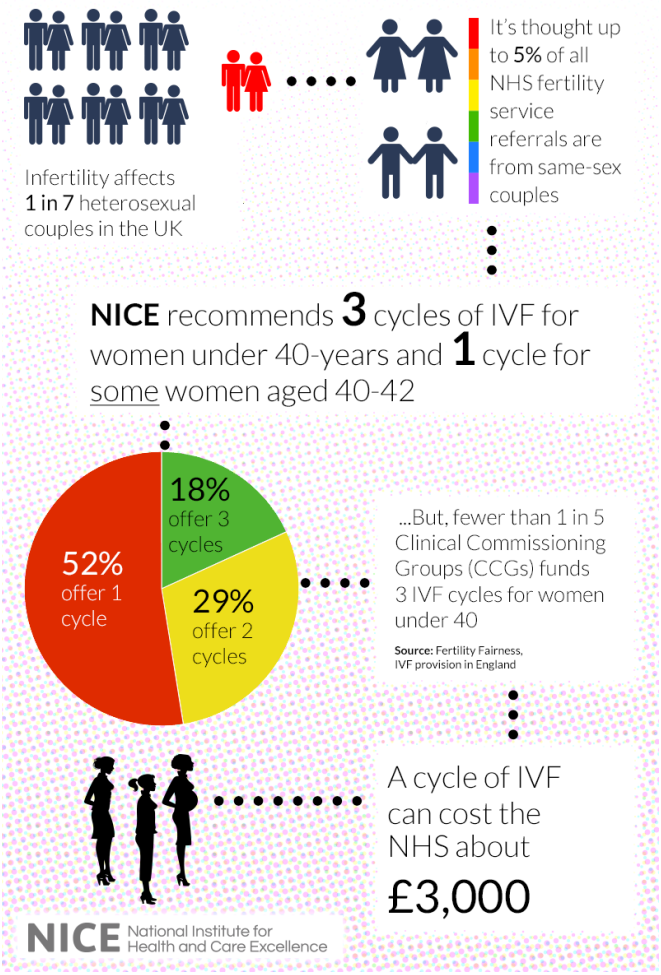
4. https://www.nice.org.uk/Guidance/CG156

The main causes of infertility in the UK



- **male infertility** 30%
- **unexplained infertility** 25%
- **ovulatory disorders** 25%
- **tubal damage** 20%
- **uterine or peritoneal disorders** 10%

Decisions on whether IVF treatment is offered to patients are made by local NHS bodies (CCGs), which is leading to a "postcode lottery" in access to IVF.



In the London Borough of Hillingdon and across the 8 London Boroughs of North West London (NWL), the NHS NWL CCGs have chosen to implement a blanket policy which only allows eligible women (under 40) to have 1 cycle of IVF and no cycles for 40-42 year olds. This does not follow the national NICE IVF recommendations.

> **"Infertility is a recognised medical condition. People affected should be able to receive treatment as a core NHS service….. It is unacceptable that parts of England are choosing to ignore NICE recommendations for treating infertility. This perpetuates a postcode lottery and creates inequalities in healthcare across the country"**
>
> **Professor Gillian Leng, deputy chief executive and director of health and social care at NICE.**

Offering solutions

Over the past 3 years, Healthwatch Hillingdon has attempted, on numerous occasions, to put the case forward for a fairer and equitable approach to improving access to IVF across North West London. The suggestions we have made include phasing in of the commissioning of IVF services at scale across NWL with a single, common contract. This practical approach could realise much needed financial efficiencies for the NHS, by reducing the cost per treatment, and lead to improved outcomes for families by increasing the chances of a successful pregnancy for women.

> **"The Claimant observes that the perceived vice which has to be tackled is the so-called "postcode lottery", but in my view it goes further than that. Any system which has the duty of distributing finite resources must do so not merely on a basis which is not arbitrary (c.f. the**

happenstance of the postcode) but also on a basis which recognises the patient's fundamental human right to be treated in exactly the same way as anyone else with the same clinical need"

MR JUSTICE JAY, in the case of Rose v Thanet NHS CCG April 2014, Case No: CO/1272/2014, Royal Courts of Justice.

We have recently highlighted to the NHS Hillingdon CCG that in addition to only receiving one procedure, some NHS-funded patients from Hillingdon are being asked to pay for additional IVF procedures that NHS patients in other areas are not charged for.

Local women have told us that at a very emotive time in their life, when they feel this one procedure is their only chance of having a child, they felt pressured and compelled to pay in excess of £1000 in additional charges.

We have requested that the NHS NWL CCGs undertake a review of current IVF contracts they commission, so that NHS-funded patients in NWL are not being financially disadvantaged by this other example of inequality for NHS patients receiving the same IVF treatment.

NHS England has a national IVF policy for service personnel in the armed forces and their families, which does allow for 3 IVF cycles and follows NICE recommendations. This creates further inequality in access to IVF as women living on the same street could have completely different access to NHS-funded IVF. Naturally, armed service personnel and their families give fantastic service to their county and rightly deserve access to the best that the NHS can offer them, but this inequality raises the question: "are other women in England less deserving to have reduced access to NHS IVF treatment?"

Sadly, to date, the NHS NWL CCGs have not been sympathetic to the views we have put across and we have been unable to improve fair access to fertility treatment for NWL residents.

"Access to NHS funded IVF is not easy and women already need to meet strict medical criteria before they can be considered for IVF and must have tried all other options first. This is not a life-style choice, nor an "easy option" for women but changes to our society and demands made on women, make starting a family difficult enough without facing a postcode lottery in access to IVF. Women across North West London are facing an uphill struggle to access fertility treatment that has been recommended by NICE as being both clinically effective and cost-effective."

Graham Hawkes CEO, Healthwatch Hillingdon.

"This represents a postcode lottery in care. Our members have paid taxes all their lives for a National Health Service and do not expect the NHS to deny women an opportunity to have a child in this random manner." *- Oak Farm Residents Association*

"Today we should live in a society of equality so I can not understand how a select few CCG's can justify a post code lottery of entitlement to IVF treatment." - *Ms E*

"Not my fault that we lost the baby, but not able to get NHS IVF as we had used our 1 cycle of IVF." - *Ms D*

"why as a 30 year old woman who has been trying to fall pregnant for 3 years and after various health checks, blood tests, procedures and an operation why I am unable to get a referral for IVF treatment. My partner who I love has a child from a previous relationship is the reason." - *Ms B*

Due to having a medical procedure years ago, G was advised that her fertility would be affected and would need IVF.

"I pay tax to the government and I don't understand why I am unable to get the same NHS service as other women in England. This is really unfair on women. We are now thinking of moving to a neighbouring area, Hertfordshire, so that we can get NHS-funded IVF. But is sad that I am been forced to move from where I live (Hillingdon) due to stupid local NHS rules." - Ms F

"I believe that this is very unfair and would ask that this issue is taken up urgently. Being unable to conceive naturally is a very alarming situation and to be discriminated due to age is not acceptable" - *Ms A*

"Living within the London Borough of Hillingdon, I wasn't entitled to an AMH blood test … All my taxpaying life I've lived here (Hillingdon) and I'm being penalised for living here, whereas my friends in High Wycombe got three rounds of IVF and Hampshire gets two and they're only a couple of miles down the road either way. It really does depend on where you live and I think that's absolutely appalling." - *Ms C*

Healthwatch Hillingdon Recommendations

1 NHS England to consider publishing robust national guidance to CCGs which may (a) assist in improving access to NHS-funded IVF treatment that meets NICE Clinical Guidelines and (b) assist NHS England in meeting its equality duty obligations.

2 Recommend that NHS England and Healthwatch England/CQC considers undertaking a national review of the access to fertility services for NHS patients and consumers.

3 We recommend that this national fertility review should give careful consideration of the merits of nationally commissioning NICE recommended fertility treatment at scale rather than delegating this responsibility to the local level.

4 Recommend that the national fertility review explores whether the current provision and commissioning arrangements are working in the best interests of patients and consumers or are placing unnecessary hurdles and/or significant financial burdens on consumers who should be able to access NHS fertility services based on clinical need.

Healthwatch Hillingdon believes that commissioning fertility services at scale across England, with a fixed national NHS tariff, incorporating nationally agreed outcome measures, and phasing in the services over a number of years, will be more cost effective for the NHS. It will eliminate the current inequality in access to fertility services and most importantly, improve the clinical outcomes for people needing IVF treatment and increase the chances of a successful pregnancy.

Healthwatch Hillingdon stands ready and willing to contribute its insight to a national fertility review.

Our plans for next year

Future priorities

The delivery of our statutory roles will always be our main priority. Focusing upon, and listening to, what our residents are saying, and protecting their rights, is key to everything we do.

We look forward to the next year and delivering Healthwatch Hillingdon's operational priorites, as set out in our 2015-17 work-plan.

We will continue to have an oversight of the quality and safety of care services in Hillingdon and be strategically involved in change programmes in the borough and across NWL.

2016 will be pivotal for The Shaping a Healthier Future programme as paediatric services will transfer to Hillingdon Hospital from Ealing at the end of June.

The delivery of the Childrens and Young Persons Mental Health Transformation Plan, and the development of the Better Care Fund, Accountable Care Partnerships and the Sustainability and Transformation Plans will also be high on our agenda.

Work-plan projects, like Discharge and Maternity are already underway and will be completed during the coming year.

After each project is completed we will evaluate our position before commencing work on the next priority. This allows us to look at current data and patient feedback, to ensure the priority remains relevant; or that another emerging priority should not take preference.

If, as this year, it is found no changes are required, in late 2016 and early 2017 we will be concentrating on:

- Care Homes
- Primary Care

Priority Focus

Discharge from Hillingdon Hospital

The discharge from Hillingdon Hospital sets out to engage with 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.

With the Better Care Fund and the general integrated care prorammes being implimented across Hillingdon, we felt it was important to get an understanding of how services are working now. This will enable us to benchmark current hospital and community services and gauge as changes are implemented how services

are improving for residents. It also gives us an opportunity to help shape future services through the experience of our residents.

Maternity Care in Hillingdon

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 'Maternity Care in Hillingdon' project is seeking the views and experiences of women who choose to give birth at Hillingdon Hospital and using this evidence, evaluate the provision of the maternity for both Hillingdon and Ealing residents.

This project is being carried out over an 8 month period and our engagement programme will speak to women at the hospital and children's centres.

Sustainability and Transformation Plans

As NHS England look to implement the the Five Year Forward View, health and care systems across the country are being asked to work together locally to plan future services around the needs of their local population. The Sustainability and Transformation Plan (STP) sets out shared plans for the next five years to bring together providers and commissioners of care (both local government and NHS) to deliver a genuine place based plan for the borough.

In Hillingdon the STP is seen as a platform for the development of new and innovative ways of funding Health and Social Care over the next 5 years. Local relationships are advanced and we are in a strong position to develop our STP.

Healthwatch Hillingdon is already well placed and part of the STP Deliver Group in Hillingdon. In our input at this early stage we have already asked for patient choice and cross boundary provision to be strengthened in the initial draft plans.

This year we want to ensure that as the Hillingdon STP evolves that our residents are not only well informed, but there is strong engagement with them so that they play a central role in the developments of plans and strategies.

Accountable Care Partnerships

Accountable Care Partnerships (ACPs) emerged as a key part of NHS policy in the Five Year Forward View. ACPs bring together providers in new organisational forms, to deliver integrated care around patients and are seen as part of essential actions to manage quality and financial sustainability for the NHS.

In Hillingdon, an ACP is being developed which brings together The Hillingdon Hospitals FT, Central North West London FT, the GP Networks and the voluntary sector organisation, Hillingdon4All. With a new Programme Director appointed, the organisations are currently working collaboratively, to develop a new joint governance structure, which will enable the ACP to deliver services in shadow form in 2016.

The integrated care delivered by the ACP will initially be for older people with long term conditions. It is planned that this will progress to all older people and other population groups with long term conditions during the next 5 years, as the Five Year Forward View is realised.

We are currently in discussion with the ACP to look at how they will involve the public in its development and are exploring the value of Healthwatch Hillingdon.

As we move into 2016-17, like the STP, we want to strengthen the involvement of the Hillingdon public in the ACP and ensure patient engagement and public accountability is imbedded in its structure.

Our people

Decision making

Our Board as at 31st March 2016

- *Jeff Maslen, Chairman*
- *Stephen Otter, Vice Chair*
- *Allen Bergson*
- *Richard Eason*
- *Turkay Mahmoud*
- *Baj Mathur*
- *Burns Musanu*
- *Kay Ollivierre*
- *Rashmi Varma*

Healthwatch Hillingdon is a Company Limited by Guarantee. The Board are bound by the companies Memorandum of Articles.

Board members act as Directors of Healthwatch Hillingdon under the Companies Act 2006 and as Trustees of Healthwatch Hillingdon under the Charities Act 2011.

Healthwatch Hillingdon is governed by a Board that consists entirely of lay people and volunteers. Selection and recruitment to our Board is through an open and transparent recruitment process.

Meetings of our Board are held in public and agendas, minutes and reports of our meetings are published on our website and available upon request.

We have published our 'Relevant Decision Making Policy' on our website, setting out how the Healthwatch Hillingdon Board makes relevant decisions. This policy is reviewed annually to ensure that the decisions taken by Healthwatch Hillingdon follow national best practice and reflect any guidance from Healthwatch England.

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 Work Plan is an open and transparent document that is shared publically on our website and with collaborative partners. We actively seek feedback on our plans and priorities and review the Work Plan annually to validate its relevance, take note of feedback and update it where necessary.

Our Staff Team

- *Graham Hawkes, Chief Executive*
- *Raj Grewal, Operations Coordinator*
- *Pat Maher, Administration & Support*
- *Charmaine Goodridge, Outreach & Volunteers*
- *Nina Earl, Engagement & Communications (until Oct 2015)*
- *Victoria Silver, Childrens Engagement (until July 2015)*

Our Volunteers

Volunteers play an important role in enabling Healthwatch Hillingdon to achieve its core functions. We consider ourselves very fortunate therefore to have a team of dedicated volunteers who bring with them a wealth of skills and experience and a passion to improve health and social care services for local people.

During 2015/16 volunteers undertook a range of activities on behalf of Healthwatch:

- **Engagement** – Manning stalls, attending events

- **Social Media** -Raising the profile of Healthwatch through social media outlets such as Facebook & Twitter, YouTube
- **PLACE Inspections** – conducting place inspections at The Hillingdon Hospital and other care facilities
- **Administration** – data inputting and office based activities

In all a total of 52 volunteers supported our work, contributing a staggering 2366 hours of their valuable time and many of those volunteers received additional training where needed to enable them to carry out their role effectively.

Without their contribution, it would be impossible to do all that we do and as our pool of volunteers continues to grow we will be in a better position to expand the work we do and reach out to those communities who would otherwise not be heard.

Case Study 1 - Shakira Sayyed

Before joining Healthwatch Hillingdon in March 2016, Shakira had previously volunteered with Healthwatch Croydon and so was familiar with the work of local Healthwatches. When she visited our shop in early February to enquire about volunteering opportunities with Healthwatch Hillingdon, our Outreach & Volunteer Officer was at hand to talk her through the current volunteering opportunities available to her. She quickly expressed an interest in the Data Entry role and it wasn't long before she was busy getting stuck into updating our various databases.

"I joined Healthwatch Hillingdon in March 2016 as a data entry volunteer. I thoroughly enjoy my work and the team are warm, friendly and supportive. As well my data entry role, I have also participated at engagement events attended by Healthwatch, helping to gather the views of local communities on health and social care. It feels great to know I am making a difference!

I would recommend volunteering to everyone, it's a fantastic way to build our confidence, meet new people, make new friends and learn new skills.

Shakira Sayyed - Volunteer

Case Study 2 - PLACE Assessors

The most popular volunteering role at Healthwatch Hilingdon is being a PLACE Assessor.

Patient-led assessments of the care environment (PLACE), are carried out in

hospitals and assess how the care environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.

As part of a team our Assessors have the opportunity to visit Hillingdon, Mount Vernon and Harefield Acute Hospitals; and Central North West London FT's mental health and childrens units at Riverside and Woodlands in Hillingdon.

As anyone of our 10 assessors will tell you, it is easy to become an Assessor. The training is light, but thorough and you can build your confidence by shadowing somebody else and you will really enjoy it.

I joined Healthwatch to help improve our NHS and social care. Healthwatch volunteers walk around the hospital or care service with the service's staff to assess the care environment in a range of acute and mental health services and care providers. It's part of a national survey called PLACE. Services are getting better and its good to know that we can all be part of the change. During assessment visits we report on cleaning and hygiene, safety and condition of equipment and decoration. We also taste and observe the food service.

Roger Dewey - Volunteer

Case Study 3- Big Thanks to the Healthwatch Hillingdon Team

The past 2 weeks have been a great experience for me, and something that will definitely help me in the future. I've learnt a great deal a lot more than I probably would have if I just done my work experience at a random retailer like

what was originally planned- no regrets from that stand point.

I'm very grateful to how kind you've all been, and how well you've all managed to put up with me. From this experience I can really see how much effort it takes to make change; It's wonderful to see people out there still willing to fight for it.

The skills and new found knowledge is greatly appreciated and I can see it really helping me, thanks to the experience I have a clearer idea what i want to in the future. If I had been more confident speaking, then I'm sure I would have enjoyed my time a lot more. I still found it interesting though, and realized for the first time how satisfying getting work done can be.

It's a great cause you're all working for and I hope you get the recognition you deserve. Keep up the good work!

Thanks for everything, best of wishes. N.

To find out more information about our volunteering opportunities please email:
charmaine.goodridge@healthwatchhillingdon.org.uk
or, call us on 01895 272997

Our finances

Financial Statement 2015/16

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	175,000
Bought forward 2014/2015	15,647
Total income	190,647
EXPENDITURE	
Operational costs	24,550
Staffing costs	133,423
Office costs	9,958
Total expenditure	167,931
Balance brought forward	22,716

NOTE: The Financial Statement is provisional and subject to the Healthwatch Hillingdon accounts for the year 2015-16, being examined by an independent examiner under section 146 of the Charities Act 2011.

Contact us

Get in touch

Healthwatch Hillingdon,
20 Chequers Square,
Pavilions Shopping Centre,
Uxbridge
UB8 1LN

01895 272997

office@healthwatchhillingdon.org.uk

www.healthwatchhillingdon.org.uk

Healthwatch Hillingdon

@healthwatch_LBH

Registered Office: Healthwatch Hillingdon, 20 Chequers Square, Pavilions Shopping Centre, Uxbridge UB8 1LN
Company Limited by Guarantee
Registered in England and Wales

Company Number: 8445068

Charity Number: 1152553

We will be making this annual report publicly available on 30th June 2016 by publishing it on our website and submitting it to Healthwatch England, Care Quality Commission, NHS England, Hillingdon Clinical Commissioning Group, London Borough of Hillingdon, Hillingdon Health and Wellbeing Board and the External Services Scrutiny Committee.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format, please contact us at the address above.

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

3. UPDATE ON PROGRESS

1. Officers from Hillingdon Clinical Commissioning Group (CCG) and LBH are continuing to work together to allocate the s106 health facilities contributions held by the Council towards schemes to improve the provision of health facilities in the Borough. In the last financial year, a total of £336,658 has been allocated and spent towards eligible schemes, in order to ensure that contributions are spent within the relevant time frames and to maximum effect to provide viable improvements for the benefit of local communities. All of the s106 health facilities contributions which had a spend deadline in 2015/16 have now been allocated and spent towards approved schemes. There are currently no deadlines for spending health contributions in 2016/17and HCCG are now proposing that any further contributions are earmarked towards longer term schemes to be implemented as part of Hillingdon CCG Estates Strategy (see paragraph 10).

Proposed new health centre in the Yiewsley and West Drayton area

2. Despite a comprehensive property search, Kirk House in High Street, Yiewsley, remains the only suitable site option to provide a new health centre in the Yiewsley/West Drayton area. Options are being explored with Central and North West London Foundation Trust (CNWL), who currently lease the site, but any proposals will also be subject to negotiation with the land owners. HCCG has so far "earmarked" a total of £425,341 from eight separate s106 health contributions currently held by the Council towards a suitable scheme.

3. In the mean time, the CCG is proposing some short term investment at the existing Yiewsley Health Centre, in order to help deal with the immediate pressures on primary health care and GP services in the area. A bid for funding has been made to NHS England and a decision is expected in October 2016. In the longer term, however, the existing building has limited capacity to expand and going forward, is no longer fit for purpose.

Clinical improvements to Otterfield Health Centre,Yiewsley

4. In addition to the short term investment proposed at the existing Yiewsley Health Centre. Hillingdon CCG has also invested the funds from the s106 contribution formerly held at H/23/209K (£37,723) towards improvements at the Otterfield Medical Centre in Otterfield Road Yiewsley (Cabinet Member Approval received 15/02/2016). This investment will help ensure that the premises continue to be fit for purpose and can deliver healthcare services until a new health centre can be provided.

5. The scheme to upgrade GP consulting rooms and refurbish the existing facilities to modern standards where practicable was completed in July 2016.

Proposed new health hub for Uxbridge (St Andrews Park)

6. Hillingdon Clinical Commissioning Group (HCCG), 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.

7. 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 consequently 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 private commercial arrangement between the two parties.

8. Proposals for a future health facility on the St Andrews site have not been discussed with the Council's Planning Service. Any proposals will be subject to obtaining the relevant planning permissions, consistent with the outline planning permission for the wider Town Centre extension. There is nothing further to report at this stage.

S106 health contributions held by the Council

9. Appendix 1 attached to this report details all of the s106 health facilities contributions held by the Council as at 30th June 2016. The Council has received three further contributions since the last report to the Board in June, these have been added to Appendix 1 and are

highlighted in bold. As at 30th June 2016, the Council holds a total of £1,145,920 towards the provision of health care facilities in the Borough.

10. In June, it was reported to the Board that in order to obtain best value from the s106 funds available, Hillingdon CCG propose that these funds should be used towards the delivery of a "hub" service to support a wide range of primary care and out of hospital services across the Borough.

11. The new "hub" service is proposed to be delivered, as part of Hillingdon CCG Estates Strategy and to support Hillingdon CCG Strategic Service Delivery Plan (SSDP). The plan intends to provide a health hub service of between 2,700 and 3,600 m2 split over three locations across the borough as follows ;

    - Uxbridge /West Drayton hub (St Andrews Park)
    - North hub (Mount Vernon site)
    - Hayes & Harlington (Hesa Medical Centre)

12. The CCG has therefore "earmarked" the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. A total of (£533k) from s106 contributions has already been allocated and spent towards the provision of the Hesa health hub which was completed in (November 2015). A request to allocate individual contributions towards further schemes will be submitted as each scheme is brought forward.

13. All of the s106 health contributions which had a spend deadline in 2015/16 have now been allocated and spent towards eligible schemes. There are currently no deadlines for spending s106 health contributions in 2016/17.

FINANCIAL IMPLICATIONS

As at 30th June 2016, there is £2,429,426 of Social Services, Housing, Health and Wellbeing S106 contributions available, of which £1,037,449 has been identified as a contribution for affordable housing. The remaining £1,391,977 is available to be utilised towards the provision of facilities for health and £536,895 of these contributions have no time limits attached to them.

The proposed new Yiewsley Health Centre development project on the former Yiewsley Pool site is not going ahead and £360,715 was previously formally allocated to this scheme. These contributions have no time limits and therefore can be re-allocated to another suitable scheme.

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. Funds totalling £1,110,301 are provisionally earmarked towards proposed health hub schemes as follows:-

Proposed Health Hub Scheme	Amount
North Hub	175,983
Uxbridge / West Drayton Hub	505,075
New Yiewsley Health Centre	425,341
Pine Medical Centre	3,902
Total Earmarked	**1,110,301**

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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2016)
			AS AT 30/06/16	AS AT 30/06/16			
H/11/195B *57	Ruislip	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494	3,156.00	3,156.00	No time limits	North Hub	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	Ux/WD Hub	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	Pine Medical Centre	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).
H/20/238F *72	West Ruislip	Former Mill Works, Bury Street, Ruislip. 6157/APP/2009/2069	31,441.99	31,441.99	2018 (Jun)	North Hub	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/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	North Hub	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/27/262D *80	Charville	Former Hayes End Library, Uxbridge Road, Hayes. 9301/APP/2010/2231	5,233.36	5,233.36	No time limits	Ux/WD Hub	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/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	North Hub	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	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2016)
			AS AT 30/06/16	AS AT 30/06/16			
H/30/276G * 85	Townfield	Fmr Hayes FC, Church Road, Hayes. 4327/APP/2009/2737	104,319.06	35,620.80	2022 (Feb)	To be determined	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	New Yiewsley HC	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 provision 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	New Yiewsley HC	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.**
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)	North Hub	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	North Hub	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)	North Hub	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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2016)
			AS AT 30/06/16	AS AT 30/06/16			
H/39/304C *97	Yeading	Fmr Tasman House, 111 Maple Road, Hayes 38097/APP/2012/3168	6,448.10	6,448.10	2020 (Aug)	Ux/WD Hub	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/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	New Yiewsley HC	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/West Drayton 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	North Hub	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	North Hub	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)	Ux/WD Hub	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	North Hub	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)	Ux/WD Hub	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.
H/50/333F *109	Yiewsley	39,High Street, Yiewsley 24485/APP/2013/138	12,444.41	12,444.41	No time limits	New Yiewsley HC	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.**

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2016)
			AS AT 30/06/16	AS AT 30/06/16			
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	North Hub	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	North Hub	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	North Hub	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)	Ux/WD Hub	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	North Hub	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/58/348B	North Uxbridge	Lancaster & Hermitage centre, Lancaster Road, Uxbridge 68164/APP/2011/2711	7,587.72	7,587.72	No time limits	Ux/WD Hub	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/59/356E *120	Yiewsley	Packet Boat House, Packet Boat Lane, Cowley 20545/APP/2012/2848	14,997.03	14,997.03	No time limits	New Yiewsley HC	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/60/359E *121	Yiewsley	26-36 Horton Rd, Yiewsley 3507/APP/2013/2327	25,273.45	25,273.45	2023 (Jan)	New Yiewsley HC	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. Spend within 7 years of receipt (Jan 2023).

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2016)
			AS AT 30/06/16	AS AT 30/06/16			
H/61/382F *128	West Drayton	Kitchener House, Warwick Rd, West Drayton. 18218/APP/2013/2183	8,872.64	8,872.64	2026 (April)	New Yiewsley HC	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. Spend within 10 years of receipt (April 2026).
H/61/382F *128	Yiewsley	Caxton House, Trout Road, Yiewsley. 3678/APP/2013/3637	15,482.07	15,482.07	No time limits	New Yiewsley HC	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 for spend.
H/62/384F *129	Northwood Hills	Frank Welch Court, High Meadow Close, Pinner. 186/APP/2013/2958	10,195.29	10,195.29	No time limits	North Hub	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 for spend.
		TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES	1,391,977.16	1,145,920.59			

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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	Ian Kent HCCG
Papers with report	Appendix 1 Local Transformation Plan – Implementation Plan update 2016/17

1. HEADLINE INFORMATION

Summary	This report provides the Board with an update on the delivery of Hillingdon's 2016/17 CAMHS Transformation plan and suggested next steps in accelerating the transformation of CAMHS.
Contribution to plans and strategies	Hillingdon's Health and Wellbeing Strategy Hillingdon's draft Sustainably and Transformation Plan Hillingdon CCG's Draft Commissioning Intentions 2017/18 Hillingdon Joint Children and Young Persons Emotional Health & Wellbeing Transformation Plan
Financial Cost	The Government publication 'Future in Mind' announced increasing funding for children's mental health services totalling £1.25billion nationally over 5 years. From April 2016 CAMHS funding for the remaining 4 years will no longer be provided by NHSE i.e. this is not new funding but part of CCG baselines (non-ring fenced). NHSE will continue to monitor the implementation of the LTP, which will form part of the CCG assurance process for CCGs.
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board:

a) **notes the progress in implementing the agreed 2016/7 Local Transformation Plan.**
b) **notes proposals to develop a new approach to commissioning CAMHS services which are to be developed and are subject to approval by HCCG and LBH.**
c) **continues to request regular performance updates against the partnership plan.**

3. INFORMATION

In August 2015, guidance for CCGs and Local Authorities was published on the development of a 5 year CAMHS Local Transformation plan (LTP). The Hillingdon plan was submitted in October 2015 as part of a wider North West London Transformation Plan, following approval by HCCG and HWBB.

The Hillingdon LTP contained 10 projects which were overseen by a monthly CAMHS Steering Group. The focus of the LTP for year 1 was to address service gaps based on evidence from the JSNA (2015) and user consultation, including the report undertaken by Healthwatch Hillingdon. In addition to addressing service gaps, the LTP also included the following activities:

- updating the Family Information Service
- undertaking a CAMHS training needs analysis
- engagement with children, young people and their families and
- engagement with schools.

The projects in the 2015/16 plan were largely delivered against and have been reported. At the same time the fact that funding for CAMHS transformation was in effect "baselined" into the CCG budget had become clear. The CAMHS steering group developed a plan for 2016/17 which built on the developments and outcomes achieved in 2015/16 and completed some outstanding actions The 2016/17 plan also incorporates feedback from a young people's "Fundamental Health" event held in July 2016 at Brunel University and a CAMHs stakeholder workshop held August 2016.

The feedback forms the basis of the performance report at Appendix 1.

The CAMHS At a recent CAMHS Steering group it was generally felt by partners that that, despite this good progress, there remains some concern that the pace and progress in delivering change in CAMHS could be more transformational and accelerated**.** Key messages in these are as follows:

- The need to co-commission a system without Tiers, focussed on treating children and young people in the right place at the right time which:
    - Promotes prevention and early Intervention
    - Improves access to effective support
    - Provides smooth care pathways at pre-crisis and crisis points and avoids unnecessary admissions to inpatient care.
    - Delivers step down alongside inpatient provision.

Hillingdon is currently in Year 2 of its CAMHS Transformation Plan, the first 18 months of the plan has seen investment in a) core CAMHS Services, b) Out of Hours Services, c) LD CAMHS, d) Self-Harm and e) Eating Disorder services.

However, there is still significant concern that despite these investments the whole pathway is not functioning optimally. Although waiting lists targets for core services are now being met concern remains over sustainability of meeting the targets if demand continues to increase as CYP and their families are telling us that there is too little self-help support or Peer Support. We also know that there remains a high rate of inappropriate referrals into Specialist CAMHs Services, which are often being used a default signposting service, outside of its core purpose and therefore inefficient use of a significant financial resource.

As a consequence HCCG and LBH are proposing to develop a more ambition 2016/17 work programme, working towards developing an integrated pathway moving away from tiers towards a journey starting with emotional wellbeing, moving through support to schools and parents, Peer Support and then specialist services with a Traffic Light alert at each transition. Key features will include

a) Mental Health Promotion in Schools

We will develop a comprehensive programme of mental health promotion activities for pupils and staff in schools. This will lead to increased awareness of mental health issues, increase emotional resilience, more awareness of self-help strategies, reduced stigma, and enable pupils to see help-seeking as a positive step.

b) Mental Health Promotion in the Community.

This will be part of Hillingdon's Wellbeing Programme, utilising our range of community resources to raise awareness of mental health issues, promote emotional resilience and raise awareness of self-care.

c) New model of care

We will commission a system not based on Tiers but organised around the needs and strengths of children and their parents and is much clearer about the limitations of what services can and can't offer, drawing a clearer distinction between treatment and support, self-management and intervention, and more coherent decision making.

d) Peer Support

We will commission a comprehensive peer education programme to raise awareness of mental health in young people. This will be based good evidence based practice in the Voluntary Sector.

e) Developing Community Services

We will expect Community CAMHs Teams to deliver the new model, enabling extended opening hours and improved response and reduced waiting times. There will be an improved crisis response offer including outreach, as well as a responsive self-harm and eating disorder service.

Next Steps

With HWBB agreement, LBH and HCCG will jointly work with stakeholders to redesign the CAMHs pathway. This will involve describing an end to end integrated pathway for children who require low level intervention/ support for their emotional wellbeing issues through to more complex clinical input for severe mental illnesses. Delivering integrated pathways will require more integrated commissioning approaches across HCCG and LBH to ensure every child who requires help is able to access support in some shape or form within the pathway. This work will be further developed through September and October with a view to seeking HCCG and LBH and HWBB approval for a model that will accelerate improvements achieved to date for children and young people.

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 'Future in Mind team' has undertaken consultation across NW London, including Hillingdon, in 2015, prior to the submission of the CAMHS LTP. There has also been consultation undertaken with children and young people, in Hillingdon at the Youth Council, forums and through schools. A children and young people's mental health event took place in July 2016 (Fundamentals Health Event) to allow children and young people have their say on Hillingdon services.

In 2015 Healthwatch Hillingdon undertook consultation with children, young people and families which focussed upon self-harm and was instrumental in the development of the new self-harm service.

Feedback from Hillingdon children and young people, to date, has also included a CAMHS Focus groups.

Policy Overview Committee comments

None at this stage.

5. BACKGROUND PAPERS

NIL.

Appendix 1 CAMHS LTP 2016/7

Year 2: 2016/17

	Areas for Development	What are we going to do	When will this happen	KPIs	KPI Target	Dashboard rating	Update and Comments as of 08/09/16
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	Compliance with CYP IAPT.	100% of data submissions are validated and submitted on time.	RAG: Amber	This is rated Amber as CNWL staff undertake outcome based practice with CYPs. This will become Green when the staff at Tier 2 services can demonstrate outcome based practice.
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	May 2016	Improved access to timely advice, information and specialist support when needed for CYP, parents, professional	Up to date Directory in place	RAG: Green	This is rated Green as the Directory has been updated and available to all by LBH Website.
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	Additional, non-recurrent funding January 2015 to 31 March 2016 to work with CYPs on the waiting list for treatment.	Numbers seen; waiting times; numbers receiving NICE treatment.	85% of CYPS waiting no more than 18 weeks for routine treatment - 1 week for urgent treatment - 4 hours for emergency	RAG: Green	This is rated green as all children and young people who are assessed as needing Tier 3 CAMHS treatment are now receiving it within the 18 weeks national target.
4.	Lack of self-harm, crisis and intensive support service	Use the LTP funding to invest in a team who will deliver across a new pathway for self-harm. Given the co-existence of substance misuse and self-harm this will require co-	Team to become operational by April 2016	All emergency referrals seen < 4 hrs; urgent < 48 hrs; routine < 2 weeks; reduction	85% of target	RAG: Green	This is rated Green as all staff now recruited and the Team functioning effectively.

		working to be developed		in inpatient admissions and incidences of self-harm.			
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	CAMHS LD team to become operational by November 2015 with all staff recruited by February 2016 LBH to recruit to PSB posts by May 2016	Pathway in place with a fully staffed team; including a service specification. Referral to treatment time is reduced. <13 weeks referral to treatment	Pathway in place 85% target referral to treatment	RAG: Green (in-progress)	This is rated Green as the Team are in place and they are working well with the special schools and LBH to provide a service for the most complex LD CYPS in Hillingdon.
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	75% of the children's workforce contacted to take part in Training Needs Analysis. Training programme in place and training rolled out to children workforce.	Publication of training needs analysis. Publication of training opportunities. 75% attendance rate at training programmes. 75% rate as useful.	RAG: Amber	This is rated Amber as the Training Needs Analysis has been completed but training providers have not been identified
7.	Understanding the role of Schools/College in emotional well-being and commissioning services such as counselling	Use the LTP funding to commence work with local Schools and College to gain this understanding and to support schools to commission emotional wellbeing services	March 2016	Mapping of current provision in schools and college The Participation Team and PH to undertake engagement to encourage them to embed emotional health and well-being in every school and	80% of special schools engaged with. 30% of mainstream schools engaged with.	RAG: Amber	This is rated Amber as we have undertaken significant engagement work with schools. This will become Green when we have engaged with more schools, have begun training their staff and have developed an assurance framework for school counselling.

				college. Achieved by sharing good practice from other schools and developing the workforce.			
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 to April 2017	CYPs have rapid access to assessment and treatment, in compliance with the new NICE model of care.	85% of targets reached.	RAG: Green	This is rated Green as the Team is now in place working to agreed national standards and compliant with associated national targets
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	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	RAG: Amber	This is rated Amber as the Project Initiation document on the new model of care and pathway has not yet been endorsed by HWBB
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	Ensure all CAMHS commissioned services undertake family work, where appropriate	Commissioners task & Finish Group to be set up Quarterly sessions/meetings with at least 1 CYP &/or parent rep at each meeting or event.	RAG: Green	This is rated Green as engagement with CYPs has commenced following the Fundamentals Health Event in July and further events scheduled January to March 2017.

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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 2016/2017

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

New regular agenda item

Starting with the 12 April meeting, a new regular non-decision item has been added to Board agendas in Part 2, to enable a private opportunity for Board Members to discuss current or emerging issues in relation to health, wellbeing and social care services within Hillingdon that may or may not be sensitive, in commercial confidence or confidential in nature. It will be the last item on the agenda.

Reporting to the Board

The draft Board Planner for 2016/2017, 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 Board meeting dates for 2016/2017 were considered and ratified by Council at its meeting on 25 February 2016 as part of the authority's Programme of Meetings for the new municipal year. The dates and report deadlines for the 2016/2017 meetings have been attached to this report as Appendix 1.

Financial Implications

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

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

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

8 Dec 2016 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 18 November 2016 **Agenda Published** 30 November 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	
	Hillingdon's Joint Strategic Needs Assessment	LBH	
	Local Safeguarding Children's Board (LSCB) Annual Report	LBH	
	Safeguarding Adults Partnership Board (SAPB)	LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

14 Mar 2017 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 24 February 2017 **Agenda Published:** 6 March 2017
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI) and Draft Better Care Fund Plan 2016/2017	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	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

** SI = Standing Item*

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