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# Health and Wellbeing Board

**Date:** THURSDAY, 8 DECEMBER 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)
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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***Putting our residents first***

**Lloyd White**
**Head of Democratic Services**
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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 29 September 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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| **5** | Developing Hillingdon's Health & Wellbeing Strategy | 9 - 40 |
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## Health and Wellbeing Board Reports - Part II (Private and Not for Publication)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.*


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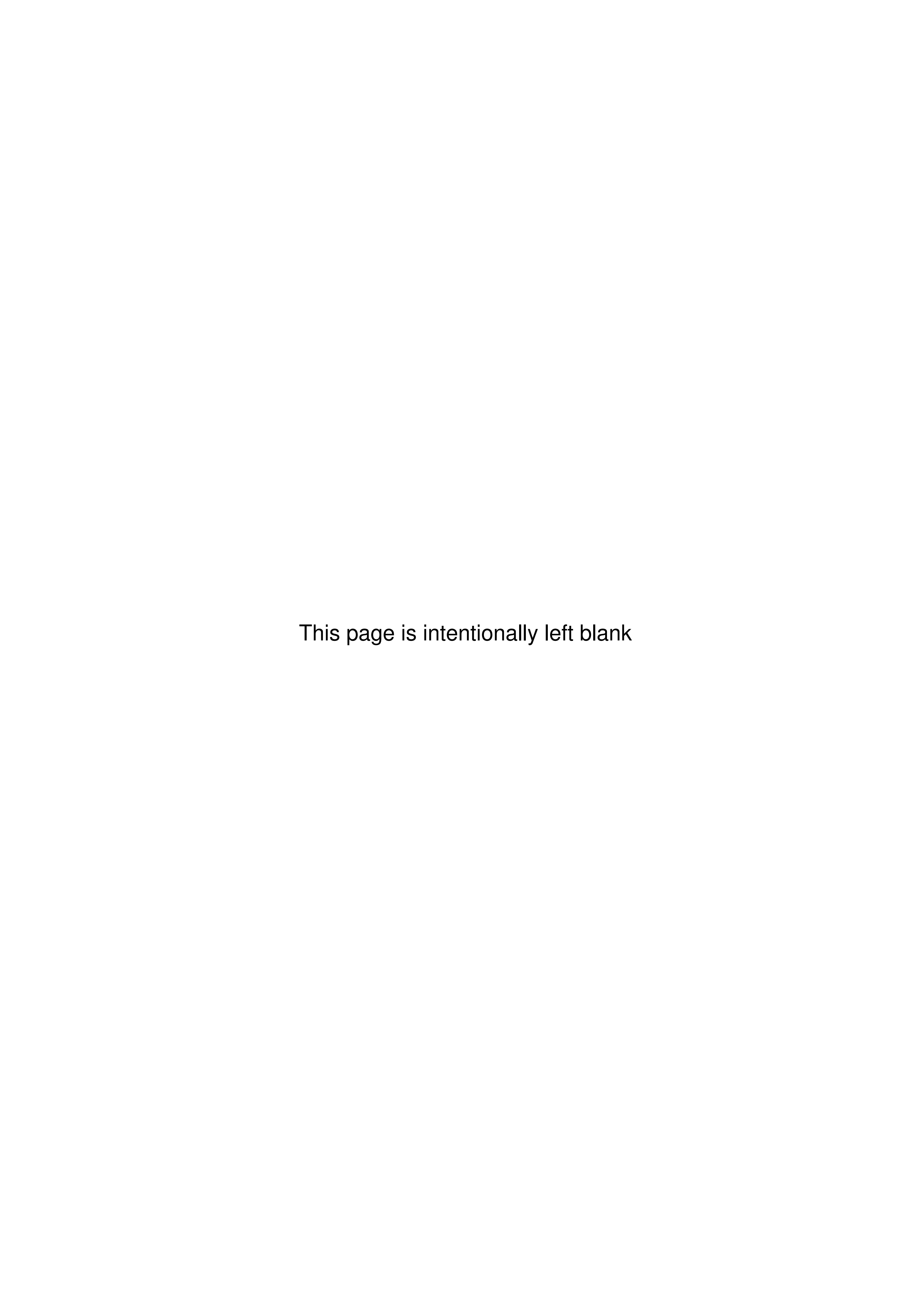
| **17** | To approve the PART II minutes of the meeting on 29 September 2016 | 409 - 416 |
| **18** | Update on current and emerging issues and any other business the Chairman considers to be urgent | 417 - 418 |



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**Minutes**

**HEALTH AND WELLBEING BOARD**

**29 September 2016**

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

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| | **Statutory Voting Board Members Present**:<br>Councillor Philip Corthorne (Chairman)<br>Councillor Douglas Mills<br>Dr Ian Goodman - Hillingdon Clinical Commissioning Group<br>Stephen Otter - Healthwatch Hillingdon (substitute)<br><br>**Statutory Non Voting Board Members Present**:<br>Tony Zaman - Statutory Director of Adult Social Services and Statutory Director of Children's Services<br>Dr Steve Hajioff - Statutory Director of Public Health<br><br>**Co-opted Board Members Present:**<br>Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust<br>Maria O'Brien - Central and North West London NHS Foundation Trust (substitute)<br>Nick Hunt - Royal Brompton and Harefield NHS Foundation Trust (substitute)<br>Dr Reva Gudi - Hillingdon Clinical Commissioning Group (clinician)<br>Rob Larkman - Hillingdon Clinical Commissioning Group (officer)<br>Nigel Dicker - LBH Deputy Director Residents Services<br><br>**LBH Officers Present**:<br>Kevin Byrne (Head of Policy and Performance), Gary Collier (Better Care Fund Programme Manager), Beejal Soni and Nikki O'Halloran (Interim Senior Democratic Services Manager)<br><br>**LBH Councillors Present:**<br>Councillor Beulah East<br><br>**Press & Public: 1** |
| 16. | **APOLOGIES FOR ABSENCE** *(Agenda Item 1)*<br><br>Apologies for absence had been received from Councillors Bianco, Burrows, Lewis, Puddifoot and Simmonds, and Mr Bob Bell (Mr Nick Hunt was present as his substitute) and Ms Robyn Doran (Ms Maria O'Brien was present as her substitute). |
| 17. | **TO APPROVE THE MINUTES OF THE MEETING ON 28 JUNE 2016** *(Agenda Item 3)*<br><br>**RESOLVED: That the minutes of the meeting held on 28 June 2016 be agreed as a correct record.** |
| 18. | **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)*<br><br>It was confirmed that Agenda Items 5 to 14 would be considered in public. Agenda items 15 and 16 would be considered in private. It was noted that current and |

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| | emerging issues could, where applicable, be included under Agenda Item 16. |
| 19. | **BOARD MEMBERSHIP UPDATE** *(Agenda Item 5)*<br><br>It was noted that the Leader of the Council had been replaced by Councillor Corthorne as the Chairman of the Health and Wellbeing Board. Councillor Corthorne, on behalf of the Board, thanked Councillor Puddifoot for the work he had undertaken both in the Health and Wellbeing Board meetings and behind the scenes.<br><br>Concern was expressed that there was no south of the Borough representation on the Board, in terms of the elected Members. The Councillor membership served the interests of the whole Borough rather than a specific locality and the Health and Wellbeing Board Chairman regularly liaised with opposition Members. Furthermore, it was noted that the Council's External Services Scrutiny Committee, which included Ward Councillors from the north and south of the Borough, provided an opportunity to hold the local health trusts to account.<br><br>**RESOLVED: That the Health and Wellbeing Board notes that:**<br>**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;**<br>**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**<br>**3. the Council's Deputy Chief Executive and Director of Residents Services had been removed from the list of co-opted voting members of the Board.** |
| 20. | **HEALTH & WELLBEING STRATEGY: PERFORMANCE REPORT** *(Agenda Item 6)*<br><br>The Chairman commended the work of the partner organisations. Although there had previously been little discussion around these update reports at Health and Wellbeing Board meetings, it was thought that this may have been (in part) due to the way the information was reported. It was noted that a fresher, more edgy approach to reporting was needed to satisfy the Board that resources were being targeted in the most effective way and with the right activities to drive improvement in performance and outcomes.<br><br>**RESOLVED: That the Health and Wellbeing Board:**<br>**1. notes the updates in the report and delivery plan.**<br>**2. notes the outcome performance indicators in the quarterly dashboard.**<br>**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 report back to the Board at its next meeting with proposals as to how to programme and project manage delivery.** |
| 21. | **BETTER CARE FUND: PERFORMANCE REPORT** *(Agenda Item 7)*<br><br>A range of options were being developed to deliver capacity around delayed transfer of care (DTOC). It was noted that, with regard to DTOC. The Hillingdon Hospital NHS Foundation Trust had recently been faced with very high patient levels but that, over the last three weeks, these levels had now reduced. There had been an 8% increase in attendances at Hillingdon A&E and UCC but this had not had a material impact on DETOC. |

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| | It was noted that the issues faced by partners highlighted the need for them to work more closely together. The Hillingdon CCG had noticed an increase in continuing healthcare spend which was also causing some pressure.<br><br>It was agreed that, as the target for the proportion of older people still being at home 91 days after discharge into reablement was going well, recommendation b (as set out in the report) would be removed.<br><br>**RESOLVED: That the Health and Wellbeing Board notes the contents of the report.** |
| 22. | **SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE** *(Agenda Item 8)*<br><br>The Sustainability and Transformation Plan (STP) process had started at the beginning of 2016 with the aim of developing a five year plan. The eight boroughs in North West London (NWL), which made up the NWL STP footprint, had submitted a draft STP plan at the end of June 2016. A further version of the plan was due for submission to NHS England (NHSE) on 21 October 2016. Concern was expressed at the speed with which NHSE was pushing the STP agenda through. It was noted that the Hillingdon chapter would form an important part of this final plan and that the priority themes ran through the Hillingdon CCG commissioning intentions.<br><br>Concern was expressed that the Hillingdon chapter lacked detail. Whilst this was not a criticism of Hillingdon CCG or partners, it was unclear what additional detail could be added by the October submission date. It was agreed that there needed to be a shift towards community services and that additional work would be undertaken to develop this further.<br><br>Of the Sustainability and Transformation funding available, it was anticipated that just under £150m would be made available to NWL. It was noted that the NWL 'do nothing' position would cost £1.3bn with the Hillingdon element of this being in the region of £104m. In order to be in a position to test new ideas, NWL would need to ensure that it was ahead of the other 43 STP areas. It was suggested that the STP would offer the Borough the best opportunity to gain investment for patients and residents.<br><br>It was recognised that there had been meaningful collaboration in Hillingdon across all partner organisations which far exceeded that in other parts of London. However, it was noted that significant resident engagement was need to ensure that the public was aware of the implications of the STP. To enable this to take place effectively, further detail would be required.<br><br>It was noted that Hillingdon was different to other boroughs by virtue of its congruence. Whilst some developments made sense to other areas, issues such as the single discharge approach would not make sense in Hillingdon. It was hoped that assurance would be provided that the distribution of the Sustainability and Transformation funding would recognise this to ensure that it was not drawn completely into acute care, but rather distributed across the wider health economy.<br><br>Although low probability, opposition to reconfiguration by some partners preventing effective delivery of the plan had been identified as a risk. It was agreed that the possibility that Hillingdon would not benefit from the available Sustainability and Transformation funding should also be included in the plan as a risk. However, it was suggested that there was a greater risk that the funding would not materialise as |

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| | originally expected rather than not at all.<br><br>**RESOLVED: That the Health and Wellbeing Board:**<br>**1. notes the Hillingdon chapter of the STP and instructs officers to develop a delivery plan to implement the priorities identified.**<br>**2. notes broad support for the draft North West London STP submission dated June 2016.**<br>**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 15 October, for submission to NHSE by 21 October.** |
| 23. | **HILLINGDON CCG UPDATE** *(Agenda Item 9)*<br><br>Hillingdon CCG (HCCG) had been disappointed to receive an overall performance rating of 'requires improvement' from NHS England (NHSE). Although it had achieved a 'good' rating for three of the five domains (well-led, delegated functions and planning), HCCG had been rated as 'requires improvement' for finance and performance. However, the financial domain rating had been as a result of a wholly technical accounting issues which NHSE was clear did not make a material difference to the good running of the CCG.<br><br>The paediatric inpatients service at Ealing Hospital had been withdrawn at the end of June 2016. HCCG had been working with The Hillingdon Hospitals NHS Foundation Trust to ensure that provision was made for the resultant increase in paediatric patients in Hillingdon. There had been a smaller number of paediatric patients transferring from Ealing to Hillingdon than expected and it was noted that paediatric patients from Ealing could still be seen by Ealing outpatients. As such, the withdrawal of the service from Ealing had not created significant additional pressure on Hillingdon Hospital.<br><br>It was noted that HCCG's finances were challenging and that it hoped to achieve a £3.6m surplus. In addition, plans were being developed to mitigate the impact of unplanned activity and emerging risks.<br><br>The Hillingdon vision for Accountable Care was that, by 1 April 2017, Hillingdon would have a formally constituted Accountable Care Partnership (ACP) Joint Alliance ready to receive an outcome based capitated contract from the CCG for delivering integrated care for people over 65. Progress on this had been made and it was anticipated that the ACP Joint Alliance would be in place in shadow form from 2017.<br><br>QIPP involved quality and productivity initiatives to manage planned and unplanned care. However, some of these initiatives had not had the expected impact and, if the QIPP efficiency savings were not met, it would result in higher than planned costs. It was noted that there had been slippage in the MSK service over the last three years but that this situation could be improved by monitoring at a practice level and regularly meeting with GPs to look at QIPP and the variation of activity levels across practices.<br><br>**RESOLVED: That the Health and Wellbeing Board noted the update.** |
| 24. | **HILLINGDON CCG'S 2017/18 COMMISSIONING INTENTIONS** *(Agenda Item 10)*<br><br>All CCGs were required to prepare Commissioning Intentions (CIs) for each financial |

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| | year with a plan setting out how the CCG proposed to exercise its functions. Each CCG was required to provide a copy of the commissioning plan to their local Health and Wellbeing Boards to ensure that the CIs were kept up to date and were routinely discussed with the Board. Hillingdon CCG's CIs were based on the health needs of the local population and had been the subject of two open afternoons where members of the public were able to input into the process. It was noted that the CIs dovetailed with the Sustainability and Transformation Plan (STP) and that requirements of the STP had been woven throughout the CI document.<br><br>The Chairman thanked Dr Gudi and colleagues for their work to develop the CI document to provide more detail regarding issues such as the provider market.<br><br>Although information about the Accountable Care Partnership (ACP) had been included in the report, there was not a great deal more information available in the public domain as it was still in shadow form. Healthwatch had been involved in discussions and Hillingdon CCG (HCCG) was encouraging the Board to have representation on the ACP.<br><br>It was noted that HCCG had attempted to address the financial cap on the 2017/2018 budget. As such, the CIs had looked at outcomes for the next year rather than taking a quantitative approach. This would be looked at by the HCCG Board as well as the ACP Board and things were now moving at pace with a commitment from partners to work together to do things differently. It was agreed that a further update would be provided for consideration at the Health and Wellbeing Board's next meeting.<br><br>**RESOLVED: That:**<br>1. **the Health and Wellbeing Board considered and noted Hillingdon CCG's commissioning intentions for 2017-18; and**<br>2. **HCCG provide an update on the development of the ACP at the next Health and Wellbeing Board meeting.** |
| 25. | **HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 11)*<br><br>It was noted that, although the recruitment process had resulted in the appointment of two Board Members and a Chair, the Healthwatch Hillingdon Board meeting scheduled for 28 September 2016 had not taken place so the appointments had not yet been ratified. It was likely that the meeting would be rescheduled for mid-October 2016.<br><br>Healthwatch Hillingdon continued to work with NHS England (NHSE) and Hillingdon CCG (HCCG) to facilitate the registration of residents who had been refused registration at a GP practice, predominantly in UB3, UB4 and UB7. Although discussions continued, a solution had not yet been found. It was noted that Heathrow Villages was situated on the edge of the Borough and that practices in that area were scarce. HCCG had had discussions with the Local Medical Committee, who would be talking to practices about boundaries, and would then speak to NHSE to determine if, when and why the boundaries had changed as the entire area had been covered when the boundaries were last agreed by NHSE. However, it was noted that NHSE was not always quick to respond to enquiries.<br><br>Healthwatch Hillingdon had been involved in the External Services Scrutiny Committee Working Group review of GP pressures. The issue of s106 agreements and the associated planning had been raised during the course of this review. |

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| | It was noted that Healthwatch Hillingdon was midway through reviews of hospital discharges and of maternity care. Once complete, these would be reported to the Health and Wellbeing Board.<br><br>**RESOLVED: That the Health and Wellbeing Board notes the report.** |
| 26. | **UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 12)*<br><br>Although there had been reports of progress in relation to the St Andrews development, there had been no further dialogue between the Council and the developer. It was noted that the initial outline planning permission at St Andrews Park would expire in January 2017 which could provide an opportunity to get the provider to recommit. As the Hillingdon CCG (HCCG) Chairman had not received a recent update, he would liaise with Sue Hardy to establish what progress had been made. The Health and Wellbeing Board Chairman would liaise with the HCCG Chairman to pursue this matter as progress needed to be made.<br><br>It was noted that the planning of GP services was outside of the HCCG remit, and was actually the responsibility of NHS England (NHSE). HCCG had commissioned a review of clinical needs and service delivery across the Borough. It was recognised that the clinical service provision in the south of the Borough was not as good as that in the north. There was currently a strong move for CCGs to take responsibility back from NHSE for GP provider contracts so that the CCGs could be more active in the planning process.<br><br>There was currently a shortage of GPs across the country. Although the Government had pledged to recruit 5,000 new GPs by 2020, only 100 had been recruited in the previous year. It was clear that the service was constrained by limited finances.<br><br>It was suggested that greater collaboration with HCCG was needed with regard to the production of this regular report to the Health and Wellbeing Board.<br><br>**RESOLVED: That the Health and Wellbeing Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.** |
| 27. | **CAMHS UPDATE** *(Agenda Item 13)*<br><br>Contrary to what was stated in the report, it was noted that the 18 week national target for Tier 3 CAMHS treatment was not being met. Although mental health promotion work continued in schools and the eating disorder and self harm services were up and running, it was clear that more needed to be been done by way of transformation. It was noted that additional work should be undertaken to shift the focus into prevention which would then provide an opportunity to recommission services and truly transform the service.<br><br>CNWL and NWL had been identified as one of three pilot sites to work with NHS England, etc, on a new model to prevent escalation to Tier 4 and reduce the number of Tier 4 patients. It was noted that it was very challenging to get spend from NHSE for Tier 4 services and it was anticipated that this pilot project could provide an opportunity to reinvest funding to undertake transformation work.<br><br>**RESOLVED: That the Health and Wellbeing Board:** |

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| | **1. notes the progress in implementing the agreed 2016/7 Local Transformation Plan.**<br>**2. 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.**<br>**3. continues to request regular performance updates against the partnership plan.** |
| 28. | **BOARD PLANNER AND FUTURE AGENDA ITEMS** *(Agenda Item 14)*<br><br>It was noted that future s106 reports would provide an update on projects that had been agreed and whether or not these had been applied. A separate PART II report would be needed in relation to significant site development opportunities and could include the top sites and provide commentary about the progress of discussions and the associated timescales. This would then provide a clear understanding of the situation for each site and any action that needed to be taken.<br><br>It was noted that, as she was standing down as Vice Chairman of Hillingdon CCG, this would be the last Health and Wellbeing Board meeting that Dr Reva Gudi attended. On behalf of the Board, the Chairman thanked Dr Gudi for the work that she had undertaken over the last 2 years and the significant role that she had played in overcoming obstacles.<br><br>Dr Gudi stated that the Health and Wellbeing Board was a positive, progressive, productive and collaborative body that was key to progressing into the future. She had enjoyed working with Councillors, Council officers and partners and wished them well in the future.<br><br>**RESOLVED: That a separate report on site development opportunities be included on the agenda for each Health and Wellbeing Board meeting.** |
| 29. | **TO APPROVE THE PART II MINUTES OF THE MEETING ON 28 JUNE 2016** *(Agenda Item 15)*<br><br>**RESOLVED: That the Part II minutes of the meeting held on 28 June 2016 be agreed as a correct record.** |
| 30. | **UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 16)*<br><br>The Board discussed a number of issues in relation to major planning developments in the Borough and the associated processes. The NHS England proposal to decommission paediatric congenital heart services from the Royal Brompton and Harefield NHS Foundation Trust was also discussed.<br><br>**RESOLVED: That the discussion be noted.** |
| | The meeting, which commenced at 2.30 pm, closed at 3.57 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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# DEVELOPING HILLINGDON'S HEALTH AND WELLBEING STRATEGY

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| **Relevant Board Member(s)** | Councillor Phillip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Kevin Byrne, policy and partnerships |
| **Papers with report** | Appendix A) Health and Wellbeing Strategy performance report and outcome indicator scorecard. |

## 1. HEADLINE INFORMATION

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| **Summary** | This report provides proposals for taking forward Hillingdon's Joint Health and Wellbeing Strategy (JHWS) and aligning this to the agreed Hillingdon Sustainability and Transformation Plan (STP). |
| **Contribution to plans and strategies** | Hillingdon's Joint Health and Wellbeing Strategy is a statutory requirement of the Health and Social Care Act 2012.<br><br>The Sustainability and Transformation Plan is required by NHS E to fulfil the ambitions of NHS five year forward view. |
| **Financial Cost** | There are no direct financial costs arising from this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. notes the approach towards developing one overall Strategy for Health and Wellbeing that will encompass delivery of the local Sustainability and Transformation Plan.

2. notes progress against the existing plan at Appendix A.

## 3. INFORMATION

### Supporting Information

At its last meeting on 29 September 2016, the Health and Wellbeing Board instructed officers to consider how to best to develop Hillingdon's Joint Health and Wellbeing Strategy to take into account the local STP and to come up with proposals for programme and project management moving forward.

The Board offered feedback that it would like to receive a report that enabled it to address the key issues regarding health and wellbeing in Hillingdon and to ensure that emerging issues were bought to the Board in a timely way to enable discussion amongst partners on future actions. The Board also commented that it would like to seek assurance that actions undertaken were maximising impact and offered best value.

The Board also recognised that the development of the STP at local and North West London level had brought partners together well to focus on common challenges within health and care systems and that it was important to ensure that the delivery of these plans was effective. The STP sets out the vision for the "system change" required and, alongside the overarching Joint Health and Wellbeing Strategy, provides the framework for partnership working and managing performance in the health and care economy through the Board.

The ambition, therefore, is to work towards having one overall Health and Wellbeing Strategy for Hillingdon and one performance report to the Board on progress. At present, however, different aspects of reporting are being dictated by requirements of NHS England and each can require Board approval and oversight. In addition, the programme and performance arrangements for the STP at North West London level are still unclear. There is also an issue with the level of granularity required for different strategies and plans. It is challenging, therefore, at this stage to amalgamate strategies and reporting into one single report. This should become easier over time, especially if NHSE were prepared to relax or join up its reporting requirements, such as for STP and BCF.

Meanwhile the key components set out below are being developed alongside each other to ensure that they are mutually reinforcing and consistent.

The key components are:

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| **Joint Strategic Needs Assessment *** | Health needs assessment of the Hillingdon population, identifying priorities for the JHWB Strategy and commissioning plans. |
| **JHWB Strategy** | Overarching strategy for meeting the health and wellbeing needs of the population. |
| **Northwest London STP *** | STP covering for 8 boroughs within footprint, setting out system changes required to fill the health and wellbeing, the care and quality and the finance and efficiency gaps identified. |
| **Hillingdon STP *** | Local plan setting out the ten local priority areas |
| **Better Care Fund Plan *** | Detailed plans and pooled fund to develop the current focus on older people (65+) into a further 2 year plan towards integration of services and as part of the STP. |
| **CAMHS local transformation plan *** | Transformation proposals to re-commission across pathway and away from the traditional four tiers, and as part of the STP. |
| **Accountable Care Partnership in Hillingdon *** | Proposals to deliver Hillingdon health and care systems through joint alliance under outcomes based capitated contract. Again a deliverable under the STP. |

The areas marked with an asterisk* have separate papers on the Board's agenda for its meeting on 8 December 2016.

**Developing a new Joint Health and Wellbeing Strategy**

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

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

- Improving Health and Wellbeing and reducing inequalities
- Prevention and early intervention
- Developing integrated, high quality social care and health services within the community or at home
- A positive experience of care

The now established detailed updates against tasks, together with the outcome scorecard are attached at Appendix A.

The paper to the Board on the Joint Strategic Needs Assessment starts the next planning cycle to inform the priorities for the JHWB strategy. Also on the agenda are papers providing further consideration of the local and North West London STP plans. There remains considerable uncertainty over access to new funding and sign off of potential investment. There will continue, therefore, to be a need to update any plans as these develop further.

In the short term and for the Board's next meeting, it is proposed that the STP delivery plan be developed to incorporate priorities identified through the JSNA, and in the existing JHWB Strategy together with the local STP priorities.

**Proposed Governance**

The Board has a statutory duty to coordinate and oversee development of joint plans and strategies. It does not, however, have powers to direct partners to act or to commit investment. Each partner has its own governing body or decision making procedures. The Board has, however, been able to bring together views and develop plans collectively such as with the local STP and before that in developing the Better Care Fund, it is felt this presents a strong foundation on which to move forward.

The Hillingdon Transformation Board has been looking at how best to organise the various partnership groups that exist already or are thought needed to take forward the delivery areas of the STP. This work is in draft and will go to the next Transformation Board early in January. Further discussion will be required to ensure the structure is able to provide the project and performance management of the Joint Health and Wellbeing Strategy, input to the NWL STP and delivery of the local STP. In other words that the "form" proposed follows the "functions" agreed in the plans.

The structure has the Transformation Board reporting to the HWB, whilst recognising that final decisions are subject to agreement by partners own sovereign Boards. Beneath this are a

number of project groups and boards to cover the detail of transformation plans. As before, some of this reflects the reporting requirements to NHSE at the moment but there is scope perhaps in developing our ambitions for one overall strategy to streamline the supporting groups or at least to set these up on more of a task and finish basis.

One area for further exploration and discussion to ensure that need for consultation and engagement with residents and service users is fully included in the detail of deliver plans.

Further proposals around governance will be included in advice to the Board's next meeting on this basis and in light of developments with STP.

**Financial Implications**

There are no financial costs arising from the recommendations in the report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

**Consultation Carried Out or Required**

None at this stage.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

Corporate Finance has reviewed the report and concurs with the financial implications set out above.

**Hillingdon Council Legal comments**

All necessary legal implications are contained in the body of the report.

## 6. BACKGROUND PAPERS

NIL.

# Appendix A Health and Wellbeing Strategy Delivery Plan Update - December 2016

| **Priority 1 - Improving Health and Wellbeing and reducing inequalities** | | | | |
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| **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 3 per week and 20 referrals during Q2. 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.<br>• Smoking Cessation: During Q2, 27 Referrals were made by midwives to the Hillingdon Smoking Cessation Service. However, a small proportion of the clients were out of borough and duly referred to an appropriate provider. Within Pharmacies, 7 pregnant women set a quit date and 2 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 Health Commissioning Plan 2016-2020, this is being progressed through the CCG governance systems. Work streams include:<br>• Integrated GP Paediatric Consultant Clinics - economic modelling & logistic planning is now |

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| | | | | progressing. The first clinic becomes operational Dec 2016, this is to test the viability of Community Integrated clinics, including outcome measures.<br><br>• Ambulatory care pathways – the new Paediatric Assessment Unit was planned to open in mid-July 2016, however it formally opened September and "is seeing good utilisation - with an average of 2.75 patients in each bed per 24 hours". This will continue to be monitored at a NW London sector level.<br><br>• 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. The roll out continues to take place, with a longer term plan to establish the relationship with the Integrated clinics.<br><br>• Critical Care Level 1 it is proposed to develop this service to provide quality care for the more complex sick child. This will enable the hospital to deliver care against London wide standards. Preparing for level 2 in the future. This will enable the hospital to care for these children close to home without transferring, to other hospitals. This programme of work is taking place with NW London and neighbouring boroughs as children attend the hospital from other areas as well as Hillingdon. Service specification under development. Plan to commission a service for 2017-18. |

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| | | | | • 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 strategic transformation group ensuring it is action-focussed as well as strategic. Membership will be reviewed. The task & finish groups continue. The first renewed meeting was held on 18th November 2016. |
| | **1.1.3** Deliver a mental wellness and resilience programme | Wellbeing Service | | • During Q2 345 people attended 3 tea dances at the Civic Centre and 216 people attended dances at the Winston Churchill Hall. Positive feedback was received at these sessions. |
| | **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).*<br>• The Smoking cessation target is 1,055 quitters. Between July to September 2016, 81 Hillingdon residents quit through the support of GP's, Pharmacies and specialist advisors.<br>• A regular weekly clinic to support residents diagnosed with mental health conditions is being delivered at Mead House. This Quarter, 10 patients engaged with the service primarily on a harm reduction basis and have achieved 1 successful quit. |

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| | | | | • 11 Health promotion events have been attended to promote the availability and support to residents through stop smoking services. These included the Hayes carnival, QPR health fair - (Rabbs primary school, Wood end park academy, Cranford park academy), Citizens Advice fair at the Pavilions, Wellbeing day at the Brookfields adult centre, Uxbridge college - Fresher's fair, Mead house wellbeing day, MIND wellbeing day, Coteford Children's Centre - Fun day, Hillingdon Hospital wellbeing week, Brunel wellbeing 'looking after your mates'.<br><br>• 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.<br><br>• A workshop was 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. The workshop was well attended by over 75 Health care professionals.<br><br>• 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 |

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| | | | | (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. Q2 saw 7 health care professionals completing the course.<br><br>• 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.<br><br>• Almost all Hillingdon Pharmacies provide COPD screening to patients accessing the stop smoking service.<br><br>• 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 | 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 started in September 2016 and will be completing before the Christmas break. |

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| | Measurement Programme, and raising awareness of the importance of physical activity across the life course | | | • In 2015/16, 4,174 children aged 4-5 and 3,385 children aged 10-11 were weighed and measured under the National Child Measurement Programme with 99% and 98% completion rates.<br><br>• Prevalence of obesity for Reception Year remained stable (9.5%), while the rate for Year 6 children (aged 10-11 years) increased by 1.8 percentage points to 21.1%. but is consistent with the national increase.<br><br>• The council continues to deliver the 'Walks Scheme'. Training is planned for 8 new volunteers in November 2016 with a view to offering a new shorter walk. An 'Every Step Counts' pilot targeting inactive groups is being planned for implementation in January 2017.<br><br>• The CCG through HENWL is funding a pilot programme between Jan-March 2017 to train staff in Primary Care in childhood obesity, asking and raising the issue and evidenced-based practice. This will inform ongoing training needs. |
| | **1.1.6** Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon | LBH | Annually | • The review of the Air Quality Action Plan requires the Borough to confirm whether the declared Air Quality Management Area (AQMA), which extends south from the Chiltern - Marylebone railway line, is still sound. The GLA pollution modelling has indicated there may be potential pollution areas outside of the current AQMA. On the advice of the |

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| | | | | transport team a detailed study is now underway to ascertain the extent of any pollution problems to ensure a decision to extend the AQMA is taken on an informed basis. This study is due for completion within this financial year.<br><br>• The drafting of the Air Quality Plan will run in parallel with the transport study and incorporate the findings in relation to the status of the AQMA. The implications of the following will all need to be factored into the Hillingdon Air Quality Plan:<br>- the recent Heathrow expansion announcement;<br>- monitoring of the assurances received by the borough in regard to HS2;<br>- the recent Judgement from the High Court that the Defra Air Quality Plan has been judged over-optimistic and will require a new plan and timetable by which to meet air quality limits.<br><br>• The Borough's specific actions to improve air quality have been recognised by the awarding by the GLA of Cleaner Air Borough Status. |
| ***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 | • Support Plans continue to be reviewed and employment and education opportunities continue to be explored.<br><br>• In Q2, 8 new service users have had the opportunity to undertake paid employment. This has included service users providing presentations to schools, colleges and other LBH Teams on different subjects of Hate/ Mate crime and Disability |

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| | | | | awareness.<br>• 21 service users had the opportunity of unpaid voluntary work to prepare for further paid work. Opportunities included kitchen assistant duties at Queens Walk and Wren, laundry tasks at Queens Walk and work placements at Heathrow Special Needs Centre.<br>Service users have had the opportunity to enrol on and commence a range of college courses. |
| ***1.3 Develop Hillingdon as an autism friendly borough*** | **1.3.1** Develop and implement an all age autism strategy | LBH | Quarterly | • The draft Autism Plan is awaiting sign off from the CCG. |



## Priority 2 - Prevention and early intervention

| Objective | Task and Metric | Lead | Metric reporting frequency | Evidence of activity against task |
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| ***2.1 Deliver the BCF*** | **2.1.1** Deliver scheme three: Rapid response and integrated Intermediate Care | LBH/CCG | Quarterly | • During Q2 the Reablement Team received 211 referrals and of these 161 were from hospitals, primarily Hillingdon Hospital and the other 50 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 122 people were discharged from Reablement with no on-going social care needs. |

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| | | | | • In Q2 the Rapid Response Team received 923 referrals, 55% (510) of which came from Hillingdon Hospital, 20% (182) from GPs, 12% (108) from community services such as District Nursing and the remaining 13% (123) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 510 referrals received from Hillingdon Hospital, 367 (72%) were discharged with Rapid Response input, 117 (23%) following assessment were not medically cleared for discharge and 26 (5%) were either out of area or inappropriate referrals. All 413 people referred from the community source received input from the Rapid Response Team.<br><br>• The first half of 2016/17 saw an increase of 12.6% on the same period in 2015/16 in the number of people aged 80 and over attending Hillingdon Hospital but a reduction of 3.4% in the number being admitted. This is largely attributable to the proactive work being undertaken by the Rapid Response Team.<br><br>• The Council's Hospital Discharge Team supported the early discharge of 157 people from Hillingdon Hospital and 62 people from other hospitals during the first half of 2016/17. 'Early discharge' means that people were identified and supported into an alternative care setting before an assessment notice under the Care Act was served. |

| 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.<br><br>• 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%).<br><br>• The mid-year position for 2016/17 as reported to Public Health England (PHE) on 29th October 2016 was:<br>- First Offers: **6,197 (8.2%)**, an increase of **1,724 (39%)** from the mid-year 2015/16 figure;<br>- Completed Checks: **3,515 (4.7%)**, an increase of **231 (7.0%)** from the mid-year 2015/16 figure;<br>- Take-up rate: **57%,** down **16%** on the mid—year 2015/16 figure.<br><br>• Since the data submission, the mid-year figures have increased slightly to **6,269 (8.3%)** for First |
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| | | | | Offers and **3,556 (4.7%)** for Completed Checks. This is an increase of **1,796 (40%)** First Offers and an increase of **272 (8.3%)** Checks from the mid-year 2015/16 position.<br>• The following targeted actions were taken during Q 2, 2016/17 to increase the numbers of NHS Health Checks offered and carried out:<br>- Three visits to support practices;<br>- The NHS Health Check service was promoted at Hayes Carnival, a Carers' Fair, an Open Evening at Hillingdon Hospital (by the Hospital's Occupational Health Team) and a Wellbeing Day 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. A revised service specification tailored to meet the needs of service users living with HIV/AIDS is being implemented in 2016/17.<br>• 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 near patient HIV testing pilot is being developed by HART. HART are liaising with Hillingdon Hospital's GUM service.<br>• The service went out to tender in September 2016. It is intended that the new service model will go live |

| | | | | on 1st May 2017.<br><br>**<u>OUTREACH:</u>**<br><br>• 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.<br><br>• Fresher's Week: The Chlamydia Outreach Team are currently preparing for Fresher's Week at Brunel and Uxbridge College – both campuses. In September the Outreach Team visited the following sites and delivered Health Promotion activities:<br>- Uxbridge College - 36 Young People;<br>- Uxbridge College Hayes - 39 Young People;<br>- Bucks University - 6 Young People;<br>- Brunel - 140 Condom Card registrations<br><br>• RAF Northolt: The Chlamydia Outreach Team continue to visit new recruits briefings at RAF Northolt in collaboration with the Practice Nurse at the base. Wellbeing Event at RAF Northolt has been booked for 12th January 2017 for the new recruits.<br><br>• 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.<br>1. Harefield Academy-Q2 - 250<br>2. Uxbridge College- Uxbridge Campus- Q2 - 32 |
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| | | | | 3. Uxbridge College- Hayes Campus-Q2- 41<br><br>• Early Intervention and Prevention - Partnership Working: In September the Outreach Team continued to visit the following sites and delivered Health Promotion activities: The Team continue to in-reach into: (a) Children Looked After homes-39 Young People; (b) YMCA hostels – 47 Young People; 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.<br><br>• 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. A meeting has been planned with the Abortion Provider to discuss, referral pathways in to local contraception and sexual health services. |
| | **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*** | **2.3.1** Ensure effective | CCG | Quarterly | • No update this quarter |

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| ***premature mortality*** | secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia | | | |
| | **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.<br>• Let's Get Moving data to 30th September 2016:<br>587 total clients (209 final assessment attendees)<br>60% achieved all their goals<br>36% achieved some of their goals<br>4% failed to achieve their goals<br>66% achieved overall reduction in BMI<br>71% achieved reduction in waist measurement<br>66% achieved an increase in the amount of times that 30 minutes of moderate intensity (breathless) physical activity was undertaken each week.<br>Reduction in BMI for those whose goal it was to lose weight 78%<br>Increase in overall activity level 91%<br>Improved fitness 66%<br>Reduction in GP visits 57%<br>Reduction in pain 46%<br>Reduction in tiredness 55% |

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| | | | | Reduction in depression 39%<br>Improved wellbeing 55%<br>Less short of breath 47%<br>Improved sleep 47%<br><br>• The internal Weight Action Programme for Council staff has 46 staff registered. Two programmes on a Tues and Weds are currently being delivered over a 10 week period).<br>• 'Get Up & Go' for residents from BME groups looking to improve their wellbeing lifestyle and take part in physical activity. In Q2 there were 6 attendees who are them referred in the Let's Get Moving Programme. |
| | **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 | | • Two new NHS dental practices are planned: One was opened in Harefield on 14th October and another one is planned for West Drayton to ensure equity of NHS dentistry across the borough. |
| | **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 | CCG | Annually | • Single Point of Access - the mental health urgent care pathway for Adults has been operational from 2nd November 2015. Community services have |

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| | the life course including the provision of Child and Adolescent Mental Health Services (CAMHS) | | | 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.<br><br>• 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.<br><br>As part of the Hillingdon Transformation Plan, the following services are all now in operation:<br>• A CAMHs self-harm, crisis and intensive support Team.<br>• Specialist Mental Health provision for Children and young People with Learning Disability and Challenging Behaviour Team, with an integrated pathway with LBH Disability Team.<br>• A Community Eating Disorder Service.<br>• Additional resources to reduce waiting times for treatment.<br>• 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 |

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| | | | | 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. |
| ***2.4 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 | • There are 10,092 16-18 year olds in Hillingdon. In September 2016, 4.9% (156) 16-18 years old in Hillingdon were NEET compared to 6.3% (221) in September 2015.<br>• The employment, education or training (EET) status of 69.2% (6938) of 16–18 year olds is classified as ‘not known’, compared to 71.6% (7159) in September last year. This figure must be read in the context of the time of year when 'not known' is expected to be varied upwards nationally at the start of term and at a time of student transition.<br>• Work is being progressed between the Participation Key-work team and Schools Improvement / Education Quality and Strategy to understand the reasons behind the reduction in the number of 16-18 year olds in learning so that improvement actions can be undertaken.<br>• Associated work is being progressed to reduce 'not known' levels in collaboration with education providers and to enable circa 3,000 young people to secure an appropriate EET destination as part of the 'September Guarantee' process which is |

| | | | | undertaken each year.<br><br>• Hillingdon delivered its September Guarantee duties to all relevant 6702 young people resident in the borough by making individual contact with each one. 88.3% (5917) are in receipt of an offer of education, employment or training compared to 89.8% (6051) at the same point last year. |
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**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 |
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| ***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 | • From 1st July 2016 to 30th September 2016, 1,516 individuals accessed Connect to Support and completed 2,292 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 132 people and 258 sessions on the same period in 2015/16.<br><br>• The number of providers registered on Connect to Support increased from 195 at the end of Q1 to 253 at the end of Q2. This includes both voluntary sector and private providers.<br><br>• During the first half of 2016/17 668 residents have accessed the H4All Wellbeing Service and nearly 77% (514) of were aged 75 and over. During this period 357 assessments have taken place using the |

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| | | | | Patient Activation Model (PAM), which tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. 73 people had a second assessment following a period of support and 48 showed an increased score and therefore increased confidence and motivation. However, 25 people either had a reduced score or there was no difference.<br><br>• There were 355 falls-related emergency admissions during the first half of 2016/17, which is marginally above the 344 total for the same period in 2015/16. |
| | **3.1.2** Deliver scheme two: better care for people at the end of their life (EoL) | LBH/CCG | Quarterly | • An information sharing agreement between the Council and the Royal Marsden NHS Hospital Foundation Trust was signed in respect of the advanced planning tool Coordinate My Care (CMC) and Adult Social Care read and write access to this system went live. This will help to improve coordination between organisations providing care for people at end of life. |
| ***3.2 Deliver the BCF*** | **3.2.1** Deliver scheme four: seven day working | LBH/CCG | Quarterly | • During Q2 the Hawthorne Intermediate Care Unit (HICU) started to accept referrals on Saturdays, which means that the unit now accepts referrals six days a week. This will assist with patient flow out of the Hospital.<br><br>• By the end of Q2 arrangements were put in place to enable the management of complex wound care delivered by CNWL to be available seven days a |

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| | | | | week for patients of the Ambulatory Emergency Care Unit at Hillingdon, which helps to prevent admissions that are avoidable.<br><br>• In Q2 there was a nearly 5% (24) increase in discharges on a Saturday compared to the same period in 2015/16 but a 24% (48) reduction in Sunday discharges. The increase in Saturday discharges was entirely attributable to an increase in discharges of people admitted for planned procedures. The number of people discharged on a Saturday who were admitted as emergencies declined by nearly 16% (34). There was a 17% (29) reduction in discharges on Sundays.<br><br>• In Q2 there has been an overall reduction in the proportion of people discharged before midday in comparison with the same period in 2015/16. For weekend discharges this has reduced from 35.5% of Saturday discharges in 2015/16 to 31.2 in 2016/17 and from 27% to 23.7% for Sunday discharges. |
| | **3.2.2** Deliver scheme six: Care home and supported living market development | LBH/CCG | Quarterly | • There were 327 emergency admissions from care homes during the first half of 2016/17, which compares to 362 admissions in 2015/16.<br><br>• A soft market testing exercise was undertaken with four potential providers of care and support for older residents living in extra care sheltered housing. The purpose of the exercise was to identify whether the proposed model was attractive to the market as well as identifying what other factors would encourage |

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| | | | | providers to bid. This exercise has helped to finalise the content of the service specification for the care and wellbeing in extra care service which will be the subject of a competitive tendering exercise in Q4. |
| | **3.2.3** Deliver scheme five: Integrated community-based care and support | LBH/CCG | Quarterly | • During Q2 the Accountable Care Partnership established four task and finish groups that are looking in detail at redesigning the services being delivered by the organisations within the ACP to improve care planning, reduce fragmentation, improve effectiveness and, most importantly, improve the resident experience of care. The work of these groups will help to inform the development of the 2017 to 2019 BCF plan. |
| | **3.2.4** Provide adaptations to homes to promote safe, independent living including the Disabled Facilities Grant | LBH | Quarterly | • In Q2 2016/17 33 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 61% of the grants provided.<br><br>• 22% (12) of the people receiving DFG's were owner occupiers, 72% (39) were housing association tenants, and 6% (3) were private tenants. The total DFG spend on older people (aged 60 and over) during Q2 2016/17 was £85k, which represented 30% of the spend during the quarter (£287k) |
| | **3.2.5** Increase the number of target population who sign up to TeleCareLine service which is free for | LBH | Quarterly | • As at 30th September 2016, 4,761 service users (4,306 households) were in receipt of a TeleCareLine equipment service, of which 3,627 people were aged 80 years or older. |

| | over 80's | | | • There are also 23 clients using the GPS technology for the Safer Walking device used by clients with early stages of dementia.<br><br>• Between 1st April 2016 and 30th September 2016, 411 new service users have joined the TeleCareLine Service of which 252 were aged over 80. |
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| ***3.3 Deliver the BCF*** | **3.3.1** Deliver BCF scheme seven: Supporting Carers. | LBH | Quarterly | • 191 Carers' assessments were completed in Q2, compared to 259 in Q1. On a straight line projection this would result in 900 assessments being completed in 2016/17, which would represent a 14.9% reduction on the 2015/16 outturn (1,058).<br><br>• During Q2 183 Carers were provided with respite or another carer service at a cost of £430.7k. This compares to 123 Carers being supported at a cost of £372.9k in Q2 2015/16.<br><br>• In September 2016 the Carers in Hillingdon contract started provided by the Hillingdon Carers Partnership and led by Hillingdon Carers. This new contract creates a single point of access for Carers. It should lead to better outcomes for Carers and the people they care for.<br><br>• A multi-agency Young Carers' Strategy was established and held its first meeting during Q2. This enables partners to work collaboratively to take a much more strategic approach to addressing the needs of young carers. |

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| | | | | • Two local Carer Forum meetings took place in Hayes and Northwood, both of which were attended by approximately 30 Carers. |
| | **3.3.2** Deliver BCF scheme eight: Living well with dementia | | | • Stirling University ran a training session for the designers of Grassy Meadow Court and Parkview Court extra care schemes to ensure that the gold standard for having a dementia friendly environment is achieved.<br><br>• 90 staff across health and social care, including GP surgery staff, took part in dementia awareness training.<br><br>• A new health service for people with learning disabilities was implemented in July with a specific focus on identification of people with dementia. This is intended to assist with the early identification, diagnosis and treatment of people with dementia. |
| ***3.4 Implement requirements of the Children and Families Act 2014*** | **3.4.1** Implement the SEND reforms including introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service planning for children, young people and families | LBH/CCG | Quarterly | • There are 998 Education, Health and Care Plans of which 663 are transfers from previous Statements. There are a further 853 Statements to transfer by 31 March 2018 in line with the Transfer Plan.<br><br>• The updated SEND Strategy is awaiting approval from the CCG.<br><br>• The resource allocation system (RAS) for children with disabilities will go live on 1st December; the RAS for special educational needs will go live by 1st |

| | | | | |
|---|---|---|---|---|
| | | | | April 2017.<br><br>• An early intervention support plan called My Support Plan is being rolled out. An early intervention funding pilot for pupils with a My Support Plan who would otherwise meet the threshold for an EHC Plan has been approved by Schools Forum.<br><br>• Disabled Go have completed the initial 1000 access surveys and will launch the Hillingdon Access Guide on 14th December 2016. |
| ***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 opened in September 2016 and young people have been started attending.<br><br>• OHCAT's application for a Free Special School for pupils with social, emotional and mental health difficulties on the YPA site to include sixth form provision was approved by the EFA.<br><br>• Eden Academy has submitted Free School applications to open 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 additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school.<br><br>• The Additional Needs Strategy has been refreshed |

| | | | | |
|---|---|---|---|---|
| | | | | and will be presented to SMT for approval in Q3.<br>• The Short Break Statement has been reviewed and updated and will be presented to SMT for approval on Q3. A Short Break Strategy has been approved by SMT. |

**Priority 4 - A positive experience of care**

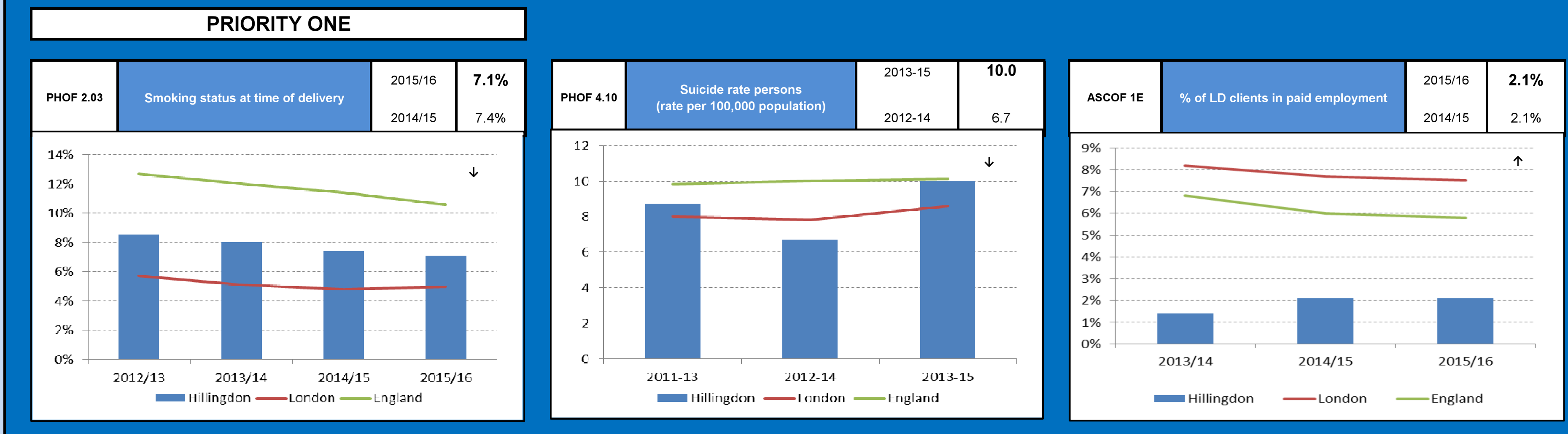
| **Objective** | **Task and Metric** | **Lead** | **Metric reporting frequency** | **Evidence of activity against task** |
|---|---|---|---|---|
| ***4.1 Ensure that residents are benefitting from implementation of BCF schemes*** | **4.1.1** Improve service user experience e.g. how easy or difficult 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 two-year (2017 - 2019) 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 | • We are working with KIDS, a national voluntary organisation, to develop a Participation Strategy linked to our Participation Network. This is a Government funded initiative as part of the support to implement the SEND reforms. |

# Health & Wellbeing Board - December 2016



## PRIORITY ONE



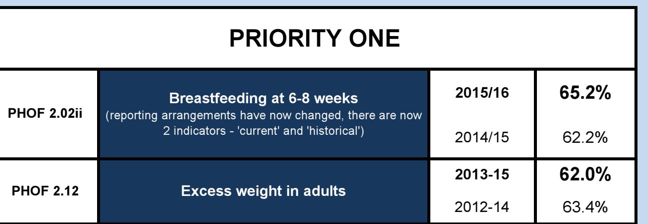
| PHOF 2.03 | Smoking status at time of delivery | 2015/16 | 7.1% |
|---|---|---|---|
| | | 2014/15 | 7.4% |

| PHOF 4.10 | Suicide rate persons (rate per 100,000 population) | 2013-15 | 10.0 |
|---|---|---|---|
| | | 2012-14 | 6.7 |

| ASCOF 1E | % of LD clients in paid employment | 2015/16 | 2.1% |
|---|---|---|---|
| | | 2014/15 | 2.1% |

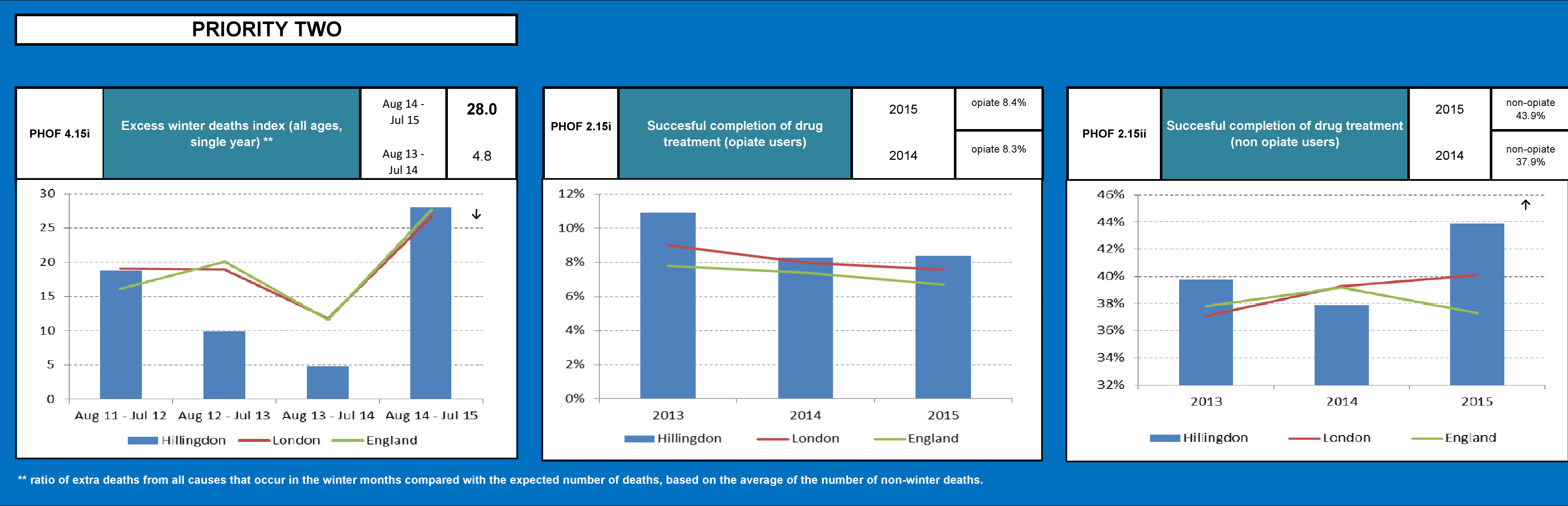


## PRIORITY ONE



| PHOF 2.02ii | Breastfeeding at 6-8 weeks (reporting arrangements have now changed, there are now 2 indicators - 'current' and 'historical') | 2015/16 | 65.2% |
|---|---|---|---|
| | | 2014/15 | 62.2% |
| PHOF 2.12 | Excess weight in adults | 2013-15 | 62.0% |
| | | 2012-14 | 63.4% |

## PRIORITY TWO



| PHOF 4.15i | Excess winter deaths index (all ages, single year) ** | Aug 14 - Jul 15 | 28.0 |
|---|---|---|---|
| | | Aug 13 - Jul 14 | 4.8 |

| PHOF 2.15i | Succesful completion of drug treatment (opiate users) | 2015 | opiate 8.4% |
|---|---|---|---|
| | | 2014 | opiate 8.3% |

| PHOF 2.15ii | Succesful completion of drug treatment (non opiate users) | 2015 | non-opiate 43.9% |
|---|---|---|---|
| | | 2014 | non-opiate 37.9% |



** ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.

## PRIORITY TWO

| PHOF 4.04i | Under 75 mortality rate from cardiovascular diseases (rate per 100,000 population) | 2013-15<br>2012-14<br>2011-13<br>2010-12 | 80.7<br>78.3<br>78.0<br>80.0 |
|---|---|---|---|
| PHOF 4.05i | Under 75 mortality rate from cancer (rate per 100,000 population) | 2013-15<br>2012-14<br>2011-13<br>2010-12 | 132.1<br>142.3<br>139.3 |
| PHOF 4.06i | Under 75 mortality rate from liver disease (rate per 100,000 population) | 2013-15<br>2012-14<br>2011-13<br>2010-12 | 15.0<br>18.7<br>17.8<br>20.0 |
| QOF | Number of people with dementia on GP register (prevalance % and number of registrations) | 2015/16<br>2014/15 | 0.60 (1,813)<br>0.53 (1,596) |

## BETTER CARE FUND METRICS

| Perm admissions | Perm admissions per 100,000 | 2016/17 | 174.9 |
|---|---|---|---|
| | | 2015/16 (FYr) | 367.6 |

New permanent admissions to residential / nursing care (per 100k residents aged 65+) ↓ ✓

Actual admissions: 2013/14 (Q4) 262.0; 2014/15 (Q1) 68.1; 2014/15 (Q2) 154.6; 2014/15 (Q3) 298.2; 2014/15 (Q4) 398.5; 2015/16 (Q1) 144.0; 2015/16 (Q2) 236.5; 2015/16 (Q3) 309.3; 2015/16 (Q4) 367.6; 2016/17 (Q1) 96.34; 2016/17 (Q2) 174.95

Target: 272.5, 272.5, 267.4, 267.4, 379.7, 379.7, 379.7, 379.7, 380.3, 380.3

| Delayed transfer of care (DToC) | DToC per 100,000 residents | 2016/17 (Q2) | 1054.5 |
|---|---|---|---|
| | | 2016/17 (Q1) | 631.0 |

Delayed Transfers of care (per 100k residents) ↓ ✓

Actual DToC: 507.62, 647.13, 413.11, 238.22, 443.66, 606.16, 561.37, 631.04, 1054.5

Target per 100k: 124.93, 660.18, 533.50, 492.80, 468.50, 616.70, 293.93, 402.96

| | | | |
|---|---|---|---|
| Perm admissions | Number of permanent admissions to residential / nursing care for residents aged 65+ | 2016/17 | 69 |
| | | 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 / nursing care per 100,000 residents aged 65+ | 2016/17 (Q2) | 174.9 |
| | | 2016/17 (Q1) | 96.3 |
| Delayed transfer of care | Total number of days in quarter | 2016/17 (Q2) | 2418 |
| | | 2016/17 (Q1) | 1,447 |
| Delayed transfer of care | DToC per 100,000 (Qtrly Outturn) | 2016/17 (Q2) | 1054.5 |
| | | 2016/17 (Q1) | 631.0 |
| Delayed transfer of care | Quarterly target for delayed discharges (total number of days) | 2016/17 (Q2) | 403.0 |
| | | 2016/17 (Q1) | 525.5 |

## 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 (Q2) | 4,761 |
| | | 2016/17 (Q1) | 4,727 |
| LBH (Local Measure) | Number of people in receipt of TeleCareLine (80+) | 2016/17 (Q2) | 3,627 |
| | | 2016/17 (Q1) | 3,582 |
| LBH (Local Measure) | Number of people in sign ups to TeleCareLine | 2016/17 (Q2) | 411 |
| | | 2016/17 (Q1) | 224 |

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

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# HILLINGDON'S JOINT STRATEGIC NEEDS ASSESSMENT

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Dan Kennedy, Head of Business Performance, Policy & Standards |
| **Papers with report** | Appendix 1 – Hillingdon's Health Profile 2016<br>Appendix 2 - JSNA work plan 2016 - 2017 |

## 1. HEADLINE INFORMATION

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

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

1. **notes the headlines from Hillingdon's Joint Strategic Needs Assessment (JSNA) which are being considered in developing updated commissioning plans.**

2. **notes and comment on the proposed JSNA work priorities (as set out in Appendix 2) which ensures that it remains a key source of local intelligence to underpin effective service planning.**

## 3. INFORMATION

Background to the Joint Strategic Needs Assessment (JSNA)

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

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

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

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

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

Summary of Hillingdon's Joint Strategic Needs Assessment

6. Overall, the health and wellbeing of Hillingdon's residents is good and continues to improve. Based on key indicators (Hillingdon's Health Profile 2016 – Appendix 1) and other data, the key headlines from the needs analysis shows that for people living in Hillingdon compared to England on average:

    - Life expectancy for both men and women in Hillingdon is higher.
    - Lower levels of mothers smoke during pregnancy.
    - There are higher levels of breast feeding.
    - Children living in deprivation are lower.
    - Levels of teenage pregnancy are similar to that of England.
    - Hospital stays related to alcohol and self-harm are lower.
    - Long term unemployment is lower.
    - Rates of homelessness are lower than England.

7. As with all Boroughs, local analysis indicates some challenges to improve health and wellbeing. These include:

    - Historically higher levels of violent crime in Hillingdon.
    - Higher rates of sexually transmitted infections and tuberculosis.
    - People diagnosed with diabetes in Hillingdon is higher than average.
    - The percentage of physically active adults is lower than England.

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

9. Certain lifestyle factors will increase the risk of ill-health, including smoking, poor diet, lack of regular exercise and higher levels of alcohol consumption and/or binge drinking. The estimated 2015 prevalence of smoking in Hillingdon (16.9%) which is the same as the estimated proportions for England (16.9%).

10. Age and other related conditions also affect health and wellbeing. Many people aged 65 and over are diagnosed with one or more long term conditions, of whom over half are typically diagnosed with multiple long term conditions which increases dependency on care and support. Other conditions include learning disability and child and adult mental health, including dementia.

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

Developing Hillingdon's JSNA

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

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

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

14. Over recent months key updates to the JSNA have included:

- May 2016, refresh of Children and Young people's Needs Assessment
- October 2016, Substance Misuse Tender slide pack update - 50+ slides updated with latest demographic data and drugs & alcohol data
- November-December 2016, a review of 2015 mortality data update looking at causes of death from dementia and other diseases

15. In addition to the above, updates to the JSNA on the web have included updates on prevalence of dementia and demographic profile of the borough. Whilst not falling under the purview of the JSNA – additional work undertaken to build a more detailed profile of the borough and to aid service planning and re-design include completion of a homelessness review (July 2016)completion of updated school places planning forecasts and the development of an updated Strategic Housing market Assessment (November 2016).

16. Future planned updates include Excess Winter Deaths, Smoking related pages and Accidents all due by the end of the financial year

**Financial Implications**

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

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

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

**Consultation Carried Out or Required**

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

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

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

**Hillingdon Council Legal comments**

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

## 6. BACKGROUND PAPERS

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

## Appendix 1 - Hillingdon Health Profile 2016

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

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average€ | England average | England worst | 25th Percentile | 75th Percentile | England best

| Domain | Indicator | Period | Local No total count | Local value | Eng value | Eng worst | Eng best |
|---|---|---|---|---|---|---|---|
| Our communities | 1 Deprivation score (IMD 2015) # | 2015 | n/a | 18.1 | 21.8 | 42.0 | 5.0 |
| | 2 Children in low income families (under 16s) | 2013 | 10,710 | 17.9 | 18.6 | 34.4 | 5.9 |
| | 3 Statutory homelessness† | 2014/15 | 32 | 0.3 | 0.9 | 7.5 | 0.1 |
| | 4 GCSEs achieved† | 2014/15 | 1,819 | 59.4 | 57.3 | 41.5 | 76.4 |
| | 5 Violent crime (violence offences) | 2014/15 | 5,735 | 20.0 | 13.5 | 31.7 | 3.4 |
| | 6 Long term unemployment | 2015 | 463 | 2.4 | 4.6 | 15.7 | 0.5 |
| Children's and young people's health | 7 Smoking status at time of delivery | 2014/15 | 288 | 7.4 | 11.4 | 27.2 | 2.1 |
| | 8 Breastfeeding initiation | 2014/15 | 3,290 | 83.4 | 74.3 | 47.2 | 92.9 |
| | 9 Obese children (Year 6) | 2014/15 | 593 | 19.3 | 19.1 | 27.8 | 9.2 |
| | 10 Alcohol-specific hospital stays (under 18) | 2012/13 - 14/15 | 77 | 38.0 | 36.6 | 104.4 | 10.2 |
| | 11 Under 18 conceptions | 2014 | 105 | 20.5 | 22.8 | 43.0 | 5.2 |
| Adults' health and lifestyle | 12 Smoking prevalence in adults† | 2015 | n/a | 16.9 | 16.9 | 32.3 | 7.5 |
| | 13 Percentage of physically active adults | 2015 | n/a | 51.5 | 57.0 | 44.8 | 69.8 |
| | 14 Excess weight in adults | 2012 - 14 | n/a | 63.4 | 64.6 | 74.8 | 46.0 |
| Disease and poor health | 15 Cancer diagnosed at early stage # | 2014 | 373 | 46.3 | 50.7 | 36.3 | 67.2 |
| | 16 Hospital stays for self-harm | 2014/15 | 371 | 124.5 | 191.4 | 629.9 | 58.9 |
| | 17 Hospital stays for alcohol-related harm | 2014/15 | 1,429 | 553 | 641 | 1223 | 374 |
| | 18 Recorded diabetes | 2014/15 | 15,803 | 6.7 | 6.4 | 9.2 | 3.3 |
| | 19 Incidence of TB | 2012 - 14 | 361 | 41.9 | 13.5 | 100.0 | 0.0 |
| | 20 New sexually transmitted infections (STI) | 2015 | 1,833 | 937 | 815 | 3263 | 191 |
| | 21 Hip fractures in people aged 65 and over | 2014/15 | 216 | 506 | 571 | 745 | 361 |
| Life expectancy and causes of death | 22 Life expectancy at birth (Male) | 2012 - 14 | n/a | 80.4 | 79.5 | 74.7 | 83.3 |
| | 23 Life expectancy at birth (Female) | 2012 - 14 | n/a | 83.9 | 83.2 | 79.8 | 86.7 |
| | 24 Infant mortality† | 2012 - 14 | 44 | 3.3 | 4.0 | 7.2 | 0.6 |
| | 25 Killed and seriously injured on roads | 2012 - 14 | 226 | 26.3 | 39.3 | 119.4 | 9.9 |
| | 26 Suicide rate† | 2012 - 14 | 50 | 6.7 | 10.0 | | |
| | 27 Deaths from drug misuse # | 2012 - 14 | 9 | $x^2$ | 3.4 | | |
| | 28 Smoking related deaths | 2012 - 14 | 955 | 262.6 | 274.8 | 458.1 | 152.9 |
| | 29 Under 75 mortality rate: cardiovascular | 2012 - 14 | 440 | 78.3 | 75.7 | 135.0 | 39.3 |
| | 30 Under 75 mortality rate: cancer | 2012 - 14 | 801 | 142.3 | 141.5 | 195.6 | 102.9 |
| | 31 Excess winter deaths | Aug 2011 - Jul 2014 | 190 | 10.9 | 15.6 | 31.0 | 2.3 |

**Indicator notes**

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016. $x^2$ Value cannot be calculated as number of cases is too small

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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**<u>Appendix 2</u> – Hillingdon's Joint Strategic Needs Assessment – Work Plan (2016-17)**

The following table summarises the key work plan activities scheduled to develop the JSNA for the remainder of 2016/17. A calendar of updates for 2017/18 will be developed and agreed in conjunction with Public Health. These activities complement the additional and routine analysis of national and local data which are undertaken to keep the JSNA up-to-date (e.g. annual data about birth rates, mortality, demographics etc.). Taken together the schedule of routine updates and more substantive pieces of work listed below will help ensure the JSNA is responsive and informs the priorities within the Joint Health and Wellbeing Strategy.

| Ref | Area of Development | Description | Timescale |
|---|---|---|---|
| 1 | Older People's Needs assessment | Analysis of the key health and social care needs of older people across Hillingdon including an analysis of data available from universal services. | By December 2016 |
| 2 | Pharmaceutical Needs Assessment (PNA) 2018 | Analysis of key health needs across the Borough and how pharmacy services are meeting these needs in specific localities. | In order to meet the statutory publication date (April 2018) – work on the PNA will commence in March 2017. |
| 3 | Respiratory Disease | Analysis of air quality and disease prevalence. | By March 2017 |
| 4 | Maternity Services | Analysis of data from conception to 1 year and late booking of maternity services. | By March 2017 |
| 5 | Mental Health/Substance Misuse | Updated analysis of previous analysis | By April 2017 |

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# SUSTAINABILITY AND TRANSFORMATION PLANS

| **Relevant Board Member(s)** | Councillor Philip Corthorne<br>Dr Ian Goodman |
|---|---|
| **Organisation** | London Borough of Hillingdon<br>Hillingdon CCG |
| **Report author** | Kevin Byrne, Hillingdon Council, Policy and Partnerships<br>Caroline Morison, HCCG |
| **Papers with report** | Appendix 1 - North West London ST Plan<br>Appendix 2 - final Hillingdon ST Plan |

## 1. HEADLINE INFORMATION

| **Summary** | The Board has received regular reports on progress towards the overarching NWL footprint STP and the local Hillingdon plan. A further iteration of the NWL STP was submitted to NHS England on 21st October and comes to the Board now for consideration. The paper also includes initial proposals for taking forward the Hillingdon STP. |
|---|---|
| **Contribution to plans and strategies** | The Hillingdon STP directly influences local plans including:<br>• HCCG commissioning intentions for 2017/18<br>• The Hillingdon Health and Wellbeing Strategy<br>• Hillingdon's Better Care Fund plan 2017/18 |
| **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 health and care economy. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

1. **notes the NWL STP submission (Appendix 1 ) and, whilst continuing to offer broad support to the direction of the plan, registers concern regarding uncertainty on the funding arrangements and to seek reassurance on flexibility to deliver what works best for Hillingdon.**

2. **notes the Hillingdon STP (Appendix 2) and progress in implementing proposals to take it forwards into a full delivery plan as part of an overall Health and Wellbeing Strategy.**

## 3. INFORMATION

### Supporting Information

### NWL STP footprint plan

The Board considered the June 2016 version of the NWL plan at its meeting in September. At that Board broad support was offered to the direction of the plan but it was agreed that the Chairman would write in response to the anticipated further iteration of the plan, which was subsequently submitted to NHSE on 21st October. This further draft is now published and a Appendix 1.

The Chairman wrote on behalf of the Board to NWL STP system leader, that letter included the following:

*"...We are also aware of the advice from NHS England that it is not expected for plans to go through formal local NHS or other organisations' board approval or formal public engagement or consultation at this stage. We also understand that it is expected that most footprints will take a version of their STP to their organisation's public board meetings for discussion between late October and the end of this year. Our board will, therefore, consider this again at its meeting on 8th December.*

*Firstly, may I record our concern to this approach which we feel needs to be passed onto NHSE. We have ensured that principles around sovereignty and subsidiarity should form a key part of developing the NWL plan and as such our approach is much stronger. The NHSE stance, however, runs counter to these principles and to gaining partner support and buy-in.*

*Given that this plan will now go to NHSE and start to be reviewed or evaluated, we feel we may have lost the opportunity to influence, challenge where necessary, and help design solutions that work best for Hillingdon. There is a growing risk of a disconnect between our agreed local Hillingdon ST plan, which recognises good progress locally and the congruence between our health and social care services, and the NWL plan. We have offered some suggested drafting changes to bring these closer together. I hope that these sorts of issues are surmountable but it is not clear how we ensure they will be taken into account.*

*Our Board has, however, recognised the broad direction of travel in the STP, based on the June submission, but with the strong caveat that we need to be satisfied that financial analysis is robust and seek greater clarity as to how the ST fund will support transformation at the local level. Until we have the opportunity to give this submission proper consideration (including seeing the financial details) we must reserve the right to disagree with elements of the plan."*

Since the submission of the latest plan at Appendix 1, further discussions have taken place to attempt to review and evidence the financial information contained in the plan, to quantify the health and social care gaps and to relate this to the local situation and the figures in the Hillingdon STP. The methodology used to calculate the social care gap has been reviewed and is now applied consistently across the eight boroughs. It is, however based upon modelling activity within each borough using individual borough estimates and assumptions about demographic changes, and pay and price inflation. Further modelling and analysis will be necessary to ensure that the final figures and supporting investment proposals are robust.

In addition, a key point in the Board's feedback on the June submission was that it did not appear to reflect the particular situation in Hillingdon, namely the congruence between social

care and having one hospital, one CCG and one community provider, in effect meaning that approximately 80% of activity remains "in borough". We have received verbal assurances through the Joint Health and Care Transformation Group that the position in Hillingdon is understood and that there is no assumption that "one size will fit all" and that there will need to be Hillingdon specific solutions such as our own Accountable Care Partnership and further development of local discharge functions.

The wider local government input across boroughs has also established that their agreement to the NWL STP should be based on following caveats:

- The implementation business case on which Delivery Area 5 of the NWL STP is based being released and understood.
- That the flow of money from acute to out of hospital settings is clarified and agreed.
- That the specifications for out of hospital settings, in particular social care, are clarified based on an agreed model of hospital care.
- That a full risk assessment for the plan with mitigation measures is agreed between partners.

Approval was offered on this basis and we understand that these areas are being actively pursued and there may be further intelligence before the end of the year.

In addition, whilst we await formal feedback, there are indications that the NWL submission has been well received and is in a strong position nationally. It is strengthened by the integral role local government has played in the governance and the development of the STP.

We are also waiting to understand how the governance and programme and project management will be delivered at sub-regional level.

**Hillingdon STP**

The Board noted at its September meeting the local Hillingdon STP, a final version is attached as Appendix 2. It is now proposed that the various tasks contained in the plan be developed further into a more detailed delivery plan with measurable milestones and assessed to gauge priority and timing.

It is proposed that these be considered against the following criteria (in no order of precedence):

- **Sustainability –** A key element of both the NWL STP and the Hillingdon STP is to ensure that services are sustainable and that the impact on the whole system is understood. Work which moves towards achieving sustainable whole system solutions will be prioritised over those that may not.

- **Value for money -** proposals which offer more efficient and effective ways of delivery and may lead to savings will be prioritised.

- **Health and social care integration –** the STP is seen by central government as a key driver towards greater integration of health and social care and a move of activity out of acute settings into the community. This has already begun with the Better Care Fund plan and there is opportunity through the Accountable Care Partnership. Priority will be given to activities which affect systems change and a move from acute care to out of hospital and social care.

- **Timescales –** Priority may be given to those actions which offer a return on investment or impact towards systems change in the short term.

- **Quality Improvements –** Hillingdon CCG and Hillingdon Council are committed to improving the quality of care that is provided to Hillingdon's residents. This is a key strand of our local STP and the Five Year Forward View, and work that will achieve this will be prioritised over work which will not.

In addition it is important to note that significant progress is being made in a number of areas contained in the STP and set out in more detail in relevant papers included on the agenda for the meeting on 8 December 2016, including:

**Better Care Fund** - has helped shift from crisis management and reactive service provision to planning for anticipated care needs, and achieving greater integration and alignment between health and social care which is ongoing.

**CAMHS** - The Hillingdon Transformation plan is continuing and progress has been made in developing the new eating disorder and self harm clinics. In addition, through the STP process the HWB has agreed to review proposals to re-commission CAMHs services across the full pathway.

**Estates and Establishing GP hubs -** There is a need to better utilise the health estate in Hillingdon. The Hillingdon Strategic Estates Group has been established and proposals for the three GP hubs across Hillingdon have been included in the STP as the identified operating model. Locally positive progress has been made in establishing requirements against opportunities in the Hayes area.

The chronic condition of physical infrastructure of The Hillingdon Hospitals NHS FT requires significant capex. Master planning by THHFT for a new hospital build is in progress, as is the establishment of an Academic Centre for Health Sciences with Brunel University London and CNWL NHSFT.

**Accountable Care Partnership -** Work on the ACP so far has focussed on preparation for a year of 'shadow' operation in 2016/17, which will allow all partners to assess the performance of the ACP model. This has paved the way for what will be a significant step towards health and social care integration and improved outcomes for Hillingdon's residents. Currently, the ACP will deliver services to older people with long term conditions, but its scope will expand to encompass all older people and all people with long term conditions.

**Engagement** - Patients and the public who have access to healthcare services in Hillingdon will continue to be at the heart of the proposed improvements. We are committed to making sure this continues - making our priorities for transforming services relevant to the people of Hillingdon.

Continued delivery of these work streams will be supported by key enablers, particularly by continuing to create a digital environment and building the workforce of the future.

**Financial Implications**

The high level estimates set out in the NWL STP October submission identifies the revised 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 is based upon a number of assumptions and models that have been reworked by finance officers from both Health and Local Government to ensure that financial costs and investments can be fully evidenced.

A further exercise to identify the 'Do nothing' option for the NWL 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 which was initially estimated as £1,299 million has increased to £1,409 million. The table below, which also includes the local position for Hillingdon, sets out the local forecast funding gap in more detail which has increased from £104m to £120m.

| **Period 2016/2021** | **Hillingdon £m** | **NWL £m** |
|---|---|---|
| CCG | (39) | (248) |
| Primary Care | (2) | (15) |
| Social Care | (34) | (297) |
| Acute and Community Care | (45) | (660) |
| Special Commissioning | 0 | (189) |
| **Total** | **(120)** | **(1,409)** |

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 'do nothing' 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. As at October 2016, this has been estimated locally as £34m over the next 5 financial years. The updated 'do nothing' forecast funding gap for Social Care now includes a corporate share of the financial savings over the 5 year period that Adult Social Care Services will need to make to contribute to the Council's statutory requirement to set a balanced budget.

The NWL STP plan 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 revised forecast for the financial impact of the strategic proposals to close the gap as at October 2016:

| | Health | Adult Social Care | Total Health and Care |
|---|---|---|---|
| | £m | £m | £m |
| **Do Nothing funding gap as at October 2016** | **(1,112)** | **(297)** | **(1,409)** |
| Business as usual savings (QIPP/CIPS/MTFF) | 572 | 108 | 680 |
| Delivery Areas (1-5) - Investment required | (118) | 0 | (118) |
| Delivery Areas (1-5) -Savings to be delivered | 446 | 63 | 509 |
| Additional estimated full year impact of ongoing costs following transformation | (56) | 0 | (56) |
| ST Funding | 94.5 | 19.5 | 114 |
| Implement 2% Social Care Precept | 0 | 72 | 72 |
| Special Commissioning Services | 189 | | 189 |
| **Forecast Residual Gap as October 2016** | **15** | **(35)** | **(19)** |

The detailed assumptions underpinning these forecasts are as follows:

- The QIPP/CIPS/MTFF savings for NWL CCG's (£572m) and Social Care (£108m) have been estimated at £680million. This includes Hillingdon CCG estimated efficiencies of £46.5m and assumed Hillingdon Social Care efficiencies of £14 million over the period 2016/21 to contribute to the MTFF.

- 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 £63m can be found from STP investment in the Delivery areas.

- STP funding is the recurrent 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 unresolved residual gap of £35m for Social Care across NWL is to be addressed through further joint working between health and social care as set out below:

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

- The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;

- Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the

Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;

- The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.

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 and review across local government and health.

The high level business cases to deliver STP transformation set out in the Annex1 are still being developed in more detail and robust analysis of the investment proposals and the estimated savings continues to be undertaken by Finance Officers across the boroughs and CCG's to ensure that the financial benefits set out in this plan are realistic and achievable over the 5 year period.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

The ST Plans offer the prospect of improving health and care in the Borough.

**Consultation Carried Out or Required**

Communications and engagement activity is integral to both plans and build on local activity to date.

**Policy Overview Committee comments**

None at this stage.

## 5. 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**

There are no specific legal implications arising from this report.

## 6. BACKGROUND PAPERS

NIL.

NW London Sustainability and Transformation Plan
Our plan for North West Londoners to be well and live well
V01
21 October 2016

# 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.

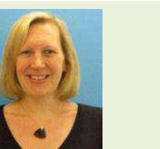
Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions. 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 £1.4bn 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. We have listened to the feedback we have received so far from our patients and residents and updated our plan in particular around access to primary care and the delivery of mental health services. We will continue to engage throughout the lifetime of the plan.

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:

| Gap | Challenges | Evidence |
|---|---|---|
| **Health & Wellbeing** | ▪ Adults are not making healthy choices<br>▪ Increased social isolation<br>▪ Poor children's health and wellbeing | ▪ 20% of people have a long term condition[1]<br>▪ 50% of people over 65 live alone[2]<br>▪ 10 – 28% of children live in households with no adults in employment[3]<br>▪ 1 in 5 children aged 4-5 are overweight[4] |
| **Care & Quality** | ▪ Unwarranted variation in clinical practise and outcomes<br>▪ Reduced life expectancy for those with mental health issues<br>▪ 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]<br>▪ People with serious and long term mental health needs (e.g. schizophrenia) have a life expectancy up to 20 years less than the average[6]<br>▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7] |
| **Finance & Efficiency** | ▪ Deficits in most NHS providers<br>▪ Increasing financial gap across health and large social care funding cuts<br>▪ Inefficiencies and duplication driven by organisational not patient focus | ▪ If we do nothing, there will be a £1.4bn financial gap by 2021 in our health and social care system and potential market failure in some sectors<br>▪ 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*

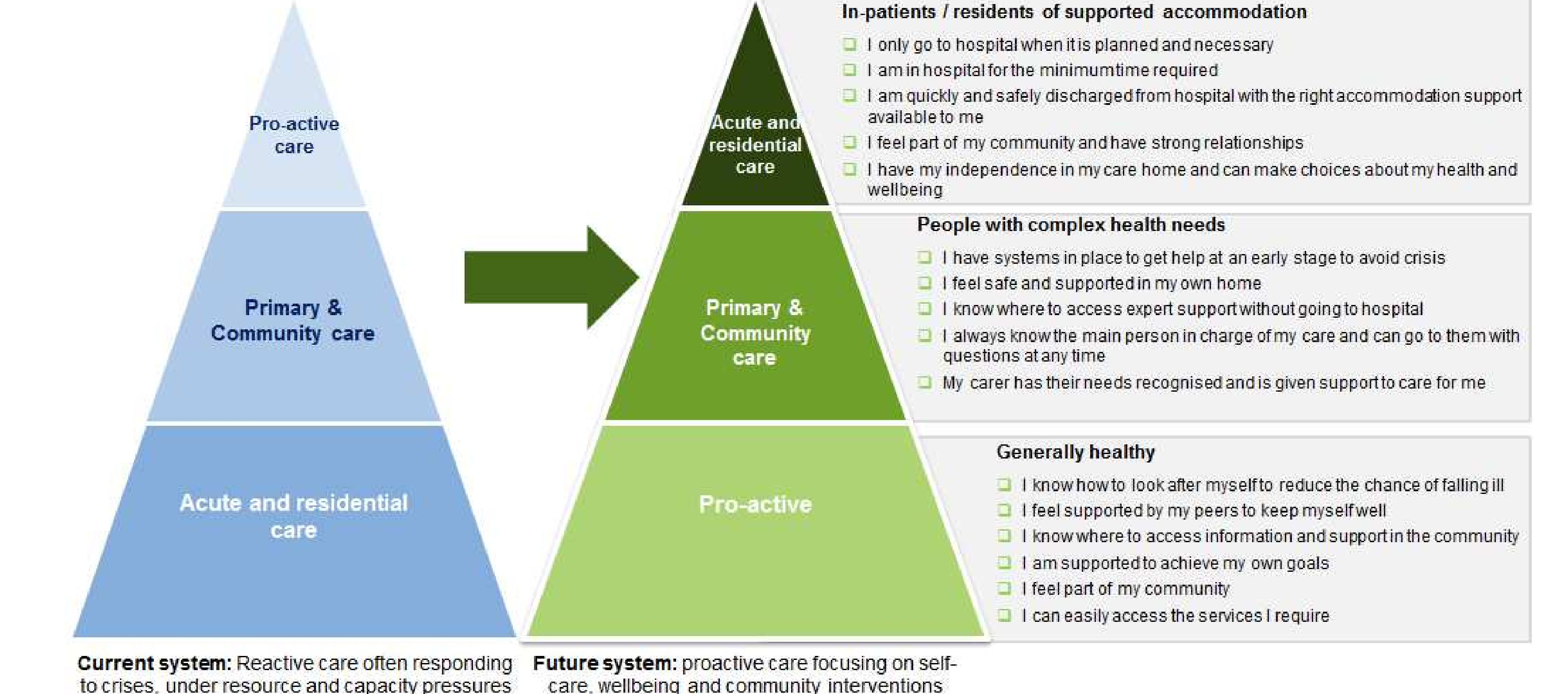
| | Mostly healthy | One or more long-term conditions | Cancer | Serious and long term mental health needs | Learning disability | Severe physical disability | Advanced dementia / Alzheimer's | Children | Socially Excluded Groups |
|---|---|---|---|---|---|---|---|---|---|
| Current Population[8] | 1,216,000 | 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) | 1,264,000 | 458,000 | 26,000 | 43,300 | 9,000 | 27,100 | 7,000 | 463,200 | |
| % Increase | 4% | 36% | 53% | 16% | 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.

| Triple Aim | | Our priorities |
|---|---|---|
| Improving health & wellbeing | 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 |
| Improving care & quality | 4 | Reduce social isolation |
| | 5 | Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease |
| | 6 | Ensure people access the right care in the right place at the right time |
| Improving productivity & closing the financial gap | 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 |
| | 8 | Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population |
| | 9 | Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed |

Primary Alignment*

| Delivery areas (DA) | Target Pop. (no. & pop. segment) | Net Saving (£m) | Plans |
|---|---|---|---|
| **DA 1** Radically upgrading prevention and wellbeing | All adults: 1,641,500<br>At risk mostly healthy adults: 121,680<br>Children: 438,200<br>Learning Disability: 7,000<br>Socially Excluded | 11.6 | a. Enabling and supporting healthier living for the population of NW London<br>b. Keeping people mentally well and avoiding social isolation<br>c. Helping children the get the best start in life |
| **DA 2** Eliminating unwarranted variation and improving LTC management | LTC: 347,000<br>Cancer: 17,000<br>Severe Physical Disability: 21,000 | 13.1 | a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care<br>b. Improve cancer screening to increase early diagnosis and faster treatment<br>c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions<br>d. Reducing variation by focusing on Right Care priority areas<br>e. Improve self-management and 'patient activation' |
| **DA 3** Achieving better outcomes and experiences for older people | +65 adults: 311,500<br>Advanced Dementia/ Alzheimer's: 5,000 | 82.6 | a. Improve market management and take a whole systems approach to commissioning<br>b. Implement accountable care partnerships<br>c. Upgraded rapid response and intermediate care services<br>d. Create an integrated and consistent transfer of care approach across NW London<br>e. Improve care in the last phase of life |
| **DA 4** Improving outcomes for children &adults with mental health needs | 482,700<br>Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability | 11.8 | a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy<br>b. Focussed interventions for target populations<br>c. Crisis support services, including delivering the 'Crisis Care Concordat'<br>d. Implementing 'Future in Mind' to improve children's mental health and wellbeing |
| **DA 5** Ensuring we have safe, high quality sustainable acute services | All: 2,079,700 | 208.9 | a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services<br>b. Deliver the 7 day services standards<br>c. Reconfiguring acute services<br>d. NW London Productivity Programme |

** 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 benefits from specialisation and innovation. The benefits of senior clinical advice available at most parts of the day are now well documented to improve outcomes as it enables the right treatment to be s delivered to the patient at the right time We know from our London wide work on stroke and major trauma that better outcomes can be achieved by consolidating specialist doctors into a smaller number of units that can deliver consistently high quality, 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 STP sets out how we will meet the needs of our population 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. 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, 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 allow us to deliver primary care to scale with an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs. Due to the on-going uncertainty of the future of Ealing Hospital 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. As Ealing 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, the current clinical model is not financially sustainable. This means it makes sense to prioritise the vision for Ealing in this STP period.

A joint statement from six boroughs is at Appendix A. Ealing and Hammersmith & Fulham Councils do not support the STP due to proposals to reconfigure acute services in the two respective boroughs. Both councils remain fully committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

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 will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

There is a similar vision for Charing Cross Hospital. Here, again, we plan to deliver ambulatory care, primary care to scale and an extensive range of diagnostic services. However at Charing Cross, during this STP period, there are no planned changes to the A&E services currently being provided.

# 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 £1,113m funding gap by 20/21 with a further £298m gap in social care, giving a system wide shortfall of £1,410m.

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 health sector is a £15.1m surplus, and the social care deficit is £35m, giving an overall sector deficit of £19.9m.

Table: North West London Footprint position in 20/21

| £'m | CCGs | Acute | Non-Acute | Spec. Comm | Primary Care | STF Investment | Sub-total (Health) | Social Care | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| **Do Nothing Oct 16** | **(247.6)** | **(529.8)** | **(131.6)** | **(188.6)** | **(14.8)** | **-** | **(1,112.4)** | **(297.5)** | **(1,409.9)** |
| Business as usual savings (CIP/QIPP) | 127.8 | 341.6 | 102.7 | - | - | - | **572.1** | **108.5** | **680.6** |
| DA 1-5 - Investment | (118.3) | - | - | - | - | - | **(118.3)** | **-** | **(118.3)** |
| DA1-5 - Savings | 302.9 | 120.4 | 23.0 | - | - | - | **446.3** | 62.5 | **508.8** |
| Additional costs of delivering 5YFV | - | - | - | - | - | (55.7) | **(55.7)** | - | **(55.7)** |
| STF - funding | 24.0 | - | - | - | 14.8 | 55.7 | **94.5** | 19.5 | **114.0** |
| Other | - | - | - | 188.6 | - | - | **188.6** | 72.0 | **260.6** |
| **TOTAL IMPACT** | **336.4** | **462.0** | **125.7** | **188.6** | **14.8** | **-** | **1,127.5** | **262.5** | **1,390.0** |
| **Final Position Surplus/(Deficit)** | **88.8** | **(67.8)** | **(5.9)** | **-** | **-** | **-** | **15.1** | **(35.0)** | **(19.9)** |

Schemes have been identified which 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 areas of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes

These schemes, as well as improving patient outcomes, are expected to cost less – requiring £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings.

In addition, 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.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, mainly attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for most providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing, once it can be demonstrated that reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met.

The remaining deficit is due to London Ambulance Service (NWL only) and Royal Brompton & Harefield, who are within the NWL footprint but primarily commissioned by NHS England.

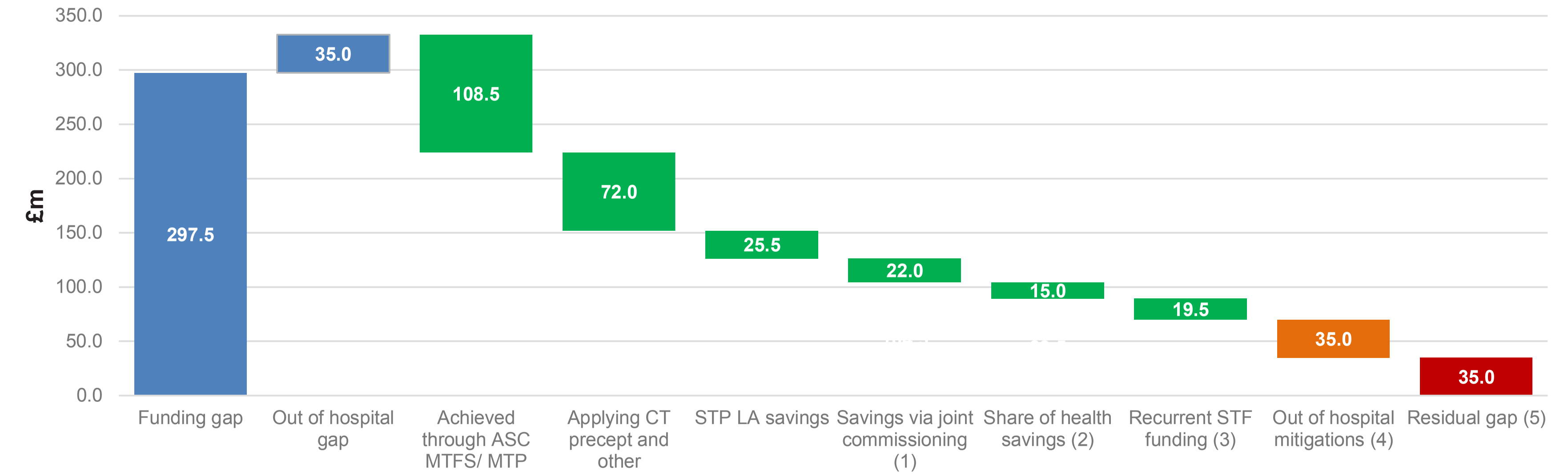
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

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 (I)

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. In addition to this there continues to be a significant level of service and demographic pressures putting further strain on the service. 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 chart below sets out below the projected gap and how this will be addressed. The savings are further broken down on the following slide.




**The following assumptions and caveats apply:**
The residual gap of £35m by 20/21 will be addressed through further joint working between health and social care. An initial estimated cost pressure of £35m illustrates the likely shift from hospital activity into adult social care, which is to be addressed through a robust business case process. £19.5m is assumed to be funded by STF on a recurrent basis, leaving an unresolved recurrent gap of £35m.

(1) Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3;
(2) The share of savings accruing to Health are assumed to be shared equally with local government on the basis of performance;
(3) Assumed that £19.5m will be recurrent funding from 2020/21through the STF fund;
(4) Further work is required to identify the impact on social care of the Delivery Area schemes, and to develop joined up health and social care business cases. Where the Delivery Area schemes result in a shift of costs to social care, it is expected that these would be NHS funded;
(5) The residual gap of £35m by 20/21 is assumed to be unresolved but both Local Government and NHS colleagues will be working collaboratively to identify how to close this gap, so as to put both the health and social care systems on sustainable footing.
NB Confirmation of what the final on-going sources of funding will be from 2020/21 is being sought.

# i. Executive Summary:
## Social Care Finances (2)

The table below sets out how the savings accruing to local authorities from joint work with Health on the Delivery Area business cases will be delivered through the 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 | - | 7.7 | 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 non-recurrent transformational investment from the NHS Sustainability and Transformation Fund of an estimated £110m over 3 years (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services. 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.

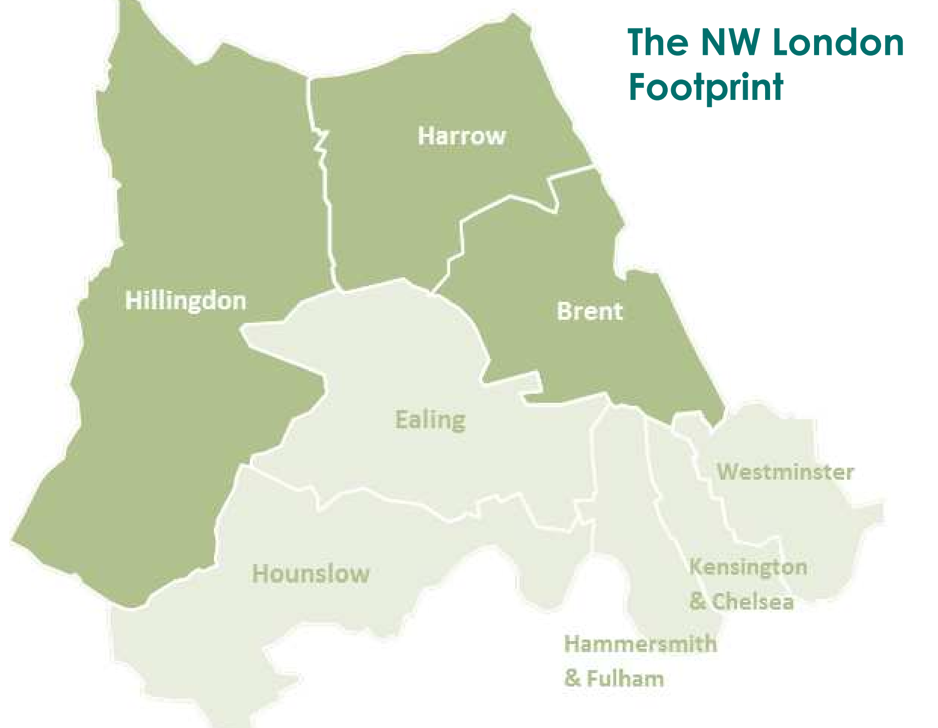
We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

### Areas with impact in 2016/17

| Delivery area | What we will achieve | Impact |
|---|---|---|
| DA1 | i. 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<br>ii. 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 | i. A shared understanding of public and professional responsibility for use of services<br>ii. Maximising opportunities working jointly to support people with mental health problems, resulting in benefits to the health system and wider local economy |
| DA2 | i. Increased accessibility to primary care through extended hours and via a variety of channels (e.g. digital, phone, face-to-face)<br>ii. Enhanced primary care with focus on providing more proactive and co-ordinated care to patients<br>iii. Comprehensive diabetes performance dashboard at practice and CCG level<br>iv. Delivery of Patient Activation Measure Year 1 targets as part of the self care framework | i. Delivering extended access for Primary Care, 8am – 8pm, 7 days a week, leading to additional appointments available for patients out of hours, every week, as well as a reduction in NELs and A&E attendances<br>ii. Unique, convenient , efficient and better care for patients as well as supporting sustainability and delivering accountable care for patients<br>iii. Improve health and wellbeing of local diabetic population<br>iv. Enable more patients with an LTC to self-manage |
| DA3 | i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17<br>ii. Training and support to care homes to manage people in their last phase of life<br>iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service<br>iv. 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]<br>ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10]<br>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<br>iv. 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)<br>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]<br>ii. Reduction in crisis contacts in A&E for circa 200 young people |
| DA5 | i. Joint safer staffing programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure<br>ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely<br>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<br>ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13]<br>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] |

# 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 £1.4bn 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

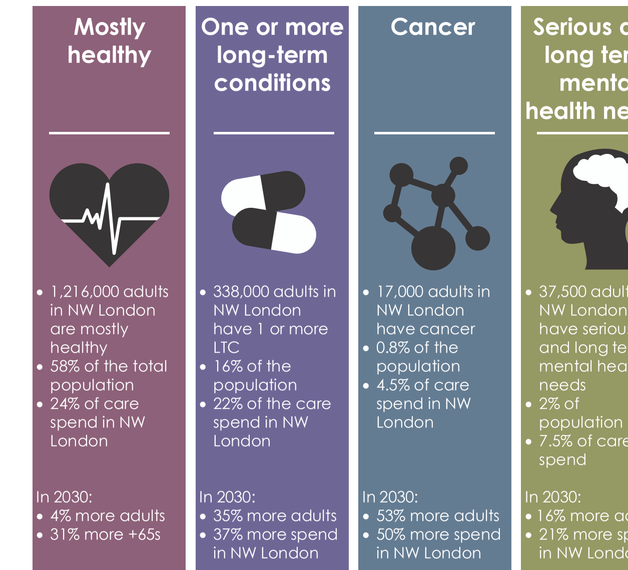
# 1. Case for Change:
## Understanding our population

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 | 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 |
|---|---|---|---|---|---|---|---|---|
| • 1,216,000 adults in NW London are mostly healthy<br>• 58% of the total population<br>• 24% of care spend in NW London | • 338,000 adults in NW London have 1 or more LTC<br>• 16% of the population<br>• 22% of the care spend in NW London | • 17,000 adults in NW London have cancer<br>• 0.8% of the population<br>• 4.5% of care spend in NW London | • 37,500 adults in NW London have serious and long term mental health needs<br>• 2% of population<br>• 7.5% of care spend | • 7,000 adults in NW London have learning disabilities<br>• 0.3% of the population<br>• 8% of care spend in NW London | • 21,000 adults in NW London have severe physical disabilities<br>• 1% of the population<br>• 18% of care spend in NW London | • 5,000 adults in NW London have advanced dementia<br>• 0.2% of the population<br>• 2% of care spend in NW London | • 438,200 children in NW London<br>• 21% of the population<br>• 14% of care spend in NW London | • Westminster has the highest recorded population of rough sleepers of any local authority in the country<br>• There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs |
| In 2030:<br>• 4% more adults<br>• 31% more +65s | In 2030:<br>• 35% more adults<br>• 37% more spend in NW London | In 2030:<br>• 53% more adults<br>• 50% more spend in NW London | In 2030:<br>• 16% more adults<br>• 21% more spend in NW London | In 2030:<br>• 29% more adults<br>• 35% more spend in NW London | In 2030:<br>• 29% more adults<br>• 26% more spend in NW London | In 2030:<br>• 40% more adults<br>• 44% more spend in NW London | In 2030:<br>• 6% more children<br>• 3% more spend in NW London | |

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.

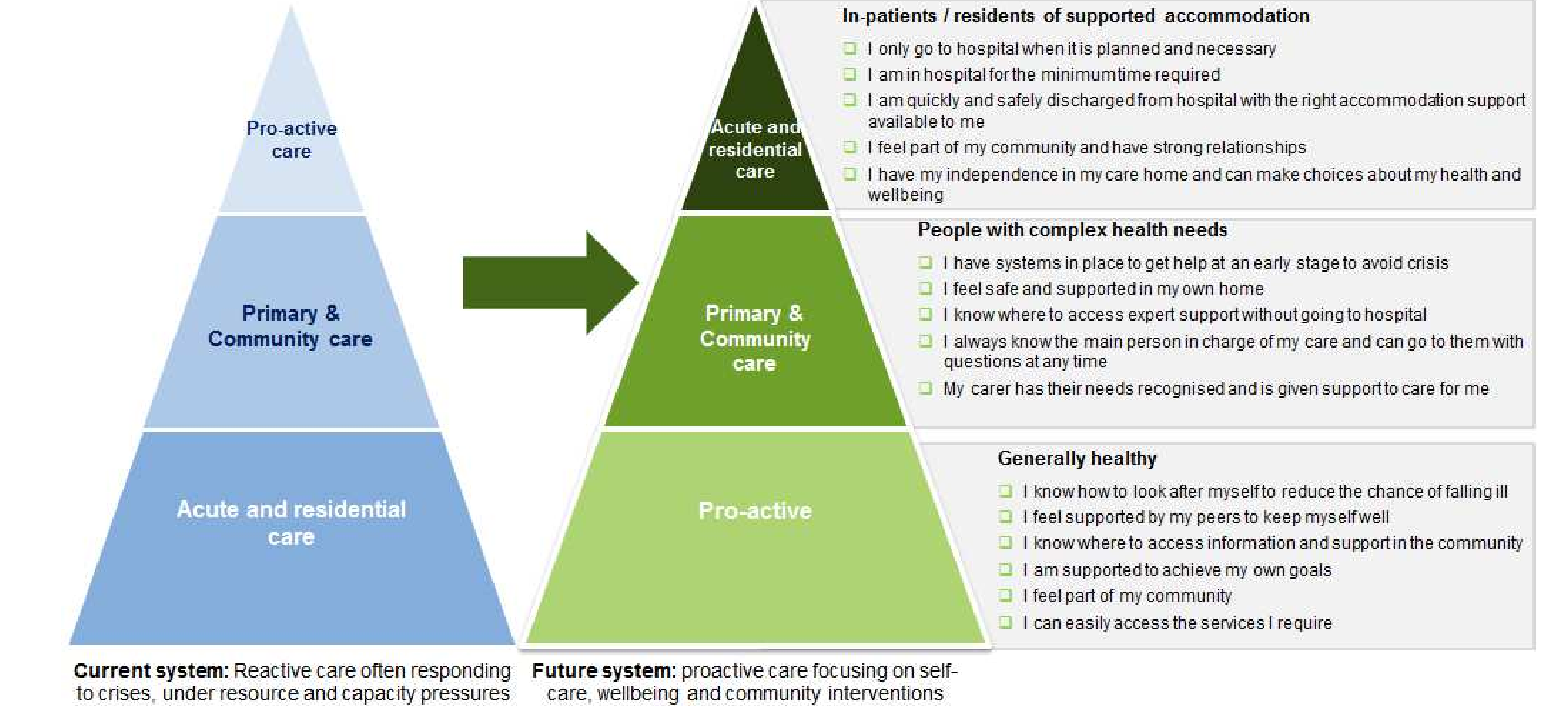
*Please note that segment numbers are for adults only with the exception of the children segment*

# 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)

Hillingdon
Harrow
Brent
Ealing
Westminster
Kensington & Chelsea
Hounslow
Hammersmith & Fulham

- **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… | Our to-be… | Our Priorities |
|---|---|---|
| 20% of people have a long term condition. 25% of people with depression and anxiety never access treatment. 13-24% of adults are obese. Only half of NW Londoners eat 5 or more portions of fruit and veg per day | 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 | 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 |
| 1 in 5 of children aged 4-5 years are overweight. 5-8% of children have conduct disorder. 1.5% of children under 5 have tooth decay, compared to 0.9% nationally. 10-28% of children are living in households with no adults in employment | 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 | 2 Improve children's mental and physical health and well-being |
| **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.** | 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. | 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 |
|---|---|---|
| 50% of people over 65 live alone. 69% of carers and 61% of social care users don't have as much social contact as they would like. There are evidenced risk factors for mental illness, especially for those with LTCs – including adversity such as debt, violence and abuse – as well as loneliness and isolation. | People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health and preventing escalation of mental health needs | 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 circa 20 years less than the average and the number of people in this group in NW London is double the national average.** | People are supported 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**.

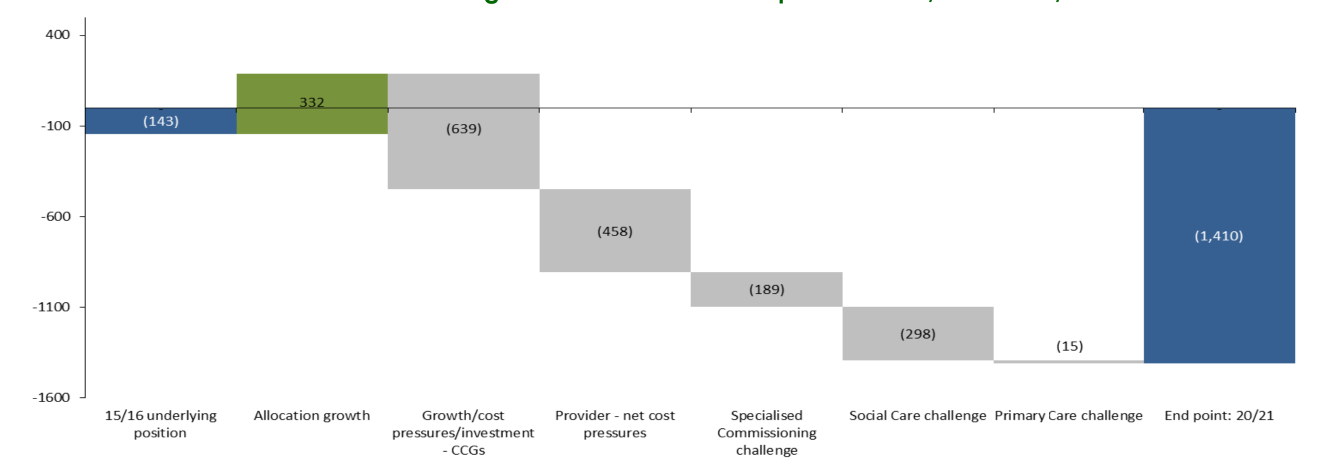
**Specialised**

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 £1,113m funding gap by 20/21 with a further £297m gap in social care, giving a system wide shortfall of £1,410m.

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.




**Profile of the 'Do Nothing' financial challenge by organisation outturn 17/18 to 20/21**

| Sector | 17/18 | 18/19 | 19/20 | 20/21 |
|---|---|---|---|---|
| | £'m | £'m | £'m | £'m |
| Providers | (403) | (493) | (579) | (661) |
| CCGs | (77) | (140) | (198) | (248) |
| Spec Comm | (44) | (90) | (138) | (189) |
| Primary Care | (1) | (12) | (19) | (15) |
| **Total NHS** | **(525)** | **(735)** | **(934)** | **(1,113)** |
| Social Care | (74) | (148) | (223) | (297) |
| **Total Health & Social Care** | **(599)** | **(883)** | **(1,157)** | **(1,410)** |

# 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.

| Triple Aim | | Our priorities |
|---|---|---|
| Improving health & wellbeing | 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 |
| Improving care & quality | 4 | Reduce social isolation |
| | 5 | Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease |
| | 6 | Ensure people access the right care in the right place at the right time |
| Improving productivity & closing the financial gap | 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 |
| | 8 | Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population |
| | 9 | Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed |

Primary Alignment*

| Delivery areas (DA) | Target Pop. (no. & pop. segment) | Net Saving (£m) | Plans |
|---|---|---|---|
| **DA 1** Radically upgrading prevention and wellbeing | All adults: 1,641,500<br>At risk mostly healthy adults: 121,680<br>Children: 438,200<br>Learning Disability: 7,000<br>Socially Excluded | 11.6 | a. Enabling and supporting healthier living for the population of NW London<br>b. Keeping people mentally well and avoiding social isolation<br>c. Helping children to get the best start in life |
| **DA 2** Eliminating unwarranted variation and improving LTC management | LTC: 347,000<br>Cancer: 17,000<br>Severe Physical Disability: 21,000 | 13.1 | a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care<br>b. Improve cancer screening to increase early diagnosis and faster treatment<br>c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions<br>d. Reducing variation by focusing on Right Care priority areas<br>e. Improve self-management and 'patient activation' |
| **DA 3** Achieving better outcomes and experiences for older people | +65 adults: 311,500<br>Advanced Dementia/ Alzheimer's: 5,000 | 82.6 | a. Improve market management and take a whole systems approach to commissioning<br>b. Implement accountable care partnerships<br>c. Upgraded rapid response and intermediate care services<br>d. Create an integrated and consistent transfer of care approach across NW London<br>e. Improve care in the last phase of life |
| **DA 4** Improving outcomes for children &adults with mental health needs | 482,700<br>Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability | 11.8 | a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy<br>b. Focussed interventions for target populations<br>c. Crisis support services, including delivering the 'Crisis Care Concordat'<br>d. Implementing 'Future in Mind' to improve children's mental health and wellbeing |
| **DA 5** Ensuring we have safe, high quality sustainable acute services | All: 2,079,700 | 208.9 | a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services<br>b. Deliver the 7 day services standards<br>c. Reconfiguring acute services<br>d. NW London Productivity Programme |

* *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

**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. We will support positive choices through sexual health service transformation. Our residents who have a learning disability are also sometimes not receiving the full 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:

- Developing a number of cross cutting approaches which will amplify the interventions described below and overleaf – embedding Making Every Contact Count and supporting national campaigns being 2 such examples.
- Interventions that are focused on **keeping our whole population well** 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 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].
- Targeted work with the population who **need mental health support** – the mortality gap is driven largely through unhealthy lifestyles and barriers to accessing the right support. We will work to address the wider determinants of health, such as employment and housing, where there is good evidence of impact. Social isolation, whether older people, single parents, or people how need mental health support affects around 200,000 people in NW London and 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].
- 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].

# 2. Delivery Area 1:
# Radically upgrading prevention and wellbeing

## What we will do to make a difference

A number of cross cutting approaches and new ways of working will support activity in this area and through working across health and social care, with public health leadership will help increase our ability to deliver the interventions and outcomes described below:

- Embedding principles of Making Every Contact Count in all services commissioned across Delivery Areas 1-5
- Supporting and publicising national campaigns and work such as on cancer prevention, mental health stigma and self care

| | To achieve this in 2016/17 we will… | …and by 2020/21? | Investment (£m) | Gross Saving (£m) |
|---|---|---|---|---|
| A Enabling and supporting healthier living – for the population of NWL | Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices.<br>• 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.<br>• 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:<br>• Introducing measures to reduce alcohol consumption and associated health risks as well as learn from and implement the output from prevention devolution pilots across London<br>• Implement NW London wide programmes for physical activity for adults<br>• Widespread availability of Long Acting Reversible contraception in GP services, maternity and abortion services and early services for early pregnancy loss | 3.5 | 9 |
| B Keeping People Mentally Well and avoiding Social Isolation | The healthy living programme plans will also cover how Boroughs will address social isolation, building on current local work:<br>In 16/17, local government already plans to deliver some interventions, such as:<br>• 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<br>• 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<br>Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability<br>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 | 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:<br>• Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes<br>• 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<br>Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda<br>Provide digitally enabled support to people , including Patient Reported Outcome Measures (PROMs), online communities, digital engagement via online and apps (especially for young people), social prescribing and sign posting to relevant support<br>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<br>Target smoking cessation activities at people with mental illness to support reducing ill-health as a consequence of tobacco usage. | 0.5 | 6.6 |
| C Helping children to get the best start in life | • Implement the prevention priorities within the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services – especially in schools – as part of a wider new model of care<br>• 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<br>• 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. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas. Improving the strength and sustainability of primary care is critical in tackling unwarranted variations and improving LTC management and outcomes. Taking action on the key SCF areas of proactive and co-ordination will equip primary care to do so.
- 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].
- Children and young people with special education needs and disabilities are a vulnerable group that can require access to specialist support, often delivered by multi-agency services. Implementing CCG responsibilities for SEND under the Children & Families Act 2014 is therefore a NW London priority.

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 | **Delivering the Strategic Commissioning Framework and Five Year Forward View for Primary Care** | • For Accessible care:<br>  • provide extended access specs with quantification of reduced attendances and admissions<br>  • Deliver affordable access solutions for the 8-8, 7 day requirements<br>  • Create minimum standards for appointment requirements<br>  • Achieve accessible read/write patient records<br>  • Deliver operational access and a communications programme for patients, key providers and stakeholders<br>  • Align extended access provision with urgent care and 111<br>• For Co-ordinated care:<br>  • define key features for primary and integrated care teams and deliver consistent outcomes for care team models across NW London<br>  • Deliver consistent outcomes for care team models across NW London<br>  • Agree targeted population within CCG as priority for co-ordinate care management across NWL<br>  • Design standard approach to risk stratification and case finding across NWL. Maximise use of WSIC dashboard to monitor patients and case find<br>  • Define core intervention for care teams for core population<br>  • Define roles that the care team will carry out daily with patients<br>• For Proactive care:<br>  • finalise key outcome measures for preventive care in LTC<br>  • Develop two clinical pathways (including diabetes) and test against provider-models and outcome-measures<br>  • Define key outcome measures for needs-based client groups (adults) and explore gap-analysis locally<br>  • All eight CCGs supported in implementation of Patient Activation Measure (PAM) programme with target patients receiving PAM assessment and tailored approach to self-care<br>• Support CCGs to deliver their GP Access Fund objectives with a consistent and systematic approach, including delivery of the Extended Primary Care Service providing significantly higher levels of access to NW London residents<br>• Continue to support the development of federations, enabling the delivery of primary care at scale<br>• Host workshops and service-user survey in key geographical areas, building on existing Healthwatch, Patient Participation Group and Lay Partner Advisory Group priorities (e.g. to review I-statements and test outcome measures)<br>• Develop two clinical pathways (diabetes, atrial fibrillation) and test against provider-models and outcome-measures<br>• Identify four to eight geographical areas to test the draft pathways against the defined outcomes with pilot clinical teams<br>• Review of key pressure-points in clinical working day | • Fully implement the primary care outcomes within the SCF in each of the eight boroughs and across NW London<br>• Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working<br>• Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers<br>• Deliver this range of co-ordinated and population-based care through a system of networked hubs, with facility for both physical and digital access by patients, including services for people with dementia<br>• Enable general practices and multi-disciplinary hubs to access and share digital patient records, including crisis care-plans and LTC pathway management<br>• Provide access to a spectrum of care, for appropriate population-based interventions for urgent LTC and on-going care needs<br>• Ambulatory and emergency care schemes in place<br>• Develop relevant LTC clinical pathways in light of co-ordinated and proactive care experience | 18 | 26.4 |

# 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) |
|---|---|---|---|---|
| **B C** **Improve cancer screening to increase early diagnosis and faster treatment** | Our Primary Care Cancer Board will take the learning from Healthy London Partnership's (HLP) 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:<br>• Share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful.<br>• 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 to ensure sufficient capacity within NW London.<br>• Roll out improved information regarding patient choice and 2 week wait to support patients referred from primary care with suspected cancer<br>• Implement straight to test endoscopy at Imperial, Ealing, Northwick Park and Hillingdon hospitals.<br>• Begin to work with the voluntary sector to research primary care learning from Significant Event Audits<br>• Work with Trusts to create more effective and efficient inter Trust referrals to support the delivery of national standards. | In partnership with Healthy London Partnership' s Transforming Cancer Programme and the Royal Marsden and Partners Cancer Vanguard, we will develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London,<br>These actions will reduce variation in acute care and ensure that patients have effective, high quality cancer care wherever they are treated in NW London. | TBC | TBC |
| **D** **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<br>• 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<br>• Ensure at least 25% of people needing to access physiological therapies are able to do so | TBC | TBC |
| **Reduce variation by focusing on 'Right Care' priority areas** | • Three key areas identified to be the largest priority to focus on at sector-wide level: diabetes prevention, atrial fibrillation and reducing hypertension<br>• Identified and/or commenced work in 2016/17 in following areas:<br>  • Mobilisation of National Diabetes Prevention Programme<br>  • Comprehensive diabetes performance dashboard at practice and CCG level<br>  • Comprehensive referral process for patients with non-diabetic hyperglycaemia into the National Diabetes Programme<br>• Aside from these three deliverables, each CCG will be addressing the issues that cause the most unwarranted variation in care in their locality<br>• 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. Brent and Harrow have are also national 1st wave delivery sites and are focussing on diabetes and MSK. | • Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools<br>• Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes<br>• Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations<br>• 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<br>• Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs<br>• 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 |

# 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) |
|---|---|---|---|---|---|
| E | Improve self-management and 'patient activation' | • Develop protocols for approved health apps to support self-care in collaboration with Digital Health London<br>• Develop a package of evidence and case studies to support local areas to adopt innovative approaches such as AliveCor, a digital device being rolled out by Hounslow GPs which uses smartphones to detect Atrial Fibrillation in patients<br>Develop best practice approaches to online-management solutions<br>• Host NW London symposium series, commencing with Activating the Workforce in November<br>• Support delivery of IG Governance toolkit L2 compliance within targeted CCG and develop case study for wider support.<br>• Development of Third sector programme framework, supporting development of the voluntary sector infrastructure to support self-care<br>• Patient Activation Measurement (PAM) programme implemented across NW London with target patients receiving assessment and tailored approach to self-care (target 43,920 patients). Self-Care programmes delivered in NW London to be aligned to PAM levels, supporting a tailored approach to self-care and a NW London mental health and wellbeing guidance to PAM levels to be developed. | • Full delivery of Self-Care framework across NW London<br>• NW London workforce supported by embedded self-care training programmes<br>• Technology, including online management solutions, in place to support self-management and health education for people with LTCs<br>• PAM embedded across health and social care supporting tailoring of care for all people with LTC (target 428,700 patients)<br>• Third Sector fully integrated within Accountable Care Partnerships with single point of access and geographically based consortiums<br>• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be offered access to expert patient programmes<br>• Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time<br>• Pro-active identification of patients by GP practices who would benefit from co-ordinated care and continuity with a named clinician to support them with LTCs<br>• Increase availability of, and access to, personal health budgets, taking on integrated personal commissioning approach, including building on good practice from within and outside NW London around the use of brokerage to manage access to such personalised services | 3.4 | 6.2 |

# 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

*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.*

**2020/2021**

Target Population: 311,500

Contribution to Closing the Financial Gap: £72.1m

- **Over 30% of people in a[...] their needs met more eff[...] 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.<br>• 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 partnerships<br>• 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 Partnerships, with joint agreement about the model of integration with local government commissioned care and support services<br>• 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 | **Upgraded 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:<br>• Identify the best parts of each model and move to a consistent specification as far as possible by identifying opportunities and agreeing transformational improvements to NW London models, either locally or NW London-wide<br>• Improve the rate of return on existing services, reducing NEL admissions and reducing length of stay<br>• Enhance integration with other service providers<br>• Establish an older people's reference group to guide this work<br>• Agreed the older person's pathway across community, acute and last phase of life<br>• Agreed areas for standardisation across NW London for IC/RR and acute frailty<br>• Agreed outcomes and standards for intermediate care function and acute frailty | • Use best practice model across all eight boroughs, creating standardisation wherever possible to enable additional capacity to decrease the inappropriate time that a person is cared for in an institutional setting<br>• Operate rapid response and integrated care as part of a fully integrated ACP model | 20.2 | 64.9 |
| D | **Create an integrated and consistent transfer of care approach across NW London** | • Agree an integrated health and social care model to improve transfer of care<br>• Implement a single needs-based assessment to support appropriate transfer of care 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<br>• Move to a 'trusted assessor' model for social care assessment and transfer of care across NW London | • Eliminate the 2.9 day differential between in borough and out of borough length of stay<br>• Transfer of care correspondence is electronic with the single assessment process built into the shared care records across NW London<br>• Fully integrated health and social care transfer of care process for all patients in NW London | 7.4 | 9.6 |
| E | **Improve care in the last phase of life** | • Improve identification and planning for last phase of life;<br>- 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'<br>- identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning<br>- patient initiated planning to help patients to self-identify<br>• Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want<br>• 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<br>• 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.<br>• Meet national upper quartile of people dying in the place of their choice<br>• 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

**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. The NW London STP has mental health threaded throughout our delivery areas – within prevention and within work on long term conditions. But we know that focus is also required as 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 – and the outcomes described in the implementation guidance are reflected in our plans[2].

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 impacted by their condition and **10% will commit suicide**
- 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 the age of 18 .
- 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 – thresholds to access services can be barriers to access care – and stigma remains a challenge for many people – and in particular within some communities,

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

- Implementing a new model of care for adults 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 the very specific needs that relate to some of our populations – such as for people with learning disabilities (through the Transforming Care Partnership) and for new mothers
- 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 – building on current Early Intervention in Psychosis and Liaison Psychiatry services.
- Implementing 'Future in Mind' 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[3].

- 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 through locally commissioned services – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training<br>• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes<br>• 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<br>• Rapid access to evidence based Early Intervention in Psychosis for all ages<br>• More support available in primary care through locally commissioned services | • Full roll out of the new model across NW London providing tailored evidence based support available closer to home to service users and carers, which will include:<br>  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support<br>  • Comprehensive self management and peer support for all ages<br>  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation<br>  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community<br>Living a Full and Healthy Life in the community → Coordinated Community, Primary and Social Care → Specialist Community based support → Urgent/crisis care to support stabilisation → Acute inpatient admissions | 11 | 16 |
| B | **Focussed interventions for target populations** | • Targeted employment services for people with serious and long term health needs to support maintaining employment<br>• Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs<br>• Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach<br>• Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams<br>• Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements | • Provide vulnerable individuals and their families with best practice support<br>• Employment support embedded in integrated community teams<br>• 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<br>• Implement digital tools to support people in managing their mental health issues outside traditional care models<br>• Specialist community perinatal treatment available to all maternity and paediatric services and children centres<br>• Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care | 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), Metropolitan police and other services – meeting access targets<br>• Round the clock mental health teams in our A&Es and support on wards, progress towards 'core 24'<br>• Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service) | • Ensure care will be available for service users and carers when they most need it through:<br>  • Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery<br>  • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis | 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<br>• 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<br>• Digital enablement to share information between care settings to support new care models<br>• 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
- Ensure all patients receive prompt treatment in accordance with the national referral to treatment (RTT) standards,
- Consolidate acute services onto five sites (the local government position on proposed acute changes is set out in Appendix A)
- 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.<br>• 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).<br>• 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.<br>• Be an active partner in the 'Like Minded' Programme | To have worked with partners in NW London and strategically across London to:<br>• 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.<br>• 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.<br>• 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:<br>• develop evidence-based clinical model of care to ensure:<br>  - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital<br>  - on-going review by consultant every 24 hours of patients on general wards<br>• 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<br>• 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:<br>• Patient Experience<br>• MDT Review<br>• Shift Handover<br>• Mental Health<br>• Transfer to community, primary & social care<br>• Quality Improvement<br><br>We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will:<br>• Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network<br>• Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care<br>• 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<br>Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units<br>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.<br>Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016<br>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<br>Fully deliver on the vision for maternity set out in *Better Births* national maternity review – through our 15/16 reconfiguration programme we have already made significant progress delivering this vision for maternity. In 16/17 we will focus on providing continuity of care for women, so that maternity care is provided by a small team of midwives during the antenatal, intrapartum and postnatal period. | Reduce demand for acute services through investment in the pro active out of hospital care model, enabled by investment in the Hubs. Develop the hospital in Ealing and jointly shape the delivery of health and social care provision of services from that site, including:<br>• a network of ambulatory care pathways<br>• a centre of excellence for elderly services including access to appropriate beds<br>• an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs<br>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.<br>Deliver on the full recommendations set out in *Better Births* national maternity review, in order to achieve joined-up, sustainable continuity of care for women in NW London. | 33.6 | 89.6 |
| D | **NW London Productivity Programme** | A Chief Transformation Officer has been appointed to lead a collaborative transformation programme across all NHS Trusts in NW London and a team of interim senior programme directors have been appointed. By the end of 16/17 we will agree and resource a sustainable team to ensure these priorities are delivered. This is a big ticket cost reduction transformation programme within the STP and we should secure investment proportionate to the costs savings.<br>Implement and embed the NW London productivity programme across all provider NHS trusts, focusing on the following four areas:<br>• **Orthopaedics**: mobilise 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) to reduce unwarranted variation and increase efficiency, thus generating both quality improvements and financial savings. Ensure all Acute Providers in North West London have agreed Best In Sector Performance Metrics and establish a NW London dashboard. Agree priorities and interventions and commence delivery.<br>• **Procurement**: deliver £3m of immediate tactical non-pay savings. Agree plan to reduce unwarranted variation in NHS supplies prices, and make £15.2m savings in non-pay spend. Develop options and agree a NW London operating model, in line with best practice and Carter and identify any structural changes required to the way procurement is currently delivered. , Establish common procurement competencies and staff development plan. Ensure robust plans in place with ownership from Procurement leads, CFOs and clinical lead and identify any investment required.<br>• **Safer Staffing**: Agree a three year delivery plan with trajectory of benefits and any required investment identified. Agree detailed proposal for reduction in agency costs via more effective staff bank, supported by technology. All e-nursing rosters agreed six weeks in advance and plan for medical roster implementation, benchmark and share all data.<br>• **Back Office**: this is **new and additional priority** agreed in September 2016. Deliver additional collaborative productivity opportunities. Agree priorities, geographic clusters and three year delivery plan with trajectory of benefits and any required investment identified. Integrated Procurement and Safer Staffing work within the wider Back Office plans. | Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together to deliver added value. **Rolling programme of pathway redesign and quality improvement initiatives to ensure trusts are consistently in the top quartile of efficiency (Getting It Right First Time principles).** Shared records is a key enabler of all pathway redesign.<br>• **Orthopaedics:** Implement plan agreed in 16/17. Agree a consolidated service model for a NWL collaborative elective Orthopaedic centre, agree a business case and implement subject to investment.<br>• **Identify and implement priorities for rolling programme following Orthopaedics.**<br>• **Procurement:** Implement a pan-NWL procurement operating model which is compliant with the National Interim Future Operating Model, Deliver Carter compliant Procurement Transformation Plans with quantified (and delivered) financial savings which all leads to Collaborative and shared service models in place for NWL procurement operating within a sustainable financial footprint assessed by improving year on year saving: cost ratios.<br>• **Safer Staffing:** build on work from 2016/17 such that rostering is optimised, bank fill rates are maximised and reliance on agency is minimised. (quantified benefits will emerge from 16/17 business case) Developed a workforce plan summarising the total workforce numbers and competencies required across NWL. Collective workforce planning and collaborative resourcing to include recruitment, development and retention with the right balance of permanent and flexible workers .<br>• **Back Office**: Implement priorities as described in business case. | 4.1* | 143.4 |

# 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

1. Radically upgrading prevention and wellbeing
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

### By 2020/21, Enablers will change the landscape for health and social care:

**Estates will…**

- Deliver **Local Services Hubs** to enable more services to be delivered in a community setting and support the delivery of primary care at scale
- 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
- **Improve and change our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care

**Digital will…**

- **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
- **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
- **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more involved in their own care
- **Provide people with tools for self-management and self-care,** enabling them to take an active role in their own care
- **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, through whole systems intelligence

**Workforce will…**

- **Target 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

# 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

Our model requires investment in the development of local hubs to enable the provision of integrated, co-located health care, social care and voluntary support across the eight local authority/CCG areas, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care.

NW London has developed and submitted a joint 'One Public Estate' bid 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.

A joint health and council estates group has been established to oversee the work and minimise gross spend through aligning health and local authority plans for regeneration and seeking innovative financial solutions to provide estate cost-effectively, realising value from surplus assets.

There has been significant local progress 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 £614m[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
  - The hub strategy and plans include community Mental Health services, such as IAPT
  - Hubs will support delivery of the GP 5 Year Forward View and are critical in enabling reconfiguration of acute services
  - Hubs will also help deliver the access and coordinated care aspects of the Strategic Commissioning Framework
- **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).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local Population
  - Trusts have developed proposals with the resultant capital requirement being presented in the Shaping a Healthier Future business case which is due to go to the NHSE investment committee for approval

## Key Impacts on Sustainability & Transformation Planning

**Delivery Area 1 - Prevention:**

- Local services hubs will provide the physical location to support integrated public health, prevention and out-of-hospital care delivered by health , social care and voluntary organisations.
- 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 day 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 appropriate bedded care

**Delivery Area 4 - Supporting those with mental health needs:**

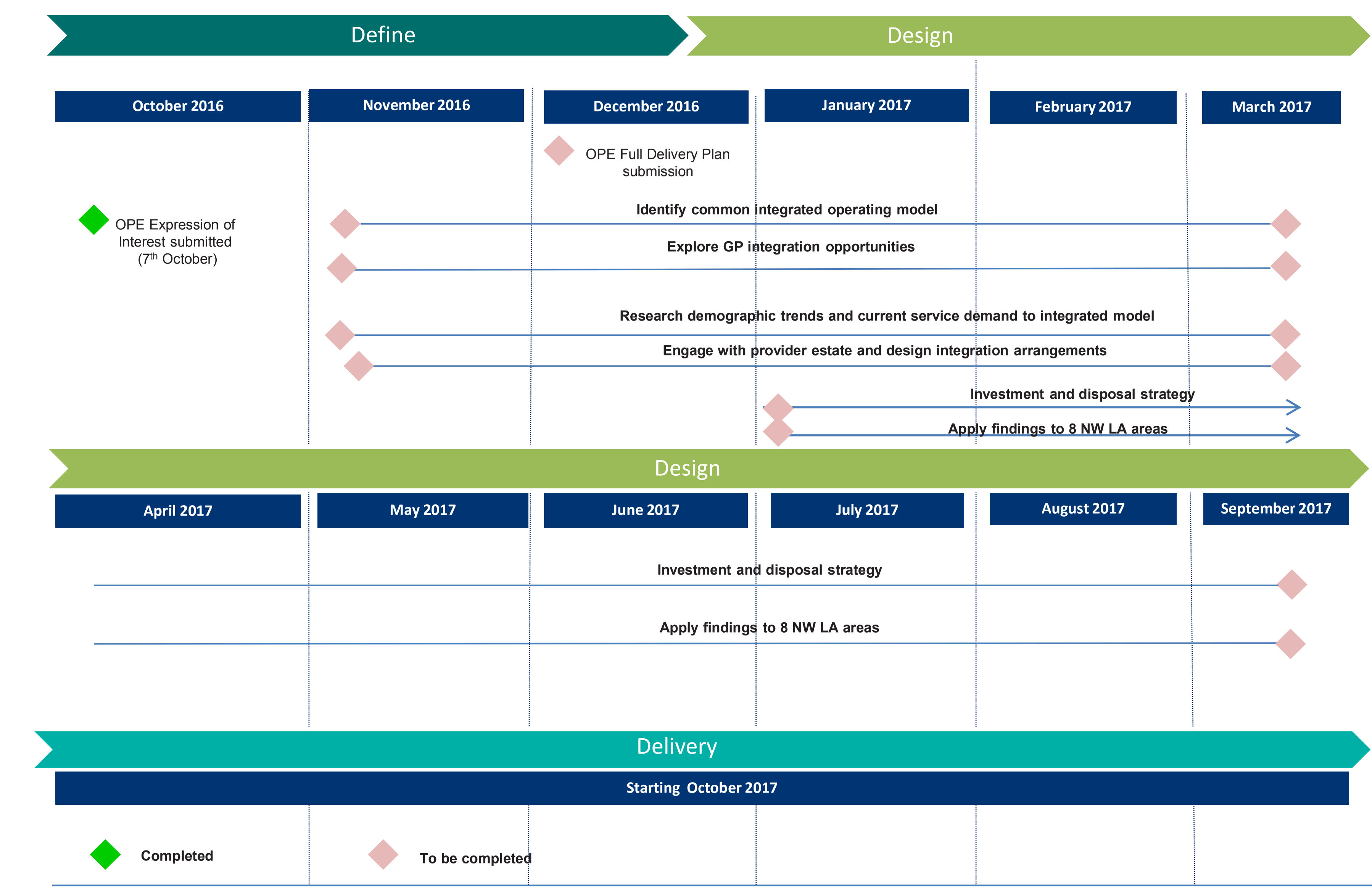
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting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

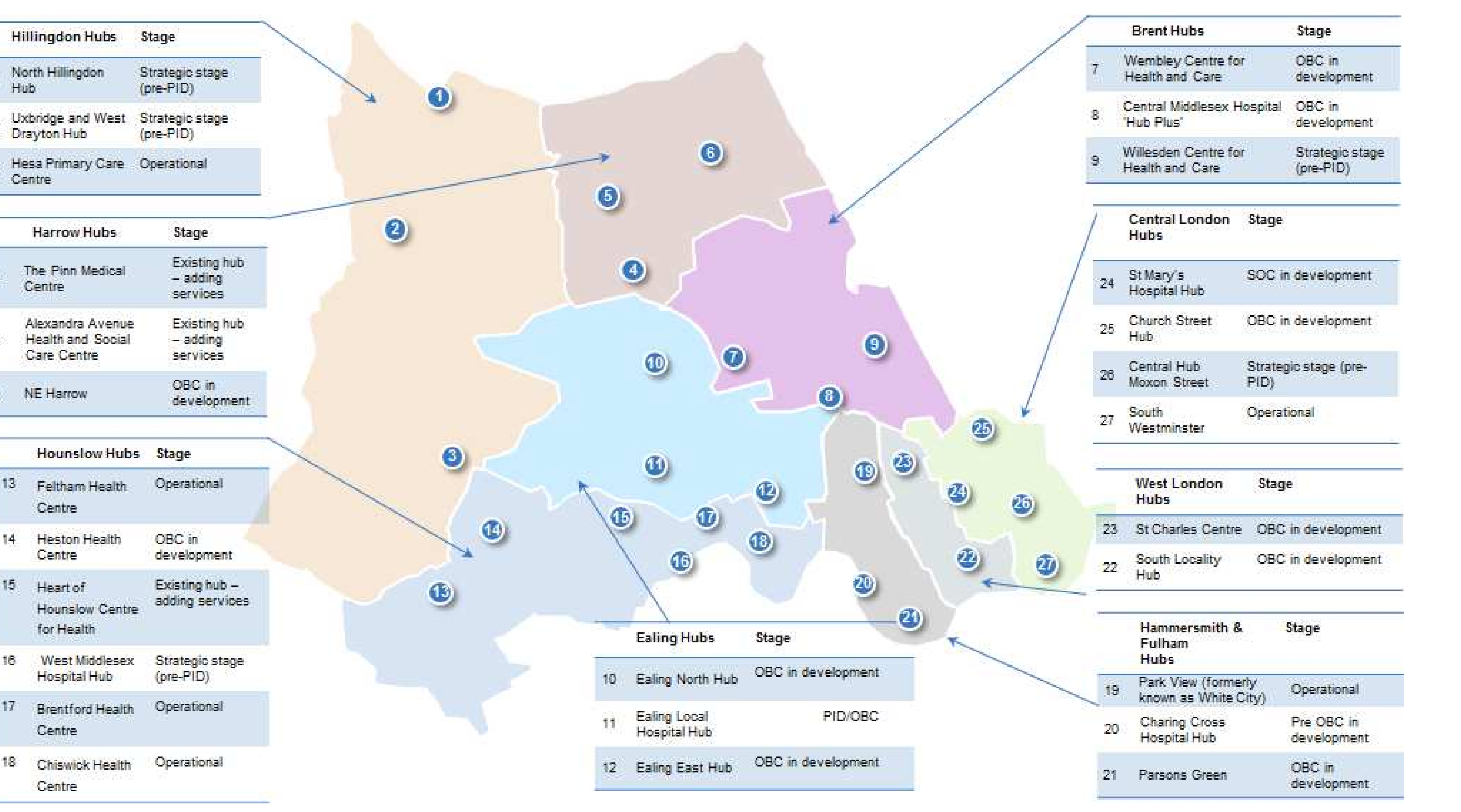
# 3. Enablers:
## Estates

### Estates Strategy to deliver Out of Hospital through One Public Estate (OPE) – High level timeline to Oct 2017



# 3. Enablers:
Estates

## Proposed Local Services Hubs map




| | Hillingdon Hubs | Stage |
|---|---|---|
| 1 | North Hillingdon Hub | Strategic stage (pre-PID) |
| 2 | Uxbridge and West Drayton Hub | Strategic stage (pre-PID) |
| 3 | Hesa Primary Care Centre | Operational |

| | Harrow Hubs | Stage |
|---|---|---|
| 4 | The Pinn Medical Centre | Existing hub – adding services |
| 5 | Alexandra Avenue Health and Social Care Centre | Existing hub – adding services |
| 6 | NE Harrow | OBC in development |

| | Hounslow Hubs | Stage |
|---|---|---|
| 13 | Feltham Health Centre | Operational |
| 14 | Heston Health Centre | OBC in development |
| 15 | Heart of Hounslow Centre for Health | Existing hub – adding services |
| 16 | West Middlesex Hospital Hub | Strategic stage (pre-PID) |
| 17 | Brentford Health Centre | Operational |
| 18 | Chiswick Health Centre | Operational |

| | Ealing Hubs | Stage |
|---|---|---|
| 10 | Ealing North Hub | OBC in development |
| 11 | Ealing Local Hospital Hub | PID/OBC |
| 12 | Ealing East Hub | OBC in development |

| | Brent Hubs | Stage |
|---|---|---|
| 7 | Wembley Centre for Health and Care | OBC in development |
| 8 | Central Middlesex Hospital 'Hub Plus' | OBC in development |
| 9 | Willesden Centre for Health and Care | Strategic stage (pre-PID) |

| | Central London Hubs | Stage |
|---|---|---|
| 24 | St Mary's Hospital Hub | SOC in development |
| 25 | Church Street Hub | OBC in development |
| 26 | Central Hub Moxon Street | Strategic stage (pre-PID) |
| 27 | South Westminster | Operational |

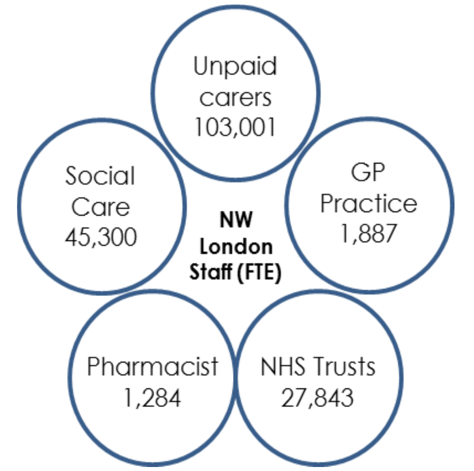
| | West London Hubs | Stage |
|---|---|---|
| 23 | St Charles Centre | OBC in development |
| 22 | South Locality Hub | OBC in development |

| | Hammersmith & Fulham Hubs | Stage |
|---|---|---|
| 19 | Park View (formerly known as White City) | Operational |
| 20 | Charing Cross Hospital Hub | Pre OBC in development |
| 21 | Parsons Green | OBC in development |

# 3. Enablers: Workforce

## Context

- Across NW London, our workforce is doing phenomenal, highly valued work. It will also be key to achieving our collective vision of improved quality of care through delivering sustainable new models of care that meet our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly to expand work across social care[1].
- Carers are also 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 to achieving our vision.
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- 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.
- Appropriate workforce planning and actively addressing workforce issues will, however, be instrumental in addressing the five delivery areas in the STP.




**The challenges our workforce strategy will address 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

## Achievements to date

### Workforce planning and addressing workforce shortages

- Developed Infrastructure for workforce planning and analytics
- Established annual workforce planning processes for acute healthcare professionals
- Extended workforce planning to cover primary care including new models of care such as the Cancer Vanguard
- Worked with Skills for Care and engaged with national project work to ensure integrated workforce planning for Social Care
- Invested in a team of 4 workforce planners to support primary care and integration. Work includes the Day of Care Audit designed to improve efficiency in General Practice
- Worked with the Healthy London Partnership to understand the demand and supply of staff in primary care and identified opportunities to close the gaps.
- Led a centralised Pan-London placement management and workforce development programme for paramedics with an investment of over £1.5m, contributing to increasing workforce supply and staff retention
- Utilised health education funding to ensure high quality education for medical trainees is on-going.

### Improving recruitment and retention

- With Capital Nurse we have started recruitment of 350 newly qualified nurses onto a rotational programme with educational and development support, this covers all NHS trusts in NW London as well as primary care. This investment will demonstrate the benefits of a rotational programme in improving retention rates and developing nurses within NW London to move on from their training to more senior nursing posts.
- We have programmes to improve the recruitment of nurses in general practice including a funded course with placements for nurse from outside of practice nursing to develop skills and experience to move into the sector. In 16/17 we have recruited 26 nurses across NW London.
- 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, 31started training in September, a further 15 will start in February 2017. 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, 95 paediatric nurses and 9 consultants paediatricians.

## Governance

Governance has been improved to deliver a comprehensive STP workforce strategy. This is supported by a strengthened collaboration between Health Education England and the CCG collaborative, local councils and other stakeholders. A CCG and HEE joint STP workforce team reports to a newly established Board that is co-chaired by the CCG, Social Care and HEE is a **key enabler** to delivery. This approach encompasses critical experience and expertise. It also maximises efficiency and ensures clinically led decision making and input from key stakeholders including health and social care providers, CEPNs (Community Education Providers Network) and the Healthy London Partnership.

**A new robust governance structure to deliver the STP workforce strategy**

Health and Care Transformation group
*Responsible for driving the delivery of the STP*

Workforce Transformation Advisory Council
*Stakeholder led vision setting and strategy development*

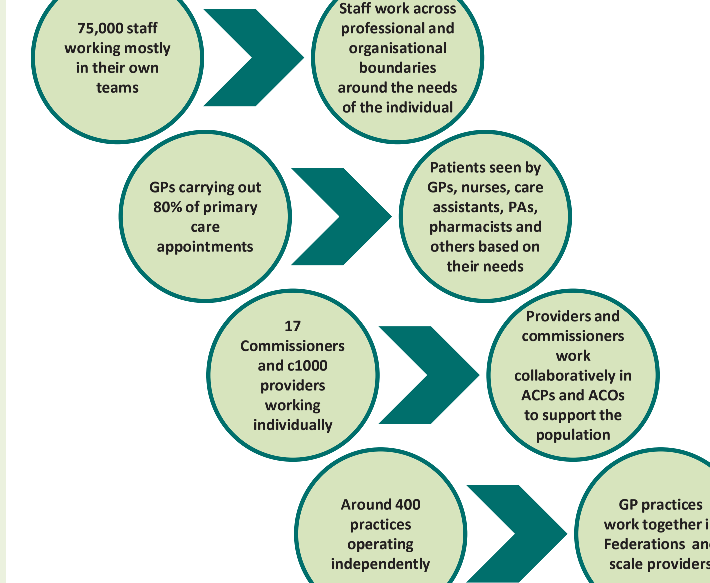
Workforce Transformation Delivery Board
*Delivering strategy, steering investment and resource*

SRO (Local Director HEE NWL)

Strategy & Transformation (CCG Collaborative)

Health Education England (NWL Team of HEE)

## What will be different in 2020[6]?



# 3. Enablers: Workforce

## Current Transformation Plans and Benefits

### Workforce planning and addressing workforce shortages

Effective workforce planning is essential for securing our future workforce, it underpins all further interventional activity and investment to support the workforce. We have the infrastructure in place to forecast shortages and develop plans to address them. This includes Primary Care and work is underway to ensure it covers new models of care such as the Cancer Vanguard. Critically this work will also include social care working with Skills for Care and through engagement and national project work.

### Improving recruitment and retention

Improving recruitment and retention across health and social care will be critical to closing the financial gap and addressing workforce shortages. Modelling in London and the south east shows £100.7 million could be saved in the next 10 years by retaining new staff for 1 extra year. Recruitment and retention issues lead to high use of agency staff costing £172m.

To reduce spend on agency we will control demand for bank shifts by improving rostering and encourage more staff to work through banks instead of agencies to reduce agency costs.

Delivering the improvements in CAMHS Eating Disorder services will require an increase in numbers of staff with these specialist skills , we know we will face competition for these staff. We will work with our Like Minded programme to make sure NW London is an attractive place to come and work to retain current staff and improve recruitment

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

Care in NW London will be delivered differently in 2021. Building on existing work we will support staff to work in new ways. To deliver the Strategic Commissioning Framework and the 10 point plan for Primary Care we will support workforce to improve productivity and build capacity in general practice and develop the whole care team. We will work with the Time for Care programme at an NW London level and develop local CCG plans based on local priorities and areas where the 10 High Impact Actions will have the greatest effect.

We have established the Change Academy. This is a collaborative programme across NW London to address workforce transformation, organisational development between providers and systems leadership. Through Change Academy High Performing Care programme we will support system change through high performing teams and improvement methodology underpinned by data enabled evidence-based decision-making. The scope of this programme will be multi-organisational change teams charged with delivery of STP on actual delivery issues in real time.

### Leadership and Organisational Development to support future services

We understand that effective leadership underpins the transformation we need to achieve in NW London. As part of the Change Academy there are programmes targeted at supporting leaders across health and care:

I. STP/SPG systems leadership
II. Joint commissioning skills development
III. Emerging GP leaders network
IV. Practice manager development programme

This work will support staff and carers across all settings through the changes required by the STP and to develop the right culture to make sure changes are successfully delivered.

## 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:**

- Using **£1.5m HEE funding** to support new models of care, self-care and LTCs
- Train up to 180 health and care professionals **to support self-care**
- Supporting 24 professionals to become **health coach trainers** to enable patients to take greater responsibility for their health
- Expand the programme in 2017/18 to develop carers as health trainers.
- Embed the NW London **Healthy Workplace Charter** to promote staff health and wellbeing initiatives and ambassadorship

**Delivery Area 2 - Reducing variation:**

- The seven day services programme is receiving an additional investment of £750K to trial new models of care and to further support the Radiography workforce.
- The Cancer Vanguard is being supported through instigating new project leads to drive evidence based service design

**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
- Delivery of the SCF and 10-pont plan for Primary Care through workforce transformation
- Consultant outreach into primary care
- CEPNs focused on developing the primary care and community workforce
- 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 were supported through an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.
- Using £600k of HEE funding to support the transformation of Serious and long term mental health and children and young people's mental health

**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 by improving recruitment and more effective rostering and thereby the cost of service

# 3. Enablers: Digital

### Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London CCGs, with good progress with Information Governance across care settings.
- Each of the eight CCGs has a single IT system across their practices, and six of the eight CCGs are implementing common systems across primary and community care.
- In the acute space, Imperial and Chelsea & Westminster have a strong track record with digital clinical systems and are working together on a common Electronic Patient Record. Imperial (with Chelwest) is expected to be nominated by NHS England as a Global Digital Exemplar and will provide leadership to the rest of the footprint in the provision of improved patient outcomes and enhanced business efficiencies.
- Digital technology will support Primary Care transformation with new models of care that support out of hospital Local Services, through shared records across care settings, including new GP provider networks/hubs and ultimately via Accountable Care Partnerships. Potential funding from the Estates & Technology Transformation Fund (ETTF) will help upskill the primary care workforce and encourage patients to use new digital channels to access care, and use digital tools to become more involved in their own care.
- The footprint has a good track record in delivery of shared records, e.g. the NW London Diagnostic Cloud. The NW London Care Information Exchange is under way, funded by the Imperial College Healthcare charity, to give patients and clinicians a single view of care across providers and platforms, and provide 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 in primary and community care. In the longer term, it is our ambition for the NWL Exchange to interface with the wider London Health and Care Information Exchange.
- There is good support from the NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London information exchange, record locator, and IG register.
- Imperial College Health Partners (ICHP), Academic Health Science Network (AHSN) for NW London, is working closely with local health and care partners to ensure that innovation plays a major part in achieving the goals set out in our STP. One example of this is the roll-out of the Intrapreneur programme which to date has enabled over 100 local executives and frontline clinicians to integrate innovation with their everyday role.

### Key Challenges

- There is a significant challenge for digital to transform current delivery models and enable new, integrated models of health and social care, shifting care out of hospitals through shared information between care settings and a reduced emphasis on traditional face-to-face care delivery.
- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access information about the patient[1]. This will be mitigated by sharing care records and converging with other footprints via national and pan-London NHS systems and capabilities (e.g. Summary Care Record, e-Referrals, Co-ordinate My Care, electronic discharges); and in the longer term addressed through the NW London Care Information Exchange and (for the 16% outside the footprint) a pan-London information exchange.
- Due to different services running multiple systems, achieving shared records is dependent on open interfaces, which primary and community IT suppliers have not yet delivered. This will require continued pressure on suppliers to resolve – in particular TPP and EMIS.
- 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 requested from NHSE to define and fund interfaces nationally.
- Clinical transformation projects are invariably costly and time consuming, which needs to be allowed for in the LDR plans
- Some citizens and care professionals have rising expectations for digital healthcare which we cannot deliver; for others, there is a lack of digital awareness and enthusiasm, requiring a greater push for communication around the benefits of digital solutions and education on how best to use them.

### Strategic Local Digital Roadmap (LDR) 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. **Enable Patient Access** through new digital channels and extend patient records to patients and carers to help them become more 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 own care
5. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, 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**
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education.
- **Digital Health** to leverage innovations such as remote monitoring, point of care and self-testing, mobile applications, interoperability of IT systems, big data analytics and AI.

The NW London Digital Programme Board will oversee delivery of the LDR, integrated with the governance of the STP.

# 3. Enablers: Digital

| STP Delivery Area | LDR Work Stream | Key Digital Enablers for Sustainability & Transformation Plan |
|---|---|---|
| 1. Radically upgrading prevention and wellbeing | • Tools for self-management and self-care<br>• Enable Patient Access<br>• Build a shared care record | **Deliver digital empowerment to enhance self-care and wellbeing:**<br>• Easier access for citizens to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients<br>• Innovation programme to find the right **digital tools** to: help people **manage their health and** wellbeing through digital apps of their choice, connected to clinical IT systems; **create online communities** of patients and carers; get children and young people involved in health and wellness<br>• **New digital channels** (e.g. online and video consultations) to help people engage more quickly and easily with primary care<br>**Embed prevention and wellbeing into the 'whole systems' model:**<br>• Support for integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care plans that are shared with patients and carers) |
| 2. Eliminating unwarranted variation and improving LTC management | • Automate clinical workflows and records<br>• Tools for self-management and self-care<br>• Build a shared care record<br>• Use dynamic data analytics | **Deliver digital empowerment by increasing patient engagement to better self-manage their LTCs:**<br>• Delivery of Patient Activation Measures (PAM) tool for every patient with an LTC to develop health literacy and informed patients<br>• Innovation programme to help people **manage their LTCs (conditions and interventions)** through digital apps of their choice, extending clinical systems to involve patients (e.g. SystmOne for diabetes) and potentially telehealth (e.g. wearable technology)<br>**Reduce variation**<br>• **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience<br>• Support for new models of multi-disciplinary care, delivered consistently across localities, through shared care records<br>• **Automation of clinical workflows and records**, particularly in secondary care settings, and support for new pathways and transfers of care through interoperability and development of a shared care record to deliver **integrated health and care records and plans** |
| 3. Achieving better outcomes and experiences for older people | • Enable Patient Access<br>• Build a shared care record<br>• Use dynamic data analytics | **Provide fully integrated service delivery of care for older people**<br>• **Shared clinical information and infrastructure** to support new primary care and wellbeing hubs and ACPs with clinical solutions<br>• Citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange, new digital channels** (e.g. online and video consultations)<br>• Support for a **single transfer of care** approach, and **new models** of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care (NW London and pan-London CIEs)<br>• **Integration of Co-ordinate My Care (CMC) for last phase of life plans** with acute, community and primary care systems; and promote its use in CCGs. through education and training and support care planning and management<br>• **Dynamic analytics** to plan and mobilise appropriate care models<br>• Whole Systems Integrated Care **dashboards** across 350 GP practices will deliver direct, integrated patient care |
| 4. Improving outcomes for children and adults with mental health needs | • Tools for self-management and self-care<br>• Build a shared care record<br>• Use dynamic data analytics | **Enable people to live full and healthy lives with the help of digital technology**<br>• Innovation programme supported by the AHSN and industry leaders to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities – for example Patient Reported Outcome Measures (PROMs); **create online communities** of patients and carers; get children and young people involved through apps<br>**Implement new models of care and 24/7 services where required**<br>• Support for **new models** for out-of-hours and inter-disciplinary care, such as **24x7 crisis support services** and **shared crisis care plans** to deliver the objectives of the Crisis Care Concordat, through shared care records<br>**Reduce variation**<br>• **Integrated care dashboards** and analytics to track consistency of outcomes and patient experience |
| 5. Ensuring we have safe, high quality, sustainable acute services | • Automate clinical workflows and records<br>• Enable Patient Access<br>• Build a shared care record | **Invest in digital technology in Hospitals**<br>• **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care.<br>• Support new models for out-of-hours care through **shared care records and the NWL diagnostic cloud**, such as 24x7 access to diagnostics, and pan-NW London radiology reporting and interventional radiology networks<br>• Better digital tools to ensure **optimisation of acute resources**, e.g. radiology Clinical Decision Support, referral wizards and decision support tools, greater use of NHS e-Referrals including Advice & Guidance capability<br>• Integrated **discharge planning and management**, and support for **acute-to-acute transfers**. through shared care records<br>• Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange (CIE)** to help them become expert patients<br>• **Dynamic analytics** to track consistency and outcomes of out-of-hours care<br>• **Partnership model for informatics delivery** that makes best use of specialist technology skills across organisations |

# 4. Primary Care

## Primary Care in the context of out of hospital transformation

The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (FYFV). In NW London, our STP sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans.

Our plans are for the development of integrated out of hospital care – Local Services – that will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be enabled to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital admissions. This will improve health and wellbeing and care and quality for patients.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London.

We will transform General Practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all, as set out in the Transforming Primary Care in London: a Strategic Commissioning Framework.

We will implement a substantial up scaling of intermediate care services, available to people locally, offering integrated health and social care teams outside an acute hospital setting.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP. Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

***'There is arguably no more important job in modern Britain than that of the family doctor'***

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

**We are determined that NW London succeeds.**

**Enhanced Primary Care:** Locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care, and co-ordination across key parts of the system against a single shared care-plan

**Self-Care:** Embedding the self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

**Upgrading Rapid Response and Intermediate Care Services:** delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

**Transfer of Care:** implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

# 4. Primary Care

## The local services landscape including primary care



Achieving an effective model of integrated out of hospital services is key to the delivery of the NW London STP. Within NW London, we have a highly diverse population, which is supported within Primary and Community Care by a mix of out of hospital services with varying levels of capacity.

We have achieved much since we began implementing Primary Care transformation across NW London in 2015, and Whole Systems Integrated Care in 2014, but we do not underestimate the remaining challenges. We now have Primary Care operating at-scale across NW London (diagram, bottom right). Our current plans for further transformation are underpinned by national and local policies and initiatives:

- **The 5 Year Forward View (5YFV)**

As part of our Local Services Transformation, we aim to tackle the triple gap identified in the 5YFV: Finance, Sustainability and Quality. All of our initiatives have had these priorities in the forefront of our planning, and are key components of NW London's STP.

- **The General Practice Forward View (GPFV)**

The GPFV sets out a plan, backed by a multi-billion pound investment, to stabilise and transform General Practice. The focus of the plan centres around workforce (incentivisation for recruitment and retention), workload (practice resilience) , infrastructure (estates and technology) and care redesign.

- **The Strategic Commissioning Framework (SCF)**

This is London's agreed approach to supporting the focus on Accessible, Proactive and Co-ordinated Care within Primary Care. Self-care is an integral part of proactive care contributing towards  Enhanced Primary Care offer.

- **The GP Access Fund (GPAF)**

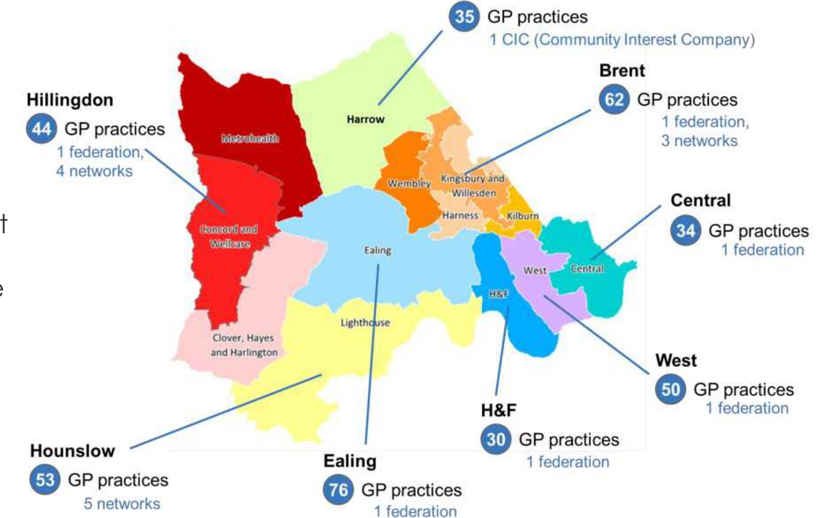
As part of the extended access aspects of Accessible Care, NW London will meet the extended access specifications by the end of Mach 2017, in order to better support our population to access Primary Care services more efficiently, at a time and place that suits them.

- **King's Fund and related reports**

Evidence based, national reports have indicated areas of focus for NW London. We have also utilised local knowledge from reviews and evaluation to assess our current status quo (blue box) and areas for development.

**In NW London, we have:**

- 1,093 GPs
- 473 practice nurses
- 273 clinical support staff
- Average list size 5,560
- GP and nurse workforce supply is the lowest in London
- 392 GP practices with 31 sites open at weekends
- 17 groups of GP providers
- 388 dental care practices
- 1,284 pharmacists
- Pharmacy and dental practice supply one of the best in London
- 5 different IC/RR services
- Multiple Single Points of Access (SPAs)
- Many care homes, often in disparate locations
- Differing provision of bedded and non-bedded care across NW London



# 4. Primary Care: CCGs have agreed to support Primary Care providers in delivering a clear set of standards over the next five years, in support of our vision

| Proactive care | |
|---|---|
| Co-design | Work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve health and wellbeing |
| Developing assets and resources to improve health and wellbeing | Work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected and supported |
| Conversations focused on individual 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 | Enable and assist people to access (inc. in schools, community and workplaces) information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. |
| Patients not accessing Primary Care services | Design ways to reach people who do not routinely access services and may be at higher risk of ill health. |

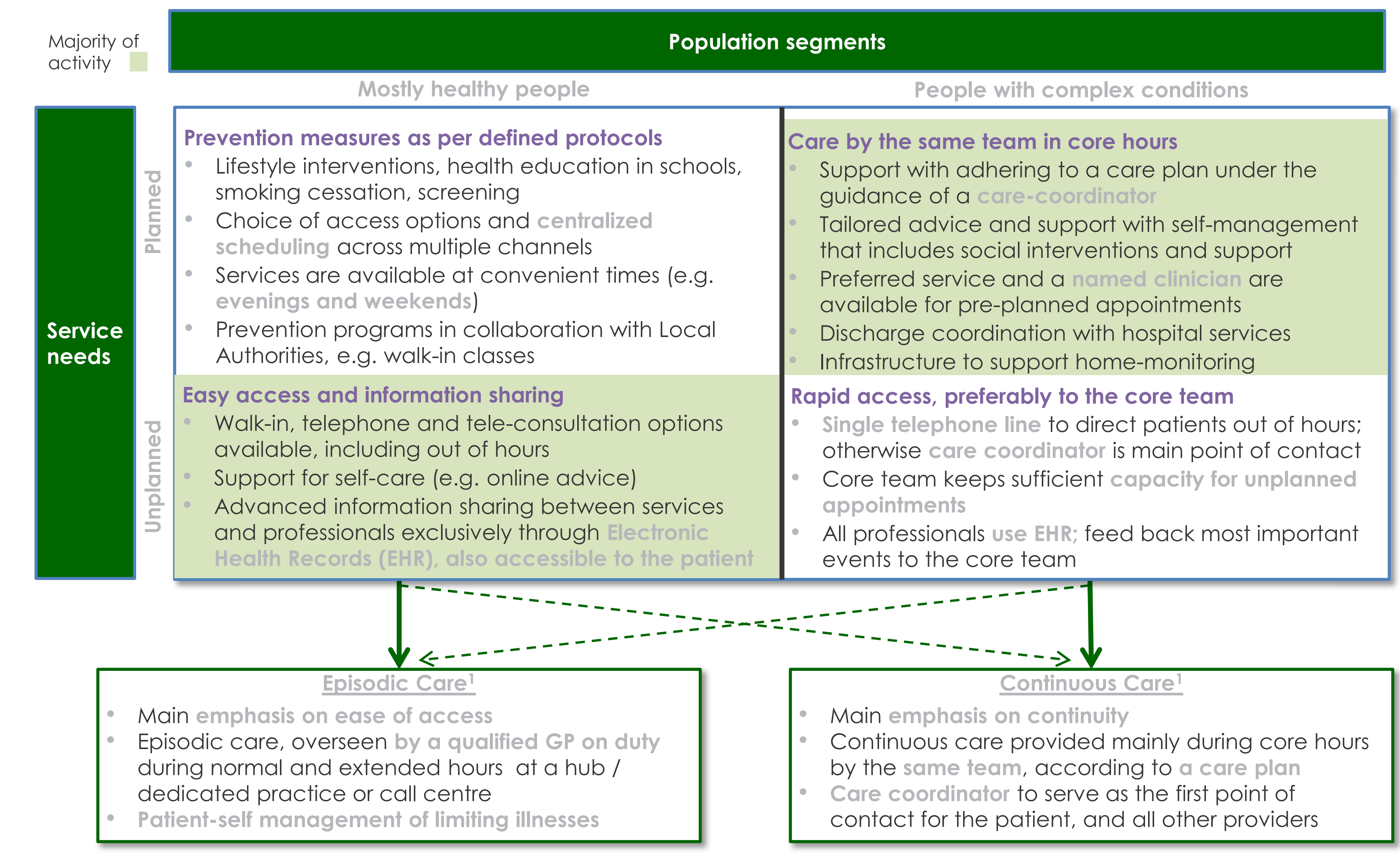
| Accessible care | |
|---|---|
| Patient choice | Patients have a choice of access (e.g. face-to-face, email, telephone, video) |
| Contacting the practice | Patients make one call, click, or contact to make an appointment. Primary care teams will actively promote online services to patients (inc. appointment booking, viewing records, prescription ordering and email consultations) |
| Routine opening hours | Patients can access pre-bookable appointments with a primary health 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 7days a week, 12 hours per day (8am -8pm or alternative equivalent based on local need), for unscheduled and pre-bookable appointments |
| Same-day access | Patients can have a consultation (inc. virtually) with a GP or skilled nurse on the same day, in their local network |
| Urgent and emergency care | Patients can be clinically assessed rapidly. Practices will have systems and skilled staff to ensure patients are properly identified and responded to |
| Continuity of care | Patients are registered with a named team member, responsible for providing coordination and continuity, with practices offering flexible appointment lengths |

| Co-ordinated care | |
|---|---|
| Case finding and review | Practices identify patients, through data analytics, who would benefit from coordinated care and continuity with a named clinician, regularly and proactively reviewing those patients |
| 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 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 the use of digital tools and education, such as health coaching. |
| Multi-disciplinary working | Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving. Care will be coordinated via shared electronic care records. |

# 4. Primary Care: A whole population approach to delivering integrated out of hospital care in NW London



We have developed a whole population approach to delivering integrated out of hospital care in NW London.




*1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)*

# 4. Primary Care: Primary care and Intermediate Care transformation is the foundation for Local Services Transformation



The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP.

**Our challenges**

- **Demand for health and care services is increasing.**
- **There is unwarranted variation in care, quality and outcomes across NW London.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

## How Local Services areas of focus fit within STP delivery areas

**DA2 – Improve quality and reducing variation across Primary Care (for LTC management)**

**DA3 – Achieving better outcomes and experiences with a focus on older people**

## What are the ways of working

**Developing sustainable services**

**Changing how we work together to deliver the transformation required**

**Our areas of focus**

DA2:

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

DA3:

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

Developing sustainable services:

- Joint commissioning and delivery models across CCGs and providers
- Evolving **Primary Care at-scale**
- Managing demand across boundaries through pathway redesign
- **Strengthening care teams** to provide effective care

Changing how we work together:

- Effective **joint governance** able to address difficult issues
- Working **cross-boundary**; across acute and social care
- Collaborating to improve quality and efficiency, e.g., through the Virtual Primary Care Team
- Building upon **Whole Systems Integrated Care**

**The impact of our plans**

**A healthier NW London**

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care.

**More productive care:**

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

**More effective system:**

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

# 4. **Primary Care:** There will be significant investment in General Practice within NW London

This diagram shows NW London's:

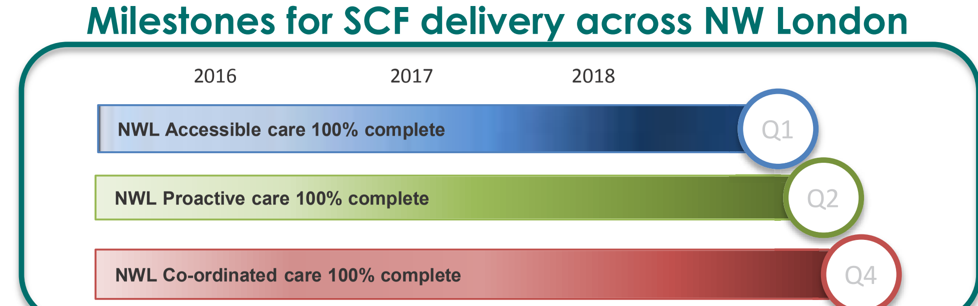
- Efficiency targets
- Increases in primary care medical allocations (blue arrows)
- The planned delivery of the Strategic Commissioning Framework and the Strategy and Transformation Plan

Key: Increases in Primary Care medical allocations

*The diagram does not show funding from national programmes (such as the General Practice Access Fund) from which NW London is aiming to access approximately £4.5m in 2016/17 – announced in the GP Forward View.*

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. Transforming general practice in line with the standards set out in the Strategic Commissioning Framework is critical to delivery of the ambitions set out in the STP. The diagram below shows the milestones to full delivery.

## Milestones for SCF delivery across NW London



# 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 overall the footprint including social care has a small deficit of £19.9m.

| £'m | CCGs | Acute | Non-Acute | Specialised Commissioning | Primary Care | STF Investment | Sub-total | Social Care | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Do nothing Oct 16** | **(247.6)** | **(529.8)** | **(131.6)** | **(188.6)** | **(14.8)** | - | **(1,112.4)** | **(297.5)** | **(1,409.9)** | **Note 1** |
| BAU Savings (CIP/QIPP) | 127.8 | 341.6 | 102.7 | - | - | - | **572.1** | 108.5 | **680.6** | **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)** | - | **(55.7)** | **Note 4** |
| STF - funding | 24.0 | - | - | - | 14.8 | 55.7 | **94.5** | 19.5 | **114.0** | **Note 4** |
| Other | - | - | - | 188.6 | - | - | **188.6** | 72.0 | **260.6** | |
| **TOTAL IMPACT** | **336.4** | **462.0** | **125.7** | **188.6** | **14.8** | - | **1,127.5** | 262.5 | **1,390.0** | |
| **Final Position Surplus/(Deficit)** | **88.8** | **(67.8)** | **(5.9)** | - | - | - | **15.1** | **(35.0)** | **(19.9)** | |
| | | | | **Note 5** | | | | **Note 3** | | |

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

Specific Points to note are:

**Note 1**: The NWL 'Do Nothing' gap has changed since Jun '16 STP due to changes in the underlying position of social care, and inclusion of the Royal Brompton & Harefield and the London Ambulance Service deficit attributable to NWL.

**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).

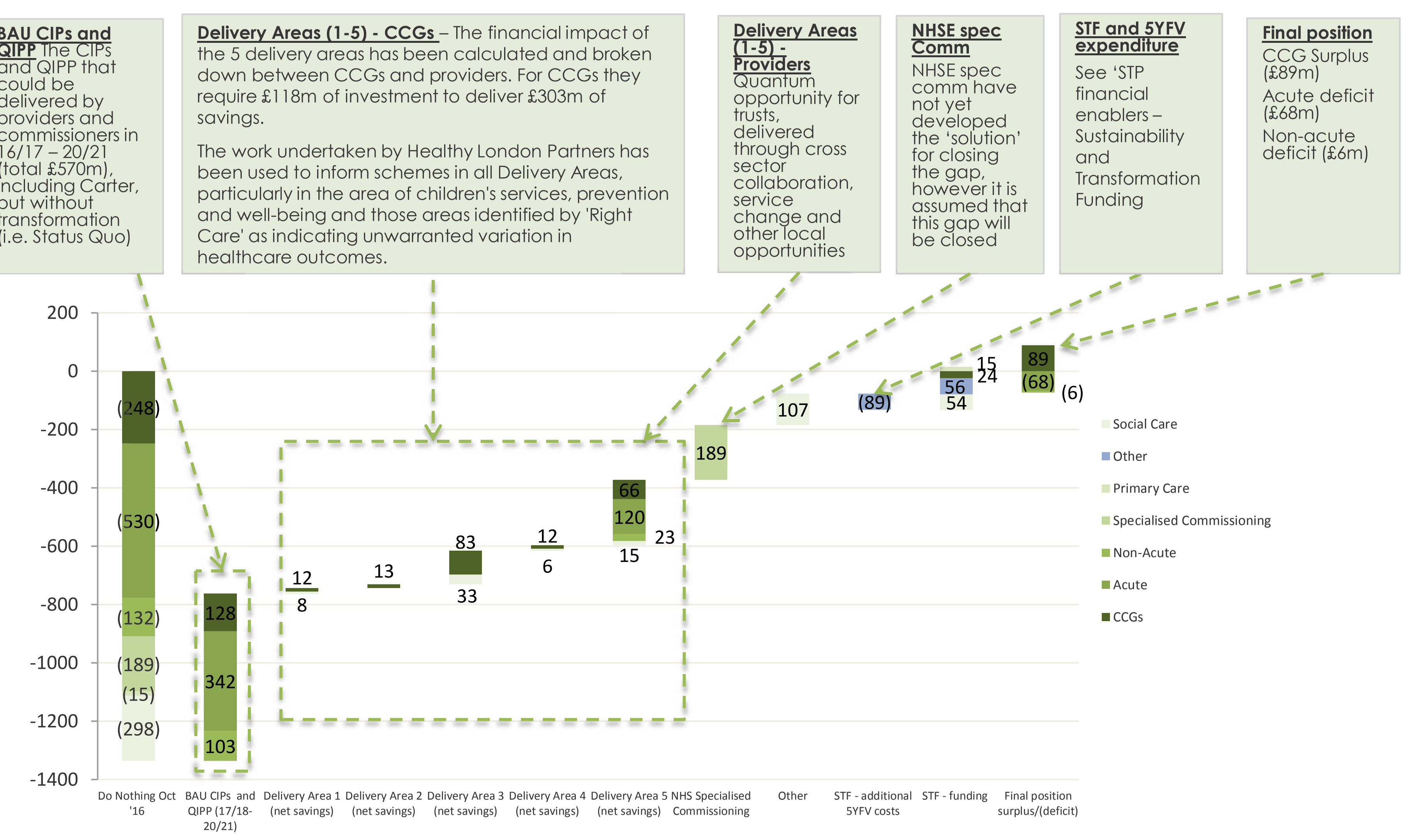
**Note 4:** £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated.

**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.

**Note 6:** As we have developed our project plans we have more clearly articulated the focus of our delivery areas. This has resulted in 'Delivering the SCF' moving from DA3 to DA2. The individual DA totals have therefore changed although overall investment and saving totals remain constant.

# 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 break even position .



# 5. Finance:
## Next steps

**Financial risks to delivery of the STP**

There are a number of risks facing NWL commissioners and providers which are inherent in the STP. These are:

- Delivery of business as usual efficiency savings
- Delivery of the service transformations set out in the five delivery areas, and the realisation of the associated savings
- Financial challenges on the provider side that remain at the end of the STP period
- Plans to close the specialist commissioning gap are not yet available
- Deterioration in underlying organisational financial positions since 2016/17 plans were agreed
- Closing the remaining social care funding gap
- Accelerating delivery of transformation plans to enable recently notified NHS financial control totals to be achieved.

The key risk to achieving sector balance is the delivery of the savings, both business as usual efficiency savings and those associated with the service transformations described in the five delivery areas.

There are also particular challenges in relation to:
- The deficit on the Ealing Hospital site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging;
- The deficit at the Royal Brompton and Harefield, which although mostly commissioned by NHSE Specialised Commissioning, is included in the NWL footprint;
- The deficit in London Ambulance Service, of which only the NWL related element is included in this plan, which requires further joint working in order to agree a solution.

The plans to close the Specialised Commissioning gap are not yet available in enough detail to allow an assessment of the level of risk facing the NWL Specialised service providers. This may pose a significant risk to the viability of some providers.

**Next steps to address the risks**

There are a number of processes in place to quantify and mitigate the risks set out above. These include:

- A robust process of business case development to validate the investments and savings that have been identified so far, and the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered
- A portfolio management approach with clear governance to ensure that project directors are held accountable for delivering agreed savings, with a change control process to close projects and agree new ones as required to deliver the planned patient outcomes and associated savings
- The work through DA5d on productivity will support the development of trust internal infrastructures to support the business as usual efficiency savings
- The acceleration of the changes relating to Ealing hospital, once out of hospital capacity is in place
- Joint pathway planning with specialist commissioning and other CCGs across London to confirm the plans to reduce demand and to quantify the impact on providers
- Quantification of changes in underlying financial positions and differences between the STP financial assumptions and notified control totals, feeding into a sector approach to the 2 year contracting round to ensure that effective risk management processes are in place.

This work will be developed and will continue over the next few months.

# 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. The STF funding being use to support provider deficits has already been notified to Trusts for 17/18 and 18/19, and is not included below. The funding below is being sought **in addition** to provider STF funding.

**Sustainability and Transformation funding requirement for North West London**

| Investment Area | 17/18 £m | 18/19 £m | 19/20 £m | 20/21 £m |
|---|---|---|---|---|
| Investment in Prevention & Social Care | 21.0 | 25.0 | 30.0 | 34.0 |
| Social Care funding gap | - | - | - | 19.5 |
| **Total Social Care and prevention** | **21.0** | **25.0** | **30.0** | **53.5** |
| Seven Day services roll out through to 2019/20 | 4.0 | 7.0 | 12.0 | 24.0 |
| General Practice Forward View and Extended GP Access | 10.0 | 10.0 | 5.0 | 5.0 |
| Increasing capacity in Child and Adolescent mental health services and reducing waiting times in Eating Disorders services | 5.0 | 5.0 | 8.0 | 10.0 |
| Implementing recommendations of mental health task force | 10.0 | 10.0 | 10.0 | 5.0 |
| Cancer taskforce Strategy | 3.0 | 5.0 | 10.0 | 3.0 |
| National Maternity Review | 7.0 | 7.0 | 2.0 | 2.0 |
| Local Digital Roadmaps supporting paper free at the point of care and electronic health records | 3.0 | 10.0 | 10.0 | 6.7 |
| **Total Health** | **42.0** | **54.0** | **57.0** | **55.7** |
| Improvement Resources | 2.0 | 2.0 | - | - |
| Additional Investment in Primary Care services | 1.0 | 12.0 | 19.0 | 14.8 |
| System support funding | - | - | - | 24.0 |
| **Total** | **66.0** | **93.0** | **106.0** | **148.0** |

# 5. Finance:
## STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £978m (funded by £713m from internal resources, £37m from disposals and £228m 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. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

The table below details the 'Do something' capital for the 5 year STP period.

**Table : Do Something Capital**

| Key Capital Schemes | 17/18-20/21 £m | Less: disposals £m | Other funding sources £m | Total £m |
|---|---|---|---|---|
| | **Gross Capital** | | | **Net capital** |
| Outer NWL (SOC1)[1] | 385 | (9) | | 375 |
| Inner NWL (SOC2)[2] | 222 | (222) | | - |
| IT Digital Roadmap[3] | 60 | | | 60 |
| CNWL - strategic investments | 79 | (53) | (26) | - |
| Royal Brompton | 100 | (100) | | - |
| **Total** | **845** | **(384)** | **(26)** | **435** |

Note 1 – The Outer NWL business case (SOC1) is modelled on an 'accelerated' approval timeline in order to address the sustainability issue at Ealing Hospital;
Note 2 – The Inner NWL Business Case (SOC2) is funded through the disposal of a charitable asset, thus placing a restriction on the use of the sale proceeds;
Note 3 - IT digital roadmap funding is expected to be funded via the Estates and Technology Transformation Fund (ETTF).

# 6. Risks and Mitigations: Strategic Risks

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 | • Maintain system attention on importance of delivery over the next five years through focus on Delivery Areas 1, 2 and 3<br>• Continue to develop delivery plans using learning from vanguards and other areas<br>• Establishment of robust governance process across NW London system focussing on both delivery and assurance<br>• Clear metrics agreed to monitor progress | |
| There is insufficient capacity or capability in primary care to deliver the new model of care | Quality and sustainability | • Support development of GP federations<br>• Early investment in primary care through joint commissioning<br>• Identification and support to vulnerable practices<br>• Digital solutions to reduce primary care workloads | • Support in developing a reliable understanding of sector demand and capacity for primary care |
| Can't get people to own the responsibility for their own health | Self care and empowerment | • Development of a 'People's Charter'<br>• Closer working with local government to engage residents in the conversation, primarily through DA1 | • 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, and the sustainability issues at Ealing Hospital | Finance and estates | • Submit a business case for capital to NHS England<br>• Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment<br>• Identification of further opportunities through One Public Estate<br>• Submit a business case for capital to NHS England that sets out the clinical and financial rationale for an accelerated timeline | • Support for retention of land receipts for reinvestment, and potential devolution asks<br>• Support for an accelerated timeline for the capital business cases |
| Information Technology systems are not in place to enable seamless integrated care and a shift towards out of hospital activity. | Information and technology | • Work within new national standards on data sharing to support the delivery of integrated services and systems.<br>• Keep pressure on primary and community IT system providers to deliver open interfaces which will enable record sharing | • NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability.<br>• Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality<br>• Continued focus at a national level on open API |

# 6. Risks and Mitigations:
## Other Risks

| Risks | Category | Proposed mitigations | Support from NHSE |
|---|---|---|---|
| There is an unplanned service quality failure in one of our major providers | Quality and sustainability | • On-going quality surveillance to reduce risk<br>• Contingency plans developed should a service be flagged as *fragile*<br>• Strengthened governance structure with clear joint leadership maintaining focus on delivery and enabling more rapid and effective responses to a situation | |
| 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 a joint market management strategy lead by the Joint Health and Care Transformation Group<br>• Specific project of work in this area through DA3<br>• On-going support to homes to address quality issues | |
| Provider and system sustainability targets result in competing local priorities | Quality and sustainability | • Joint Health and Care Transformation Group provides forum for system wide discussion. | • Alignment of NHS England and NHS Improvement positions on provider sustainability versus system sustainability |
| 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 | • Establishment of Workforce Transformation Delivery Board to provide system leadership and focus<br>• Development of cross-sector workforce strategy<br>• Close working with HEENWL | |
| There is resistance to change from existing staff | People and workforce | • OD support and training for front line staff and system leaders<br>• Wide staff engagement in the design and delivery of new models through project delivery groups. | |
| Impact on the health sector and our workforce of 'Brexit' | People and workforce<br><br>Finance and sustainability | • Work closely with partners to understand the implications of 'Brexit'<br>• Provide staff with support to ensure they feel valued and secure. | |
| Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan | Partnership working | • Developing relationships between health and local authority organisations, supported by joint governance via the Joint Health and Care Transformation Group<br>• Joint statement agreed and areas of commonality identified to enable progress | |

# 7. References



| Section | Slides | References |
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# Partnership organisations with the NW London STP Footprint

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# NW London Sustainability and Transformation Plan

## Appendices

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

V1.0

21 October 2016

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# Appendix A: NWL Sustainability and Transformation Plan

Joint Statement on Health and Care Collaboration in North West London from the boroughs of Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster

## Appendix A: Joint Statement on Health and Care Collaboration in North West London from the boroughs of Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster



**The six boroughs 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 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, the six boroughs also agree that the following conditions must be reflected in the STP:**

1. Explicit reference to how the NHS will help to close the 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.

**The boroughs ask that NHS partners commit to work jointly to:**

- Continue to develop an agreed approach to the delivery of the commitments
- 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
- Agree a 'review point' in 2018 to review the agreed criteria
- Continue to co-produce the final delivery plan with leaders, clinicians and the public.

# Appendix B: NWL Sustainability and Transformation Plan

## How our STP addresses the nine national priorities

# Appendix B: How our STP addresses the nine national priorities

| National Priority Area | National Description of Delivery Requirements | Section of NW London STP |
|---|---|---|
| **1. STPs** | • Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.<br>• Achieve agreed trajectories against the STP core metrics set for 2017-19. | • Addressed through finance template, STP and delivery plans. |
| **2. Finance** | • Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.<br>• Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.<br>• Demand reduction measures include: implementing Right Care; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.<br>• Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving roistering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services. | • Section 5 for financial summary.<br>• Delivery Areas 1-5 for demand management initiatives.<br>• DA5d for collaborative provider productivity improvements. |
| **3. Primary Care** | • Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.<br>• Ensure local investment meets or exceeds minimum required levels.<br>• Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.<br>• By no later than March 2019, extend and improve access in line with requirements for new national funding.<br>• Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes. | • DA2a for Delivering the Strategic Commissioning Framework and General Practice Forward View.<br>• Workforce enabler for approach to primary care workforce planning.<br>• Primary care plan in the out of hospital chapter for further detail on access and general practice at scale. |

# Appendix B: How our STP addresses the nine national priorities

| National Priority Area | National Description of Delivery Requirements | Section of NW London STP |
|---|---|---|
| **4. Urgent & Emergency Care** | • Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.<br>• By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.<br>• Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.<br>• Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.<br>• Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis. | • DA2e for self care, DA3c for intermediate care, DA4a for mental health model of care and DA4c for crisis support, all resulting in lower U&EC usage.<br>• DA2a for 24/7 integrated care service.<br>• DA5b for seven day hospital services. |
| **5. Referral to Treatment Times and Elective Care** | • Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).<br>• Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.<br>• Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.<br>• Implement the national maternity services review, *Better Births*, through local maternity systems. | • DA5c for out of hospital hub development and maternity service improvements.<br>• DA5d for improved elective care productivity.<br>• Digital enabler for e-referrals.<br>• DA5c for continuing improvement to maternity services. |

# Appendix B: How our STP addresses the nine national priorities

| National Priority Area | National Description of Delivery Requirements | Section of NW London STP |
|---|---|---|
| **6. Cancer** | • Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.<br>• Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.<br>• Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.<br>• Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.<br>• Ensure all elements of the Recovery Package are commissioned, including ensuring that: i) all patients have a holistic needs assessment and care plan at the point of diagnosis; ii) a treatment summary is sent to the patient's GP at the end of treatment; and iii) a cancer care review is completed by the GP within six months of a cancer diagnosis. | • DA2c for improvements to cancer services. |
| **7. Mental Health** | • Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:<br>- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;<br>- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;<br>- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;<br>- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;<br>- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and<br>- Reduce suicide rates by 10% against the 2016/17 baseline.<br>• Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.<br>• Increase baseline spend on mental health to deliver the Mental Health Investment Standard.<br>• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.<br>• Eliminate out of area placements for non-specialist acute care by 2020/21. | • DA4a for implementation of the MHFYFV.<br>• DA1c and DA4d for focus on children's mental health and wellbeing.<br>• DA4c for crisis support services.<br>• DA2a for integrated approach to dementia support. |

# Appendix B: How our STP addresses the nine national priorities



| National Priority Area | National Description of Delivery Requirements | Section of NW London STP |
|---|---|---|
| **8. People with Learning Disabilities** | • Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.<br>• Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.<br>• Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.<br>• Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism. | • DA4b for delivery of the NWL Transforming Care plan.<br>• DA2d for Right Care as an enabler to support Transforming Care.<br>• DA1b for access to healthcare and annual health checks.<br>• Digital enabler for innovative support tools. |
| **9. Improving Quality in Organisations** | • All organisations should implement plans to improve quality of care, particularly for organisations in special measures.<br>• Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.<br>• Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. | • DA5b for focus on service quality improvement.<br>• DA5d for acute care productivity and quality improvement.<br>• DA4a for focus on mental health services.<br>• Workforce enabler for workforce planning and strategy. |

# Appendix C: NWL Sustainability and Transformation Plan

Further information about our Mental Health and Wellbeing Transformation

# 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.

## 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

People with serious and Long-term Mental health needs

People with common mental health needs

Mostly Healthy people

Children and Young People's mental health and wellbeing

Eating Disorders services development

Conduct Disorder - parenting interventions

New Model of Care and support for S<MHN

Learning Disabilities & the Transforming Care Partnership

Perinatal pathway redesign pilot

Delivering the Crisis Care Concordat

Common Mental Health needs

Workplace Wellbeing

Dementia

Children and Young People

Working Age Adults

Older People

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.

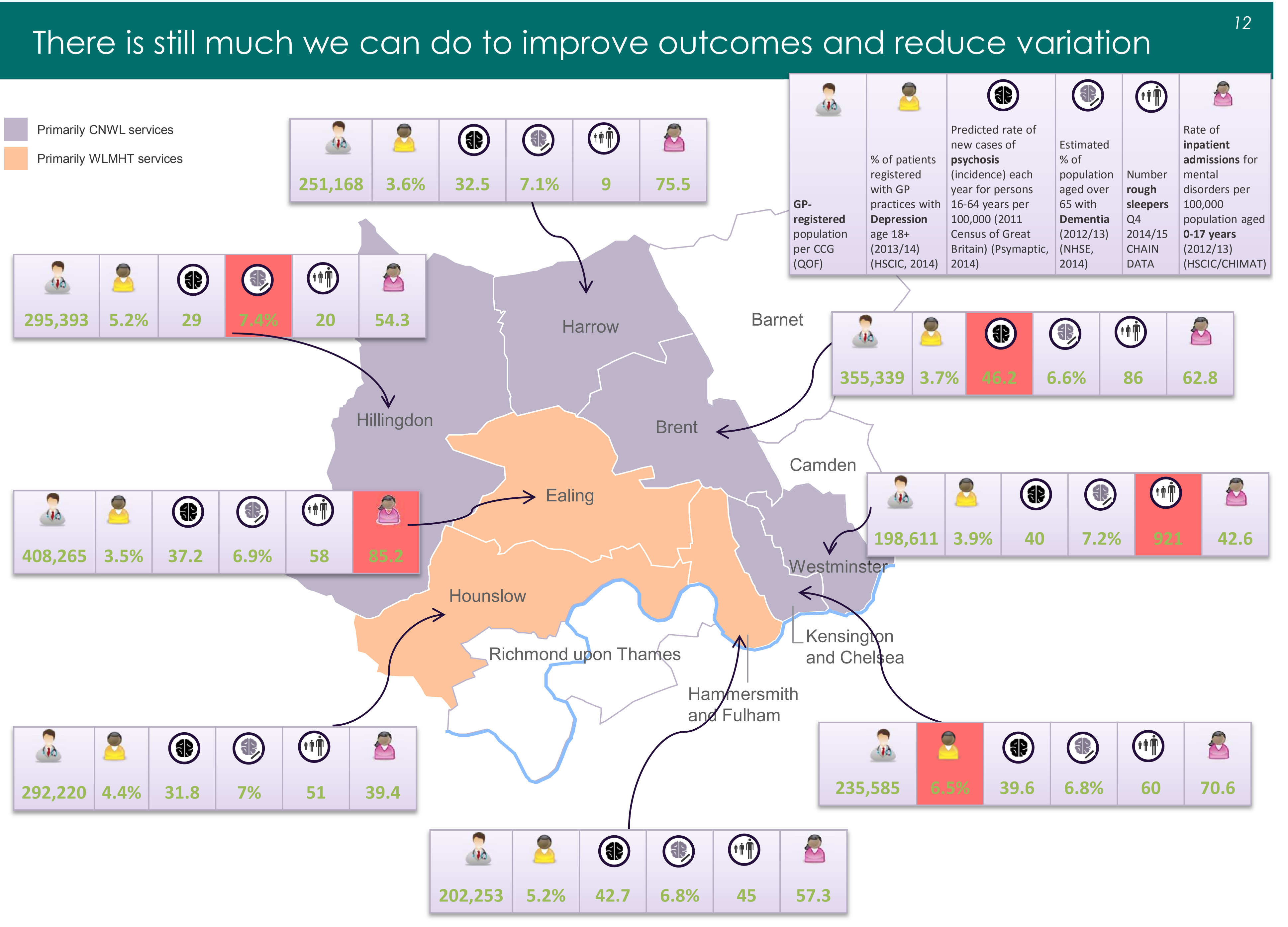
We are not starting from scratch – our 24/7 urgent care pathway has been the critical development over the last year and unlocks the gateway to wider services for adults with serious and long term needs. We have also developed primary care mental health services, specialist pathways for children and perinatal services as examples of work to date. But everyone working together on mental health transformation would recognise there is still much more we can do to improve the experience of our population – and the national focus, strategy and leadership provides additional focus and clarity on our priorities.

*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*

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.

# There is still much we can do to improve outcomes and reduce variation





# Within the transformation programme our work on a new whole systems pathway has the greatest impact on the greatest number of people



The model below has been coproduced with partners across the system – and is the core of our activity and financial modelling which in turn supports achievement of the change set out in the mental health Five Year Forward. This work is focused on improving services for the 37,500 adults in North West London with serious and long term mental health needs.

**Principles**

- Care and support should be safely provided in the least intensive setting necessary
- As risk of relapse increases, additional support should be rapidly available
- Individuals will have needs that simultaneously exist across the system
- People can seamlessly transition between boxes not just those adjacent (i.e., not a tiered system)

**Increasing intensity of need** →

**Whole Systems model focused on the community** | **Urgent care pathway**

| Living a Full and Healthy Life in the community | Coordinated Community, Primary and Social Care | Specialist Community based support | Urgent/ crisis care to support stabilisation | Acute inpatient admissions |
|---|---|---|---|---|
| Support to people and carers to effectively manage their own mental health and wellbeing at home and in their community with a focus on prevention | Continuity of care and support around individual needs including co-produced care-plan, case management, and proactive multi-disciplinary support | Specialist care for individuals with higher intensity needs that require ongoing support for complex needs or specialist care packages (e.g., psychosis, PD) | Support to anyone feeling in crisis including 24/7, single point of access, timely assessment, more crisis management and recovery at home and in the community | Inpatient admission when community-based support is no longer appropriate, and for shortest time necessary with continuity in the community to support recovery to living well |

Better transitions and transfers across different parts of the system

Enablers to support integrated working including shared data and new governance and payment models

← **Living well in least intensive setting**

# As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business



With the publication of the Mental Health Five Year Forward and supporting Implementation plan in 2016 across North West London we have mapped our existing plans (as set out in the Like Minded Case for Change and defined in the June submission of the STP) against the national must-dos.

The table below describes the congruence that exists and where there are additional areas that we need to place more focus on. We also describe where existing workplans exist – with clear financial modelling, defined outcomes and shared milestones. There remain some areas where more detailed work is ongoing to support delivery from 17/18 and beyond. We note a range of additional guidance is expected over the next 18 months and also opportunities to secure additional funding above that which will be made available through the CCG baseline allocations.

Lastly we are committed to work with colleagues across London – supported by Healthy London Partnerships – to take advantage of areas where we can avoid duplication and simplify pathways across the Capital.

**The Mental health Five Year Forward –** mental health workstreams are threaded throughout the STP to ensure integration with other key work programmes.

| Detailed Plans developed | NWL STP | Outline plans developed (to be agreed by end Q3 16/17 | NWL STP | Further work required | NWL STP |
|---|---|---|---|---|---|
| **Children and Young People's Mental Health**<br>- Eating Disorder services lives<br>- Crisis Care pathway pilot live<br>- New Model of Care in development | DA4d | **Adult Common Mental Health Needs**<br>- Workstream formed and Hillingdon agreed as NHSE pilot area<br>- Good work on digital support, employment and GP engagement<br>- Detailed implementation plans for increase in IAPT provision for LTC | DA2b | **Adults, community acute and crisis care**<br>- Co-commissioning Mental health care for armed forces community to be developed | DA4b |
| **Perinatal Mental health**<br>- Service live in 4/8 boroughs<br>- Coproduction underway to commence in 4/8 boroughs in 17/18 | DA4b | **Health and justice**<br>- Good joint work on Childrens pathways/youth offending<br>- Liaison and Diversion a priority for Crisis Care group in 17/18 | DA4d<br>DA4c | **Adults mental health, secure pathway**<br>- Specialised commissioning now have a place on the Delivery Area 4 Board. Plans required for future years | DA4b |
| **Adults, community, acute and crisis care**<br>- Detailed plans coproduced in most areas<br>- Early Intervention in psychosis<br>- Healthchecks<br>- Independent Placement Support (employment)<br>- Increased access to HTT – developed in 15/16 with a 24/7 service | DA4c<br>DA4a<br>DA1b<br>DA4a | **Suicide prevention**<br>- Good borough based plans and activity to date<br>- Any joint work to be agreed in collaboration with GLA and work on the Mental Health roadmap for London<br>- Liaison Psychiatry Services Core 24<br><br>**Adults, community, acute and crisis care**<br>- Liaison Psychiatry Services – progress towards Core 24 | DA4<br><br>DA4c | | |
| **Sustaining Transformation**<br>- New Model of Care for CAMHS pilot across NWL<br>- Governance and resource exists to support transformation | DA4d<br>DA4 | There are also a number of workstreams within the NWL programme which are not explicitly referenced in the Mental Health Five Year Forward<br>- Delivery the Transforming Care Partnership (DA4b)<br>- Social Isolation and loneliness (DA1b)<br>- Prevention of Conduct Disorder (DA1c) | | | |
| **A healthy NHS workforce**<br>- NHS organisations across NWL signed up to the Healthy London workforce charter | DA1b | | | | |
| **Infrastructure and hard-wiring**<br>- Workforce – a sub-group focusing on mental health exists<br>- Payment and Outcomes | | | | | |

Our financial modelling reflects

- Parity of esteem
- Detailed business case modelling where completed
- The NWL share of new funding for mental health – and expected savings

# Our Single Point of Access (SPA) case study provides one example of NWL's recent progress in mental health and wellbeing transformation

## The SPA – Implementation and Early Impact

Across North West London the 8 Clinical Commissioning Groups, West London Mental Health Trust (WLMHT) and Central & North West London NHS Foundation Trust (CNWL) have a longstanding commitment to improving the experience and outcomes of their population with mental illness.

Through a process of co-production, we have implemented a single point of access (SPA) 24/7/365 telephone line, with access to rapid response and home treatment covering the entire North West London population of 2.2 million people who may need support in a mental health crisis.

The SPA is a 24 hours a day, 7 days a week central advice line, accepting referrals from individuals, GPs, the ambulance service, housing associations, the police, and anybody else with access to a phone.

**"The service allows me to give all the information quickly with one phone call. When you're a busy GP and your patient's in distress you want to help them as soon as possible. Being able to get advice and answers quickly with one phone call makes a huge difference"**

*On average, WLMHT received 3,439 calls per month between April and June*

- Through our available measurable statistics, we believe the benefits within the mental health system are already apparent.
- The quick, paperless access to a clinical opinion has significantly cut the amount of time between a crisis being reported, evaluated and acted upon
- Previously there were around 15 different ways to refer into services and no clear way to track waiting times, frustrating for all involved. Now, having a clear single point of access means a quicker and more sensitive response.
- Across the collaboration demand is clearly rising but we are confident that the triage process and de-escalation trend we are seeing are supporting GPs help their patients in the community. The clinical triage allows thorough assessing: 30% agreed with referrer, 65% considered. For de-escalation, 5% escalated higher.
- Both CNWL and WLMHT (providers of the service) produce detailed dashboards describing activity, and ahead of formal evaluation this supports a clear picture of the way in which the services are meeting an obvious need for our population. The approach is now embedded in local pathways and referenced as a clear example of 7 day services.  We are currently evaluating the services across NWL.
- GPs have reported that the 24/7 line has led to increased confidence in dealing with mental health crises. Overall feedback from GPs has been very positive: One GP fed back that "the Single Point of Access is the best anti-anxiety drug for GPs"

***A Case Study:***
A Senior Practitioner, C, in the SPA received a crisis call. An emergency intervention was requested for a female, S. Her son had recently been diagnosed with ADHD and had been allocated a social worker who was working with both of them. When the social worker got to the house, she found S in a very anxious state, clearly experiencing some kind of break down. Our senior practitioner spoke to both the Social Worker and then to S. S was previously known to services and had counselling in primary care years ago when depressed following a relationship break-up. After years of not being able to cope with her son, he has "finally got a diagnosis", and she is "finally getting support for him and for herself". Along with the relief of finally getting help, all the old anxiety and low mood to come to the surface. The Senior Practitioner managed to talk her down and to explore what she needed. She clearly didn't need or want secondary mental health services, but identified that talking therapies had helped in the past and this is what she now wanted again.
C referred her on to (IAPT) Talking Therapy service – S was really happy with the outcome and grateful for her help. This rapid response de-escalated the crisis, supporting the family to ensure they were happy.

# Appendix D: NWL Sustainability and Transformation Plan

## Communications and Engagement

# Communications & Engagement (1): Guiding principles and initial engagement with our patients, residents and staff



## We continue to ensure that people's voices drive our decision-making:

In NW London we collaborate with residents, patients and staff at all stages of the commissioning, mobilisation and delivery cycle; **co-production with service users is fundamental to our culture** and we have been recognised for our 130 strong Lay Partner Forum and its approach to co-production, which includes significant engagement with other patient groups including Healthwatch and Patient and Public Participation Groups.

We have joint governance and leadership across the communications and engagement space, with a work stream led by the CCG Director of Communications in partnership with communications leads from providers and local government. This group sets the overall direction for communications and engagement but working in partnership with colleagues from across all sectors involved in the STP.

We follow best practice in all the work we do, with all our engagement guided by the principles that we discuss early and that we listen. We will work in partnership with commissioners, providers, local government, Healthwatch, patients groups and residents associations.

Building on our history of collaborative working the STP is already a product of the work we have done with the wider community. The engagement so far has been to help us co-design the local plans and formulate the emerging priorities and delivery areas.

**Having established the delivery areas in the checkpoint submission the purpose of this phase is to engage our partners, staff, patients and residents on whether our focus is right and what more they would like to see.**

## Engagement – Work done to support the development of the plan (April – July)

### At a local level we:

- Held 22 face to face engagement events across all eight boroughs to help co-design the local plans, on top of regular meetings of the STP planning groups
- These events have included workshops, seminars and public meetings and been very popular with providers, patients, Healthwatch, carers and their families and lay partners
- We have also used Health and Wellbeing Boards along with CCG Governing Body meetings to engage people
- In Brent the Healthy Partners Forum had a turnout of around 100 people with table discussion focussed on the emerging priorities, while in Hillingdon over 100 people attended a STP focussed workshop
- We have promoted these events through our social media platforms to maximise attendance
- These local plans, co-designed with the local community, in turn form the basis for the full North West London STP.

### At a pan North West London level we have:

- Hosted two co-production workshops with lay partners, Healthwatch and providers to help feed into the checkpoint submission and provide an early opportunity to shape the direction of the STP
- Ideas from the first session included the Peoples Health Charter which is an important part of our STP moving forward.
- Hosted two workshops with communications leads from across sectors to help co-design the engagement strategy
- Co-designed the engagement strategy with Healthwatch chairs
- Hosted sessions with clinicians to get their input into the priorities and delivery areas, ensuring our workforce is a driver and owner of change
- We ran a market stall event for our core partners (20 July) to showcase the range of work which is happening across North West London
- Created a core narrative covering our health and social care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – ensuring it is in patient- focused and in accessible language

# Communications and Engagement (2) – Engaging on the checkpoint submission (July – October)



**Throughout the summer and the autumn we are engaging through:**

### Face to face meetings:

- We have organised a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations to ensure that we get real input from the local community
- The events are a mix of presentation, Q&A and table workshops to allow as many attendees as possible to participate in the discussion. The events are genuinely collaborative with most being hosted and led by a senior clinician and a senior Councillor from the borough
- Feedback from all these events is provided to both all those who attend and to the team producing the STP to ensure it is reflected in this final iteration of the plan.

### An online engagement tool:

- On the 17 August we launched an online engagement tool with the specific aim of targeting those residents who want to contribute to the discussion but don't have the chance to attend a public meeting.
- Since launching we have had 1,257 visitors to the site with 150 comments and 110 registering for further information and updates.
- We supported this activity with Facebook advertising which has so far been seen by over 16,000 residents through either Facebook or Instagram.

### Public outreach:

- We know there are groups out there who won't proactively engage with us and so we have launched a programme of public outreach with the aim of getting to those harder to reach groups.
- Utilising the stakeholder lists held by both local government and the health service, and lists provided by Healthwatch and other partners, we have so far contacted over 500 groups. These are as diverse as faith groups, community organisations and charities.
- We are also surveying residents and holding pop up stalls where we can talk about our plans in supermarkets, libraries, stations and community centres

### With staff & partners:

- Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Each of our partners – whether in health or local government – is working up plans for specific staff engagement.
- Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP
- STP updates are already a regular staple of all our internal communications materials through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.
- We are also working in tandem with our GP federations to engage primary care providers

**Some highlights of our activity**

**Public meetings**

- 20 September – Ealing town hall style event
- 26 September – Brent town hall style event
- 27 September – Hounslow town hall style event
- 03 October – H&F town hall style event
- 05 October – Westminster public meeting (HWB)
- 11 October – Harrow town hall style event
- 12 October – RBK&C town hall style event

**Online**

- 17 August – Online engagement tool launched
- Over 1,250 visitors to the site already
- Supported by Facebook advertising
- Over 16,000 people have seen the ad either on FB or on other FB platforms (e.g. Instagram).
- FB says 419 have taken action after seeing it (this is either them clicking through, sharing, commenting, liking etc.).
- It says 106 people have clicked through to the tool.

**Public outreach**

- Over 500 organisations have been contacted with meetings now being set up
- 05 September – Ealing PPE
- 06 September – NW London PPRG
- 10 September - Stall at West Ealing Festival
- 14 September – Lay Partners Forum
- 15 September – Healthworks Information Exchange, Dalgarno Community Centre
- 21Setpember – Stall at Kensington Central Library

# Communications and Engagement (3): Co-design of services and engagement on implementation and delivery



**A core principle of all our activity is that engagement is continuous and does not stop with this iteration of the plan. To make the STP a success we need to be clear on how we will engage on implementation and delivery and ensure our residents are involved in the co-design of services and any service change. Over the next twelve months following publication of the plan we will:**

- **Hold regular public meetings –** building on the series of town hall style events we are running for this iteration of the plan we will look to hold regular update meetings where we can discuss latest developments, take questions and sign post people as to how they can get involved in the specific delivery areas.
- **Continue our online engagement –** given the popularity and range of issues which have been raised through the process so far we will continue to use this tool to ensure a continuous dialogue with the wider public across the eight boroughs.
- **Continue with the public outreach –** it will take time to work our way through the diverse groups and communities that make up our STP footprint and we want to ensure that we talk to as many as possible and give them an opportunity to get involved in the implementation and delivery of the plan.
- **Staff –** and of course staff, whether in local government or the health service, will remain our best advocates for the plan and so across all our partners we will continue to engage with them through all available outlets.

**Just as importantly we want to ensure full participation and co-design in all five delivery areas and the projects and programmes that sit within them. We will:**

- **Patient involvement –** we will ensure that we have patient representation across the five delivery areas and that patients are involved in the co-design of services and any service change.
- **Specific engagement –** we will work with those patients to design engagement plans for those areas of work, using a combination of the methods set out above.
- **Consultations –** Where specific programmes or projects require consultations, as set out under section 14Z2 of the NHS Act 2006, we will carry those out.
- **Equality Impact Assessments –** Where specific programmes or projects require equality impact assessments, we will carry those out.

# NW London STP – Feedback from the public

**Summary of public engagement for the STP to September 30 2016.**

The public engagement strategy for the NW London STP built on tried and tested approaches, and also tested a new interactive online offer to try and reach new audiences, particularly younger people and infrequent users of the NHS. This led to a four pronged approach, which can be summarised as:

**1. Face to face meetings:** these include a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations to ensure that we get real input from the local community. This engagement also includes briefings with MPs and local authorities, and through formalised routes such as overview and scrutiny committees and CCG governing bodies.

**2. Public outreach:** We know there are groups out there who won't proactively engage with us and so we have launched a programme of public outreach with the aim of getting to those harder to reach groups. Utilising the stakeholder lists held by both local government and the health service, and lists provided by Healthwatch and other partners, we have so far contacted over 500 groups. These are as diverse as faith groups, community organisations and charities. We are also surveying residents and holding pop up stalls where we can talk about our plans in supermarkets, libraries, stations and community centres

**3. With staff & partners:** Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP. Updates are already a regular staple of all our internal communications materials through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.

**4. An online engagement tool:** designed to engage with all sections of the public, and be fully accessible on computers, tablets and phones. A 'survey' version was also included, linked to the same system, for face-to-face conversations during community engagement. Since launching we have had over 1100 visitors to the site and 150 face-to-face surveys with more than 300 comments received. Over 100 people have signed up for further information and updates. We supported this activity with Facebook advertising which has so far been seen by over 18,000 NW London residents through either Facebook or Instagram.

**Summary of Feedback Received**

We are grateful for the time the public and stakeholders have given to feedback on the STP, and this feedback can be categorised into two distinct areas. First, there was a clear demand from those we most regularly engage with - for example stakeholders like Healthwatch, established patient groups and 'more informed' individuals - for greater clarity on 'technical' issues relating to the STP. These included its background, scope, legal standing, governance, timelines, implementation plans and likely impact on future funding for the NHS and local authorities. Other issues raised included engagement and consultation plans and how the STP related to future NHS organisational forms, such as accountable care partnerships. Answers were provided wherever possible, and the draft STP was made publically available in response to the obvious appetite for more information. The second area was more subjective, and related to the five STP delivery areas in the NW London draft document. The vast majority of this feedback was received via responses from the online engagement and its face-to-face survey mode, as public meetings tended to be dominated by the first category above. All comments received can be viewed online, and there is some evidence that by using this approach we have successfully reached out to new audiences, as well as receiving useful service specific feedback to help shape local and at scale plans which fit under the STP. This is summarised below.

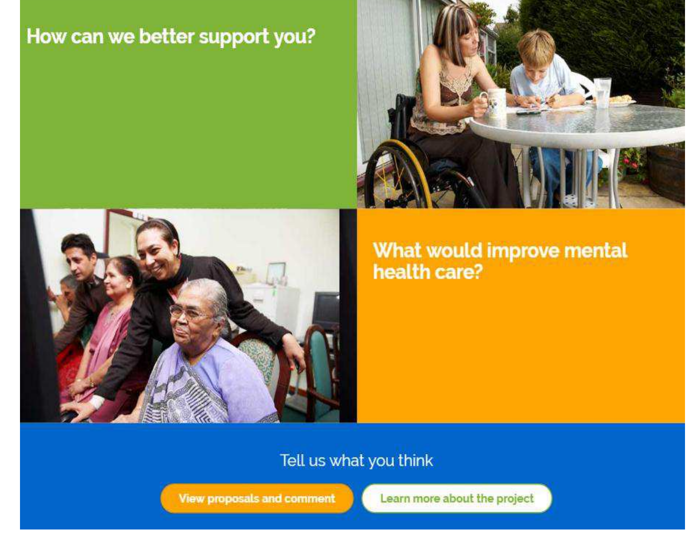
# Online engagement with our residents

## Online engagement

Historically, in the NHS there are known proactive voluntary organisations and residents who are readily engaged with. While face-to-face meetings with hard to reach groups and stands in shopping centres and local festivals reach more people, who do not normally have the time to spare during work hours to offer their opinions, there is still work to be done to reach younger and working members of our communities.

To try and target this audience we have developed an online engagement tool. This is an innovative and exciting way of reaching residents online and via social media and It sits along-side tried an tested methods of engagement.

To-date, of those who have used the online tool, the largest age-bracket is the 25-34, with those aged 35-44 being the second largest age group to respond. This means we are reaching a younger audience, who are not normally engaged with.




## The online tool

Participants have the option to comment on five key areas that we are looking to improve across NW London:

- Preventing ill health
- Long term care
- Care for over 65s
- Mental health
- Quality of care

Each area has a simple outline of what we would like to achieve and a opportunity for respondents to comment on whether they agree with th priority, choose what we should be focusing and provide further comments.

The online engagement can be used remotely via an iPad so face-to-face surveys in the community are automatically uploaded to the database, ensuring consistency. The online survey can also support multiple languages via Google Translate.

## Feedback

***Respondents viewed our suggested priorities positively, with suggestions being made for:***

***"Bed-blocking in hospitals by elderly***, infirm patients is a major problem for the NHS and there needs to be a lot more provision for alternative care outside of hospitals."

**"More resources** need to be put into enabling the elderly and those with long-term conditions to remain independent and to stay well at home. This requires a lot of joined-up care across the health/social care interfaces."

"***Staying well at home*** and in a familiar environment is very beneficial for the elderly both mentally and physically."

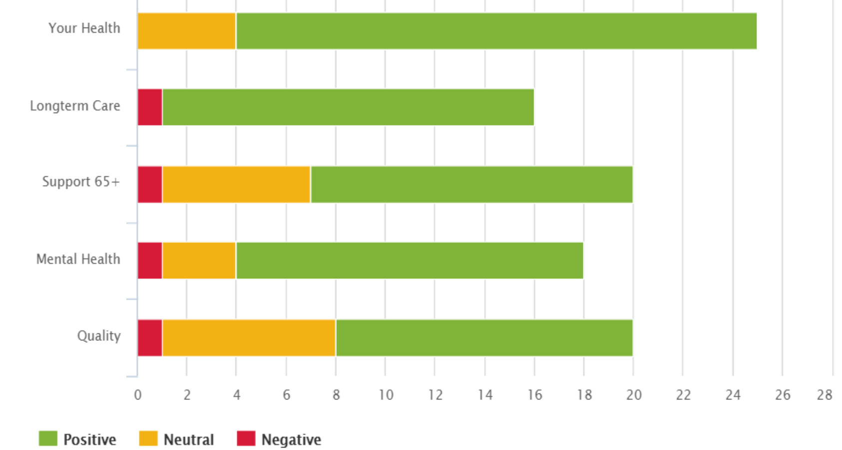
***"Although you want people to exercise*** but health centres are still very expensive. For some people it is hard, almost impossible to exercise outside, so please make more places available at an affordable price for people to exercise."

"***Support the carers of mental health patients*** by educating them and letting them be involved in care plans."

"***Living (and dying) at home*** is always the preferred course. It also generally saves money (compared to hospital 'bed-blocking') but it would probably be worth bringing back care homes for those unable to look after themselves and who need more help than just a quick daily/twice-daily visit."

"***Housing is a key issue*** but I'm not sure how much you can do to resolve it."

***"Better use of volunteers***, particularly for reducing isolation."




"***Healthy lifestyle and mind set is important***, how about offering a referral to a course that involves learning to cook healthy food, how to do basic fat burning and cardio exercises in your own home/outdoors, how to relax/meditate/mindfulness, how to find fun, manage stress, meet others."

**"Quicker access to psychologist and physiatrist** is so important. I have been hospitalised twice -2 months each time in a mental hospital- with serious depression which drove to tempted suicide. When I start getting depression I refuse asking for help just to hit rock bottom and my family suffer when I'm at those stages."

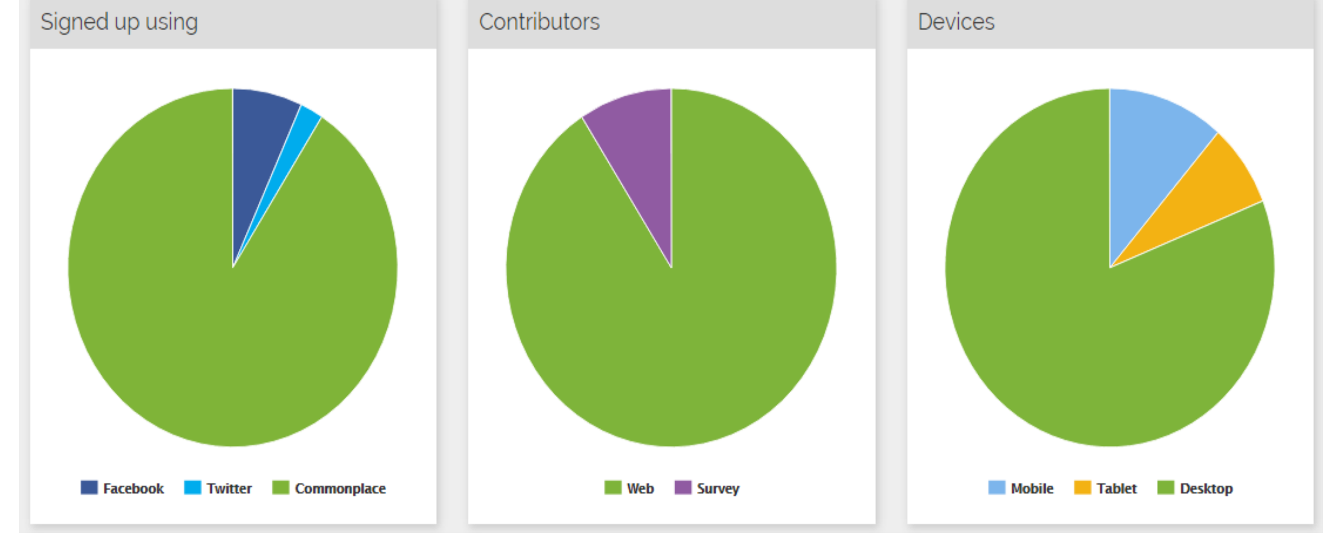
***"For over 65s, I see a huge need to join up physical and mental health*** with social care. A 76 year old neighbour has diabetes, crippling anxiety and no fridge and is unwilling to switch on hot water for financial reasons. A perfect example of why response needs all 3 areas to work together."

# Online engagement with our residents

## Dashboard

The information is presented in a dashboard which allows our engagement team to review and arrange face-to-face meetings with audiences whose comments are not represented so far.

The dashboard also shows how people arrived at the site, e.g. through social media channels, face-to-face surveys from our engagement team or by email. This information will give a useful insight into how effective our current engagement channels are.



## Online and survey feedback

The online and face-to-face survey option had three parts to it: an interactive 'sliding scale' for individuals to indicate their level of support, or not, for a particular delivery area; a number of buttons which could be selected to show favoured priorities within a delivery area and; a free text box for respondents to set out their views as they saw fit. The free text comments often covered a range of topics and points, as well providing personal experience and views on problems with current services and opportunities for improvement.
The analysis below sets out the key quantitative feedback based on the most popular priorities selected for each delivery area and; summarises the key themes drawn from the qualitative free-text responses.

**Quantitative feedback**
Under each delivery area, respondents were invited to select one or more priorities from a range of options.

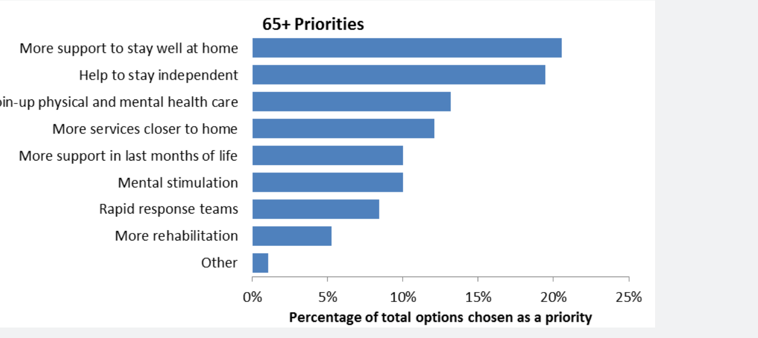
## Public priorities

Your Health Priorities

Healthier diet
Mental health support
Quicker GP appointments
Reducing isolation
More places to exercise
Weight loss
Cleaner air
Better housing
Stopping smoking
More expert advice
Drinking less alcohol
Parenting support
More job opportunities
Online support
Meeting people
Other

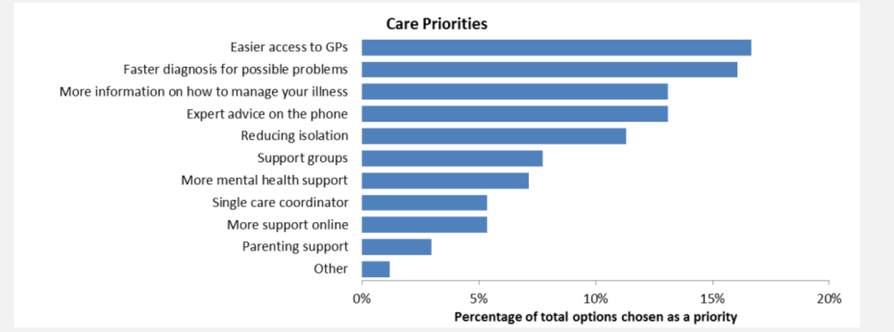
0% 2% 4% 6% 8% 10% 12%
Percentage of total options chosen as a priorty

Your health is affected not only by physical illness, but by the environment and communities you live and work in. NW London wants to support the public to have a healthy life. When asked what the public would want to prioritise when it came to improving their health and wellbeing, a healthier diet and mental health support were the options that were most often chosen.

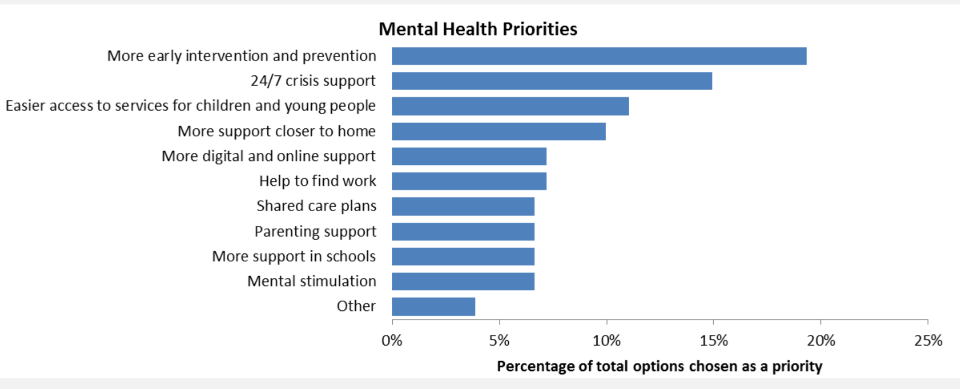



NW London is home to over 300,000 over 65s, and more than 5,000 of these residents have advanced dementia. NW London wants to improve care for older people. When asked what care they would prioritise for over 65s, the options that were most often chosen were more support to stay well at home, and help to stay independent.

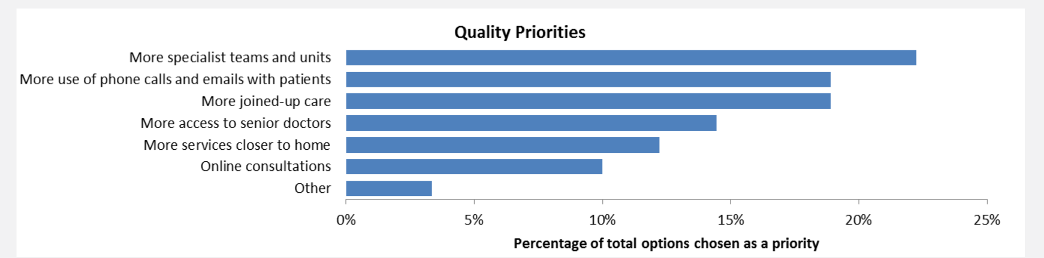
## Public priorities

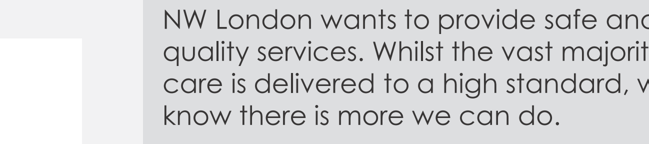



NW London wants to make sure that everyone who needs lifetime or long term treatment or care for illness, disease or disability, receives consistent high quality care and gets the support they need to help manage their condition. When asked what care they would prioritise for people with long term needs, most respondents prioritised easier access to GPs and faster diagnosis for possible problems.




NW London wants to reduce the impact of mental health needs or a learning disability. In NW London, we currently have over 260,000 residents with mental health needs or learning disabilities. Those responding to this section of the survey mainly prioritised early intervention and prevention, as well as 24/7 crisis support.



NW London wants to provide safe and high quality services. Whilst the vast majority of care is delivered to a high standard, we know there is more we can do.

To make local health and care service more modern, safe and effective, most people responded that they would prioritise more specialist teams and units, and more use of phone calls and emails with patients.

**Qualitative analysis**

The qualitative online and face-to-face survey responses varied widely, from the very personal to detailed system analysis. Some gave single sentence comments, others covered multiple topics over many paragraphs.

Separating these comments into categories is challenging, but it has been possible to group the main points raised under 11 main themes, which are set below in order of occurrence, highest first.

- More information and support*
- Funding and structural concerns for NHS and local authorities*
- More integrated support and services
- Better GP services and access
- Importance of mental health*
- Power of positive communities*
- Service and quality concerns
- Benefits of technology
- Better environment
- Faster treatment*
- Impact of carers and volunteers*.

*joint positions.

The most commonly mentioned themes which could be extracted from the comments were:

- better information and support
- funding concerns and;
- more integrated care and services.

There were three themes which featured in comments across all five delivery areas, which were:

- better GP services and access;
- funding concerns and;
- importance of mental health.

**Feedback for each delivery area**

**Delivery area 1 – radically upgrading prevention and wellbeing**
The prevention and wellbeing area was very popular and provided the largest number of comments which could be themed. This is perhaps not surprising as this delivery area provide wide topics for comment, from air quality, to lack of amenities, to the power of closer communities. An example comment is:

*"There should be more focus on helping people stay in the same communities as their elderly parents, so that children are able to care for their elderly parents, particularly if they suffer with multiple health problems. This will help with reducing the need for social services providing Carer's and also help the elderly to have a motivated active and social life which would also reduce NHS costs. Communities that can support themselves by encouraging relatives to look after their elderly by offering incentives such as housing to stay in the community. Loneliness leads to bad physical and mental health. (sic)."*

The most common themes for this delivery area were: **funding concerns** (linked often to lack of investment in local facilities and communities); **a better environment** and; **more information and support**.

**Delivery area 2 –eliminating unwarranted variation and improving long term condition management**
This area contained the least amount of feedback which has been themed, perhaps reflecting that fewer respondents felt qualified to comment unless they or close relative had a long term condition. This supposition is supported by the fact that those of respondents who chose to register and provide more detail, only a small percentage identified as having a long-term condition.

The most common theme for this delivery area was for **more integrated support and services**, probably reflecting the multiple care needs for those with one or more long-term conditions. As one respondent said: "*I am completely lost in this system. It is seems over complicated without continuity with medical advisors* ".

The next most popular theme was **better information and support**, as reflected in this comment: "*Support groups are the answer more hands on than when I went to Ealing hospital. In church halls for over 65s. It's a very friendly group rather than the hospital which is very cold. This support group for my arthritis is a community treasure we should value."*

The third most popular theme was for **better GP services and access**.

**Delivery area 3 – achieving better outcomes and experiences for older people**
Feedback received in this delivery area was, as with delivery area 4, often very personal, as demonstrated by this quote, which also shows the importance of improving and joining-up care: "*I am 88 and have no one to look after me when my daughter is away. My house is very cold as I can't afford to heat my house all the time."*

## NW London STP – Qualitative analysis of feedback from the public cont.



More integrated care and services was the stand-out theme in this delivery area, with a very equal spread across the other themes. The impact of carers and volunteers, funding concerns and better information and support all measured equal second in popularity. Service and quality concerns, power of positive communities and importance of mental health all ranked equal third. Here are two more comments which bring the themes to life:

*"I'd like to see holistic support tailored around the person. People need to be recognised as individuals and the relationship between services (be they provided by whoever) should be consistently high quality with the emphasis of developing and maintaining the individual's trust in services and be respectful and dignified. People need to be involved in their care and support."*
*"For over 65s, I see a huge need to join up physical and mental health with social care. A 76 year old neighbour has diabetes, crippling anxiety and no fridge and is unwilling to switch on hot water for financial reasons. "*

**Delivery area 4 – improving outcomes for children and adults with mental health needs**
This delivery area provided the second highest number of comments which could be themed and again, some very personal and powerful contributions:

*"Quicker access to psychologist and physiatrist is so important. I have been hospitalized twice -2 months each time in a mental hospital- with serious depression which drove to tempted suicide. When I start getting depression I refuse asking for help just to hit rock bottom so to end my life. (I don't know why though, but that's how I feel). My family suffer when I'm at those stages."*

Overall, better information and support was the stand out theme, as shown by this comment: *"Support the carers who care for the mental health patient by educating them and let them be involved in the care plan for the cared for person".*

This theme was almost twice as common as the next popular, concerns around funding, followed by calls for more integrated support and services. These themes are drawn out in the following comment: *"We need more psychologists! However, this will obviously cost more money, but if people in need don't get psychological help then they will have more episodes and this will cost even more. They also need support for housing and disability support allowance is not enough. Also not just parenting support. But also carers need support. 24/7 crisis support need is important and so are more places of safety in the community line. We have an emergency line in Ealing with clinical support and social care follow up. 03001234244. Any line has to have both these requirements (clinical + social care)"*

**Delivery area five – ensuring we have safe, high quality sustainable acute services**
Interestingly, this delivery area attracted the only comments related to the benefits of technology, which was the most common theme for this section. As one respondent wrote: *"GPs could also help by increasing access to telephone, video and email consultation."*. Funding and structural concerns were, perhaps unsurprisingly for this delivery area, a close second and closely followed in third place by calls for more integrated support and services. Here are two further examples which highlight the public's views of how we can improve:
*"Being under outpatient care of two separate hospitals it would be good if they communicated with each other. Currently correspondence I receive from one or other is photocopied by me and delivered when attending an appointment. This is archaic method of communication."*
*"Integrating health and social services would provide better care at reduced cost once IT systems are integrated. Workers can then work from shared premises."*

**Conclusion**
This feedback will be shared widely across the NHS and local authorities to help drive and shape our future plans for health and social care in NW London.

# Appendix E: NWL Sustainability and Transformation Plan

You said, we did – Response to patient and organisation feedback on the 30 June Submission

# Appendix E: You said, we did – response to patient and organisation feedback on the 30 June Submission

One of the key principles of our engagement process is that we listen and then act upon the advice we receive, feeding back as much as possible. Below we set out the initial feedback we have received through written submissions, public meetings, via the online engagement tool and from questions raised through public outreach in relation to the 30 June checkpoint submission. Given the large volume of feedback we have received the below list is not exhaustive, far from it, and we have concentrated our time now on reflecting as much of that as we can in the document itself. We will be producing a fuller feedback log which we will release and will set out clearly how we have addressed all the comments we have received.

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Governance** | The Hillingdon Hospital FT | Query around board responsibilities on receiving the final STP version | The formal governance approach is in the process of being agreed across CCGs, local authorities and providers. |
| | Hillingdon Partner | Query around board responsibilities as the draft goes through local approval processes (consistent form of words e.g. supporting/endorsing) | See above |
| | West London CCG | Clarification on governance – STP implies engagement rather than decision-making | The STP has been updated to reflect the governance development since the June submission. The decision making powers of the JHCTG remain unchanged. |
| | | Programme of work across the 8 CCGs would be best served by a standard decision-making pathway rather than a structure for each programme. | The governance structure of the STP can be seen on page 21 of the Delivery Plan paper. |

# Appendix E: Response to patient and organisation feedback

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Financial** | Central and NW London FT | Concerns around spend and savings for mental health against the national requirements | The five year forward view for mental health has been incorporated into the Mental Health chapter for the October submission. |
| | Hillingdon Partner | Further information about how the plan will lead to access and allocation of funding | Project delivery plans are being developed which will set out the relevant financial information. |
| | Chelsea and Westminster FT | Prevention and H&WB target will be challenging to realise within 5 years | Project delivery plans are being developed for prevention schemes. |
| | Hounslow CCG and LA | Establishing the origin of the £110 million of investment that has been linked to LAs under DA1<br>The £145 million LA budget gap in the STP has been underestimated given the time frame | The June submission of the STP included the references for prevention opportunity, which included the HLP Report and the Prevention Report from the WLA.<br><br>Local authorities have commissioned work to review the social care gap. This will feed into the STP's Strategic Finance and Estates Group which will update the STP's finances where required. |
| | | Financial resource required for extra sheltered housing and care home places has not been included. | Delivery plans for projects in Delivery Area 1 include requirements for sheltered housing and care home initiatives and will set out existing resources and resource requirements. |
| | Brent Patient Voice | Too much financial detail is missing from the checkpoint submission. It's impossible to properly analyse the plan without all the figures and the workings which sit behind them to understand whether this is really sustainable. | The financial data has been included in this iteration of the plan to demonstrate how it will be sustainable |

# Appendix E: Response to patient and organisation feedback

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Financial** | ICHT | Given the scale of our combined financial gap over the five years greater assurance is required on the return on the investment in the work programme to close the £1.3bn gap, the phasing of realising the net savings outlined and the process to mitigate significant risks. | A robust programme governance process has been established through the Delivery Areas to manage the risks associated with delivery of the constituent projects. Each project team is in the process of undertaking a detailed financial analysis profiled to their delivery plan and will maintain a risk and mitigation log. This approach is outlined in the NWL Delivery Plan. |
| | | We have a clear internal sign off process for our STP financial data which we submit through the Finance and Activity Modelling Group (FAM). Understanding the upwards approvals process in generating the combined footprint level financial analysis is necessary to contextualise the financial messages and promote greater ownership of the numbers behind the STP's financial position. | As well as the Financial And Activity Modelling Group the health Chief Finance Officers are meeting weekly for this reason. We have also established a finance and estates working group that reports into the Joint Health and Care Board. |
| **Engagement** | | The engagement document provides a helpful position statement and sets out some immediate actions. There is scope to develop this more fully into a strategy which clearly signposts to staff and the public areas where their input will add the most value, identifies measures of success and the mid to longer term opportunities for engagement throughout the period that the STP covers. | An updated communications and engagement strategy is included in this version of the STP. At it's core is a belief that this is a continuous and transparent process that will run across the five yeas of the STP |
| | RBKC | Public engagement needed to be enhanced, perhaps by production of a summary document that the public could understand. | A public-friendly presentation has been widely circulated which can be adapted for local needs. The online version is also available to the public. We will speak to RBKC to address this further. |
| | Healthwatch | A number of Healthwatch colleagues, in particular from Ealing, raised issues around lack of engagement on the implementation of SaHF, most notably for Ealing and Charing Cross Hospitals. Engagement activity must not ignore changes to these two hospitals as it is of key concern to residents. | The engagement activity to date has focussed specifically on the overarching principles that sit behind the plan and how we tackle the challenges we face in NW London. We agree that it is essential to engage with residents about developments at both Ealing and Charing Cross Hospitals as we move towards having a IMBC, we will start that engagement and we will look to work with Healthwatch to ensure we engage with as many residents as we can. |
| **Evidence base** | Brent Patient Voice | There needs to be a proper evidence base for the out of hospital strategy. | An independent piece of work was commissioned by five of our local authorities to assess the evidence base for moving more services to an out of hospital model. |

# Appendix E: Response to patient and organisation feedback

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Policies** | Hillingdon CCG | CCG does not support current wording of primary care standards in the STP – request change to wording. | Please see revised Primary Care chapter |
| | Chelsea and Westminster FT | Harness NWL's capacity in research and services | The academic health science network attends the NW London Strategic Planning Group (SPG) and has been involved in the development of the STP. It is also involved in the mobilisation of the Delivery Areas. |
| | Hounslow CCG and LA | There are not enough plans around wider determinants of health, particularly housing, social isolation or community resilience. There should also be an approach to tackling underperformance in primary care. | The Wider Determinants of Health project was a new initiative in June 2016. A project delivery plan is being developed which will provide further details around deliverables and resources. There will be an updated Primary Care chapter. |
| **Nomenclature** | NWL CCGs Strategy & Transformation | '7 day discharge' or 'expanding common discharge' rather than introducing new term 'single discharge' as in STP | The STP October submission has been updated with this change. |
| **Local & Central plans** | Ealing CCG | Have a central response as to why local plans are not being published | The local plans were an important part of the early work in developing the NW London STP. Where there has been an interest in that local plan, we have made it available, for example the Ealing plan is available online |
| | Hillingdon Partner | Will the final version of the STP have local chapters? | The local plans were an important part of the early work in developing the NW London STP. NHSE have not asked for them to be included in the final version, but the plans ultimately shape the priorities within each borough |
| | Hounslow CCG and LA | Local services programme should be emphasised | The Local Services Programme is a critical component of delivering the STP as its projects fit under 3 of the Delivery Areas. For the October submission of the STP we will also submit detailed implementation plans for each delivery area, this will set out in more depth the activities that will be undertaken, including through the Local Services Programme. |

# Appendix E: Response to patient and organisation feedback

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Communication** | Chelsea and Westminster FT | Communicating impact to the population and the workforce rather than just a plan | There is agreement on the importance of communicating with the population and our workforce in NW London. The STP will only be successful if those who live and work in NW London own, understand and are involved with the STP.<br><br>A series of engagement events and activities are taking place which will set out the impacts to residents and staff. |
| | West London CCG | Reference public meetings | We will update the STP to reflect the public meetings and online engagement as these activities have developed since 30th June. |
| | | Information for staff is essential | There is agreement on the importance of providing information to staff. We have a programme of communication and engagement activities planned across organisations in NW London. |
| | Ealing LA | Ealing has not signed up to the STP (due to concerns around acute configuration) and wants this to be emphasised | We have a strong relationship in NW London with all eight councils and the health service working together to deliver the best care and support for all our residents, particularly around prevention and out of hospital services. That relationship means we are open and honest about where we disagree. We will continue to work with both Ealing and Hammersmith & Fulham councils on all the areas we do agree on, mainly local services and our out of hospital strategy to deliver joined-up health and social care for our residents. |
| | | Ealing and Charing Cross hospital plans have not been clearly explained | We have a strong relationship in NW London with all eight councils and the health service working together to deliver the best care and support for all our residents, particularly around prevention and out of hospital services. That relationship means we are open and honest about where we disagree. We will continue to work with both Ealing and Hammersmith & Fulham councils on all the areas we do agree on, mainly local services and our out of hospital strategy to deliver joined-up health and social care for our residents. |

# Appendix E: Response to patient and organisation feedback

| Theme | Organisation | Feedback | Changes/response to/in STP document |
|---|---|---|---|
| **Timelines and overlaps** | Chelsea and Westminster FT | NHSEs approach to reviewing services aligns with STP checkpoints in October which should be addressed in DA5 | For the October submission more detailed implementation plans will be included. This will set out further detail on Delivery Area 5. |
| | | There are significant overlaps with productivity and improvement in acute services and the SaHF planning workstream. | The existing Provider Board which oversees the productivity work, and the Implementation Programme Board which oversees the acute transformation work are now merging into a STP Delivery Area 5 Board which is currently in planning and handover stage. This Board will help us to ensure that productivity work programmes continue to be aligned with SaHF programmes of work. The existing Boards have representation from NWL acute and community providers, and the productivity piece of work in particular is provider-led. The productivity work programmes are overseen by a Chief Transformation Officer who is based alongside the SaHF team. Some overlap is intentional, as the productivity work is more achievable in a shorter timescale than the larger scale transformation work associated with the hospital reconfiguration. |
| | | The timeline for estate enabled benefits (acute) is outside of the 5 year period of the STP. | The assurers for the acute transformation work have requested that the team produce both an accelerated timeline as well as a traditional timeline for this piece of work. Under the accelerated timeline, some elements of the acute transformation will be delivered within the five year period of the STP. This timeline is currently in process of being assured and will be finalised in early 2017. |
| **Lay Partner Feedback** | Lay Partner Meeting | Increase in community centres; better access to counselling and therapy; education around health and wellbeing; A proactive approach to long-term care; review of medications for over 65s. | All of these areas are integral to the Delivery Areas outlined in the STP. Further detail will be set out in the implementation plans which will be included in the October submission. |

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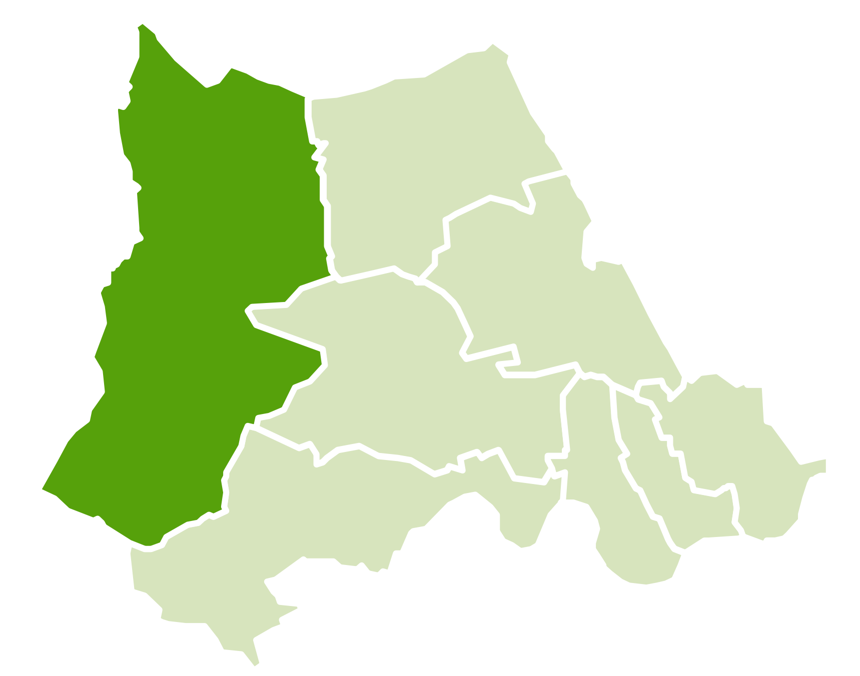
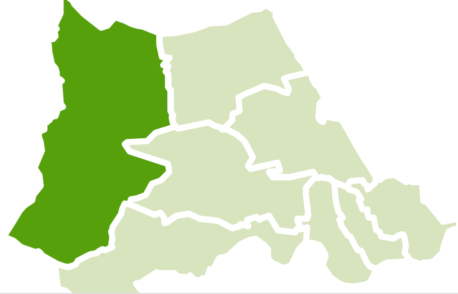
# Hillingdon Executive Summary

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



# This plan has been developed jointly with health and care partners in Hillingdon

# 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. In line with the NHSE guidance we will undertake an extended period of engagement on the local Hillingdon STP and ensure that public and stakeholder views are integral to how we progress our plans. 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.

| 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)*** |

* *Figure not inclusive of children element*

# 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 carers 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 (e.g. 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 a 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.

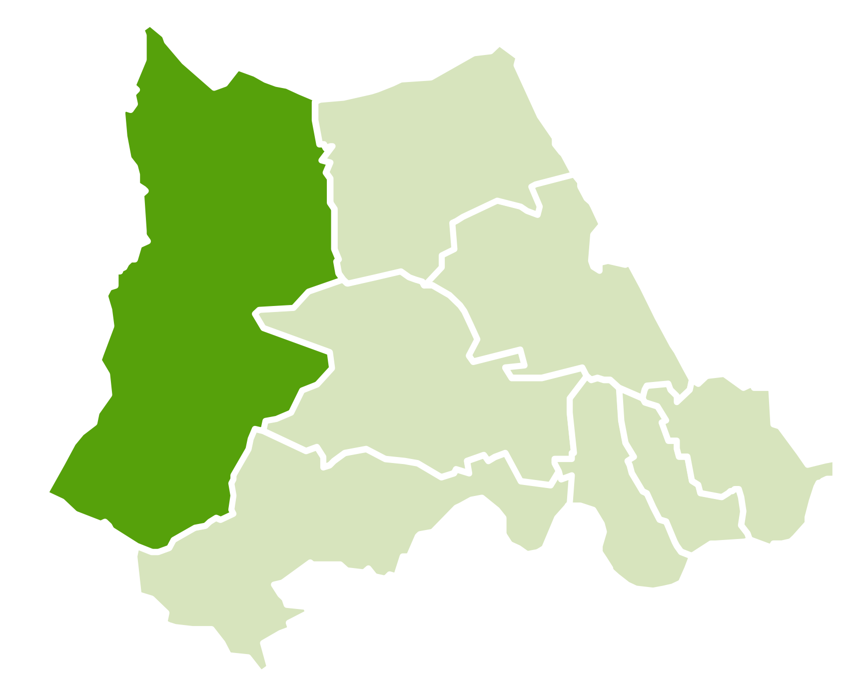
We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices.

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?

| | |
|---|---|
| **DA 1**<br><br>**Focus on prevention and wellbeing rather than treating illness** | *Our focus will be on developing services 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.*<br><br>*Our healthcare services will be focused on engaging people in keeping healthy.*<br><br>*People in Hillingdon will have the support they need to manage of their own health and maintain their independence.* |
| **DA 2**<br><br>**Ensuring healthcare is delivered consistently well and improving the management of long term conditions** | *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 there will be a reduction in variation in both quality of care and access to care throughout our Borough.*<br><br>*Patients will receive more responsive, personalised care delivered out of hospital in a safe and effective way; such as our existing dermatology and pain management services.*<br><br>*People with long term conditions will be supported to help lead a healthier life.* |
| **DA 3**<br><br>**Achieving better experiences and greater choice for older people in our communities** | *Our health and social care services will work better together to ensure local people receive better coordinated care – especially those with multiple long term conditions.*<br><br>*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.*<br><br>*Mental health professionals and GPs will work better together with care home staff so they can help patients more effectively.*<br><br>*We will have community based teams of local specialist clinicians including practice and community nurses, social care workers, allied health professionals, community mental health workers, GPs, and geriatricians.* |

# What will be different for Hillingdon residents in 2021?

| | |
|---|---|
| **DA 4**<br><br>**Improving outcomes for children and adults with mental health and wellbeing 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.*<br><br>*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.*<br><br>*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**<br><br>**Ensuring we have safe, high quality sustainable hospital services** | *Our hospitals will operate to a higher 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.*<br><br>*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.

| Delivery Area | Work in progress |
|---|---|
| **DA 1**<br><br>*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<br>• By the end of 2016/17 supporting 3,500 patients to have a better understanding of their long terms conditions through the Empowered Patient Programme<br>• Developing a new service model for people at risk of falls<br>• Developing a model for strengthening medical support to care homes<br>• Currently evaluating the effectiveness of the joint Better Care Fund schemes developed by Hillingdon Local Authority and CGG<br>• Development of a three-year BCF plan joint with LBH by March 2017<br>• Sign-off and implementation of our local Prevention Strategy<br>• Expanding our programme of medication reviews in GP Practices to ensure effective and cost-efficient use of medicines<br>• Consult on and agree an air quality and public health action plan<br>• Ongoing implementation of the new Hillingdon Carers Strategy<br>• 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<br>• Implementing Patient Champions in the Urgent Care Centre<br>• Improve access to online advice |
| **DA 2**<br><br>*Eliminating unwarranted variation and improving LTC management* | • Delivering services for patients with LTCs (Cardiology, Respiratory and Diabetes) through community based multi disciplinary integrated teams<br>• A redesigned service for children suffering from asthma conditions<br>• Development of an accountable care partnership for the Hillingdon population<br>• Develop a programme to focus on management of long term conditions co-morbidities<br>• Enhancing the effectiveness of primary care IT systems through use of clinical decision support tools to help ensure patients access the right pathways<br>• Implementation of Hillingdon Cancer Improvement Strategy<br>• Implement National Cancer Vanguard Programme in partnership with Royal Marsden<br>• Developing plans to create direct access cancer diagnostic capacity for Hillingdon GPs to support early diagnosis of cancer<br>• Effectiveness of Long Term Condition Strategy to be captured and measured by patient outcomes data<br>• Implement Remaining Cancer Stratified Pathways<br>• 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)?

| Delivery Area | Actions |
|---|---|
| **DA 3**<br><br>*Achieving better outcomes and experiences for older people* | • Implementing a new Older People's Integrated Care service model<br>• Implementing Intermediate Care 'In Reach' from Community /Third Sector from October<br>• Reviewing Homesafe Programme (Early Supported Discharge) and expanding integrated discharge planning<br>• 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<br>• 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<br>• 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<br>• Better engagement with voluntary and community sector via Hillingdon4All<br>• Embedding health and wellbeing gateway and Patient Activation Measures (PAM) to support self-management<br>• Embedding of memory clinics and ensuring robust links to primary care<br>• Developing an integrated health and social care service model for Hillingdon<br>• Developing a range of focused programmes targeting the Care Homes population<br>• More patients able to access consultants in community setting including a new care of the elderly consultant post in Hillingdon A&E<br>• Integrated service model available 7 days a week<br>• Delivery of anticipatory care planning and coordinated care through deployment of Care Connection Teams across Hillingdon (following pilot) |
| **DA 4**<br><br>*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<br>• Implement and deliver national and NWL strategies - Future in Mind / Like Minded from March 2017<br>• Implementation of all age Early Intervention Services from October 2016<br>• 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<br>• Development of a strategy for adults and children with autism<br>• Evaluating the effectiveness of 24/7 Mental Health Single Point of Access service model<br>• Implementing new Community Learning Disabilities Service from July 2016, including ASD, ADHD packages of care to provide enhance health planning and community based services<br>• Developing a Suicide Prevention Strategy following publication of audit in October 2016<br>• 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<br>• Developing CYP IAPT service in partnership with children & young people and their parents/carers<br>• Improving perinatal mental health service provision along with the development and implementation of perinatal strategy<br>• Ensure that mental health support to people with LTCs and at End of Life is integral to the ACP programme |
| **DA 5**<br><br>*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<br>• Mainstreaming of 7 day therapy in HICU (intermediate care unit) by January 2017<br>• Develop dashboard to monitor outcomes and activity over 7 days<br>• Developmental work with Bucks New University in partnership with THH, CNWL and others to ensure development of the future workforce.<br>• CNWL leadership programme for all new Band 7 and 8a posts.<br>• Review quality of Delayed Transfers of Care monitoring data to ensure patients receive seamless services<br>• THH audit of neo-natal births & babies screening programmes.<br>• THH working with GPs and community providers to pilot new models of acute care using a networked approach.<br>• Master-planning process for redesign of the hospital site<br>• Develop new consultant led escalation model for enhanced care linked to optimised community intermediate care services<br>• Pilot a nurse-led acute medical clinic, before offering the service 7 days per week<br>• Adopt e-prescribing at Hillingdon hospital and Mount Vernon hospital.<br>• 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?

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

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

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

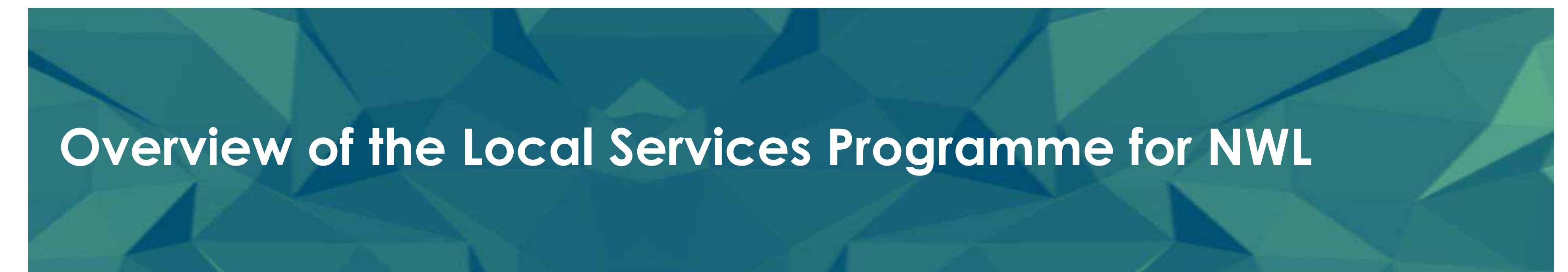
- Wider population health – development of range of interventions to prevent deterioration – management of demand by preventing or delaying the onset of ill-health
- Resilience in primary care
- Development of localised programmes enabling people managing their own conditions through easily available 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 of 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

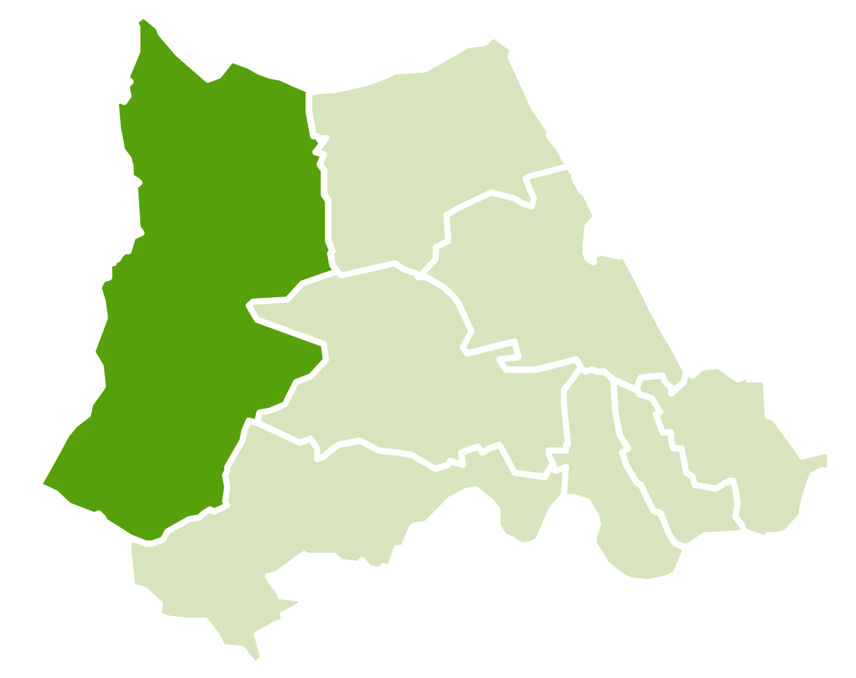
- Current capacity of the health system - the most likely growth assumptions over the next five years will see approx. 21% more activity
- Access rates to first intervention – development of new referral / care pathways
- National shortage of suitably qualified staff
- Improved pathways for vulnerable 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
- Capital 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

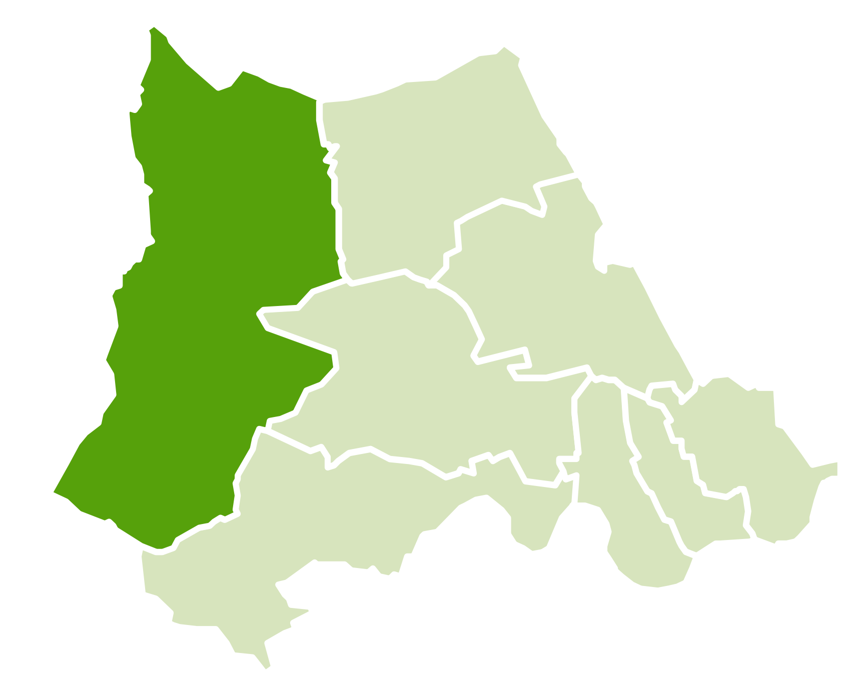


# Overview of the 6 Local Services Programme Initiatives

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<br>• Improved Health Outcomes through focusing on LTCs and complicating factors<br>• Integrated Health & Social Care support for those patients who need it<br>• Reduced frequency of unplanned events | • Whole System Integrated Care Strategy<br>• Better Care Fund | • Reduction in Non-Elective Admissions<br>• Reduction in Zero-Length of Stay Admissions<br>• Reduction in overall costs associated with supporting Older People | • Implement phase 1 of the Care Home Initiative<br>• Develop Carers Support Programme<br>• Rollout H4All Wellbeing Gateway<br>• Integrate Unplanned Support for Older People<br>• Develop new 'Core Offer' for Care Homes including support for EMI and people with SMI<br>• Proactive identification of those at risk of social isolation<br>• Embed the Memory Assessment Clinic Support<br>• Development of capitated budget as part of ACP | • Rollout new care model via ACP focused on Older People<br>• Rollout new core offer for Care Homes integrating Primary, Community and Secondary Care support<br>• Embed Frailty Tool<br>• Embed Care Connection Teams<br>• Deliver the Like Minded Programme |
| **2. New Primary Care Model of Care** | • Increasing number of patients 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<br>• 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<br>• 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<br>• 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<br>• Better Care Fund | • Increase in people dying in their preferred place of death<br>• Increase in people with anticipatory care plans<br>• Reduction in the costs associated with managing people at End of Life | • Finalise End of Life Strategy and manage via EoL Forum<br>• Develop integrated service model including 24/7 SPA and Out of Hours Nursing Support<br>• Develop procurement plans around third sector services | • Rollout EoL Strategy and new integrated service model<br>• 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<br>• Improved outcomes and support for people with multiple LTCs and complex needs<br>• Reducing unplanned care needs arising associated with LTCs<br>• Significant progress in patient activation and the numbers of patients self-managing elements of their care<br>• Increase access to and usage of Personal Health Budgets (PHBs) | • Long Term Conditions Strategy<br>• Dementia Action Plan<br>• Better Care Fund<br>• Prevention Strategy | • Reduction in prevalence growth<br>• Reduction in prevalence gap<br>• Reduction in unplanned events for people with LTCs<br>• Reduction in the costs associated with supporting people with LTCs<br>• increase in people with an LTC who self-manage elements of their care<br>• Increase in people with an LTC who have an anticipatory care plan<br>• Achieve 280 PHBs by 2020/21 | • Refresh Long Term Conditions Strategy<br>• Rollout Integrated Services for Respiratory, Cardiology (HF) and Diabetes and seek to expand to cover AF and Stroke<br>• Rollout new Empowered Patient Programme<br>• Develop plans around co-morbidity management and support to complex service users<br>• Develop plans around management of MH related LTCs | • Expand usage of Patient Activation Model (PAM)<br>• Embed AF and Stroke Services<br>• Improve support for patients with MH related LTCs<br>• Rollout programme for complex users<br>• Proactive engagement with groups at high risk of developing LTCs<br>• Expand access to and use of online advice<br>• Implement MH support for patients with a physical LTC<br>• Expand ICP to wider cohort |
| **5. Transforming Care for People with Cancer** | • Holistic pathways covering both medical and non medical care pathways elements<br>• Integrated cancer rehab<br>• Early identification<br>• Improved uptake rates for screening programmes<br>• SPA survivorship service model<br>• DA and STT diagnostics model | • Hillingdon Cancer Improvement Plan – Cancer Strategy<br>• London Cancer Strategy | • Reduction in unplanned events<br>• Early identification of Cancer patients in primary care/community settings<br>• GP DA and STT community diagnostics<br>• Pathway stratification<br>• Treatment options close to patients homes | • Finalise rollout of Cancer Stratified Pathways<br>• Roll out Lymphedema service model<br>• Develop Hillingdon Cancer Board for non clinical cancer support services<br>• Develop diagnostic capacity to meet demands and targets for Cancer pathways<br>• Review screening programmes<br>• Review Q Cancer Tool utilisation | • Roll out clinical protocol for the follow ups in community<br>• Develop SPA rehab model<br>• Implementation of DA and STT<br>• Rollout outstanding actions from Cancer Improvement Plan |

# Our Transformation Programmes in Detail

| HILLINGDON TRANSFORMATION PROGRAMMES | | | | | |
|---|---|---|---|---|---|
| | 2020/21 OUTCOMES | UNDER-PINNING STRATEGIES | EXPECTED IMPACT | KEY 16/17 ACTIONS | ACTIONS 17/18+ |
| **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<br>• Reduction in risk of harm to vulnerable people<br>• Improved support for people with an urgent mental health need<br>• Significant progress in closing the mortality gap between people with an LD and the wider population | • Learning Disability Action Plan<br>• Dementia Action Plan | • Reduction in the mortality gap<br>• Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD<br>• Reduction in unplanned care needs arising for people with a known mental health condition | • Rollout of 24/7 SPA for people with MH needs<br>• Develop all age early intervention service<br>• Review Community MH Teams<br>• Develop and rollout MH Rapid Response Service<br>• Implement post discharge follow ups | • Expand ICP to include people with MH Conditions<br>• Rollout new model of Community MH Support<br>• Rollout Community LD Service |
| **7. Integrated Care for Children & Young (CYP)** | • Coordination of support for children and young people across all health and social care services<br>• Improved outcomes for children and young people with one or more LTCs<br>• Reduction in the risk of harm to children and young people | • CAMHS Action Plan<br>• Children's Transformation Plan | • Reduction in the need for secondary care activity associated with CYP<br>• Reduction in unplanned care needs for CYP<br>• Reduction in the costs associated in managing CYP per capita | • Develop eating disorder support for CYP<br>• Develop 24/7 SPA for CYP<br>• Implement Consultant Led Acute Model with support to Primary Care & Community Services<br>• Rollout Paediatric Asthma Programme | • Rollout SPA for CYP<br>• Implement crisis and Out of Hours support for CAMHS<br>• Rollout Joint Physical Activity strategy with LBH |
| **8. Integration across Urgent & Emergency Care Services** | • Coordination of support across all Urgent & Emergency Care services<br>• Increase in the number of patients who have their unplanned care needs met outside of a hospital setting<br>• Increased awareness in the community about how to access appropriate services<br>• Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay | • Unplanned Care Strategy<br>• Commissioning Standards for Integrated Urgent Care | • Reduction in rate of growth for unplanned attendances at hospital<br>• Increase in people accessing non-hospital based support for their unplanned care needs<br>• Reduction in the costs per capita managing unplanned care needs<br>• Reduction in Zero-Length of Stay and Unplanned Admissions<br>• Reduction in Length of Stay following an unplanned admission | • Develop plans for new 111 Service and Primary Care Triage Service<br>• Expand Urgent Care Centre capacity<br>• Rollout Patient Education Programme<br>• Expand Intermediate Care Services and integrate with Homesafe | • Rollout new 111 Service and Primary Care Triage Model<br>• Expand access to and use of online advice<br>• Embed Patient Education Programme |

# Our Transformation Programmes in Detail

| HILLINGDON TRANSFORMATION PROGRAMMES | | | | | |
|---|---|---|---|---|---|
| | 2020/21 OUTCOMES | UNDER-PINNING STRATEGIES | EXPECTED IMPACT | KEY 16/17 ACTIONS | ACTIONS 17/18+ |
| **9. Prevention of Disease & Ill-Health** | • Reduction in prevalence gap for key conditions<br>• Reduction in the rate of growth in prevalence<br>• Reduction in the variation in management of conditions | • Prevention Strategy | • Reduction in the prevalence gap for key conditions<br>• Reduction in the rate of growth of prevalence<br>• Reduction in the management of people with LTCs | • Develop Prevention Strategy<br>• Develop Suicide Prevention Strategy<br>• Develop plans to close Hypertension and Diabetes Prevalence Gaps<br>• Rollout Air Quality Review with Public Health | • Rollout of Prevention Strategy<br>• Rollout of Proactive Case Finding in Primary Care<br>• Work to close prevalence gap |
| **10. Transformation in Local Services** | • Reduction in the rate of growth in hospital attendances and admissions for planned care needs<br>• Reduction in Length of Stay following a planned admission<br>• Increased use of alternative services to deliver planned care support | • Local Services Strategy | • Reduction in growth rate for planned attendances and admissions<br>• Increase in planned care provided in non-hospital based settings<br>• Reduction in the planned care costs per capita | • Deliver 4 Priority Acute Standards for 7 Days<br>• Rollout 7 Day Services in HICU<br>• Develop 7 Day Services Dashboard<br>• Re-establish CATS and rollout to Gastro and Neuro Services<br>• Rollout Pain and Dermatology Services to more patients | • Implement post discharge follow ups<br>• 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<br>• Clear information available to aid planning of services | • Digital Roadmap | • High utilisation of Shared Care Record across setting<br>• Services planned using accurate and timely data<br>• Improved outcomes for patients through shared record keeping | • Improve access to Shared Care Records<br>• Develop plans for digitally enabled self-care<br>• Develop plans for use of real time data in decision making | • Become paper free at the point of care<br>• Eradicate use of fax in care services<br>• Deliver robust Shared Care Record that is highly utilised<br>• 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<br>• Reducing sickness and absence rates<br>• Improving skills and competences within the workforce | • Develop recruitment and retention strategy<br>• Develop mutli-professional workforce plans<br>• Brunel University London (BUL) with THH NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences<br>• 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<br>• Continued focus on improvement in A&E Performance<br>• Develop resilience plan around core measures<br>• 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<br>• Improved outcomes for people utilising medicines and a reduction in avoidable harm | • Medicines' Management Strategy | • Reducing spend per capita on medication<br>• Reducing incidents of harm<br>• Improving outcome for people arising from the effective use of medication | • Implement ePrescribing in acute care<br>• Focus on reducing wastage and reducing inappropriate usage of antibiotics<br>• Increase support to Care Homes<br>• 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<br>• A diverse market of quality providers maximising choice for local people | • Integrated Care Strategy | • Significant proportion of care delivered through integrated delivery vehicles<br>• A high functioning, cost effective Accountable Care Partnership | • Develop and test financial assumptions around the ACP<br>• Create Network Development Strategy<br>• Develop Primary Care Estates Strategy<br>• Rollout Local Estates Strategy and Rationalisation Plan<br>• THHFT Estates Master planning for new hospital build<br>• Joint market shaping activities with CCG and LBH for care services | • Rollout and trial ACP model and develop plans for future cohorts<br>• Develop Network Development Strategy<br>• Implement recommendation of THH master planning exercise<br>• Implement the 2016/17 market shaping activities |

# BETTER CARE FUND: PERFORMANCE REPORT (JULY - SEPTEMBER 2016)

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Ray Puddifoot MBE<br>Councillor Philip Corthorne<br>Dr Ian Goodman |
| **Organisation** | London Borough of Hillingdon<br>Hillingdon Clinical Commissioning Group |
| **Report author** | Paul Whaymand, Finance<br>Tony Zaman, Adult Social Care<br>Kevin Byrne, Policy and Partnerships<br>Caroline Morison, Hillingdon Clinical Commissioning Group (HCCG) |
| **Papers with report** | Appendix 1) BCF Monitoring report - Month 4 - 6: July - Sept 2016<br>Appendix 2) BCF Metrics Scorecard<br>Appendix 3) Hillingdon Hospital Discharges Day by Day (July - Sept 2014/15 to 2016/17)<br>Appendix 3A) Hillingdon Hospital Discharges Before Midday (July - Sept 2015/16 and 2016/17) |

## HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This report provides the Board with the second 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 £22,531k for 2016/17 as at month 6. |
| **Ward(s) affected** | All |

## RECOMMENDATIONS

**That the Health and Wellbeing Board:**

a. **notes the contents of the report.**
b. **provides feedback to officers on outline proposals for the 2017 to 2019 BCF plan contained within the report (paras 6 to 12).**
c. **provides feedback to officers on the Board's preferred sign-off arrangements for submission to NHSE of any draft planning templates or narrative documents.**

## INFORMATION

1. This is the second 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. **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:

- In Q2 there were 2,420 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,345. Although above the ceiling for the quarter, this level of activity is actually lower than during the same period in 2015/16 when there were 2,468 admissions.

- During the first half of 2016/17 there were 355 falls-related emergency admissions during, which compares to 344 during the same period in 2015/16.

- During Q2 there were 196 admissions to Hillingdon Hospital from care homes compared to 197 admissions during the same period in 2015/16.

- Delayed transfers of care - There were 2,418 delayed days during Q2, which was above the ceiling of 924, which means that activity during the quarter was significantly higher than projected. The position in Q2 2015/16 was 1,002 delayed days. The projected outturn for 2016/17 based on Q1 and 2 activity is 7,730 delayed days against a ceiling of 4,117 for the year.

- There were 31 permanent admissions of older people to care homes in Q2, which suggests that the outturn for 2016/17 is going to be below the ceiling for the year of 150.

- The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q2 was 88% against a target for 2016/17 of 93.8%.

- Although there has been an increase in the number of people admitted to Hillingdon Hospital for planned procedures being discharged at weekends, initiatives to improve patient flow and produce a more even distribution of discharges across the week have yet to take effect.

- 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 Q2 33 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

Delayed Transfers of Care

4. There are a number of factors contributing to the increase in Hillingdon's DTOC position and these include:
- Recording practice - It is unclear as to the extent to which the increase in DTOC reporting in 2016/17 is related to an under-reporting in 2015/16 or an actual increase in accordance with the legal definition. Ensuring consistency and compliance with the legal definition of a DTOC is included within the hospital discharge action plan referred to **Appendix 1**;
- Increasing complexity of need of people admitted to hospital;
- Inefficient post-admission processes, such as an inconsistently applied approach to discharge planning; and
- Care home market capacity and willingness to address the placement needs of people with complex needs, including challenging behaviours.

**DTOCs Defined**

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready leave this type of care but is still occupying a bed. A patient is ready for transfer when:
a) A clinical decision has been made that a patient is ready for transfer AND
b) A multi-discilpinary team decision has been made that the patient is ready for transfer AND
c) The patient is safe to discharge/transfer

A multi-disciplinary team (MDT) should be made up from people from different professions, including social workers where appropriate.

5. These issues are reflected in the Hospital Discharge action plan. However, the Board should be aware that whilst improvements in the efficiency of internal pathways within Hillingdon Hospital and establishing discharge to assess provision within care home settings should assist in reducing the rate of increase in DTOCs the ceiling for 2016/17 is unachievable. In addition, securing a market solution to addressing the needs of residents with more challenging needs is not something that can be achieved quickly. It should also be emphasised that Hillingdon's experience in seeking to address this issue is a reflection of a national problem and is not unique.

**Developing the 2017 to 2019 BCF Plan**

6. From the information available from NHS England (NHSE) at the time of drafting, the expectation is that two documents will be published by the end of November 2016 critical to the completion and finalisation of the 2017 to 2019 plan:

- *BCF Policy Framework* - As for the 2016/17 plan, the purpose of this document will be to set out the national conditions that all Health and Wellbeing Board areas will be required to satisfy and also the assurance framework for the draft plans;

- *BCG Guidance and Key Lines of Enquiry* (KLOEs) - This will set out detailed requirements for completing the plan and the criteria against which plan assurance will be decided.

7. It is understood that the following requirements are likely to feature in the above documents:

a) As with the 2016/17 plan, there will be a requirement to complete a planning template and a narrative document. How extensive the narrative document and any supporting information will need to be will be dependent on the KLOEs. National feedback to NHSE from local authorities and CCGs has been that the KLOEs should focus on encouraging joint working and integration and be significantly reduced in number;

b) The plan will be required to identify how it will contribute to the delivery of the STP and the Government's vision of achieving *'full integration'* between health and social care by 2020;

c) It is expected that nothing in the planning template or the narrative document would commit the Council or HCCG to anything until the HWB and HCCG Governing Body have formally agreed the final plan. This would reflect the process for the 2016/17 plan;

d) There is a possibility that the 2017 to 2019 plan may be the last national iteration of the BCF as there is an expectation that by 2019 the integration agenda will have moved on considerably. What happens post April 2019 is likely to be dependent on the delivery of the broader integration agenda reflected in STPs and also the implications of devolution;

e) Once again reflecting the 2016/17 plan, the assurance process will be undertaken at a regional rather than national level, which for Hillingdon means at a London level. This is to be welcomed as the people who will be involved in this process are known, e.g. Director of Adult Social Care at Newham, the London Better Care Manager and London NHSE Director of Commissioning Operations and have a better understanding of the different issues faced by boroughs and CCGs across London. They are also easily contactable.

8. Officers will update the Board with any additional information that becomes available prior to its December meeting.

9. In the meantime, partners are continuing to work on proposals for the next plan, which are being developed within the context of the Sustainability and Transformation Plan (STP). The September Board update advised that proposals under consideration included:

- ***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. CAMHS is the subject of a separate report on the agenda for the Board's December meeting.

- ***Intermediate Care*** - Options for a fully integrated intermediate care service that will lead to 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.

10. Other proposals also under consideration include:

- ***Children and Young People*** - This is considering integrated commissioning options for placements/services for children with complex needs as well as integrated approaches to addressing the education, health and/or care needs of young people aged 19 to 25 with special educational needs and disabilities.

- **Council participation in the Accountable Care Partnership (ACP)** - This looks at the scope for producing better outcomes for residents through the Council joining the ACP and how this might develop during the two year period of the new BCF plan and beyond.

**Accountable Care Partnership Explained**

An ACP is a partnership of organisations which:

- Is commissioned to deliver outcomes for local people;
- Includes the functions most necessary to deliver these outcomes;
- Is accountable for end to end care of the population;
- Built around a registered population, e.g. people aged 65 and over;
- Functions at a scale sufficient to hold clinical and financial accountability for a population;
- Makes decisions on resource allocation and performance within the partnership, sharing financial risks and benefits;
- Embeds service users in decision making and governance.

11. In accordance with the Board's mandate for officers to be more ambitious in the approach to the next iteration of the BCF plan, partners are also exploring a variety of lead arrangements between the Council and HCCG for major service areas. Subject to future Board, Council and HCCG Governing Body approval, this could result in different lead arrangements during the two year period of the plan. For illustrative purposes only, intermediate care and end of life are examples of where the bulk of the expenditure and provider contract management responsibility sits with the CCG and that therefore a CCG commissioning lead would seem to be logical. With both intermediate care and end of life care HCCG's intention is that its existing contracts will be reflected within its contract with the ACP. This therefore impacts on the development of the ACP and the role of the Council within it.

12. Homecare and care homes are areas where the majority of expenditure is with the Council and where a local authority lead may prove most appropriate. The sustainability of the local homecare and care home markets will be impacted by the development of the ACP, e.g. through availability of professional advice and support to providers. These proposals would also represent the development of a more collaborative approach to supporting the whole health and care system in Hillingdon, which would be new and reflect a greater level of ambition. This would greatly contribute to supporting the sustainability of the health and care system.

13. With Board approval, the proposals as outlined in paragraphs 10 and 11 above will be developed further within the detailed 2017 to 2019 BCF plan proposals to be brought before a future meeting of the Board and HCCG Governing Body.

**Financial Implications**

14. The Quarter 2 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £204k an improvement of £159k from Quarter 1 arising from a favourable movement on the budget for community equipment for both organisations of £125k. 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 movements within the LBH - *Protecting Social Care* funding due increased demand on placement budgets offset by staffing underspends.

## EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendations?**

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

**Consultation Carried Out or Required**

16. 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**

17. None at this stage.

## CORPORATE IMPLICATIONS

**Corporate Finance Comments**

18. 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**

19. 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:** December 2016 | **Period covered:** July - Sept 2016 - Month 4 - 6 |
| **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.<br>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.<br><br>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.<br><br>Scheme lead to attend Core Officer Group. |
| **RED** | Remedial action has not been successful OR is not available.<br><br>The timeline and/or cost and/or objectives are an issue. | Escalate to Health and Wellbeing Board and HCCG Governing Body.<br><br>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 6** | **Variance as at Month 3** | **Movement from Month 3** |
|---|---|---|---|---|---|
| | **£000's** | **£000's** | **£000's** | **£000's** | **£000's** |
| HCCG Commissioned Services funding | 11,965 | 11,865 | (100) | (110) | 10 |
| LBH - Protecting Social Care Funding | 7,109 | 7,005 | (104) | 65 | (169) |
| LBH - Protecting Social Care Capital Funding | 3,457 | 3,457 | 0 | 0 | 0 |
| **Overall BCF Total funding** | **22,531** | **22,327** | **(204)** | **(45)** | **(159)** |

1.1 The financial position at Quarter 2 for the BCF shows an underspend of £204k, which is an improvement of £159k from Quarter 1

## B. Outcomes for Residents: Performance Metrics

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

1.3 **Emergency admissions target (known as non-elective admissions)** - In Q2 there were 2,420 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is above the ceiling for the quarter of 2,345. 1,742 of the admissions (nearly 72%) were to Hillingdon Hospital. Although activity is above the ceiling for the quarter it is actually lower than the same period in 2015/16 when there were 2,468 emergency admissions.

1.4 **Delayed transfers of care (DTOCS) -** There were 2,418 delayed days during Q2, which was above the ceiling of 924. The Q2 2016/17 position represents a significant increase on the same period in 2015/16 when the outturn was 1,002 delayed days. It is unclear as to the extent to which the increase in DTOC reporting in 2016/17 is related to an under-reporting in 2015/16 or an actual increase in accordance with the legal definition. Ensuring consistency and compliance with the legal definition of a DTOC is included within the hospital discharge action plan referred to paragraph 1.11.

1.5 If activity during Q1 and 2 continues at the same level during the remainder of 2016/17 then the projected outturn for the year could be 7,730 against a ceiling of 4,117. Although measures are in place to make improvements in the efficiency of internal pathways within Hillingdon Hospital and establish discharge to assess provision within care home settings, which should assist in reducing the rate of increase in DTOCs, the ceiling for 2016/17 is unachievable.

1.6 London comparative position - With a total of 3,865 delayed days for both Q1 and 2 Hillingdon had the 8th highest level of DTOCs in London (London average 483; highest was Ealing at 5,073; City of London was lowest with 502). Hillingdon had the 12th lowest number of DTOCs in London in 2015/16. The Q1 and 2 2016/17 social care DTOC position of 642 delayed days was 11th lowest in London (London average 173; highest was Ealing at 2,560; City of London was lowest with 0). Hillingdon's social care delays in 2015/16 were the 9th lowest in London.

1.7 Table 2 provides a breakdown of the delayed days during Q2 2016/17.

| Table 2: Q2 DTOC Breakdown | | | |
|---|---|---|---|
| Q2 DTOC Breakdown | | | |
| **Delay Source** | **Acute** | **Non-acute** | **Total** |
| NHS | 1,268 | 651 | 1,919 |
| Social Care | 270 | 45 | 315 |
| Both NHS & Social Care | 0 | 184 | |
| **Total** | **1,538** | **880** | **2,418** |

1.8 36% (880) of the delayed days concerned people with mental health needs in non-acute beds and of these nearly 62% (542) arose due to difficulties in securing suitable placements. 91% (802) of the non-acute delayed days concerned patients in beds provided by CNWL.

1.9 Nearly 59% (1,057) of the 1,789 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.

1.10 Table 3 shows the breakdown of delayed days by NHS trust for Q2.

| Table 3: Distribution of Delayed Days by NHS Trust | |
|---|---|
| **Trust** | **Number of Delayed Days (Q2)** |
| CNWL | 802 |
| Chelsea & Westminster | 1 |
| Hillingdon Hospitals | 1,315 |
| Imperial College, London | 24 |
| Luton & Dunstable | |
| North West London (Northwick Park and Ealing) | 107 |
| Oxford University | 1 |
| Royal Brompton and Harefield | 13 |
| Royal Orthopaedic Hospital | 16 |
| University College | 4 |
| West Hertfordshire (Watford General) | 102 |
| West London Mental Health Trust | 33 |
| **TOTAL** | **2,418** |

1.11 **Care home admission target** - During Q2 there were 31 permanent placements into care homes (11 nursing homes and 20 residential homes) against a ceiling of 37, which means that the level of activity was below the ceiling. On a straight line projection, activity in Q1 and Q2 would suggest an outturn for 2016/17 138 permanent placements against a ceiling of 150.

1.12 It should be noted that the new permanent admissions figure in paragraph 1.11 above is a gross figure that does not reflect the fact that there were 33 people who were in permanent care home placements also left during the period 1st July 2016 to 30th September 2016. As a result, at the end of Q2 there were 457 older people permanently living in care homes (228 in residential care and 229 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q2 and were, therefore, counted as older people.

1.13 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 166 people discharged from hospital to Reablement in Q1 2016/17, 88% (146) were still at home 91 days later, i.e. in Q2 2016/17. Of the 20 people who were not at home at the end of the 91 day period 9 people passed away and 11 were readmitted. 9 of the readmissions were for reasons unrelated to the original cause of admission. The reporting period for the national metric that is used for national comparison purposes is Q3 and for these residents their 91 period will be completed in Q4.

## C. Relationship Maturity Metrics

1.14 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 4: 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. | **Some slippage (Amber)** - Approval for revised proposals that will include nursing home placements, bed-based short-term respite, homecare as well as an expansion of Personal Health Budgets (PHBs) 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) -** Discussions about an integrated model of homecare between health and social care will take place in Q3. |
| **6.** | An integrated outcomes framework for older people. | **On track (Green)** - 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 Q4. |
|---|---|---|
| 8. | The risk and benefits share arrangements following a shadow arrangement in 2016/17. | **On track (Green)** - This will developed as part of the process of developing the 2017 - 2019 BCF plan. |

## 2. Scheme Delivery

| Scheme 1 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | **£000's** | **£000's** | **£000's** | **£000's** | **£000's** |
| LBH - Protecting Social Care | 657 | 659 | 2 | 3 | (1) |
| HCCG Commissioned Services funding | 390 | 390 | 0 | 0 | 0 |
| **Total Scheme 1** | **180** | **1,049** | **2** | **3** | **(1)** |

**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 *Connect to Support* - From 1st July 2016 to 30th September 2016, 1,516 individuals accessed Connect to Support and completed 2,292 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 132 people and 258 sessions on the same period in 2015/16.

2.3 During Q2, 17 people completed online social care assessments and 7 were by people completing it for themselves and 10 by Carers or professionals completing on behalf of another person. 12 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 4 self-assessments undertaken by Carers in Q2.

2.4 A range of activity to promote Connect to Support took place during Q2 and this included training for GP receptionists, attendance at District Nurse and Community Matron team meetings as well as running stalls at the Carers', Citizens' Advice and Age UK 60 + fairs. There were also articles in *Hillingdon People*. The impact of this activity in terms of increased utilisation of Connect to Support will be reported in future performance reports.

2.5 *H4All Wellbeing Service* - During the first half of 2016/17 668 residents have accessed the service and nearly 77% (514) of were aged 75 and over. In this period 357 assessments have taken place using the Patient Activation Model (PAM), which tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. 73 people had a second assessment following a period of support and 48 showed an increased score and therefore increased confidence and motivation. However, 25 people either had a reduced score or there was no difference. The service is now testing how different types and levels of support will impact on increasing confidence and motivation for all residents accessing it. This evidence is also being evaluated to demonstrate how these PAM scores translate in terms of actual A&E and GP attendances.

2.6 *Falls-related Admissions* - There were 355 falls-related emergency admissions during the first half of 2016/17, which is marginally above the 344 total for the same period in 2015/16. The total cost of the falls-related admissions in Q1 and 2 2016/17 was £1,193k, which compares to £1,149k during the same period in 2015/16.

2.7 *Making Every Contact Count* - A training package for delivering Making Every Contact Count (MECC) was developed by the Council's Wellbeing Service and tested out on staff within the team. MECC is about making use of the interactions that staff have with residents in the community to identify those at risk of escalating needs where small changes in their lifestyle, e.g. stopping smoking, increasing physical activity, moderating alcohol consumption, could make a significant difference to their health and wellbeing. This type of prevention can help reduce future demand on health and care services. Face to face training will be delivered to Library staff in Q4.

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

| **Scheme 2: Better care at the end of life** |
|---|

| **Scheme 2 Funding** | **Approved Budget** | **Forecast Outturn** | **Variance as at Month 6** | **Variance as at Month 3** | **Movement from Month 3** |
|---|---|---|---|---|---|
| | **£000's** | **£000's** | **£000's** | **£000's** | **£000's** |
| LBH - Protecting Social Care | 50 | 50 | 0 | 0 | 0 |
| HCCG Commissioned Services funding | 106 | 106 | 0 | 0 | 0<br>0 |
| **Total Scheme 2** | **156** | **156** | **0** | **0** | **0<br>0** |

**Scheme Financials**

2.8 The forecast outturn is in line with HCCG contracted spend. LBH spend on end of life care is forecast to be on budget.

**Scheme Delivery**

2.9 An action in the 2016/17 BCF plan is to commission an integrated specialist end of life care at home service. This had been delayed pending the outcome of the bid for external funding to develop an integrated end of life service in Hillingdon. The results of the bid process were due in Q3 but are now unlikely to be known until Q4. 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. However, partners are currently exploring the value of establishing a short-term integrated service as a test of concept to be commissioned from a local third sector organisation by the Council. Award of contract approval from the Leader of the Council and the Cabinet Member for Social Services, Housing, Health and Wellbeing will be sought in Q3.

2.10 An information sharing agreement between the Council and the Royal Marsden NHS Hospital Foundation Trust was signed in respect of the advanced planning tool Coordinate My Care (CMC) and Adult Social Care read and write access to this system went live. This will help to improve coordination between organisations providing care for people at end of life.

| Scheme 3: Rapid response and integrated intermediate care. | Scheme RAG Rating | Red |
|---|---|---|
| | a) Finance | Green |
| | b) Scheme Delivery | Red |

| Scheme 3 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| HCCG Commissioned Services funding | 5,347 | 5,347 | 0 | 0 | 0 |
| LBH - Protecting Social Care funding | 2,920 | 2,857 | (63) | 99 | (162) |
| **Total Scheme 3** | **8,267** | **8,203** | **63** | **99** | **(162)** |

**Scheme Financials**

2.11 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 which is offset by forecast staffing underspends following the restructure of the Reablement Service .

**Scheme Delivery**

2.12 During Q2 the Reablement Team received 211 referrals and of these 161 were from hospitals, primarily Hillingdon Hospital and the other 50 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 122 people were discharged from Reablement with no on-going social care needs.

2.13 In Q2 the Rapid Response Team received 923 referrals, 55% (510) of which came from Hillingdon Hospital, 20% (182) from GPs, 12% (108) from community services such as District Nursing and the remaining 13% (123) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 510 referrals received from Hillingdon Hospital, 367 (72%) were discharged with Rapid Response input, 117 (23%) following assessment were not medically cleared for discharge and 26 (5%) were either out of area or inappropriate referrals. All 413 people referred from the community source received input from the Rapid Response Team.

2.14 The Board may wish to note that the first half of 2016/17 saw an increase of 12.6% on the same period in 2015/16 in the number of people aged 80 and over attending Hillingdon Hospital but a reduction of 3.4% in the number being admitted. This is largely attributable to the proactive work being undertaken by the Rapid Response Team.

2.15 The Council's Hospital Discharge Team supported the early discharge of 157 people from Hillingdon Hospital and 62 people from other hospitals during the first half of 2016/17. 'Early discharge' means that people were identified and supported into an alternative care setting before an assessment notice under the Care Act was served.

2.16 During Q2 the ACP established four task and finish groups that are looking in detail at redesigning the services being delivered by the organisations within the ACP to improve care planning, reduce fragmentation, improve effectiveness and, most importantly, improve the resident experience of care. Adult Social Care is involved with these groups to ensure alignment between health and social care and with the objectives of Hillingdon's BCF plan. The work of these groups will help to inform the development of the 2017 to 2019 plan for the Board and CCG Governing Board approval.

2.17 The detail of a proposal for a bed-based Discharge to Assess Service based within a local nursing home to address a possible winter demand surge have been agreed between partners with the intention of the Council acting as lead commissioner. Provider appointment approval will be sought during Q3 in accordance with the Council's governance process.

2.18 Other actions relevant to the delivery of this scheme are addressed within the DTOC action plan update referred to in table 5 below. The development of the action plan was an NHSE requirement as part of the development of the 2016/17 BCF plan.

**Table 5: DTOC Action Plan Update**

| Task | Update | RAG Rating |
|---|---|---|
| 1. Complete development of a joint discharge policy and procedure. | A draft setting out roles and responsibilities of partners has been completed. This will be taken forward by the Joint Hospital Discharge Pathway Group for formal sign-off by partners in Q4. | Amber |
| 2. Develop information for patients. | Drafts have been produced using templates provided by NHSE. An application to a one off BCF Small Grant Fund (e.g. ≤£5K) provided by NHSE is being made to for printing. If approved this should be available for | |

| | | |
|---|---|---|
| | residents in Q4. | |
| 3. Establish electronic transfer of assessment, discharge notices, withdrawal and change of circumstances notices. | A funding bid has been approved that will enable this action to be implemented in Q4. | |
| 4. Develop a consistent approach to discharge planning across all THH wards. | These actions are being addressed as part of Hillingdon Hospital's transformation programme. Progress on delivery will be seen in Q4, although all actions are unlikely to be fully implemented in 2016/17. | |
| 5. Embed earlier referrals to Hospital transport | | |
| 6. Ensure that patient medication is available by midday on the day of discharge. | | |
| 7. Ensure the availability of sufficient capacity for timely Continuing Healthcare assessments to be undertaken. | Discharge to assess pilot includes additional CHC nurse assessor capacity to better meet demand. This will be operational in Q4. | |
| 8. Secure accommodation on main THH site for Adult Social Care Hospital Discharge Team. | A lack of space on the main site means that this action is not deliverable in the foreseeable future. | Red |

**Scheme Risks/Issues**

2.19 Service delivery has been RAG rated as red for scheme 3 because of the level of DTOCs. The Board may wish to note that were not for the some of the positive work taking part as part of the delivery of this scheme, the DTOC situation would be much worse.

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

| Scheme 4 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| LBH - Protecting Social Care funding | 100 | 102 | 2 | 0 | 2 |
| **Total Scheme 4** | **100** | **102** | **2** | **0** | **2** |

**Scheme Financials**

2.20 A minor overspend is forecast on seven day working which relates to Mental Health Social Workers.

## Scheme Delivery

2.21 Table 6 below identifies the key deliverable under the Out of Hospital Seven day Working Standard action plan for Q2. 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** |
| Key acute healthcare professionals are accessible 7-days a week. | A & E consultants are contactable until midnight 7-days a week.<br><br>There is an acute physician on site seven days a week and for 8 hours on Saturdays and Sundays. | Completed<br><br>(Green) |
| Ensure that there is sufficient transport capacity 7-day a week. | Hillingdon Hospital will be tendering its transport contract in the New Year and the results of this will not be completed in 2016/17. | Slippage<br><br>(Amber) |
| Develop care home provision for older people with challenging behaviours, including people with dementia, able to admit 7-days a week. | Addressing the supply issues within the care home market is unlikely to be resolved in-year. | Slippage<br><br>(Amber) |

2.22 During Q2 the Hawthorne Intermediate Care Unit (HICU) started to accept referrals on Saturdays, which means that the unit now accepts referrals six days a week. This will assist with patient flow out of the Hospital.

2.23 By the end of Q2 arrangements were put in place to enable the management of complex wound care delivered by CNWL to be available seven days a week for patients of the Ambulatory Emergency Care Unit at Hillingdon, which helps to prevent admissions that are avoidable.

2.24 Improved communication between the Emergency Department and the Psychiatric Liaison Team has led to earlier involvement of the team in supporting people in A & E exhibiting mental distress and this has helped to prevent admissions.

2.25 **Appendix 3** shows the comparison in discharge activity at Hillingdon Hospital in Q2 from 2014/15 to 2016/17. From this it is possible to see that there was a nearly 5% (24) increase in discharges on a compared to the same period in 2015/16 but a 24% (48) reduction in Sunday discharges. The increase in Saturday discharges was entirely attributable to an increase in discharges of people admitted for planned procedures. The number of people discharged on a Saturday who were admitted as emergencies declined by nearly 16% (34). There was a 17% (29) reduction in discharges on Sundays.

2.26 **Appendix 3A** shows the comparison of discharges taking place before midday in Q2 from 2014/15 to 2016/17. It is possible to see from this information that there has been an overall reduction in the proportion of people discharged before midday in comparison with the same period in 2015/16. For weekend discharges this has reduced from 35.5% of Saturday discharges in 2015/16 to 31.2 in 2016/17 and from 27% to 23.7% for Sunday discharges.

2.27 The conclusion from this data is that initiatives to improve patient flow through the Hospital and produce a more even distribution of discharges across the week have yet to take effect.

**Risks/Issues**

2.28 Although all the tasks scheduled to be completed within Q2 are on track, there are tasks due to be completed in Q3 where there is slippage. These are noted in table 6 above and result in this scheme being RAG rated amber.

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

| Scheme 5 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 5 | Movement from Month 5 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| HCCG Commissioned Services funding | 6,021 | 5,921 | (100) | (111) | 11 |
| LBH - Protecting Social Care funding | 5.405 | 5,417 | 12 | (37) | 49 |
| **Total Scheme 5** | **11,426** | **11,338** | **(88)** | **(148)** | **60** |

**Scheme Financials**

2.28 Both HCCG and LBH are currently showing an underspend for the 2nd Qtr due to lower spend 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. The forecast includes a pressure of £37k for Older People placements. For LBH, this scheme also includes the capital funding grant for Disabled Facilities, which is currently forecast to be fully spent.

**Scheme Delivery**

2.29 Reference to the development of the four service redesign task and finish groups by the ACP referred to in paragraph 2.15 is relevant to the delivery of this scheme.

2.30 In Q2 2016/17 33 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 61% of the grants provided.

2.31 22% (12) of the people receiving DFG's were owner occupiers, 72% (39) were housing association tenants, and 6% (3) were private tenants. The total DFG spend on older people (aged 60 and over) during Q2 2016/17 was £85k, which represented 30% of the spend during the quarter (£287k).

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

| Scheme 6 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| LBH - Protecting Social Care | 150 | 157 | 7 | 7 | 0 |
| HCCG Commissioned Services funding (including non elective performance fund) | 83 | 83 | 0 | 0 | 0 |
| **Total Scheme 6** | **233** | **240** | **7** | **7** | **0** |

**Scheme Financials**

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

**Scheme Delivery**

2.33 Emergency admissions from care homes - There were 327 emergency admissions from care homes during the first half of 2016/17 at a total cost of £1,106k. This compares to 362 admissions in 2015/16 at a cost of £924k. The increased cost of the lower number of admissions in 2016/17 can be explained by increased lengths of stay.

2.34 A soft market testing exercise was undertaken with four potential providers of care and support for older residents living in extra care sheltered housing. The purpose of the exercise was to identify whether the proposed model was attractive to the market as well as identifying what other factors would encourage providers to bid. This exercise has helped to finalise the content of the service specification for the care and wellbeing in extra care service which will be the subject of a competitive tendering exercise in Q4.

**Risks/Issues**

2.35 This scheme has been RAG rated amber on scheme delivery due to delays in the undertaking the modelling work to project the need for bed-based services over the next five years. Discussions are currently in progress between the Council and HCCG about the scope for jointly engaging an external organisation to undertake this work and necessary approvals will be sought in due course if required. This work is intended to lead to the development of a care home market position statement which will give the market advanced notice of Council and NHS requirements over the next five to ten years.

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

| Scheme 7 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| LBH - Protecting Social Care | 899 | 871 | (28) | 9 | (37) |
| HCCG Commissioned Services funding | 18 | 18 | 0 | 0 | 0 |
| **Total Scheme 7** | **917** | **889** | **(28)** | **9** | **(37)** |

## Scheme Financials

2.36 For LBH, there is forecast to be a pressure on respite services to Carers due to increased placement cost being charged by providers which is offset by a reduction in the cost of carers' assessments.

## Scheme Delivery

2.37 There has been further refinement of the recording of carers' assessments to ensure greater accuracy of recording and reporting. What is recorded is the first assessment taking place within the financial year and any subsequent assessments that are completed within 90 days of the previously counted assessment. Assessment figures include sole assessments, joint assessments and reviews. Using this methodology there were 191 assessments in Q2, compared to 259 in Q1. On a straight line projection this would result in 900 assessments being completed in 2016/17, which would represent a 14.9% reduction on the 2015/16 outturn (1,058).

2.38 During Q2 183 Carers were provided with respite or another carer service at a cost of £430.7kk. This compares to 123 Carers being supported at a cost of £372.9k in Q2 2015/16.

2.39 In Q2 the Carers in Hillingdon contract started provided by the Hillingdon Carers Partnership and led by Hillingdon Carers. This new contract creates a single point of access for Carers. It should lead to better outcomes for Carers and therefore the people they care for.

2.40 A multi-agency Young Carers' Strategy was established and held its first meeting during Q2. This enables partners to work collaboratively to take a much more strategic approach to addressing the needs of young carers. The long standing Carers' Strategy Group for adults has proved successful in enabling partners to work together to deliver better outcomes for adult Carers.

2.41 Two local Carer Forum meetings took place in Hayes and Northwood, both of which were attended by approximately 30 Carers. The local Carer Fora are intended to create an opportunity for Carers to meet other Carers and identify what support is available to them, including how they can be assisted to support one another.

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

| Scheme 8 Funding | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| LBH - Protecting Social Care | 305 | 267 | (38) | (15) | (23) |
| **Total Scheme 7** | 305 | **267** | **(38)** | **(15)** | **(23)** |

**Scheme Financials**

2.42 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £38k.

**Scheme Delivery**

2.43 Stirling University ran a training session for the designers of Grassy Meadow Court and Parkview Court extra care schemes to ensure that the gold standard for having a dementia friendly environment is achieved.

2.44 90 staff across health and social care, including GP surgery staff, took part in dementia awareness training.

2.45 A new health service for people with learning disabilities was implemented in July with a specific focus on identification of people with dementia. This is intended to assist with the early identification, diagnosis and treatment of people with dementia. People with learning disabilities, especially people living with Down's syndrome, have a particular susceptibility to dementia that increases with age.

**BCF Programme Management Costs**

| | Approved Budget | Forecast Outturn | Variance as at Month 6 | Variance as at Month 3 | Movement from Month 3 |
|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's |
| BCF Programme Management | 80 | 81 | 1 | 1 | 0 |
| **Total** | 80 | **81** | **1** | **1** | **0** |

**3. Key Risks or Issues**

**IT Interoperability**

3.1 *Carer Information Exchange* - There have been delays in starting the Care Information Exchange (CIE) pilot, which is intended to test a software system that will enable organisations involved in a person's care to update details of their intervention electronically onto an online system that would also be accessible to the resident. The system is intended to enable Hillingdon's care community to get to the point where residents/patients only have to tell their story once. The delays in starting the pilot are due to information governance concerns of the Local Medical Council (LMC). Discussions are in progress to address these.

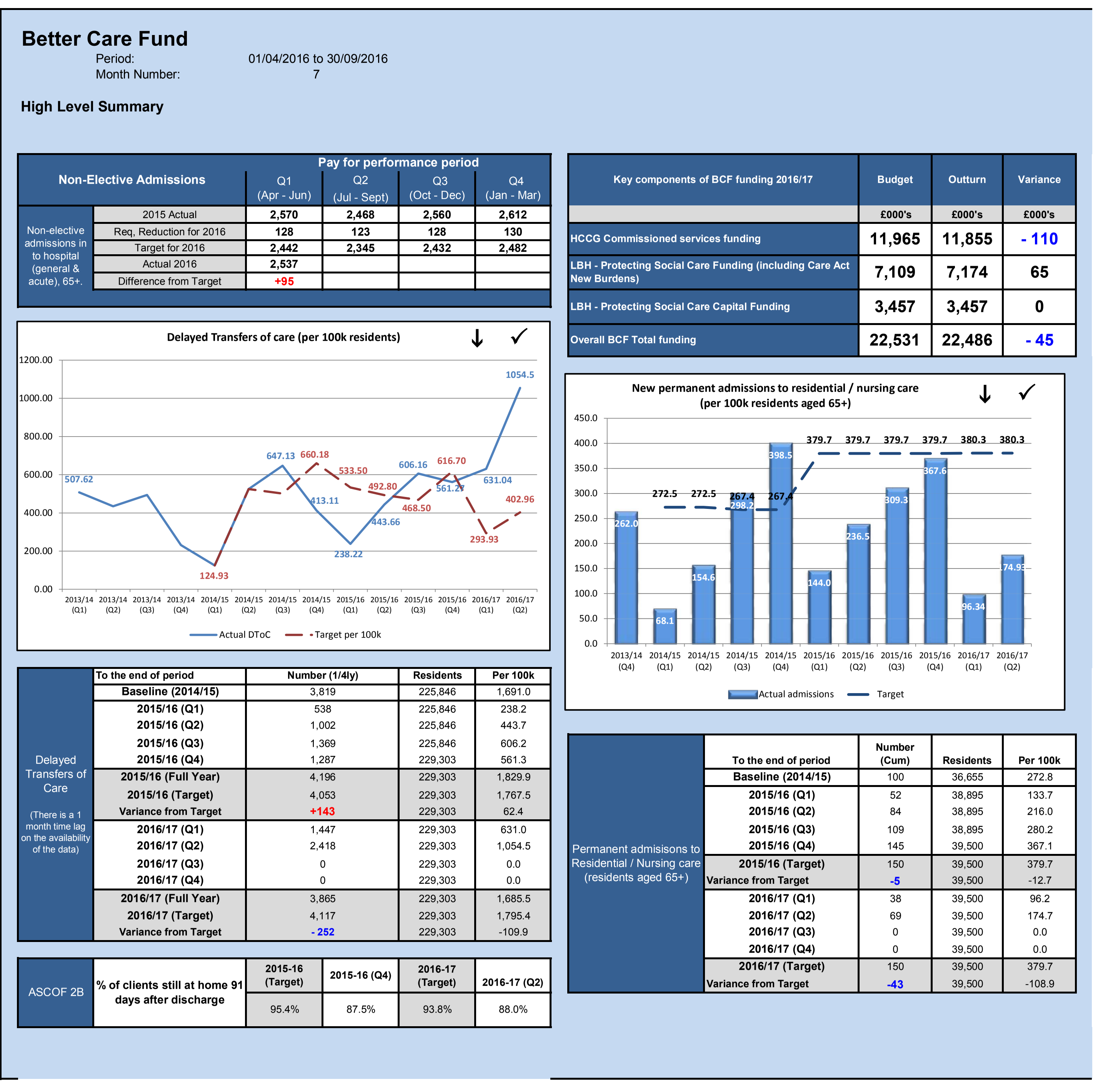
**2017 to 2019 BCF Plan Delivery Timescale**

3.2 It is expected that the timescale for developing and finalising the plan is likely to be very tight and this will inevitably limit the scope for involving residents and service users and other stakeholders, e.g. health, social care and third sector staff, in the development process. A communications plan will be drafted once the plan has been agreed by the Board and HCCG Governing Body and has cleared the NHSE assurance process. Consultation will be undertaken as part of the development and delivery of the specific elements within the plan, many of which, in mitigation, will be seeking to address issues that have been identified in the many consultation exercises undertaken in recent years.

# Better Care Fund

Period: 01/04/2016 to 30/09/2016
Month Number: 7

## High Level Summary



| Non-Elective Admissions | | Q1 (Apr - Jun) | Q2 (Jul - Sept) | Q3 (Oct - Dec) | Q4 (Jan - Mar) |
|---|---|---|---|---|---|
| | | Pay for performance period | | | |
| 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 | | | |

| 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 |



| Delayed Transfers of Care (There is a 1 month time lag on the availability of the data) | Number (1/4ly) | Residents | Per 100k |
|---|---|---|---|
| To the end of period | | | |
| 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) | 2,418 | 229,303 | 1,054.5 |
| 2016/17 (Q3) | 0 | 229,303 | 0.0 |
| 2016/17 (Q4) | 0 | 229,303 | 0.0 |
| 2016/17 (Full Year) | 3,865 | 229,303 | 1,685.5 |
| 2016/17 (Target) | 4,117 | 229,303 | 1,795.4 |
| Variance from Target | - 252 | 229,303 | -109.9 |

| ASCOF 2B | 2015-16 (Target) | 2015-16 (Q4) | 2016-17 (Target) | 2016-17 (Q2) |
|---|---|---|---|---|
| % of clients still at home 91 days after discharge | 95.4% | 87.5% | 93.8% | 88.0% |

| Permanent admisisons to Residential / Nursing care (residents aged 65+) | Number (Cum) | Residents | Per 100k |
|---|---|---|---|
| To the end of period | | | |
| 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) | 69 | 39,500 | 174.7 |
| 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 | -43 | 39,500 | -108.9 |

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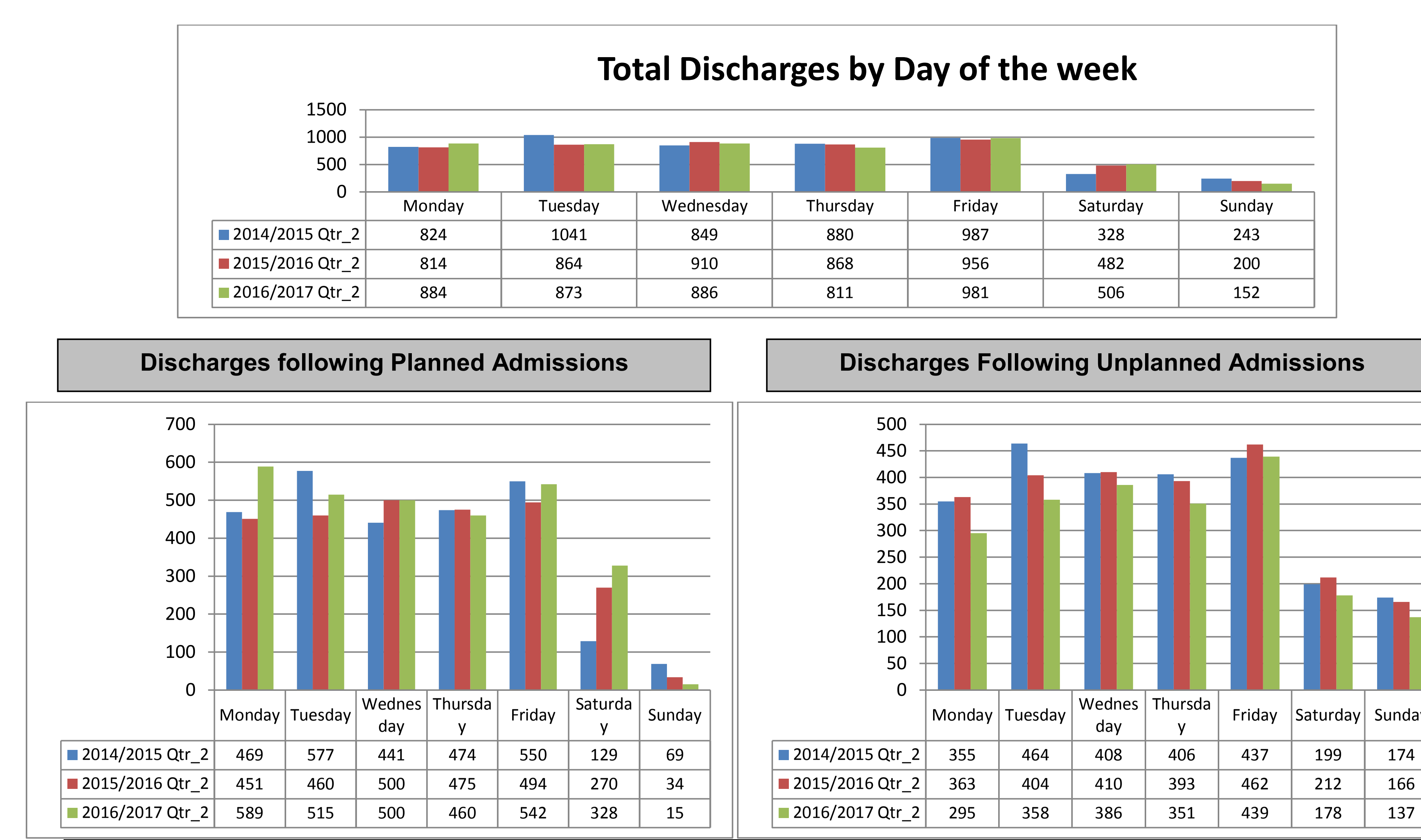
**Total Discharges by Day of the Week July - September 2014/15 to 2016/17**




Total Discharges by Day of the week

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 2014/2015 Qtr_2 | 824 | 1041 | 849 | 880 | 987 | 328 | 243 |
| 2015/2016 Qtr_2 | 814 | 864 | 910 | 868 | 956 | 482 | 200 |
| 2016/2017 Qtr_2 | 884 | 873 | 886 | 811 | 981 | 506 | 152 |

Discharges following Planned Admissions

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 2014/2015 Qtr_2 | 469 | 577 | 441 | 474 | 550 | 129 | 69 |
| 2015/2016 Qtr_2 | 451 | 460 | 500 | 475 | 494 | 270 | 34 |
| 2016/2017 Qtr_2 | 589 | 515 | 500 | 460 | 542 | 328 | 15 |

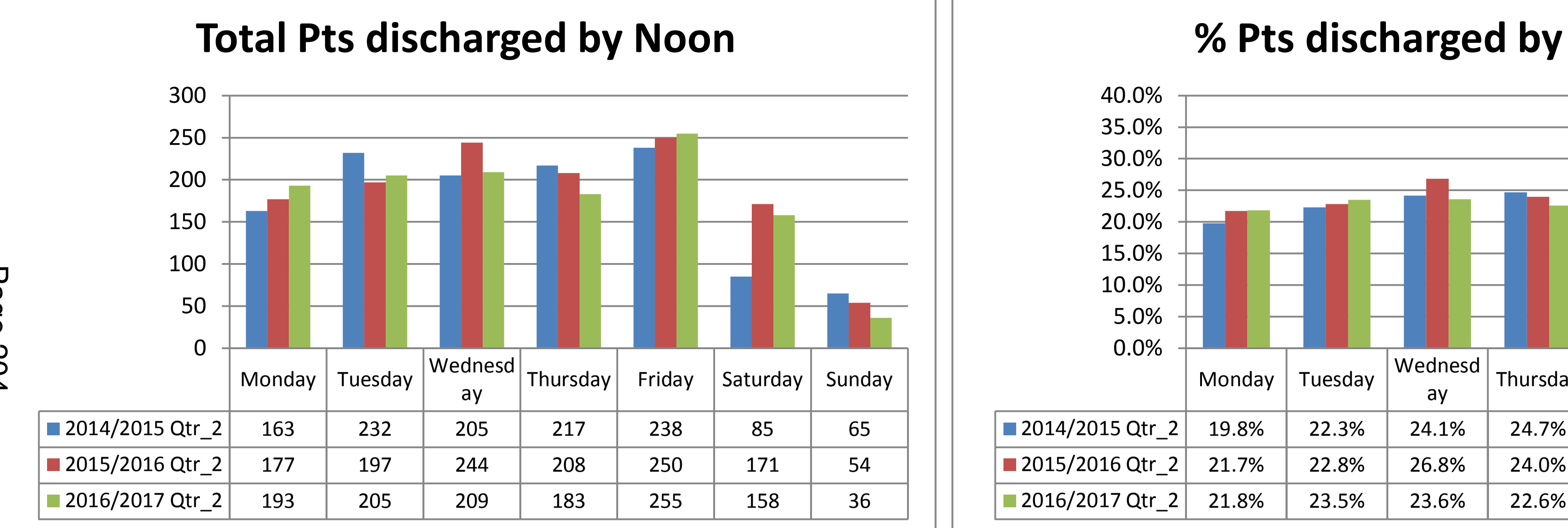
Discharges Following Unplanned Admissions

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 2014/2015 Qtr_2 | 355 | 464 | 408 | 406 | 437 | 199 | 174 |
| 2015/2016 Qtr_2 | 363 | 404 | 410 | 393 | 462 | 212 | 166 |
| 2016/2017 Qtr_2 | 295 | 358 | 386 | 351 | 439 | 178 | 137 |

**Appendix 3A**

## Discharges Taking Place before Midday July - September 2014/15 to 2016/17

**Number of Patients Discharged Before Midday**




| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 2014/2015 Qtr_2 | 163 | 232 | 205 | 217 | 238 | 85 | 65 |
| 2015/2016 Qtr_2 | 177 | 197 | 244 | 208 | 250 | 171 | 54 |
| 2016/2017 Qtr_2 | 193 | 205 | 209 | 183 | 255 | 158 | 36 |

**% of Patients Discharged Before Midday**

% Pts discharged by Noon

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 2014/2015 Qtr_2 | 19.8% | 22.3% | 24.1% | 24.7% | 24.1% | 25.9% | 26.7% |
| 2015/2016 Qtr_2 | 21.7% | 22.8% | 26.8% | 24.0% | 26.2% | 35.5% | 27.0% |
| 2016/2017 Qtr_2 | 21.8% | 23.5% | 23.6% | 22.6% | 26.0% | 31.2% | 23.7% |

# CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE NOVEMBER 2016

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Ian Goodman<br>Councillor Philip Corthorne |
| **Organisation** | Hillingdon CCG<br>London Borough of Hillingdon |
| **Report author** | Pranay Chakravorti, London Borough of Hillingdon / HCCG |
| **Papers with report** | None. |

## 1. HEADLINE INFORMATION

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|---|---|
| **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<br>Hillingdon's draft Sustainably and Transformation Plan<br>Hillingdon CCG's Draft Commissioning Intentions 2017/18<br>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 Local Transformation Plan (LTP), which will form part of the CCG assurance process for CCGs.<br><br>There are no direct financial implications arising from this update report |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

That the Health and Wellbeing Board:

a) notes the progress in implementing the agreed 2016/17 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 the Council.
c) continues to request regular performance updates against the partnership plan.

## 3. INFORMATION

At the August CAMHS Steering Group, it was generally felt by partners 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.

There is still significant concern that despite investment, the whole pathway is not functioning optimally. Although waiting lists targets for core services are now improving, 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 as a default signposting service, outside of its core purpose and therefore inefficient use of a significant financial resource.

As a consequence, HCCG and the Council are developing a more ambitious 2016/17 work programme. Key features include developing an integrated pathway which moves 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.

**Next Steps**

The intention to commission an integrated CAMHS pathway without Tiers, which is included in Hillingdon's STP, and was discussed in detail at a strategic seminar facilitated by the Anna Freud Centre on 20th October. The report, following the seminar, was received on 16th November 2016 and will be discussed in detail at the Children's and Young people's Steering Group on 1st December when a confirmed direction of travel and timeline will be developed.

With Health and Wellbeing Board (HWBB) agreement, the Council and HCCG will jointly work with stakeholders to co-commission a system without Tiers. 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 the Council 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 December 2016 with a view to seeking HCCG, the Council and HWBB approval for a model that will accelerate improvements achieved to date for children and young people.

## 4. PERFORMANCE

### a) CAMHS

**CAMHS performance via HCCG contract with CNWL - 18 Week waiting times**

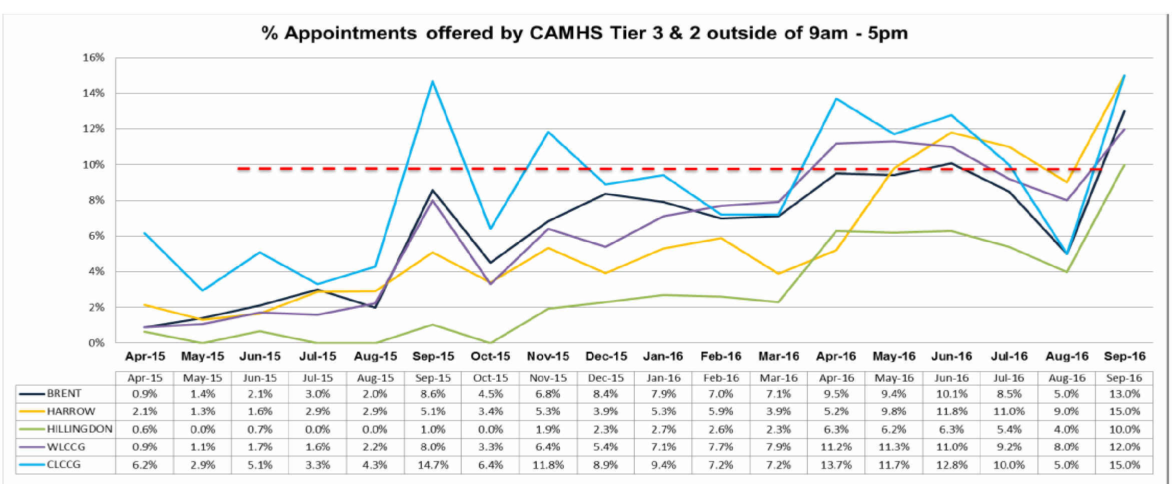
The CCG is investing an additional £128k in 2016/17, non-recurrent, to reduce waiting times. Underperformance has arisen due to historical demand exceeding capacity. There is currently a backlog of approximately 177 children waiting to be seen, down from 210 in April 2016. A revised plan and accompanying trajectory has been requested from the Trust by December 2016 to address the poor level of in-year performance linked directly to the additional funding provided. This will attempt to ensure the national 18 weeks referral to treatment target is met by 31st March 2017. The revised plan will consider the use of measures such as on-line therapies, with licenses purchased for a 12 month period to ensure that improvements in waiting times continue post the end of the financial year for which funding has been committed.

As part of the 16/17 contract negotiation process a trajectory to increase performance to target by month 6 has been agreed between CNWL and HCCG. CNWL presented a paper to commissioners as part of the 16/17 contract negotiation process, which detailed demand exceeding capacity, which has been addressed through additional investment in the 16/17 contract, including investment in Learning Disabilities provision. Whilst this additional investment has addressed the gap in capacity, there remains a historical backlog of children waiting to be seen and increasing growth in referrals due to demographic and need changes. Agreement of additional funding for additional posts was committed in April 2016. Full recruitment to these positions was completed in October 2016 with the full impact of these appointments expected to reflect in performance from December 2016 / January 2017 onwards.

CNWL are currently trying to reduce the backlog of children waiting to be seen through targeted resources and this has reduced from 210 children in April 2016 to 177 children currently waiting for treatment. Furthermore the 16/17 CQUIN focuses on reviewing patients waiting and service models. CNWL has introduced a number of initiatives to reduce the backlog of children waiting including offering group appointments where possible, reducing the number of follow up appointments where practical and ensuring services are as productive, efficient and safe as possible. The results of this work are due to be shared with commissioners at the end of quarter two as part of the agreed CQUIN's. This work includes evaluating the current caseload to establish primary diagnosis by sub team, and time length on case load.

**% Appointments offered by CAMHS clinic Tier 3 & 2 outside of 9am -5pm**

CNWL CAMHS has been set a target to see 10% of children outside of the times 9am to 5pm. This was introduced in April 2015 and performance has increased to date. The clinic locations for Central London and West London CAMHS services moved in March 2016 which has enabled Central and North West London Trust (CNWL) to have more control over clinic opening times in the new locations, and therefore impacted positively on performance.




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BRENT | 0.9% | 1.4% | 2.1% | 3.0% | 2.0% | 8.6% | 4.5% | 6.8% | 8.4% | 7.9% | 7.0% | 7.1% | 9.5% | 9.4% | 10.1% | 8.5% | 5.0% | 13.0% |
| HARROW | 2.1% | 1.3% | 1.6% | 2.9% | 2.9% | 5.1% | 3.4% | 5.3% | 3.9% | 5.3% | 5.9% | 3.9% | 5.2% | 9.8% | 11.8% | 11.0% | 9.0% | 15.0% |
| HILLINGDON | 0.6% | 0.0% | 0.7% | 0.0% | 0.0% | 1.0% | 0.0% | 1.9% | 2.3% | 2.7% | 2.6% | 2.3% | 6.3% | 6.2% | 6.3% | 5.4% | 4.0% | 10.0% |
| WLCCG | 0.9% | 1.1% | 1.7% | 1.6% | 2.2% | 8.0% | 3.3% | 6.4% | 5.4% | 7.1% | 7.7% | 7.9% | 11.2% | 11.3% | 11.0% | 9.2% | 8.0% | 12.0% |
| CLCCG | 6.2% | 2.9% | 5.1% | 3.3% | 4.3% | 14.7% | 6.4% | 11.8% | 8.9% | 9.4% | 7.2% | 7.2% | 13.7% | 11.7% | 12.8% | 10.0% | 5.0% | 15.0% |

Nearly all boroughs have, howeve, struggled with parents opting for their children to be seen during 9-5, impacting on uptake outside these hours. This information is not captured on Jade and therefore CNWL have agreed with commissioners to uptake a quarterly audit to see whether patients were offered appointments outside of, but were opting to be seen during 9-5.

It was agreed with NWL CSU that a 5% sample size would be audited each quarter, equating to the following number of records:

| | Patients | Appointment | 5% audit |
|---|---|---|---|
| NHS BRENT CCG | 525 | 274 | 26 |
| NHS CENTRAL | 328 | 207 | 16 |
| NHS HARROW CCG | 413 | 191 | 21 |
| NHS WEST LONDON | 538 | 321 | 27 |
| NHS HILLINGDON CCG | 354 | 198 | 18 |

The results of the quarter one audit are as below:

| | **Offered an appointment outside of 9-5** | | **Not offered an appointment outside of 9-5** | |
|---|---|---|---|---|
| | **Number** | **%** | **Number** | **%** |
| NHS BRENT CCG | 3 | 12% | 23 | 88% |
| NHS CENTRAL | 2 | 13% | 14 | 87% |
| NHS HARROW | 4 | 19% | 17 | 81% |
| NHS HILLINGDON | 2 | 11% | 16 | 89% |
| NHS WEST | 8 | 30% | 19 | 70% |
| **Grand Total** | **19** | **18%** | **89** | **82%** |

As detailed in the tables above, all the CCG's have had more than 10% of parents offered an appointment outside of 9-5 but in fact opting to be seen during 9-5.

b) **Paediatric Eating Disorders - Performance Summary Sep-16**

| Target Description | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug- | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Waiting times - routine | 30% | 50 | 100 | 50 | 82 | 75 | 67 | 100 | | | | | |
| Waiting times - | 100% | n/a | 80 | 78 | 25 | 100 | 67 | 100 | | | | | |

c) **Self- Harm**

There are currently two patients in Tier 4 inpatient settings receiving treatment for self-harm. This represents an improvement from the position in October where there were four patients. HCCG are working closely with NHS England to facilitate safe discharge of these patients when their conditions are stabilised.

**Financial Implications**

This is an update report on the progress that has been made in implementing the agreed 2016/17 Local Transformation Plan and sets out the steps that have been taken to reduce the backlog of children waiting to be seen, by the investment of £128k by the CCG. There are no direct financial implications arising from this report.

## 5. 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 CAMHS Focus groups.

**Policy Overview Committee comments**

None at this stage.

## 6. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

None.

**Hillingdon Council Legal comments**

There are no legal issues arising out of the recommendations proposed at the outset of this report.

## 7. BACKGROUND PAPERS

None.

# PROGRESS UPDATE ON THE DEVELOPMENT OF AN ACCOUNTABLE CARE PARTNERSHIP IN HILLINGDON – AN INTRODUCTION TO HILLINGDON HEALTH AND CARE PARTNERS

| | |
|---|---|
| **Relevant Board Member(s)** | Shane Degaris, Chief Executive, The Hillingdon Hospitals NHS Foundation Trust<br>Maria O'Brien, Divisional Director of Operations, CNWL<br>Dr Ian Goodman – Chair, Hillingdon CCG |
| **Organisations** | Hillingdon Health and Care Partners:<br>• Central and North West London NHS Foundation Trust (CNWL),<br>• Hillingdon Hospitals NHS Foundation Trust<br>• H4All CIC<br>• The four Hillingdon GP networks – due to become single Hillingdon GP federation in April 2017.<br>Hillingdon CCG |
| **Report author** | Jo Manley - Hillingdon ACP Programme Director |

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|---|---|
| **Papers with report** | None |

## 1. HEADLINE INFORMATION

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|---|---|
| **Summary** | This report provides the Board with an update on the design and delivery of an Accountable Care Partnership (ACP) for Hillingdon.<br><br>HCCG plans to commission integrated services for people age 65 years from an Accountable Care Partnership (ACP) offering integration of services and partnership working at significant scale.<br><br>Hillingdon Health and Care Partners (HHCP) consists of a partnership of:<br>• Central and North West London NHS Foundation Trust<br>• Hillingdon Hospitals NHS Foundation Trust<br>• H4All Community Interest Company<br>• The four current Hillingdon GP networks |
| **Contribution to plans and strategies** | North West London footprint Sustainability and Transformation Plan<br>Hillingdon's Sustainability and Transformation Plan<br>Hillingdon CCG's Commissioning Intentions 2017/18 |

| | |
|---|---|
| **Financial Cost** | None arising directly from this report. The financial model is described in the report |

| | |
|---|---|
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

a) **notes the update on the work that is going on in Hillingdon develop an Accountable Care Partnership (ACP), initially for older people**
b) **notes the progress to date, the proposed actions going forward and the current challenges within the ACP work plan.**
c) **has to opportunity to discuss and input ideas into the further development opportunities that may exist for this model within the Borough.**

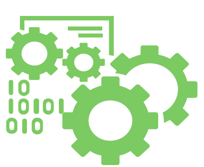
## 3. INFORMATION

### What's the case for the proposed change to an ACP in Hillingdon?

According to the most credible growth assumptions for the next five years, Hillingdon will see approximately **21% more activity creating a system-wide funding gap of around £100m**. Our do nothing position is therefore untenable.

Approximately **one in six people with a long term condition over the age of 65 years is admitted to hospital each year**. Activities that improve anticipatory care, reduce the need for crisis management and support joined up care for vulnerable groups are key to affecting rising non elective activity and in providing a better standard of care closer to home, with **providers working together to improve care.**

Contracts and organisational forms as they exist currently hinder rather than help the integration of services and the development of innovative approaches to service redesign. Perverse incentives exist that reward providers for doing more activity rather than doing **the right activity and achieving the outcomes that matter** to patients and citizens.



Changes in care models will therefore be combined with a **new commissioning approach** where provider organisations are required to collaborate to manage the common resources available to them, based on a set of design principles. This will require changes to the current **contractual forms, development of outcomes based commissioning, reallocation of risks within the health care system and sustainable financial payment system** based on a capitation payment model.

**What's our vision for care of older people in Hillingdon?**

We've listened to older people and their carers and some of things they have told us that would make their care better include:

- those involved in their care talking to each other, sharing information and knowing what each other is doing.
- to only have to tell their story once.
- to feel their care is being co-ordinated.
- to have less visits from or to different teams/ departments/services.
- to receive the best possible care and to stay in their own home.
- to know who they can call if the need any help or advice and try to avoid needing to call out emergency services or be rushed to the hospital unless it's absolutely needed.
- If they do have to go into hospital then when they are discharged to have the information about their care shared with their GP and for services to be ready to support them on their return home.

In Hillingdon, we have been have looking at how we can work together in partnership to provide a more positive experience for residents/service users whilst delivering shared outcomes and a shared budget.

We want older people to experience joined up care, bringing together hospital services, community care and GP services that they may be using to form a partnership to provide a more proactive, preventative and supportive care plan.

**What is an Accountable Care Partnership (ACP)?**

In order to achieve the types of changes we'd like to see delivered for older people we are looking to introduce an accountable care partnership (ACP)as the vehicle through which deliver more integrated care.

An ACP is a partnership of organisations which:

- Is commissioned to jointly deliver an agreed set of outcomes
- Is accountable for end to end care of the population so that the resident receives a seamless offering across organisational boundaries
- Built around a registered population e.g. older people, children
- Functions at a scale sufficient to hold clinical and financial accountability for a population
- Makes decisions on resource allocation and performance within the partnership, sharing financial risks and benefits
- Embeds service users/residents in decision making and governance

Hillingdon CCG commissioning intentions for 2016/17 said:

*"We believe that high quality, integrated services can **best be delivered by accountable care partnerships** which have developed **appropriate models of care** for their population; which are commissioned to deliver **clear outcomes** for the different segments of the population; which **share accountability** for achieving those outcomes and which **share financial risks and benefits** through a capitated budget"*

A capitated health budget is one where the total allocated amount available for the population cohort's health care is held in a single budget.

The local STP plan outlines our intention to develop care models and supporting system enablers to encourage greater integration in the delivery of health care between the current separate providers, moving to a single outcomes based contract for people aged 65 and over, funded through a capitated payment.

**What is the ACP contracting model?**

In Hillingdon we are initially looking to deliver our ACP through an alliance contract model. This is a form of contractual joint venture. It does not create a new legal entity. It generally involves bi-lateral "pillar contracts" based on the NHS Standard Contract, with a separate multi-lateral alliance contract, the scope of which is flexible.

When entering into alliance contracting arrangements, the separate sovereign organisations remain, and appropriate delegations need to be made to those interacting between organisations at the governance forum created by the alliance contract.

The design of the governance arrangements under an alliance contract is flexible, however there are limits upon the decision making authority of the governance forum, which is dependent upon those participating in the governance forum, and the extent of their authority from their own sovereign organisations.

**Who are the current ACP partners in Hillingdon?**

In Hillingdon four provider organisations have come together to form a Hillingdon based ACP, commissioned by Hillingdon CCG to deliver better quality integrated services for older people in Hillingdon.

These partners are:

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central and North West London NHS Foundation Trust (CNWL),
- H4All CIC, a federation of voluntary sector partners – Hillingdon Age UK , Harlington Hospice, DASH, MIND Hillingdon and Hillingdon Carers
- Hillingdon four GP networks, due to become Hillingdon GP federation from April 2017

Together as an ACP we are now named Hillingdon Health and Care Partners:

Although the Council is not formally part of the ACP, Adult Social Care and the Hillingdon Health and Care Partners have been working closely together where this will deliver better outcomes for Hillingdon's residents, e.g. delivery of the 2016/17 Better Care Fund Plan.

**What does our partnership in Hillingdon aim to achieve?**

Our aim is to establish a truly integrated health and social care system which:

- Addresses individual needs in a holistic way
- Offers more care in the community and in people’s homes rather than in acute hospitals
- Invests in prediction, prevention, early intervention and out of hospital services
- Joins up services across organisations and across care settings
- Adopts evidence based pathways
- Concentrates acute services to enable delivery of care in the most appropriate setting
- Offers better overall value for money

**The HHCP goals are to:**

| | | |
|---|---|---|
| Reduce reliance on A&E and hospitals improve our current performance | Improve patient outcomes experience & quality of care | Share clinical information effectively and in a timely way |
| Improve access to primary care in hours and deliver extended and seven day care | Reduce variation in practice and duplication across the system | Create better continuity of care and have more time to see our complex patients |
| Create a sustainable workforce to increase patient benefits and improve staff recruitment & retention | Deliver more care closer to home | Create empowered patients who effectively self manage |

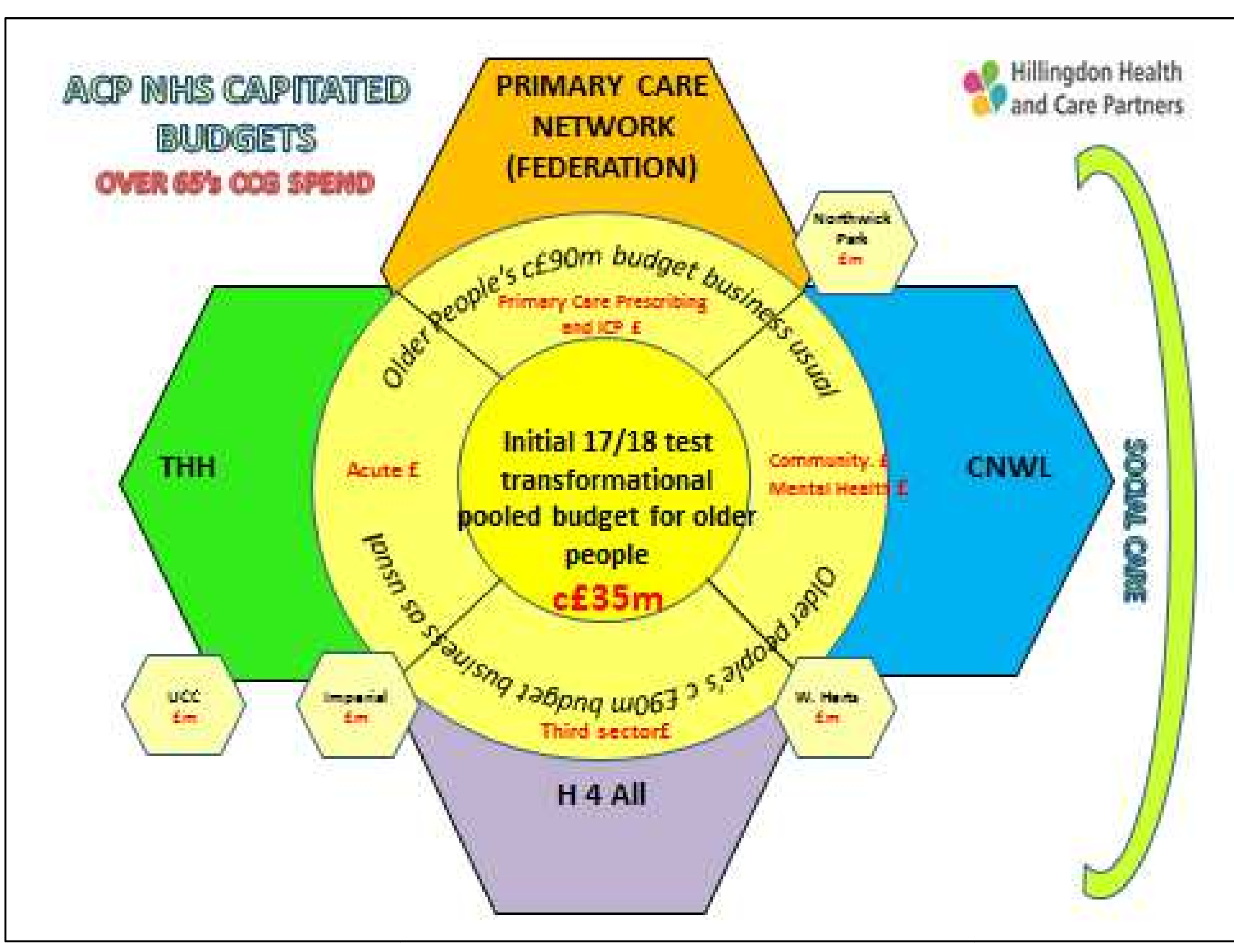
**What population group will the ACP initially cover?**

We have agreed that the first step of the alliance in Hillingdon is to focus on older people, over the age of 65.

The initial work on the capitated budget for this population group GP registered in Hillingdon is suggesting a value of circa £90m spend (15/16), though there is still work to be done on exact costs and scope of the envelope.

For 17/18 the providers have agreed to initially pool into the ACP, a range of service budgets which are specifically targeted at the over 65's that totals approximately £35m. However it is expected that we will monitor the impact on the full capitated budget for this client group (£90m) in order to test the concepts in advance of 18/19 when it is expected that we will be contracting for a full capitated budget for all people over 65.

**This picture aims to provide a simple illustration of the ACP model and budget we intend to pool (2017/18) in the dark yellow area, with the lighter yellow indicating the total financial value over 65's spend which will be monitored, with the intention of moving to a fully capitated budget in 2018/19 :**




**What will this mean for how care will change for older people in Hillingdon?**

Services in the initial alliance 'pool' include: care of the elderly wards and clinical teams at the hospital, community nursing and rehab services, rapid response, discharge teams, health and well-being services, primary care integrated care planning, end of life and palliative care.

These services are really key to the delivery of care for older people but we recognise that there is real scope for them to be delivered in more joined up and effective ways so that patients only have to tell their story once, that they are enabled to move out of hospital more quickly and be better supported at home.

A Clinical Design Group (CDG) is overseeing the development of a more joined-up approach to the way that the ACP partners work. Through a range of task and finish works streams work is underway to change care models which will reduce duplications, identify gaps and put the patient at the centre of their proactive care plan. We are working to ensure we have service users and carers involvement in this planning work and are going out to listen to people in Hillingdon whenever the opportunities present.

The core element at the centre of the Hillingdon model of care is the Care Connection Team (CCT). We aim to have 15 of these locality teams throughout the Borough. Each one will work with a very small group of GP practises (2-5 depending on list sizes) to identify those people at

greatest risk, to proactively plan their care to reduce risk of emergency admission and to enable people to remain in  their own home as long as possible. The team will costs of the GPs, a senior Guided Care Matron and a Care Co-coordinator, liaising and involving a much wider range of health, social care and voluntary sector providers as needed.

Supporting this primary care model is the outreach of acute hospital services such as community geriatricians and specialist nurses. We are also working on the closer integration of arrange of smaller contracts to try and ensure that hospital and community services work better together to enable timely and effective discharge processes, as well as prevent the need for admission.

We then also have the newly re designed health and wellbeing services being delivered by our voluntary sector partnership H4All, working with individual and communities to improve self-directed care and reduce areas such as social isolation.

**So how does it work in real practice?**

We have been running two Care Connection Team pilots in the north of the Borough and this is a typical sample case study to show how it's working in practice**:**

Mr N is a 79yr old man who lives with his wife who is also his main carer. Mr N's GP had noticed an increase in his attendances to A&E and that he was making frequent calls made to the surgery requesting GP home visits. The Practice made a decision to refer Mr O to the Care Connection Team (CCT).

The CCT Guided Care Matron (GCM) went out that same day to conduct an initial assessment on Mr O. This determined that Mr N suffered from a number of health conditions which caused him anxiety and he needed some reassurance about his conditions. One of his concerns was the stoma bag he had, which he was having difficulty managing, and this was resulting in him going to A&E.

The GCM discussed and agreed a Care Plan with Mr N, which was then also discussed and agreed with his GP. This Integrated Care Plan was then out on Mr N's primary care clinical record.

Initially, the GCN conducted domiciliary visits with Mr N on a weekly basis to review his health concerns and alleviate any anxieties he had. In addition, Mr N was provided with a telephone number to contact the Care Coordinator should he experience difficulties with his anxieties in-between his planned appointments.  The Care Coordinator would listen to his concerns, reassure him, and agree to ring him back later in the day until he became more confident.

Mr N's progress was discussed with the GP and Care Coordinator during the weekly 'huddle' meeting, which kept the GP regularly informed.

The CCT also referred Mr N to various other services including:

- Dietician- to help mitigate problems with the Stoma.
- Talking Therapy – to help with his low mood caused by worrying about his health problems.
- Social Services – to help provide more support, as his main carer (wife) was not managing well and needed a carer assessment.
- Weekly contact from the GP practice's over 75's GP service.

Mr N has had approximately 13 home visits by the GCN since being admitted onto the CCT caseload. Initially he was seen once a week, but with progress his visit frequency reduced and he is now being reviewed monthly by the GCN. It is anticipated that this will further be reduced to telephone contact with the Care Coordinator if the CCT deems this appropriate for Mr N's needs.

Since the involvement from the CCT Mr N has not had any A&E attendances or GP visit. He describes feeling much less anxious and more able to cope. The CCT has been able to reduce the number of admissions through support from using the GCN and Care Coordinator by phone calls and visits and referring him to relevant services.

**What's been achieved so far in 16/17?**

- **CCG support for transition costs to enable development of an HHCP development team**. Programme director & officer roles including information and finance roles and senior clinical leadership capacity

- **Introduction and delivery of the new clinical model**
    - evaluation of two pilot Care Connection Teams in the north of the Borough next step is developing the 15 care connection teams across the Borough.
    - new community geriatricians are in post.
    - H4All wellbeing scheme started and using Patient Activation Measure (PAM).

- Overarching governance of the development is through the **ACP Development Board** which has membership of the Chief Executives of the four provider partners and the CCG.

- Progress is being made on building the **capitated budget model** including risk and gain share arrangements through the joint finance and contracting group with the CCG.

- **Provider-led sub work streams with work plans** are in place for workforce, legal, IT, information and finance and communications.

- There is now a **signed off Heads of Terms** by all partners. Next step is the Alliance Contract.

- The four GP networks have agreed to develop **a single Hillingdon GP federation** and the Chief Officer has been appointed.

- The providers have been using the NWL Change Academy coaching programme to **develop trust, relationships & approaches to problem solving and change.** Strong provider relationships in place and a real commitment to working together for the senior team. Hillingdon were selected to be part of the **NHSE's Accelerated Development Programme** designed to support progress in areas that show innovation and potential for integrated working and the CCG and Programme Director have been regular attenders at these workshops.

- **IT and interoperability**; NWL dashboard is being rolled out and used as part of risk stratification, Hillingdon hospital care record in place with CMC flag, working on how CIE can support integrated clinical service design.

**What are the current opportunities and risks?**

Is should be noted that whilst the Local Authority is not currently formally within the ACP partnership we would expect to work very closely to design and develop the outcomes and are very aware that the current pressures facing the social care system are going to be a key consideration in the design and delivery of integrated care for older people in Hillingdon. We are keen to have officers involved at all stage of our plans and to look at all opportunities to work more effectively and productively together.

**Financial issues**

- Primary care GP services that can currently be included are only those which the CCG directly commissions from our local practices. This limits their scale of involvement at this stage.
- The four providers are current contracts are different and the financial risks to each organisation for this partnership are different. Ongoing work is taking place to identify these and see how they can be best mitigated.
- The two FTs are both currently in deficit and therefore how the proposed capitated budget model is developed over a 5 year period to address QIPPs, inflation, demographic growth etc. will need to be considered.
- The more limited size of the proposed pooled budgets will limit the degree of transformational change that might be achieved and not be seen as sufficiently ambitious.
- We need to be able to model and measure/evaluate the impact of changes within this element of services on the wider health economy.
- The length of the contract will affect how much ambition there is to take risks on investment into radically new ways of working.

**Governance issues**

- The ACP providers are working towards an alliance partnership but recognise there is a lot of development work required to design the way it will actually work. It is a national area of learning and development and no defined model that is well tried and tested. Areas we are working through include:
    - risk share,
    - dispute resolution,
    - relationships with 'sovereign' boards,
    - lay involvement including the relationship with FT governors.
- Very tight timescale to get the Alliance contract agreed by April 17 – we have to take arrangements through the four sovereign boards and the CCG.
- HCCG will need to be assured that the ACP can meet the requirements of commissioners and will be able to deliver the contract and outcomes framework for integrated, high-quality and cost effective services. Commissioners also need to be assured that any alliance agreement is robust and sustainable over the proposed life of the contract agreement and enables substantial progress in ACP development and capability. This will involve the CCG carrying out a 'due diligence' assurance process prior to signing a contract for the 2017/18 testing year, addressing a number of key development areas in partnership during that year, including service integration and quality improvement, finance and capitation, risk and reward and capturing new developmental outcome measures, as well as carrying out a robust 'most capable provider' procurement process throughout 2017/18.
- Need to ensure robust clinical governance structure that works in integrated services
- Engaging and establishing relationships with the Council to consider how social care can become fully signed-up partners in the model going forwards.

**Clinical and workforce challenges**

- Capacity of stretched clinicians to be involved in service re-design.
- Making sure everyone knows what's going on and feels involved.

- Developing existing staff and recruiting, training and developing the new type of workforce needed to work in the new ways of delivering care.
- Involving service users/residents in service design.
- Individual organisational interests v commitment to a more integrated whole.
- The engagement challenge – to get all levels staff involved in integration and seeing this as part of how the ‘’day job’ is done.
- No new extra bridging funds to develop new models so have to ascertain appetite for risk to develop new arrangement within existing limits with expectation of significant savings in year 3-5.
- Need for more capacity to design and test the business case for the care model-modelling activity and costs.
- Ensuring services such as mental health, pharmacists etc. know about and join the integration.

## 4. FINANCIAL IMPLICATIONS

None in relation to this update paper.

## 5. LEGAL IMPLICATIONS

None in relation to this update paper.

## 6. BACKGROUND PAPERS

None but the Board is also referred to reports on this same HWB agenda on STP and the Hillingdon CCG update which reference the development of the Hillingdon ACP.

# HILLINGDON CCG UPDATE

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Ian Goodman |
| **Organisation** | Hillingdon Clinical Commissioning Group |
| **Report author** | Caroline Morison, Joan Veysey; Jonathan Tymms; Andrew Round |
| **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:<br>• Sustainability and Transformation Plan (STP) and approach to operating plan 17-19<br>• Children's services at Hillingdon Hospital<br>• IAPT early adopter<br>• Finance<br>• Update on QIPP 2016/2017<br>• Delegation of primary care commissioning<br>• Update on integration<br>• London devolution<br>• Changes to the governing body |
| **Contribution to plans and strategies** | The items above relate to the HCCG's:<br>• 5 year strategic plan<br>• Out of hospital ( local services) strategy<br>• Financial strategy<br>• Shaping a Healthier Future |
| **Financial Cost** | Not applicable to this paper |
| **Relevant Policy Overview & Scrutiny Committee** | External Services Overview and Scrutiny Committee |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board 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 Sustainability and Transformation Plan (STP) and operating plan 17 - 19

The NWL STP was submitted to NHS England on 21st October and has now been published. The financial modelling for the STP underpins the approach to our contracting rounds across NWL. The STP finances were contained in the commissioning intentions letters sent to providers on 30th September along with our local plans as set out in the paper to the September board.

Operating plan guidance issued by NHS England states that contracts must be signed by 23rd December 2016, bringing the timeline forward from 31st March. In addition contracts must be agreed for a 2 year period to 2019. Chief Officers and Chief Financial Officers are working with Chief Executives and Directors of Finance across NWL to agree a common process and principles that will support an expedited process including:

- A common set of contract schedules
- A collective focus on a small number of 'big ticket' items (ie transforming outpatient care, reduction in use of escalation beds, redesigning diagnostic pathways)
- System-wide transparency of finances

Locally we continue to progress our contracting discussions to ensure that our delivery of the financial envelope in the STP is underpinned with robust plans across our 10 transformation themes.

### 3.2 Update on Transition of Children's Services

Since the transition of Ealing paediatric emergency services on the 30 June, the opening of the Paediatric Assessment Unit and the establishment of a resident consultant model, performance against the 4-hour A&E standard for children has improved.

The weekly data shows, from 07/10/2016 up to 04/11/2016 that the 4 hour A&E and UCC waiting time target is now considerably improved for A&E and is being met as shown below:

| **% of patients (<16yrs) seen in A&E & UCC within 4 hours** | | Baseline[1] | 07-Oct | 14-Oct | 21-Oct | 28-Oct | 04-Nov | |
|---|---|---|---|---|---|---|---|---|
| Hillingdon Hospital | A&E | 86.4 | 96.01 | 94.71 | 94.41 | 95.31 | 97.31 | |
| | UCC | 98.2 | 99.01 | 99.01 | 99.01 | 99.01 | 98.01 | |

Notes: ¹ = Hospital average pre 30 June 2016; ² = Performance v baseline; 1 1 = performance v 95% target

Data is collected on a weekly and monthly basis via the Shaping a Healthier Future Programme (SaHF) and reported to the Children's Forum (formally the SaHF Programme Board).

It should be noted that October was the busiest month for A&E to date with over 1335 attendances.

In the first week of November, Hillingdon are well above the 95% target at 97.3%. Hillingdon have been carefully working to improve their A&E performance, which is clear from the step change in results. Hillingdon are also working with the UCC to ensure breaches caused by late referrals from the UCC are minimised. Hillingdon A&E continues to see high numbers of Ealing

patients, however these remain within the confidence intervals of what was expected from the activity modelling[1].

The new Paediatric Assessment Unit (PAU) continues to see good utilisation, on average there are 8 children through the 4 beds every 24 hours. The resident consultant model is proving to be successful and Hillingdon are continuing to embed the model[2].

The newly refurbished and expanded Paediatric A&E at Hillingdon, provides a suitable environment and facilities for children and their families, including bigger bed bays with chair-beds for parents. The area was formally opened in October by Boris Johnson MP, Secretary of State for Foreign Affairs.

The first pilot to provide paediatric integrated community clinics becomes operational in December. This is a small scale test of viability to transform paediatric outpatient services to a GP setting, increasing GP paediatric knowledge and skills and brings a number of professionals together in multi-disciplinary meetings for children and young people with specific challenges to the system. There is a strong emphasis on co-production with families using the service to gather learning and ensure there are positive outcomes.

The remaining priorities for Hillingdon CCG are to:

- Commission a Critical Care Level 1 service.

Priorities for wider paediatrics include:

- Continue to implement the SEND agenda
- Remodel paediatric services, using co-production as a way forward. This will include community services, using technologies and providing an integrated model where it makes sense for families / carers, children and young people

The Children's Health Partnership Group which included members from the local health, education and social care partnership was suspended in January 2016. This group is now being revised and refreshed as the strategic transformation group for children and young people; 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 November 18th 2016.

### 3.3 IAPT early adopter bid

The CCG and CNWL have been successful in their joint bid to become a national early implementer of the new access targets for Improving Access to Psychological Therapies (IAPT).

Currently 4,344 people a year with anxiety and depression in Hillingdon are offered evidence based talking therapies, of which 50% of people will achieve recovery following therapy. The CCG has increased resources year on year since 2013 to improve access to talking therapies.

Currently 15% of our population with common mental health needs are accessing treatment, and this additional funding will increase this number to 25% by 2020. This will mean that 7,500

[1] Paediatric Weekly Dashboard Shaping a Healthier Future. Week Ending 04/11/2016
[2] A/A

people of people in Hillingdon with common mental health needs will be accessing treatment every year. 6% of this increased capacity will be focused on people with long term physical health conditions such as COPD and Diabetes where improved access to mental health support can lead to improved health outcomes. The additional funding will be used to increase the number of staff offering talking therapies, including back fill to enable new staff to be trained. The CCG and CNWL are working together as part of the National Early Implementer Network to start mobilising these changes from January 2017.

The employment Trailblazer also goes live in December, and it is anticipated that about 70% of those clients being supported back into work will be receiving IAPT services.

### 3.4 Financial position

Overall, at month 7, the CCG is achieving its YTD planned surplus of £2.1m. The CCG is reporting to achieve its £3.6m planned surplus by Year End, although this is in part due to some non-recurrent benefits (see below).

Whilst the CCG continues to report achievement of its planned YTD and FOT financial targets, there remain 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 contract with THH relates to higher than planned increases in Accident & Emergency activity and also OP referrals in a number of specialties. Emergency admissions have reduced from last year but costs have increased due to an increase in the length of stay and 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 £2.9m (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, older people and also Section 117s.

To achieve its forecast outturn plan, the CCG has now deployed most of its available reserves, in both programme and running costs, and has also factored in non-recurrent balance sheet gains from 2015/2016 (£2.2m) into the FOT.

## Overall Position- Executive Summary Month 7 YTD and FOT

### Table 1

| EXECUTIVE SUMMARY | Final Budgets (£000) | YTD Month 7: YTD Budget (£000) | YTD Actual (£000) | Variance Sur/(deficit) (£000) | Forecast Outturn Position: FOT Actual (£000) | FOT Variance Sur/(deficit) (£000) | FOT QIPP Variance (£000) |
|---|---|---|---|---|---|---|---|
| **Commissioning of Healthcare** | | | | | | | |
| Acute Contracts | 206,485 | 120,670 | 123,717 | (3,047) | 211,638 | (5,154) | (1,278) |
| Acute Reserves | 2,588 | 1,298 | 0 | 1,298 | 945 | 1,643 | 0 |
| Other Acute Commissioning | 13,117 | 6,935 | 6,642 | 292 | 12,635 | 482 | 268 |
| Mental Health Commissioning | 25,216 | 14,422 | 14,395 | 26 | 25,344 | (128) | 132 |
| Continuing Care | 16,074 | 9,260 | 11,044 | (1,784) | 19,011 | (2,937) | (90) |
| Community | 30,928 | 17,966 | 17,871 | 95 | 30,843 | 85 | 70 |
| Prescribing | 35,784 | 21,033 | 20,590 | 443 | 35,138 | 646 | 210 |
| Primary Care | 6,296 | 3,196 | 3,018 | 178 | 6,091 | 205 | 0 |
| **Sub-total** | **336,487** | **194,780** | **197,277** | **(2,498)** | **341,644** | **(5,157)** | **(688)** |
| **Corporate & Estates** | 4,573 | 2,645 | 2,628 | 16 | 4,458 | 115 | 0 |
| **TOTAL** | **341,060** | **197,424** | **199,906** | **(2,481)** | **346,103** | **(5,042)** | **(688)** |
| **Reserves & Contingency** | | | | | | | |
| Contingency | 2,293 | 1,337 | 0 | 1,337 | 0 | 2,293 | 0 |
| Uncommitted Reserves | 4,149 | 0 | 0 | 0 | 4,149 | 0 | 0 |
| 2015/16 Balance Sheet Gains | 0 | 0 | (1,050) | 1,050 | (2,227) | 2,227 | 0 |
| **RESERVES Total:** | **6,442** | **1,337** | **(1,050)** | **2,387** | **1,922** | **4,520** | **0** |
| | | | | | | | |
| **Total 2016-17 Programme Budgets** | **347,502** | **198,761** | **198,856** | **(94)** | **348,024** | **(522)** | **(688)** |
| **Planned Surplus/(Deficit)** | 3,616 | 2,109 | 0 | 2,109 | **0** | **3,616** | **0** |
| **Total Programme** | **351,118** | **200,871** | **198,856** | **2,015** | **348,024** | **3,094** | **(688)** |
| **RUNNING COSTS** | | | | | | | |
| **Running Costs** | **6,279** | **3,206** | **3,112** | **94** | **5,757** | **522** | **0** |
| | | | | | | | |
| **CCG Total** | **357,397** | **204,077** | **201,967** | **2,109** | **353,781** | **3,616** | **(688)** |

## Year To Date Position- Acute Contracts and Continuing Care

### Table 2

| ACUTE CONTRACTS | SLA Value (£000) | YTD Month 7: YTD Budget (£000) | YTD Actual (£000) | Variance Sur/(deficit) (£000) |
|---|---|---|---|---|
| **In Sector SLAs** | | | | |
| Chelsea And Westminster Hospital NHS Foundation Trust | 2,353 | 1,382 | 1,403 | (21) |
| Imperial College Healthcare NHS Trust | 12,066 | 7,060 | 7,329 | (270) |
| London North West Hospitals | 16,594 | 9,629 | 10,126 | (497) |
| Royal Brompton And Harefield NHS Foundation Trust | 6,442 | 3,758 | 4,652 | (894) |
| The Hillingdon Hospitals NHS Foundation Trust | 131,788 | 77,119 | 80,138 | (3,020) |
| The Hillingdon Hospitals NHS Foundation Trust - Transitional Support | 3,300 | 1,925 | 0 | 1,925 |
| **Sub-total - In Sector SLAs** | **172,543** | **100,872** | **103,649** | **(2,777)** |
| **Sub-total - Out of Sector SLAs** | **32,000** | **18,666** | **18,910** | **(244)** |
| **Sub-total - Non NHS SLAs** | **1,942** | **1,133** | **1,159** | **(26)** |
| **Total - Acute SLAs** | **206,485** | **120,670** | **123,717** | **(3,047)** |

| CONTINUING CARE | | YTD Month 7 | | |
|---|---|---|---|---|
| | Annual Budget (£000) | YTD Budget (£000) | YTD Actual (£000) | Variance Sur/(deficit) (£000) |
| Mental Health AMI (Under 65) | 59 | 34 | 3 | 32 |
| Mental Health EMI (Over 65) - Residential | 2,865 | 1,672 | 1,874 | (202) |
| Mental Health EMI (Over 65) - Domiciliary | 277 | 162 | 170 | (8) |
| Physical Disabilities (Under 65) - Residential | 2,015 | 1,175 | 1,446 | (271) |
| Physical Disabilities (Under 65) - Domiciliary | 2,201 | 1,284 | 1,046 | 238 |
| Elderly Frail (Over 65) - Residential | 951 | 555 | 769 | (215) |
| Elderly Frail (Over 65) - Domiciliary | 92 | 54 | 114 | (60) |
| Palliative Care - Residential | 381 | 222 | 415 | (193) |
| Palliative Care - Domiciliary | 424 | 247 | 463 | (215) |
| **Sub-total - CHC Adult Fully Funded** | **9,265** | **5,405** | **6,299** | **(894)** |
| **Sub-total - Funded Nursing Care** | **2,095** | **1,222** | **1,574** | **(352)** |
| **Sub-total - CHC Children** | **1,263** | **737** | **944** | **(208)** |
| **Sub-total - CHC Other** | **657** | **266** | **473** | **(207)** |
| **Sub-total - CHC Adult Joint Funded** | **2,794** | **1,630** | **1,753** | **(123)** |
| **Total - Continuing Care** | **16,074** | **9,260** | **11,044** | **(1,784)** |

## FOT Position- Acute Contracts and Continuing Care

### Table 3

| ACUTE CONTRACTS | YTD Month 7 | | 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 | 1,403 | (21) | 2,404 | (51) |
| Imperial College Healthcare NHS Trust | 7,329 | (270) | 12,694 | (629) |
| London North West Hospitals | 10,126 | (497) | 17,052 | (458) |
| Royal Brompton And Harefield NHS Foundation Trust | 4,652 | (894) | 8,140 | (1,699) |
| The Hillingdon Hospitals NHS Foundation Trust | 80,138 | (3,020) | 137,039 | (5,252) |
| The Hillingdon Hospitals NHS Foundation Trust - Transitional Support | 0 | 1,925 | 0 | 3,300 |
| **Sub-total - In Sector SLAs** | **103,649** | **(2,777)** | **177,331** | **(4,788)** |
| **Sub-total - Out of Sector SLAs** | **18,910** | **(244)** | **32,428** | **(428)** |
| **Sub-total - Non NHS SLAs** | **1,159** | **(26)** | **1,880** | **62** |
| **Total - Acute SLAs** | **123,717** | **(3,047)** | **211,638** | **(5,154)** |

| CONTINUING CARE | YTD Month 7 | | Forecast Outturn Position | |
|---|---|---|---|---|
| | YTD Actual (£000) | Variance Sur/(deficit) (£000) | FOT Actual (£000) | FOT Variance Sur/(deficit) (£000) |
| Mental Health AMI (Under 65) | 3 | 32 | 3 | 56 |
| Mental Health EMI (Over 65) - Residential | 1,874 | (202) | 3,237 | (372) |
| Mental Health EMI (Over 65) - Domiciliary | 170 | (8) | 248 | 29 |
| Physical Disabilities (Under 65) - Residential | 1,446 | (271) | 2,382 | (367) |
| Physical Disabilities (Under 65) - Domiciliary | 1,046 | 238 | 1,805 | 396 |
| Elderly Frail (Over 65) - Residential | 769 | (215) | 1,413 | (462) |
| Elderly Frail (Over 65) - Domiciliary | 114 | (60) | 211 | (119) |
| Palliative Care - Residential | 415 | (193) | 750 | (369) |
| Palliative Care - Domiciliary | 463 | (215) | 834 | (410) |
| **Sub-total - CHC Adult Fully Funded** | **6,299** | **(894)** | **10,883** | **(1,618)** |
| **Sub-total - Funded Nursing Care** | **1,574** | **(352)** | **2,731** | **(636)** |
| **Sub-total - CHC Children** | **944** | **(208)** | **1,507** | **(244)** |
| **Sub-total - CHC Other** | **473** | **(207)** | **926** | **(269)** |
| **Sub-total - CHC Adult Joint Funded** | **1,753** | **(123)** | **2,963** | **(169)** |
| **Total - Continuing Care** | **11,044** | **(1,784)** | **19,011** | **(2,937)** |

### 3.4 2016/2017 QIPP

The 2016/2017 net QIPP target is £8,673k. Current FOT at M7 is £7,946k, showing a variance of £688k. This is an improvement of £37k on M6 FOT.

A summary of performance against each area is below:

| QIPP Category | Comment |
|---|---|
| Unplanned Care | Performing well with a FOT currently £201k above target |
| Planned Care | Focus needed as FOT currently £493k below target. This has worsened by £49k since M6. Currently predicting that ~ 80% + of the original £2,734k target will be delivered |
| Long Term Conditions | Key area of concern – FOT currently £199k below target. This has worsened by £21k since M6 and now just ~ 60% of the original £519k planned saving are being predicted to be delivered |
| Older People | Focus needed as FOT currently £320k below target. This is an improvement of £75k on the M6 position. Currently predicting that ~ 70% + of the original £1,107k target will be delivered |
| Mental Health | Performing well with a FOT currently £38k above target |
| Prescribing | Performing well with a FOT currently £174k above target |
| CHC | Area of concern – FOT currently £90k below target. This has worsened by £66k since M6 and there is significant known overspend is this area |

**Planned Care** - At M7 the FOT is £2,241k, a shortfall of £493k. This is £49k worse than the M6 position. The two areas where slippage has occurred is the Ophthalmology and Gastroenterology Clinical Assessment and Treatment Service (CATS) schemes.

For Ophthalmology there continues to be slippage in the June 16 start date however the CWG has met and is now active.

For Gastroenterology (CATS) there has been slippage in the October 16 start date. The CWG met in mid Nov 16 and is now active. The M6 – M7 slippage of £39k is unlikely to be recovered. A clinical pathway review is now underway.

**Older People, Intermediate Care -** At M7 the FOT is just £89k, a shortfall of £210k. This is £15k worse than the M6 position. Savings are directly linked to the Care of the Elderly Consultant (COTE) avoiding admissions in A&E. The first COTE consultant started in Sep 16.

**Long Term Conditions** – The respiratory project is still suffering slippage largely due to lack of progress on discussions between providers however the providers have committed to support the schemes.

Significant focus and attention is being paid to the delivery of the 2016/2017 QIPP schemes to minimise / reverse scheme slippage thus maintaining / improving the current FOT position. Actions to support this include:

- Work continues on implementing a 'quick win' project for Cancer including tariff changes given that all outpatient activity is being charged as first appointments
- Work continues 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. Proposals have been requested covering 500, 600 and 700 patients
- Agreement of a new CDU Tariff for the patient chairs that will come into use from Dec 16 with an expected benefit of ~ £100k in 2016/17
- Agreement on a reduction in costs for GP Out of Hours Services for opted out Practices with an expected benefit of ~ £10k+ in 2016/17
- Further savings arising from NHS111 with an expected ~ £50k for 2016/17 from Dec 16

### 3.5 Delegation of primary care commissioning

Responsibility for commissioning primary care (general practice) currently sits with NHS England. As part of the changes set out in the NHS Five Year Forward View NHS England are encouraging CCGs to take on a greater role in the commissioning of primary care.

Hillingdon CCG currently commissions jointly with NHS England (known as 'level 2' delegated commissioning). However NWL CCGs are considering whether to apply for and take on 'level 3' delegated commissioning from April 2017. This would mean that commissioning decisions related to primary care would be solely determined at a CCG level.

Work is ongoing to better understand the opportunities and risks related to level 3 delegation. Whilst an expression of interest will need to be made by 5th December, NHS England have

extended the deadline for agreement by members to 28th February in order to allow sufficient time for engagement and buy-in from local practices.

**3.6 Update on integration**

Whole systems integrated care for people age 65 and over is a key element of the Hillingdon STP, to enable high quality, coordinated care, improved health outcomes and financial sustainability. The local STP plan outlines our intention to develop care models and supporting system enablers to encourage greater integration in the delivery of health care between the current separate providers, moving to a single outcomes based contract for people aged 65 and over, funded through a capitated payment.

The key features of this approach are:

- An alliance of providers offering integration of services and partnership working at significant scale.
- An integrated model of care for people age 65 years and over which improves care outcomes and patient experience.
- Outcomes based specification which incentivises improved outcomes and system wide transformation.
- Capitation payment for a defined population to ensure effective use of resources and incentivise care in the best setting.
- Risks and gain share with commissioners and ACP partner organisations.
- Alliance contract between ACP and commissioners.
- System enablers including information sharing.

Hillingdon CCG has now developed the specification for integrated care for people age 65 years and over. This describes the scope of services, key elements of the care model and the outcomes required to ensure care is safe and effective and delivers improved patient outcomes. An outcomes framework will form part of the outcome based contract, which includes: patient related outcomes based on the National voices "I statements", system metrics to monitor the processes needed to ensure the outcomes are achieved, core quality requirements, and areas of specific clinical focus. These areas of clinical focus include continence, falls, medicines optimisation and social isolation.

Since the September update to the HWBB, the Joint ACP Development Board have continued to jointly develop the 5 year capitated budget and payment model, associated risk and gain share arrangements, and contractual arrangements that will need to be in place from April 2017. The ACP (Hillingdon Health and Care Partners) are continuing to develop their new governance arrangements under an alliance contract for the care of people aged 65 , and are gearing up to test these arrangements from April 2017.

Prior to April 2017 the CCG will need to be assured that the ACP can meet the requirements of commissioners and will be able to deliver the contract and outcomes framework for integrated, high-quality and cost effective services. Commissioners also need to be assured that any alliance agreement is robust and sustainable over the proposed life of the contract agreement and enables substantial progress in ACP development and capability. This will involve the CCG carrying out a 'due diligence' type assurance process prior to signing a contract for the 2017/18 testing year, addressing a number of key development areas in partnership during that year, including service integration and quality improvement, finance and capitation, risk and reward

and capturing new developmental outcome measures, as well as carrying out a robust 'most capable provider' procurement process throughout 2017/18.

April 2017 onward will be a testing phase characterised by live running of an ACP and the underlying outcome based contract, to enable substantial progress in ACP development and capability, and earnable significant ramp up from April 2018 to full capitated budget for 65 years and over.

### 3.7 London devolution

Discussions are ongoing across London with regards to the next phase of the devolution proposal. Key areas of focus are currently estates and integration. The London Health and Care Devolution programme requested that CCG governing bodies note the progress of the programme and review and comment on the proposals for the next phase. In addition CCGs have been asked to support the development of the final devolution agreement and delegate authority to a named individual to agree and sign the agreement on behalf of the CCG.

Hillingdon CCG governing body noted the progress made however has not currently agreed to support the devolution agreement. A request has been made to the programme to provide further evidence of benefit from the five pilot sites in London and a clearer description of how the devolution process aligns with and supports the STP process.

### 3.8 Changes to governing body

Dr Reva Gudi has stepped down from the CCG Governing Body. Reva has made a significant contribution to the CCG during her time on the Governing Body and more recently in her role as Vice-Chair, in particular through her work with the Local Authority which will have a lasting impact on the way care is delivered to Hillingdon residents. We thank Reva for her leadership and commitment and wish her all the best in her general practice work.

The process to select a new representative for practices in Hayes and Harlington is underway and a new member will join GB from the December meeting. The election for vice-chair will take place once the new GP member has joined.

Jan Norman, Director of Quality for Brent, Harrow and Hillingdon CCGs, will be retiring in December, we are in the process of recruiting to the post. We thank Jan for her contribution to the development of the quality agenda in Hillingdon.

## 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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# HEALTHWATCH HILLINGDON UPDATE

| | |
|---|---|
| **Relevant Board Member(s)** | Stephen Otter, Chair |
| **Organisation** | Healthwatch Hillingdon |
| **Report author** | Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon |
| **Papers with report** | None |

## HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | To receive a report from Healthwatch Hillingdon on the delivery of its statutory functions for this period. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy |
| **Financial Cost** | None |
| **Relevant Policy Overview & Scrutiny Committee** | External Services Scrutiny Committee<br>Social Services, Housing and Public Health |
| **Ward(s) affected** | N/A |

## RECOMMENDATION

**That the Health and Wellbeing Board note the report received.**

## 1. INFORMATION

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

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

## 2. SUMMARY

The body of this report to 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. GOVERNANCE

We have pleasure in confirming that Stephen Otter has been duly appointed as Chair of Healthwatch Hillingdon.

Turkay Mahmoud has been appointed to the Board and subsequently appointed Vice - Chair through a nomination process.

Angela Kelly has been appointed as a Board Member.

These appointments, for a term of 3 years, were ratified at the Healthwatch Hillingdon Board meeting on 26 October 2016.

We would advise that Burns Musanu has resigned as a member of the Board, as he has attained a position with The Hillingdon Hospital NHS FT (THH). We express our gratitude to him for his contribution to the work of HWH during his tenure and wish him all the best in his new role.

## 4. 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.

**GP Access in UB7**
We are pleased to confirm that following our work with Hillingdon CCG, NHS England and the local practices in UB7, that all areas are now covered by a GP practice catchment area. This should now mean that residents will be able to register directly with a GP, without having to be assigned by NHS England. We will continue to monitor the situation to ensure this has rectified the issue.

**Care Home**
We were asked by a resident of a Hillingdon care home and their family to accompany them to a family meeting, arranged to discuss current issues within the home. Due to our concerns at the standard of care being outlined by residents and their families we immediately contacted Social Services, who attended the home the following working day. This resulted in the provider putting a plan in place to address the issues and return care to appropriate levels, which we both continue to monitor with Social Services.

This is a great example of how our close working relationship with Social Services is benefitting residents and we would especially thank the officer involved for their prompt action.

**Fertility Services**
As part of our work on access to IVF services, we have highlighted to the NWL CCG Collaborative that NHS providers should not be charging patients for supplementary IVF treatments as part of their NHS funded care.

Recent national fertility survey suggests that between 20-31% of NHS-funded patients had also paid for additional tests and treatments as part of their care, which appears to contradict national NHS guidance: http://bit.ly/2fDRdDd

We are seeking written assurances from fertility providers that this practice will cease and Healthwatch Hillingdon will explore whether there is scope for reimbursement, or compensation, for NWL patients who were previously asked to pay for part of their NHS funded IVF care.

**Podiatry**
Healthwatch Hillingdon worked with Central North West London NHS FT (CNWL) during this period on the changes made within the community podiatry service.

Our contact details were included on a letter sent to approximately 2800 podiatry patients, giving them the opportunity to speak to us independently, about the proposals and how the reconfiguration of delivery sites would affect them.

In total, we were contacted by 45 people. The majority of those who raised a concern were worried about how they would be able to get to their appointments at the new location. This was expected by CNWL who in mitigation have arranged for those affected to be assessed for patient transport.

**Phlebotomy Service**
One of the unforeseen results of the changes made in podiatry, reported to us by residents, was the suspension of the phlebotomy service provided by THH in the premises vacated by CNWL in Yiewsley.

We have raised this with the Hillingdon CCG and work continues to overcome the reasons for the suspension and have the service reinstated for residents.

**Presentation to Local Healthwatch**
Healthwatch England invited Healthwatch Hillingdon to give a presentation of our work on using NICE Guidance at their Quarterly National Policy Development Group in September, hosted by Healthwatch Bristol. This presentation provided Healthwatch Hillingdon an opportunity to showcase our success in influencing uptake of NICE Clinical Guidelines by commissioners, as well as highlighting some of the barriers to successful implementation, using our work on IVF as an example.

The presentation was aimed at providing peer-to-peer best-practice learning for our local Healthwatch colleagues and the presentation slides were made available to share for the whole local Healthwatch network.

## 4.1 Information, Advice and Support

During this quarter we recorded a total of 296 enquires.173 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 | 36 | 21% |
| Refer to a voluntary sector service | 19 | 11% |
| Requesting information / advice | 50 | 29% |
| Requesting help / assistance | 7 | 4% |
| General Enquiry | 61 | 35% |

**Table A**

Table B shows the source of these enquiries.

| Source of enquires | Number | % of source |
|---|---|---|
| shopper | 123 | 71% |
| event | 1 | 1% |
| referral | 11 | 6% |
| promo | 5 | 3% |
| advert | 1 | 1% |
| website | 2 | 1% |
| known | 18 | 10% |
| other | 2 | 1% |
| unknown | 10 | 6% |

**Table B**

Access to our service through the shop remains the main point of contact and we are pleased to advise that we have secured an extension to our lease until August 2017.

We have set out in Table C where we have signposted people to this quarter, to give the Health and Wellbeing Board a sense of the variety in the enquiries we receive.

| | Number | % | | Number | % |
|---|---|---|---|---|---|
| Age UK | 9 | 6% | HCCG | 4 | 3% |
| H Carers | 8 | 5% | NHSE | 2 | 1% |
| DASH | 10 | 7% | GP | 20 | 13% |
| MIND | 1 | 1% | THH | 3 | 2% |
| CAB | 4 | 3% | CNWL-MH | 4 | 3% |
| Other Vol | 14 | 9% | CNWL-CH | 6 | 4% |
| Optician | 0 | 0% | CQC | 1 | 1% |
| Dentist | 8 | 5% | V-Ability | 1 | 1% |
| Pharmacy | 0 | 0% | W/Chair | 6 | 4% |
| LBH - SS | 9 | 6% | Other HW | 12 | 8% |
| LBH – PH | 0 | 0% | Other | 22 | 14% |
| LBH - Oth | 8 | 5% | | | |

**Table C**

As noted from previous reports, the support provided to residents and our subsequent interventions are also of a varied nature. We would highlight the following:

<u>Sleeping Tablets</u>
One of the worrying contacts for us related to a vulnerable patient who has a history of alcohol and drug dependency. They wanted advise on how they could get their doctor to prescribe more sleeping tablets as they didn't want to keep buying them.

We discovered that currently to safeguard them, their GP prescribes the sleeping tablet, Zolpidem, on a restricted basis by 1 week prescriptions. However, this patient was freely and cheaply purchasing Zolpidem, which is a Class C Controlled Drug, without prescription on the internet.

Having checked what appeared to be a UK based website and verified the possibility of supply of this medication without prescription, we reported this to the Medicines and Healthcare Products Regulatory Agency. They advised us that this is an ongoing issue because as soon as they shut down this site, it will reopen again under different credentials. This is obviously a disturbing and worrying fact.

We would advise that support have been given to this individual through appropriate channels.

Lymphoedema Service
This case is one of several this year where we have been highlighted to a lack of primary lymphoedema services by residents. As a result, Healthwatch Hillingdon is currently investigating provision of this service. Our initial findings show that there does not seem to be primary lymphoedema services commissioned in Hillingdon, and that differing providers are taking responsibility for caring for individuals in the community.

We have raised this with Hillingdon CCG as our assumption appears to be verified by a recent report by the Healthy London Partnership http://bit.ly/2fLbXt0.

Reassurance
Mrs D was due to have a hip replacement in October 2016. She had attended a pre-operation class. She did not want to complain and had found the class interesting and useful, but in the discussions about discharge after the operation, she did not feel she was listened to. She was very concerned about going home after the operation as she felt she was being discharged to soon and was not confident that she will be able to look after herself.

We contacted the hospital and a member of the MSK team contacted Mrs D to listen to her concerns and put a discharge package together that met her needs.

Further Support
An individual visited our offices in September in a highly distressed state. They had been referred to ARCH (Addiction Recovery Community Hillingdon) by their GP, as although they had been previously prescribed methadone and codamol for 20 plus years by a GP, their current GP was not now authorised to prescribe methadone. The patient informed us that following a review by ARCH, the codamol was withdrawn which were for her back pain. The patient explained that they were in severe pain and had been unable to contact their key worker and had been told she would not be able to see the ARCH clinician for a further 3 weeks.

We contacted ARCH who provided further support to help the individual. We feel it is so important that whenever medication is withdrawn that this is done in a controlled and supported manner to reduce the impact on the individual and prevent them from going into crisis.

ARCH is new service in Hillingdon, provided by CNWL. When working with the above individual we noted that the new ARCH website did not provide details of their PALS Department, or how a patient can make compliments, or a complaint. We contacted CNWL who rectified this, to ensure all residents using the website now have these details.

## 4.2 Concerns and complaints

Healthwatch Hillingdon recorded 123 experiences, concerns and complaints in this quarter. Of these 45 were in response to the CNWL Podiatry service changes.

The areas by organisational function are broken down in Table D.

| Concern/complaint Category | Number | % of recorded |
|---|---|---|
| CCG | 2 | 2% |
| Primary care: GP | 17 | 14% |
| Primary care: Pharmacy | 0 | 0% |
| Primary care: Optician | 0 | 0% |
| Primary care: Dental | 2 | 2% |
| Hospitals | 25 | 20% |
| Mental Health Services | 9 | 7% |
| Community Health | 51 | 41% |
| Social Care | 11 | 9% |
| Care Agency | 0 | 0% |
| Care Home | 2 | 2% |
| Patient Transport | 0 | 0% |
| Community Wheel Chair Service | 2 | 2% |
| London Ambulance Service | 1 | 1% |
| Voluntary Sector | 1 | 1% |

**Table D**

Referring to Advocacy
During July/Aug/Sept 2016 we directly referred 8 people: 5 to VoiceAbility and 3 to safeguarding (2 LBH & 1 to Hounslow council).

Overview
The following is to note from the analysis of the recorded concerns and complaints data this quarter.

GP Access
In August we were contacted by a resident whose mother had been discharged from hospital following a difficult life-changing illness. They told us they had found a lovely care home where they new their mother would be safe, but were horrified to find that the home were having extreme difficulties in registering their mother with a GP practice.

On speaking to the home we found that they had 7 new residents that the local GP practices had refused to register. Due to current pressures the GP practices were reluctant to register these patients although it was their legal duty. Even after we involved NHS England, the practices continued to put up administrative barriers, which resulted in the home having to take 3 of these frail elderly residents physically to the GP surgery to enable registration.

Residents of the nursing home are all currently registered but with only 15% of the current homes capacity taken up this will be an ongoing issue. We continue to work with NHS England and Hillingdon CCG to ensure residents are registered and a long-term solution can be found, to benefit all parties.

Autism Diagnosis Service
We have continued to note the long delays for assessment, experienced by some patients who had been referred by their GP to the Autism diagnosis service. We were originally highlighted to this in March, and raised this with Hillingdon CCG. It turned out that the problem lay with a contractual disagreement with the local service provider.

Under the NHS Constitution a CCG has a legal duty to ensure that residents have access to appropriate timely treatment and must refer to an alternative provider, outside of the area, if one is not available locally. As this issue had not been rectified by May, we were concerned for these vulnerable residents and urged the CCG to find a solution.

We are pleased to note that as a temporary solution an alternative provider has been commissioned this quarter, and that the CCG are planning to procure a permanent autism assessment service for the borough's residents.

Care Package
We were contacted about an elderly Hillingdon resident, who suffers from mental health issues and numerous physical long term health conditions. They live alone and for many years have received a jointly funded care package, which included the regular reapplication of compression bandages for their lymphoedema (chronic swelling of limbs). However, without any notice, the family were informed that the care agency will no longer be providing this service and that the care package had been withdrawn by social services. This was very concerning for the family as the resident had previously had a life-threatening leg infection due to their lymphoedema.

We contacted Social Services who immediately investigated the case and reinstated the care package to ensure the resident received the care they needed.

We also received reassurance that the reason for the error had been identified and a process had been changed immediately to stop it happening again.

An individual requested the NHS fund a placement at a specialised treatment centre to treat his condition. A funding review panel was established and the individual requested independent advocacy support to help him through the process, but was unable to get this support as this service is not available in London Borough of Hillingdon. Healthwatch Hillingdon, at the patients request were asked to help. We agreed to attend a funding review panel as "independent observers" (not as advocates, as we are not commissioned to provide this service) to ensure process was fair and reasonable. We found the NHS funding panel to be fair and reasonable and that the patient's rights were respected and that his clinical needs were been appropriately meet.

Sharps disposal
A few patients with diabetes, who are managing their condition at home, have contacted us as in relation to the disposal of the needles (sharps) they use for their insulin injection.

There seems to be confusion amongst professionals and a lack of information for patients on where clinical sharps are disposed.

On investigation, we found that the national policy for the disposal of “domestic clinical waste” provided by the Department for Environment, Food & Rural Affairs advises that “Local authorities have a duty to collect household waste including healthcare waste from domestic properties.” (https://www.gov.uk/guidance/healthcare-waste)

In Hillingdon there is a sharps service provided by both the NHS and the Council for substance misuse. But for diabetes patients the disposal service is provided by a select number of pharmacies and a few GP practices and these are not readily publicised for patients.

Further clarity and clear information to the public on who to contact to arrange the safe removal of clinical waste (including sharps) from domestic property would be welcomed.

In the meantime, we have suggested that Hillingdon CCG and the Council publish a list of the pharmacies and GP practices who provide the sharps disposal service on their websites.

## 5. Strategic Working

Suicide Prevention Planning

In recent months, there have been two important publications on suicide.

- ‘The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer’ http://bit.ly/2dt1m1b; and
- Public Health England’s resource guide “Local suicide prevention planning” http://bit.ly/2g9B9pQ.

The first highlights several key facts, which we feel impact significantly upon the successful delivery of the NWL Like Minded programme:

- Suicide by mental health in-patients continues to fall, most clearly in England where the decrease has been around 60% during 2004-14.
- There are now around three times as many suicides by CRHT (crisis resolution home treatment) patients in the community, than in-patients.
- A third of CRHT patients who die by suicide have been under the service for less than one week. A third have been discharged from hospital in the previous two weeks.
- 43% of CRHT patients live alone.

These facts suggest that providing acute mental health care in the community has not been the most suitable setting and that inpatient provision is safer. As the NWL Like Minded programme looks to shift activity into the community and may possibly mean a reduction of acute mental health inpatient bed capacity across NWL, we have written to the NWL Like Minded Programme Board to strongly recommend that the contents of this report be carefully noted.
We therefore welcome the second document “Local suicide prevention planning”. This guidance supports Local Authority Public Health Teams to work with CCGs, Health and Wellbeing Boards, the Voluntary Sector and wider networks of partners, to develop a local suicide prevention plan.

In light of the National report, it will be essential that the London Borough of Hillingdon suicide prevention plan be developed, to inform the Like Minded strategy and ensure that care is designed and delivered to meet the needs of Hillingdon residents. It will also enable local partners plan to meet the mandated STP commitment to reduce suicides by 10%.

The Sustainability and Transformation Plan (STP)
As the Health and Wellbeing Board are aware the draft of the NWL STP was shared on the 13th October for partner comment, prior to submission to NHS England on 21 October 2016.

At the Healthwatch Hillingdon Board Meeting of 28th October 2016, members unanimously endorsed the letter from the Chair of the Health and Wellbeing Board submitted to Dr Mohini Parmar, the Chair of the Joint NWL Health & Care Transformation Board.

As a non-decision making group, representative of all NWL partners, The NWL Joint Health and Care Transformation Group will oversee the development and delivery of the STP and allocations of the Strategic Transformation Funding.

Healthwatch Harrow and Central West London sit on this group and we will deputise for Harrow when required.

In September NHS England published 'Engaging local people'. This document outlines the expectations upon statutory organisations to involve the public in the STP and sets out their relevant legal duties to engage and consult on their STP proposals.
http://bit.ly/2epU9lB

We asked that these expectations are written in to the NWL STP plan before it was submitted on the 21 October 2016.

Shaping a Healthier Future Programme (SaHF)
Healthwatch Hillingdon continues to be strategically involved in the SaHF process, through our seats on the NWL Patient Participation Reference Group (PPRG) and The Hillingdon CCG Governing Body.

Paediatric Transfer
On 30 June the children's ward at Ealing Hospital closed and ambulances are no longer taking children to Ealing's accident and emergency (A&E) department. Healthwatch Hillingdon were fully sited on the assurance process undertaken prior to this closure.

Implementation Business Case (ImBC) Strategic Outline Case (SOC)
Healthwatch Hillingdon are currently reviewing the draft ImBC SOC part 1 document. Comments from this final review will be incorporated prior to the ImBC SOC part 1 document being approved by the individual NWL CCGs for submission to NHS England.

Hillingdon CCG Commissioning Intentions
The Hillingdon CCG Commissioning Intentions for 2017-18 are aligned with the five year planning for the STP and the two-year contracts required by NHS England to be signed by 23 December 2016.

The commissioning intentions document was circulated to partners in September 2016 for comment. Healthwatch Hillingdon Board members reviewed the document and the recommendations made in our considered response were incorporated into the final document, which was discussed at the H&WB on 29 September and approved at the October 2016 Hillingdon CCG Governing Body. http://bit.ly/2e6GhfJ

Accountable Care Partnership (ACP)
The ACP continues to develop in preparation for coming out of shadow form in April 2017. The ACP Provider Shadow Board are currently looking at their governance model, service development, their financial model and risk share for all partners.
The governance model for ACPs outlined in the NWL best practice guidance suggests inclusion of a lay chair and further lay membership from shadow form. Currently there is no lay membership on the Shadow Board and we have asked that this guidance be considered as the providers develop their governance structure.
The ACP have set up a Clinical Design & Delivery Group to oversee the service development which Healthwatch Hillingdon attends.

## 6. Engagement Overview

During the quarter we have directly engaged with 270 people through 20 events attended by over 1,100 members of the public. These figures demonstrate a significant increase on our exposure on the previous quarter, due to an increase of the number of events attended.

We took part in Hillingdon Age UK's 60 + Fair, Uxbridge Freshers Fair, Hillingdon Health Conference, Parkinson's Information Day and Hillingdon Carers Health MOT day amongst others. There events were targeted towards different segments of the community and so presented an excellent opportunity to gather experiences from diverse audiences.

We also continued to complete our drop-in sessions at all Hillingdon libraries, and have now held surgeries at 15 of Hillingdon's 17 libraries – although these events did not prove as effective as we would have hoped in collecting resident feedback, it has helped us to raise our profile.

Our attendance at Uxbridge College Freshers Fair was one of the highlights of our engagement activities this quarter as we were able connect with a younger audience (16-24) who very rarely share their experiences of health and social care services. We were accompanied by 2 of our younger volunteers to assist on our stall as we felt the students would respond better to their peers. This proved to be a positive approach as during the two-day event we spoke to over 50 young people and handed out our literature.

During the next quarter, we plan to carry out more intensive outreach and engagement activities with our younger residents via youth centres, pupil referral units, schools and colleges.

Feedback tools
We have recently introduced a new feedback form called 'Have Your Say'. The form will be used at public events to capture individual experiences – both positive and negative of accessing services.

We initially trialled the new form at the Age UK 60+ Fair which was attended by over 100 local people. The form proved effective, as during the event we collected a total of 13 feedback forms, in addition to providing information and advice. There was a good balance between positive and negative feedback although many shared their concerns about accessing GP appointments. One resident who shared her feedback was concerned she had to wait 5 weeks to get an appointment for her 13-year-old son.

Media
We continue to engage with residents and other stakeholders via our social media channels and are pleased to announce that we recently reached our 1,000th follower on Twitter. More recently we introduced Instagram as part of our social media strategy as a means of engaging with the under 25's and since the beginning of June, we have attracted over 40 followers including Hillingdon Council. This proves that Instagram has the potential to become a high engagement and effective marketing tool for Healthwatch to promote its work via images and videos.

Traffic to our website remains constant. It was pleasing to see that when looking at the statistics, almost 50% of the 5500 who access the website each month, do so directly rather than through a search engine.

We have also seen further coverage in the Evening Standard, when an article was published on Fertility Services in July 2016.

Volunteers
Volunteer retention rates remain high and 4 Healthwatch volunteers have now completed 6 months of volunteering. As part of our maternity and discharge project work, 5 Healthwatch volunteers supported the project leads with conducting surveys on the wards at The Hillingdon Hospital and the Children Centres. In total volunteers contributed 154 hours of their time between July -September. As a way of saying thanks we are planning a thank you lunch later in the year.

We have also nominated our Social Media volunteer – Lily Doyle for the annual 'Hillingdon Volunteer Award' to receive formal recognition for the fantastic work she has carried out for us on Twitter and Facebook - Thank you Lily!

## 7. PROJECT UPDATES

### 7.1. Maternity Care

The engagement programme has now spoken to 241 women and exceeded the 200 target set. We are now engaging in Hillingdon Hospital, Children's Centres in Hillingdon and Southall, have run workshops and attended several mother & baby groups. In general, women are reporting positive experiences and staff are receiving positive feedback for good respectful care. Women have informed us of areas which for them would have improved their maternity experience and our report will outline these in due course.

On the analysis of the data at the recent project operation meeting a decision was taken to carry out some focussed engagement with women from British, Black, Asian, and minority ethnic (BAME) backgrounds, to look at language barriers. We contacted several

community groups in both Hayes and Southall and carried out some focus groups in November 2016.

We have also started to follow up women who have previously given us permission to contact them after the birth of their child to gauge their experience of the birth and the provision of post-natal care.

7.2. **Hospital Discharge**

The engagement programme for the project has now been completed. We have spoken to 172 patients/family in their hospital beds and followed up 60 patients/family in their homes after discharge.

In late October 2016 we held a project meeting to analyse the data collected and produced an initial evidence document for stakeholders on the patient experience of discharge. This evidence was shared with The Hillingdon Hospital NHS FT, Hillingdon CCG and Hillingdon Social Services and presented to the Older Peoples Service Strategy Group on 9th November. All Partners will be providing a response to the evidence and a final report, outlining our findings, will be produced and published in the New Year.

We are also looking to create a short film to accompany the report. Filming was completed in early November and following production, it will be released later this year.

The Council's Social Services, Housing and Public Health Policy Overview Committee are currently looking at hospital discharge. We are scheduled to present an overview of our evidence on 15th December.

## 8. ENTER AND VIEW ACTIVITY

PLACE Assessments

Our Enter and View Team committed 28 hours to the PLACE Assessments of the care environment at Hillingdon and Mount Vernon Hospitals in September 2016.

## 9. 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 | **522** | 583 | 462 | | 637 | 729 | |
| 2 | People directly engaged | SP1 SP4 | 350 | | 354 | **434** | | 333 | **270** | | 250 | | | 354 | |
| 3 | New enquiries from the public | SP1 SP5 | 175 | 124 | 232 | **177** | 126 | 402 | **296** | 96 | 241 | | 98 | 227 | |
| 4 | Referrals to complaints or advocacy services | SP5 | N/A* | 19 | 9 | **12** | 15 | 14 | **8** | 18 | 7 | | 12 | 7 | |
| 5 | Commissioner / Provider meetings | SP3 SP4 SP5 SP7 | 70 | 68 | 49 | **93** | 68 | 60 | **69** | 87 | 54 | | 112 | 72 | |
| 6 | Consumer group meetings / events | SP1 SP7 | 10 | 62 | 22 | **16** | 48 | 25 | **15** | 42 | 10 | | 89 | 22 | |
| 7 | Statutory reviews of service providers | SP5 SP4 | N/A* | 0 | 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 | **2** | 4 | 3 | | 2 | 7 | |

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# UPDATE: STRATEGIC ESTATE DEVELOPMENT

| | |
|---|---|
| **Relevant Board Member(s)** | Dr Ian Goodman, Chair, Hillingdon CCG<br>Councillor Philip Corthorne |
| **Organisation** | Hillingdon Clinical Commissioning Group<br>London Borough of Hillingdon |
| **Report author** | Sue Hardy, Head of Strategic Estate Development, Hillingdon CCG<br>Nicola Wyatt, S106 Monitoring & Implementation Officer, Residents Services Directorate, London Borough of Hillingdon |
| **Papers with report** | Appendix: Section 106 Healthcare Facilities Contributions (Sept 2016) |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | This paper updates the Board on the CCG strategic estate initiatives and the proposed spend of S106 health facilities contributions in the Borough. |
| **Contribution to plans and strategies** | Joint Health & Wellbeing Strategy, Out of Hospital Strategy, Strategic Service Delivery Plan |
| **Financial Cost** | To be identified as part of the business case for each individual project |
| **Relevant Policy Overview & Scrutiny Committee** | N/A |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCGs strategic estates plans.**

## 3. BACKGROUND

In 2014 Hillingdon CCG published its Strategic Service Delivery Plan (SSDP) which outlines the local context in Hillingdon CCG, the scale of change required to deliver the Out of Hospital Strategy and the model of care that is being developed at a national, regional and local level.

The document also considers the delivery implications of this new model of care. The aim is to achieve a patient-centred and integrated system of accessible, proactive and coordinated care;

but in order to implement this major change to the existing health and care infrastructure is required.

The SSDP presents detailed activity and estates modelling, focusing on the use of the existing health estate, the future space requirements and the identification of potential sites for locality based health and wellbeing hubs.

The pipeline for hubs has been identified as the following:

Hayes and Harlington: Hesa Health Centre (already operational)
Uxbridge and West Drayton: St. Andrew Park development as the preferred location
North Hillingdon: Mount Vernon Hospital site as the preferred location

To realise the benefits outlined in the Five Year Forward View, Department of Heath issued a guidance document in June 2015 entitled ‘Local Estate Strategies – a framework for commissioners’. CCGs were asked to:

- produce a Local Estate Strategy in partnership with local stakeholders
- establish a Strategic Estate Group

The Hillingdon Strategic Estates Group was formed in September 2015 and has met quarterly since then. Representatives from the Council, Central and North West London Trust, Hillingdon Hospital Trust, NHS Property Services, the Local Medical Council and CCG have been in attendance.

It is essential that service and estates planning are integrated to ensure that we deliver high quality services and make well informed investment decisions. This approach will facilitate the best use of existing property, ensure that new estate developments meet service need and enable the disposal of surplus estate.

Good quality strategic estates’ planning is vital to:

- maximising use of facilities
- delivering value for money
- enhancing patients/public experiences

Local circumstances should dictate what is appropriate for local health economies. The strategy should reflect the local footprint and should include secondary and tertiary care in addition to community and primary care to include wider public sector partners in its development.

The main priority of the Strategic Estates Group to date has been to produce the draft estate strategy; this document is based on the SSDP and in addition provides an overview of the entire estate in the Borough used for the delivery of healthcare services and capturing future investment plans of each stakeholder. The aim is to create a strategy that identifies and enables joint development opportunities across the Borough and embraces the key objectives of the ‘One Public Estate’ programme.

## 4. HILLINGDON ESTATE STRATEGY

In summary, the draft Hillingdon Estate Strategy sets out the following:

## Strategic Context

The document provides a summary of the CCG local estate strategy review process and estate proposals within the context of the NWL Shaping a Healthier Future (SaHF) programme and the Hillingdon CCG Strategic Service Delivery Plan (SSDP) which both support the NHS Five Year Forward View.

The document feeds into the Strategic Transformation Plan (STP) for the Borough. Below is an outline of the Hillingdon vision of how the key priorities outlined within the Five Year Forward view and the STP guidance will be addressed:

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.

The SSDP had previously been developed to identify the estate solution required to support the delivery of the transformation of care and established a plan for a hub service of between 2,700 and 3,600 $m^2$ split over three key locations across the Borough.

The estate strategy has been further developed to include the Local Authority and primary care estate used for the delivery of health/social care and overall estate metrics on condition, market rent impacts and cost per clinic room/workstation.

## Key Drivers and Challenges

- To meet an estimated increase in demand and complexity of care delivered in the community for out of hospital care across the area of 30%-35%

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

- A need to improve utilisation of the existing estate and effectively target strategic investment in new estate in locations appropriate for a Hub health care delivery model.

Forecast population and demographic growth in Hillingdon suggests an increasingly diverse population. In North West London generally, the youthful, ethnically diverse, communities will be the principal health service users.

Property overview

§ 71 property holdings: 21 health centres, 3 hospitals, 1 administration office and 48 primary care properties comprising over 148k $m^2$ Net Internal Area (NIA).

§ 10 holdings are NHS PS estate representing 5% of total NIA.

§ Total annual running costs in 2015/16 of circa £53m (Community Health & Primary Care 10%, acute hospitals 90%).

Key points emerging from the strategic review

§ The need to progress the aims of the SSDP and implement the hub strategy. Focussing investment in locations which support the out-of-hospital health care challenge at Uxbridge/West Drayton, North Hillingdon and Hayes & Harlington

§ The need to secure long term premises solution for the Shakespeare Medical Centre

§ The need to address poor primary care infrastructure by making sure GP practices are in the right location and in fit for purpose accommodation

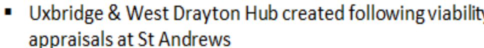
Current status of strategic estate priorities

Clinical Estate

**As-Is Position**

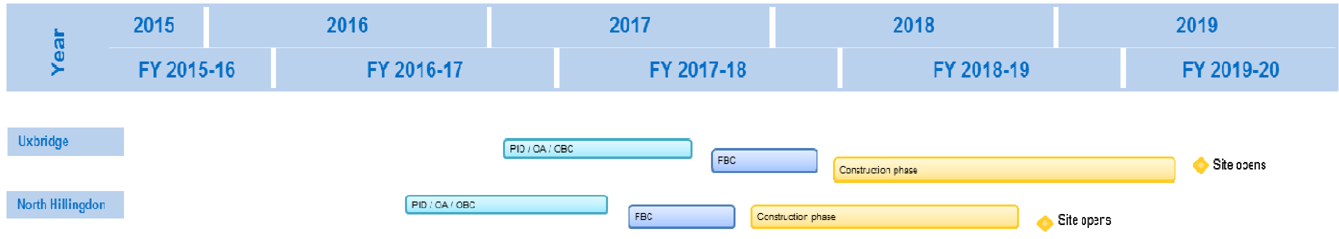
- Uxbridge Health Centre – limited capacity, good primary care coverage but restricted capacity for OoH activity
- Yiewsley Health Centre not fit for purpose
- HESA – Hayes & Harlington hub
- Mount Vernon - Master planning
- Shakespeare Medical Centre (Elers Road)
- Mixed GP estate to be reviewed on condition & suitability

**To-be Position**



- Uxbridge & West Drayton Hub created following viability appraisals at St Andrews
- Yiewsley replacement Health Centre created
- Central hub created at Hesa Primary Care Centre plus overflow OoH capacity in the area created
- North Hillingdon Hub created at Mount Vernon
- New larger premises acquired following project information document (PID) appraisal
- All GP surgeries located in fit-for-purpose sites

The indicative timeline for delivery of the two Hubs.




Property opportunities and savings

There is potential to exit Kirk House at lease break in 2017 (£871k p.a. revenue savings) depending on the acquisition plans for the new Yiewsley Health Centre site for which Kirk House could be an option.

Determine the future of the vacant Northwood & Pinner Community Hospital site. Options are currently being assessed by NHS PS; this includes the potential of a whole site redevelopment (including Northwood Health Centre).

Other property considerations

- Further data and property analysis on the condition of the public sector estate undertaken and being analysed
- A full review of the GP estate by NHS England and the CCG has been undertaken and will inform the production of a primary care strategy in early 2017
- Conclude work with Hillingdon Hospital Trust over the next 3 months to determine potential site options at Mount Vernon Hospital for north Hillingdon hub and produce a Project Initiation Document (PID) for approval by NHS England
- Work with the planning and property teams at the Council to establish the future health estate requirements within the Hayes Housing Development Zone

Financial considerations

Across North West London the NHS is undertaking a review of the Implementation Business Case (ImBC) developed for the Shaping a Healthier Future Programme, including both the capital and revenue implications of the Hubs. The NWL Collaboration of CCGs is intending to take a refreshed business case to NHS England in early 2017 following sign off by CCG Governing Bodies in December.

Hillingdon Council, in consultation with the NHS in Hillingdon, has been collecting S106 contributions for health from residential developers where the size and scale of the housing scheme has been identified as having an impact on the delivery of local health services. Funding has been secured by the Council for investment in health premises and services in the Borough in order to help meet increased demand for health services as a result of new development. This additional non-recurrent funding has been used to build capacity within the primary care estate and subject to the Council's formal s106 allocation process, it is proposed that any further contributions received are used to the remainder will help to offset the cost of the Hubs.

The CCG will identify the financial implications of all estate investment as part of the business case development process for each project.

## 5. S106 HEALTH CONTRIBUTIONS HELD BY THE COUNCIL

Appendix 1 attached to this report details all of the s106 health facilities contributions held by the Council as at 30th September 2016. The Council has received two further contributions since the last report to the Board in September, these have been added to Appendix 1 and are highlighted in bold. As at 30th September 2016, the Council holds a total of £1,169,759 towards the provision of health care facilities in the Borough.

The CCG has "earmarked" the majority of the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. To note, a total of (£533k) from s106 contributions previously held by the Council, 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.

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.

## HILLINGDON COUNCIL FINANCIAL IMPLICATIONS (

As at 30 September 2016, there is £2,377,753 of Social Services, Housing, Health and Wellbeing S106 contributions available, of which £1,207,994 has been identified as a contribution for affordable housing. The remaining £1,169,759 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.

Officers in conjunction with the CCG and NHSPS are actively working towards allocating the outstanding health contribution to eligible schemes. Funds totalling £1,134,138 are provisionally earmarked towards proposed health hub schemes as follows:

| Proposed Health Hub Scheme | Amount |
|---|---:|
| North Hub | 175,983 |
| Uxbridge / West Drayton Hub | 520,593 |
| New Yiewsley Health Centre | 433,660 |
| Pine Medical Centre | 3,902 |
| **Total Earmarked** | **1,134,138** |

## HILLINGDON COUNCIL 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.

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| CASE REF. | WARD | DEVELOPMENT / PLANNING REFERENCE | TOTAL INCOME | BALANCE OF FUNDS | SPEND BY | PROPOSED PROJECT | DETAILS OF OBLIGATION (as at mid November 2016) |
|---|---|---|---|---|---|---|---|
| | | | AS AT 30/09/16 | AS AT 30/09/16 | | | |
| 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 November 2016) |
|---|---|---|---|---|---|---|---|
| | | | AS AT 30/09/16 | AS AT 30/09/16 | | | |
| 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 November 2016) |
|---|---|---|---|---|---|---|---|
| | | | AS AT 30/09/16 | AS AT 30/09/16 | | | |
| 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 November 2016) |
|---|---|---|---|---|---|---|---|
| | | | AS AT 30/09/16 | AS AT 30/09/16 | | | |
| 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 November 2016) |
|---|---|---|---|---|---|---|---|
| | | | AS AT 30/09/16 | AS AT 30/09/16 | | | |
| 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/62/384F *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/63/385D *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. |
| **H/64/387E *136** | **Uxbridge North** | **Norwich Union House, 1-2 Bakers Road, Uxbridge. 8218/APP/2011/1853** | **15,518.40** | **15,518.40** | **2023 (Sept )** | 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 be spent within 7 years of receipt.** |
| **H/66/390D *137** | **West Drayton** | **Fmr Anglers Retreat, Cricketfield Road, West Drayton (11981/APP/2013/3307)** | **8,319.90** | **8,319.90** | **2021 (Sept)** | 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. Funds to be spent within 5 years of receipt.** |
| | | **TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES** | **1,415,815.46** | **1,169,758.89** | | | |

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# HILLINGDON LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor David Simmonds CBE |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Stephen Ashley, Hillingdon Local Safeguarding Children Board |
| **Papers with report** | Hillingdon Safeguarding Children Annual Report |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | The Hillingdon Local Safeguarding Children Board (HLSCB) has a statutory duty to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the Borough. Once agreed by the HLSCB, the report is submitted each year to the Chief Executive, the Leader of the Council and the Chairman of the Health and Wellbeing Board. |
| **Contribution to plans and strategies** | N/A |
| **Financial Cost** | There are no financial costs relating to the publishing of this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes the report.**

## 3. INFORMATION

### Supporting Information

The annual report sets out the work undertaken by the Board this year, and includes specific reports from each of the agencies that make up the Board. The purpose of the annual report is to provide evidence about the standard to which the agencies responsible for safeguarding children in the London Borough of Hillingdon have performed.

There has been considerable change over the last year, both to the Board and to the structure of a number of the agencies engaged in child safeguarding. In terms of the Board, we have restructured it so that it is more effective and the Executive Board now has representation at the most senior level. We have also formed a small business unit to manage not only the Safeguarding Children Board, but also the Safeguarding Adults Board. This has enabled us to develop progressive training packages for all agencies and provide administrative and project

management skill to move the Board forward. The appointment of a business manager has seen rapid development and, perhaps most importantly, the introduction of audit and performance processes to ensure we are able to properly hold agencies to account.

We are all aware that austerity measures have placed huge pressures on all agencies. Whilst we accept that this makes safeguarding children more difficult, it is not an excuse for failure and there is no doubt that organisations working together will be more likely to reach acceptable standards of safeguarding.

We will, over the coming year, continue to monitor changes to services to ensure that children are not harmed as a result of those changes. There will be a number of serious case reviews, some of which are historical, published by the Board this year relating to occasions where a child or children have been injured or lost their lives. These reports are a sad reminder that safeguarding children is a difficult task and those organisations and individuals make mistakes that can have tragic consequences. These reports will speak for themselves, but we are determined that where we have fallen short of the required standard we are able to ensure that the same mistakes are not repeated. This requires a multi-agency approach and a vigorous governance system holding agencies to account. The Board continues to provide this scrutiny, together with its partners, across the sector.

The report lays out in detail the areas where we need to make further progress, but the Board are satisfied that, despite the difficult financial circumstances, agencies in the Borough of Hillingdon are providing services that ensure our children are properly safeguarded. In particular, it is worth drawing attention to the huge investment and re-structuring of Children's Services by Hillingdon Council and the work undertaken at Hillingdon Hospital to ensure that its child safeguarding standards are now regarded as 'good' by the Care Quality Commission.

We have looked again at our priorities this year and they are set out in the report. We are determined that we do more work to listen to the views of children and young people and will be exploring ways in which we can be more responsive and better engaged with all our communities; particularly young people.

**Financial Implications**

There are no financial implications related to this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

There is no effect to local residents.

**Consultation Carried Out or Required**

No consultation required.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

Corporate Finance has reviewed the report and concurs with the financial implications set out above.

**Hillingdon Council Legal comments**

There are no legal issues related to this report. Pursuant to s14A Children Act 2004, the Hillingdon Local Safeguarding Children Board must, at least once in every 12 month period, prepare a report about safeguarding and promoting the welfare of children in its area.

## 6. BACKGROUND PAPERS

NIL.

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# 2015-2016

# LSCB Annual Report

Andrea Nixon

Local Safeguarding Children Board

2015- 2016

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## 1. Foreword

Thank you for taking the time to read our annual report. The report lays out the work undertaken by the Board this year, and includes specific reports from each of the agencies that make up the Board. The purpose of the report is to provide evidence about the standard to which the agencies responsible for safeguarding children in the London Borough of Hillingdon have performed.

I have been in post for a year. There has been considerable change over that period both to the Board and to the structure of a number of the agencies engaged in child safeguarding. In terms of the Board, we have restructured it so that it is more effective and I have been pleased that the Executive Board now has representation at the most senior level. We have also formed a small business unit to manage not only the Safeguarding Children Board, but also the Safeguarding Adults Board. This has enabled us to develop progressive training packages for all agencies and provide administrative and project management skill to move the Board forward. The appointment of a business manager has seen rapid development and, perhaps most importantly, the introduction of audit and performance processes to ensure I am able to properly hold agencies to account.

We are all aware that austerity measures have placed huge pressures on all agencies. Whilst I accept that this makes safeguarding children more difficult, it is not an excuse for failure and there is no doubt that organisations working together will be more likely to reach acceptable standards of safeguarding. I know that agencies have had to make difficult decisions and choices this year, but my experience has been that agencies in this Borough engage in open and honest discussion about the ramifications for children when services are to be cut or significantly changed. Agencies are prepared to discuss their plans and listen to the views of others before making any final decisions. I will, over the coming year, continue to monitor changes to services to ensure that children are not harmed as a result of those changes.

There will be a number of serious case reviews, some of which are historical, published by the Board this year relating to occasions where a child or children have been injured or lost their lives. These reports are a sad reminder that safeguarding children is a difficult task and that organisations and individuals make mistakes that can have tragic consequences. These reports will speak for themselves, but I am determined that where we have fallen short of the required standard we are able to ensure that the same mistakes are not repeated. This requires a multi-agency approach and a vigorous governance system holding agencies to account. The Board continues to provide this scrutiny, together with its partners, across the sector.

The report lays out in detail the areas where we need to make further progress, but I am pleased that, despite the difficult financial circumstances, agencies in the Borough of Hillingdon are providing services that ensure our children are properly safeguarded. In particular, it is worth drawing attention to the huge investment and re-structuring of Children's Services by Hillingdon Council and the work undertaken at Hillingdon Hospital to ensure that its child safeguarding standards are now regarded as 'good' by the Care Quality Commission.

We have looked again at our priorities this year and they are set out in the report. I am particularly pleased that the work around Early Intervention is making progress and will be the cornerstone of our work this year.

I am determined that we do more work to listen to the views of children and young people and will be exploring ways in which we can be more responsive and better engaged with all our communities; particularly young people.

Finally, I would like to express my thanks to all of those individuals and organisations who have worked together over the last year to safeguard our children. It is the most important work we can do and Hillingdon is fortunate to have so many dedicated and passionate individuals, across agencies, protecting our children.

I hope you enjoy the report and would always welcome any comments you may have through our website.

Steve Ashley

## 2. The London Borough of Hillingdon - Local Demographics and Safeguarding

Hillingdon is the second largest of London's 32 boroughs, with a population of 69,207 children and young people under the age of 18.

Greater London Authority population projections estimate that in 2014 there were 292,000 people living in Hillingdon. 22,000 (7.5%) are aged 0-4 years and 39,000 (13.3%) are aged 5-15 years. 193,000 (66%) Hillingdon residents are of working age (16-64 years). 20,000 are aged 65-74 (6.8%) and 18,000 (6.1%) are aged over 75.

Hillingdon is an ethnically diverse borough with 43% of residents from Black and Minority Ethnic groups.

The School Census 2014 shows that 24% of pupils in Hillingdon are Asian or Asian British, 11% Black or Black British, 10% Mixed background, 8% White backgrounds other than White British, 6% other ethnic groups, and 1% not known. Almost 40% of the school population do not have English as their first language. 183 languages were recorded in Hillingdon schools with 46% of Primary school pupils and 40% of Secondary school pupils having a first language that is not English.

Hillingdon is a comparatively affluent borough (ranked 23rd out of 32 London boroughs in the 2010 index of multiple deprivations, where rank 1 is the most deprived). Within Hillingdon there is variation between the north and south of the borough, with some areas in the south falling in the 20% most deprived nationally. Heathrow Airport is located entirely within Hillingdon boundaries and this has a major impact, particularly in respect of children and young people who pass through the airport. Close and effective multi-agency work has led to Hillingdon being considered a national leader in the field of protecting children and young people from potential and actual trafficking.

**Child Population Profile:** There are significant variations in the population of children and young people (age 0-19) across Hillingdon, with more younger people in the south of the borough, and also higher proportions who are from ethnic minority groups (e.g. 80% in Pinkwell, compared with 21% in Harefield). About 45% of children and young people (aged 0-19 years) in Hillingdon are White British, 26% Asian or Asian British groups, 11% Black or Black British groups, 8% in any Mixed background, 6% White backgrounds other than White British groups, and 4% in other ethnic groups. Over the last 10 years the proportion of children born to mothers who were born outside the UK has risen to over 50%, with the biggest increases in births to mothers born in Asia and the Middle East and in countries which have joined the EU since 2004.

**Poverty:** Over a quarter of children aged 0-15 in Hillingdon are deemed to be living in poverty, including over 40% of children in two wards in the south of the borough, and 17% of school age children across the borough are eligible for free school meals.

**Vulnerable Groups:** Children can become vulnerable and subsequently be at increased risk of harm for a variety of reasons. National case reviews have indicated that children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are said to be at greater risk. In Hillingdon the most common primary need identified is abuse or neglect, followed by absent parenting which was the primary cause in almost 20% of cases, probably related to the number of Unaccompanied Asylum Seekers who become the responsibility of Hillingdon Council through Heathrow airport.

## Social Care contacts and referrals:

Contacts have decreased by 11% since March 2015. Contacts are largely dealt with at the point of contact; this is reflected in the contact to referral conversion rate of 19% in March 2016, which has reduced from 20% in February.

The number of referrals in March 2016 has decreased by 11% compared to the same time last year.

Chart 1 shows the trend of referrals, contacts and the conversion rate for the past year from March 2015.

## Chart 1

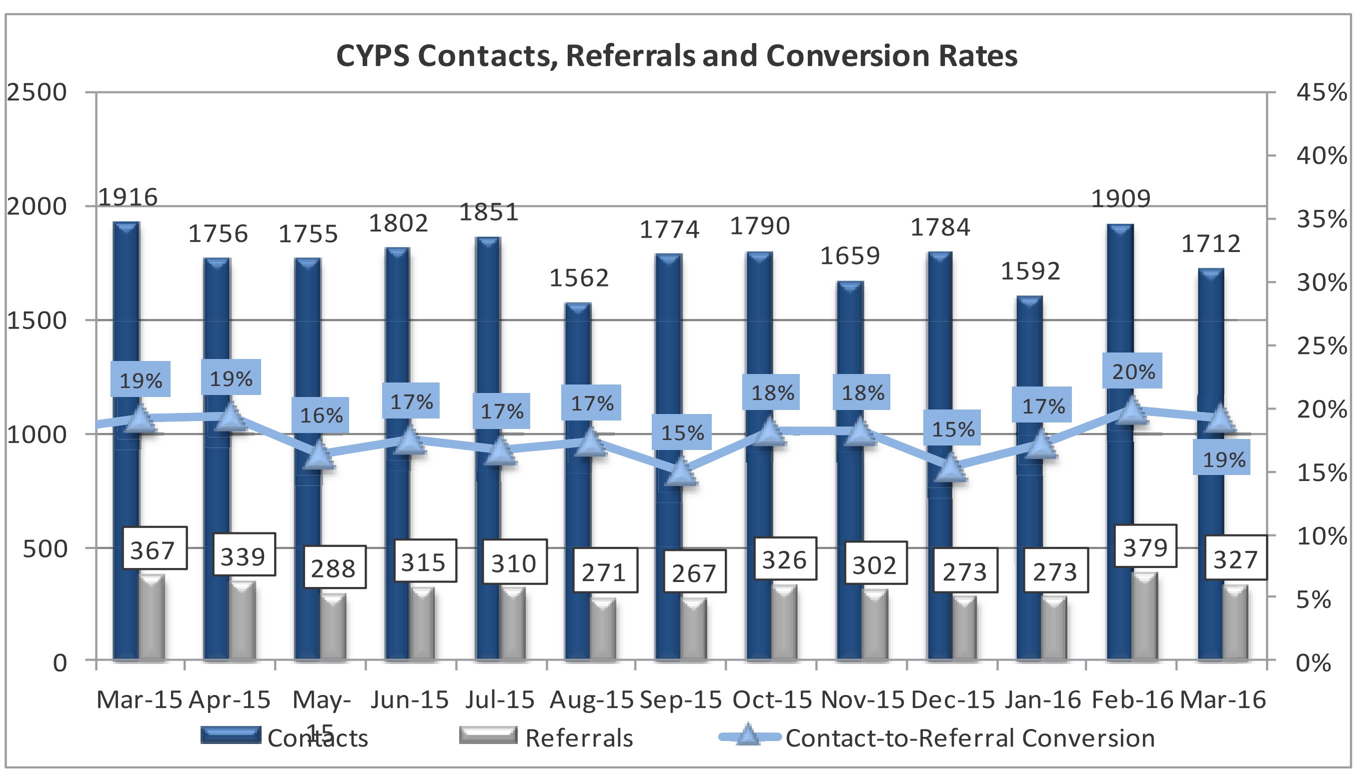


Table 1 provides the published data (2014/15 CIN Census) to compare Hillingdon to national and London referral rates per 10,000. The full year figure for 2014/15 shows a 21% increase in referrals compared to 2013/14. The referral rate in February shows a 0.2% rise against the 2014/15 position.

**Table 1**

| REFERRAL RATES PER 10,000 OF CHILDREN AGED UNDER 18 | | |
|---|---|---|
| **2014/15** | England | 548.3 |
| | London | 477.9 |
| | Outer London | 456.0 |
| | Hillingdon | 532.2 |
| | | |
| **YTD February 2016** | Hillingdon | 533 |

The Hillingdon LSCB recognises the long term damaging effects of neglect on children, which is why this is listed as one of the Boards priorities for 2015/2016. We are also aware that children who go missing from school, home or care are placed at greater risk of abuse, not only child sexual exploitation but also targeted youth violence and crime. The Board wish to ensure that partners work together to protect Hillingdon children from identified risks to their safety.

## 3. Governance & Accountability

Hillingdon LSCB is made up of statutory and voluntary partners. These include representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (CAFCASS), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our main role is to co-ordinate what is done locally to protect and promote the welfare of children and young people in Hillingdon and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people.

The efficacy of Hillingdon LSCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

Our purpose is to make sure that all children and young people in our authority are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

**Regulation 5 of the Local Safeguarding Board Regulations 2006** sets out the functions of the LSCB as per section 14 of the Children Act 2004.

**The Children Act 2004** places a duty on every local authority to establish an LSCB.

The Government's Statutory Guidance, **Working Together to Safeguard Children (2015)** defines safeguarding and promoting the welfare of children as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best life chances

This is to enable those children to have optimum life chances and enter adulthood successfully.

The Operational Board is made up of representatives at a senior level from across agencies in Hillingdon. Members take responsibility for decision making on behalf of their agencies to make sure they abide by policies, procedures and recommendations of the Board.

The Executive Board manages the business and operations of the board ensuring there are clear governance arrangements in place and drives forward the strategic priorities as outlined in the business plan.

The Executive Board and Operational Board meet 4 times during the year. Where there has been insufficient attendance or engagement at the Board, this has been challenged by the Independent Chair.

# 4. Board Membership and Structure

## i. Members and Lay Members

Hillingdon LSCB has recently recruited three lay members for the Board. The role of the lay members is to support stronger public engagement in local child protection and safeguarding issues and contribute to an improved understanding of the LSCB's work within the community.

Following a robust induction programme, one of the areas that we wish the lay members to assist in is ensuring that we hear the voice of the child and young person. One of our lay members is themselves a Hillingdon care leaver and feels passionately about ensuring that children and young people have a voice.

## ii. LSCB Operational Board Members

| Name | Organisation | Job Title |
|---|---|---|
| **Ana Popovici** | London Borough of Hillingdon | Assistant Director of Children's Social Care |
| **Andrea Nixon** | London Borough of Hillingdon | LSCB & SAB Business & Development Manager |
| **Andrew Smith** | Metropolitan Police | Detective Inspector |
| **Ann Nardecchia** | London Borough of Hillingdon | Learning & Development Officer |
| **Ann Shelvin** | St Marys School | Head Teacher |
| **Annette Thomas** | Border Force | Senior Officer, Terminal 5 |
| **Carole Jones** | Yeading Junior School | Head Teacher |
| **Chelvi Kukendra** | Clinical Commissioning Group | Designated Safeguarding Doctor |
| **Daniel Kennedy** | London Borough of Hillingdon | Head of Business Performance, Policy and Standards |
| **Deborah Mbofana** | London Borough of Hillingdon | Health Promotion Manager |
| **Duncan Struthers** | Interfaith Communities | |
| **Erica Rolle** | London Borough of Hillingdon | Domestic Violence Strategic Coordinator |
| **Fiona Gibbs** | London Borough of Hillingdon | Stronger Communities Manager |
| **Gloria Okello** | SSAFA | Personal and Family Support Worker |
| **Glyn Jones** | Metropolitan Police | Detective Sargeant |
| **Graham Hawkes** | Hillingdon Healthwatch | CEO |

| | | |
|---|---|---|
| **Helen Smith** | London Borough of Hillingdon | LSCB & SAB Training & Quality Assurance Manager |
| **Jenny Reid** | Clinical Commissioning Group | Designated Safeguarding Nurse |
| **Joanna Smith** | London Borough of Hillingdon | Safeguarding & Reviewing Service Manager |
| **Lisa Crawshaw** | CNWL Trust | Named Safeguarding Nurse |
| **Lucy McLeod** | London Fire Brigade | Deputy Station Officer |
| **Lynn Hawes** | London Borough of Hillingdon | Youth Offending Service Manager |
| **Manjit Bringan** | Whitehall School | Head Teacher |
| **Naveed Mohammed** | London Borough of Hillingdon | Performance & Intelligence Service Manager |
| **Nikki Cruickshank** | London Borough of Hillingdon | Assistant Director for Safeguarding and Children's Service Improvement |
| **Nominated rep** | NHS | LAS |
| **Sally Morris** | London Borough of Hillingdon | CP Schools Advisor |
| **Seb Florent** | Metropolitan Police | Detective Superintendent CAIT |
| **Stephen Ashley** | London Borough of Hillingdon | Independent Chair |
| **Tendayi Sibanda** | The Hillingdon Hospital | Named Safeguarding Nurse |
| **Tom Murphy** | London Borough of Hillingdon | Assistant Director Early intervention and Prevention Services |
| **Vanessa Saunders** | NHS | Deputy Director of Nursing |

## iii. LSCB Executive Board Members

| Name | Organisation | Job Title |
|---|---|---|
| **Andrea Nixon** | London Borough of Hillingdon | LSCB & SAB Business Manager |
| **Antony Rose** | London Probation | Assistant Chief Officer |
| **Cllr David Simmonds** | London Borough of Hillingdon | Cabinet Member |
| **Daniel Kennedy** | London Borough of Hillingdon | Head of Business Performance, Policy and Standards |
| **Gavin Hughes** | Uxbridge College | Director |
| **Ian Macauley** | CAFCASS | Senior Service Manager |
| **Joan Veysey** | Clinical Commissioning Group | Executive Lead |
| **Manjit Bringan** | Whitehall School | Head Teacher |
| **Martina Lecky** | Ruislip High School | Head Teacher |
| **Nick Downing** | Metropolitan Police | Borough Commander |
| **Maria O'Brien** | CNWL | Divisional Director of Operations |
| **Reva Gudi** | Clinical Commissioning Group | GP Lead |
| **Richard Claydon** | London Fire Brigade | Borough Commander |
| **Sam Rosengard** | CRC (Community Rehabilitation Company) | Head of Stakeholders and Partnerships, NW London |
| **Shikha Sharma** | Public Health | Consultant |
| **Stephen Ashley** | London Borough of Hillingdon | Independent Chair |
| **Steve Hajioff** | London Borough of Hillingdon | Director of Public Health |
| **Sue Pryor** | Swakeley's School | Headteacher |
| **Theresa Murphy** | The Hillingdon Hospital | Director of Nursing |
| **Tony Zaman** | London Borough of Hillingdon | Corporate Director Adults, Children and Young People's Services |

## iv. LSCB Sub-Committees

CSE

**Chair: Nikki Cruickshank**

Case Review

**Chair: Andrea Nixon**

Child Death Overview Panel

**Chair: Shika Sharma**

Learning & Development

**Chair: Helen Smith**

**Operational Board**

Joint Strategic Safeguarding & Trafficking Group

**Chair: Boarder Force Terminal Senior Officers**

Performance & Quality

**Chair: Dan Kennedy**

**Independent Chair:**
Stephen Ashley

Children, Young People and Learning Policy Overview Committee

Corporate Parenting Board

**Executive Board**

Youth Justice Management Board

Member Agencies Executive Management Board

Health & Wellbeing Board (HWB)

Safeguarding Adults Board

Domestic Violence Action Forum

## 5. LSCB Achievements 2015/2016

We have revised the structure of the LSCB. The LSCB now has an Operational Board and an Executive Board. This allows for decisions to be made at the appropriate level and for challenge at a senior level.

Development of LSCB & SAB business unit. This is a joint unit to include a coordinator for each board and a joint training and quality assurance officer.

Work of the Board has been informed by clear agreed priorities and underpinned by an up to date and well structured Business Plan.

We have raised the profile of Hillingdon LSCB by; disseminating LSCB newsletters, bulletins on children social care information screen and establishing a presence on Twitter.

Purchase and development of audit tool 'Enable'. Staff within children and adult services are now able to complete comprehensiive audits and action plans.

LSCB Terms of Reference revised.

LSCB priorities agreed for 2016/2017.

Risk register implemented and updated regularly to provide regular progess on identified concerns.

SCR guidlelines produced.

Development of case review sub-committee to ensure that recommendations from serious case reviews, domestic homicide reviews and serious adult reviews are acted upon and regluar progress reports are fed back to the Operational and Executive Meetings.

Charging policy in place for LSCB training to ensure that we are able to deliver appproprate and quality training.

FGM resource park prodcued and distributed to staff within children and adult services.

Health referral pathway for FGM developed and implemented within The Hillingdon Hospital.

We participated in 'Children's takeover day' supported by schools.  Visits were made to ask children and young people what made them feel safe or unsafe.  The results were presented to the Operational Board and this exercise is to be continued on a regular programme to encompass all the schools in the Borough.

We have developed a more effective multi-agency dataset which, whilst still a work in progress, is used to routinely scrutinise operational partners performance, and challenege and audit where necessary.

Learning & Development sub-committee now includes Safeguarding Adult Board L&D.  New Terms of Reference and training needs analysis adopted.

Revised training programme available.

Chelsea's choice, CSE awareness production, delivered to secondary schools. Feedback from schools was extremely positive.

CSE audit completed by internal audit team.  Outcome 'Reasonable' which is very positive.

Section 11 audit developed using Enable audit tool.

Schools section 175 audit developed using Enable audit tool.

DFE Campaign signposted through the Board 'Together we can tackle child abuse', developed to encourage members of the public to report concerns. The Board ensured that this campaign ran effectively in Hillingdon.

Explored and resolved concern raised regarding the organisation of invitations and minute circulation at Child Protection Case Conferences.

The Board facilitated discussions between the Hospital and children social care to ensure that child protection medicals take place in a timely and child focused way. Protocol for this has been developed.

Police checks for child death overview panel agreed.

We have recruited three Lay Members for the board including a young person who is a care leaver. This will help the Board receive challenge from a comprehensive section of our community.

## 6. What we have achieved against 2015/16 priorities

### i. Child Sexual Exploitation

- LSCB Child Sexual Exploitation Sub-Committee established. Terms of Reference and Membership from lead agencies.
- Operation Limelight continues at Heathrow with participation from Children's Social Care and Child Sexual Exploitation Prevention Manager.
- Audit completed and grade 'reasonable' achieved.
- Chelsea's choice presented in secondary schools.
- Risk Assessments and CSE toolkit embedded in practice.
- MASE meetings held monthly to track cases.
- Border Force, Asylum Team and ECPAT attend LSCB trafficking sub-group which identified trends and aims to improve intelligence sharing.
- Training available through LSCB and well attended.

### ii. FGM & Radicalisation

- FGM toolkit distributed to agencies which includes risk assessment.
- FGM good practice mapped within the local authority.
- FGM part of Operation Limelight.
- Training available through LSCB training programme.
- Prevent training available. All board members received Prevent presentation.
- Prevent strategy promoted by LSCB.
- Schools include FGM/Prevent in their Child Protection policies.

### iii. Develop an understanding of the quality of multi-agency practice and the child's journey

- Development of the Performance Web.
- Challenge of agencies through the Performance and Quality Sub-Committee.
- Purchase of 'Enable' audit tool to provide quality safeguarding audits and more robust evaluations.
- Section 11 audit to take place and to include more partners than before.
- Section 175 audit to be completed by schools.
- Core Group audit and audit of child protection plans to take place.

### iv. Membership of Board

Membership of Operational and Executive Boards has been reviewed and the Chair is satisfied that we have membership at the correct level in order for members to influence their own policies and procedures, and to offer challenge to others.

### v. Collaborative work between children and adult board

The Business Unit works across the Adult and Children's Board. Sub-committees have been developed to include both adult and children workforce e.g. Learning & Development and Case Review sub-committees.

## 7. LSCB Challenges 2015/2016

i. Now that Early Help & MASH arrangements have become embedded, the LSCB will need to build an improved understanding of the effectiveness of early help assessments and interventions. We will want to be assured that the provision of early help is being delivered in a timely way and that the LSCB and our partners can evidence the difference for children, particularly those who are most vulnerable, in making sure they receive the help they need before things escalate to child protection.

ii. With the retirement of our CDOP Manager, and awaiting the outcome of the national review of CDOP, the Board need to ensure that we are fulfilling our requirement in this area and support the CDOP Coordinator in this rule.

iii. The Board needs to improve its communication and raise its profile with the public by developing and launching its own website.

iv. We need to collate and analyse information from children missing return interviews.

## 8. Learning and Development

One of the ways that Hillingdon LSCB fulfils its statutory objectives is by commissioning and providing training to the wide range of professionals who work directly with children and young people or in services affecting the safety and welfare of children in Hillingdon. The inter-agency training provided by Hillingdon Local Safeguarding Children Board offers a range of opportunities for practitioners to work together in a learning environment with a common aim of improving children's safety and wellbeing.

In December 2015 Hillingdon LSCB appointed a Training and Quality Assurance Officer to coordinate the multi-agency training and develop a multi-agency borough-wide picture of training needs, patterns in take up of training and gaps and to evaluate the quality and measure the outcomes of the multi-agency training programme. The role has enabled Hillingdon to become a substantive member of the Pan London LSCB training subgroup to enable sharing of skills and knowledge from across London to inform learning and development in Hillingdon.

### i. Multi-agency Training offer

In June 2015 following consultation and agreement at the Executive Board Hillingdon LSCB developed a charging policy for multi-agency training. This was implemented in December 2015 enabling the LSCB to charge agencies that do not financially contribute to the LSCB for delegates to attend training. The income generated from the charging policy is being reinvested into the LSCB and training programme for the forthcoming year. The 2015/2016 training schedule offered training to all our multi-agency partners. Training was offered across a variety of topics. In total 591 training places were accessed by 476 individual delegates over the 28 training sessions held.

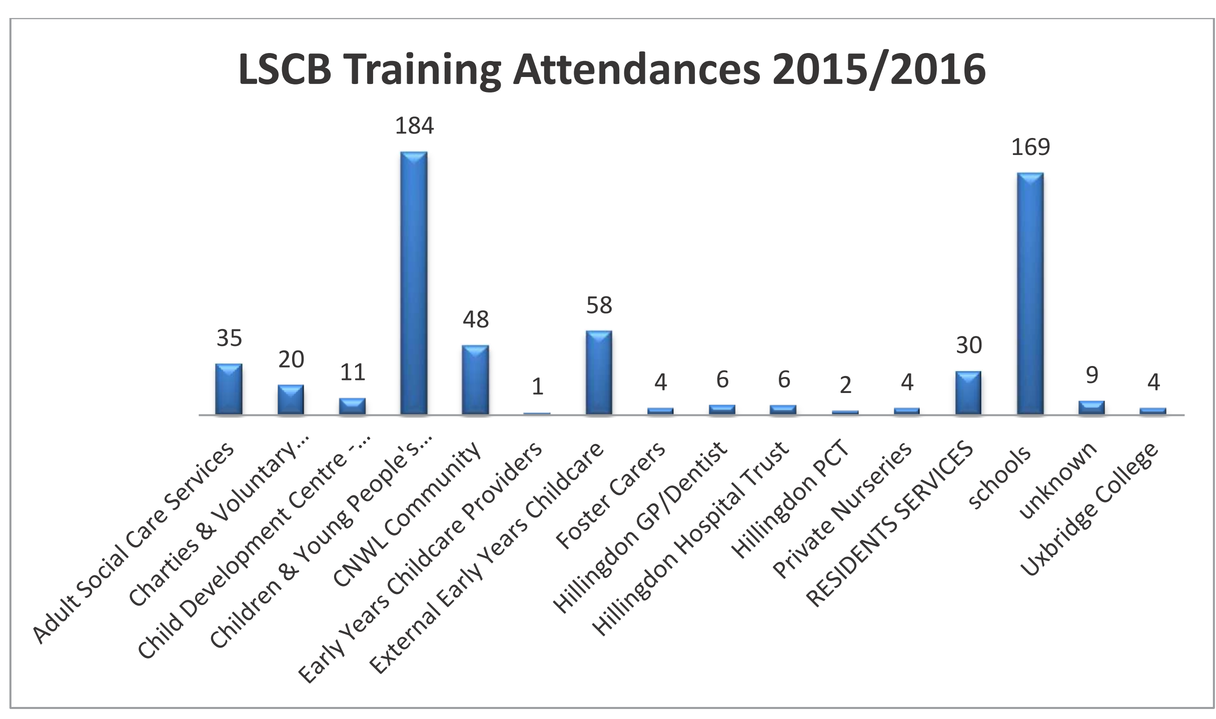
Table 2 Identifies the breakdown in number of delegates attending courses held - please note that some delegates attended more than one course in 2015/2016.

### Table 2

| TRAINING PLACES ACCESSED | |
|---|---|
| Domestic Abuse Awareness & the Impact on Children | 70 |
| Core Groups and Child Protection Plans | 20 |
| Initial Working Together to Safeguard Children (Level 3) | 188 |
| Introduction to Child Sexual Exploitation - What do professionals need to know? | 133 |
| Refresher Working Together (Level 3) | 147 |
| Signs of Safety Awareness | 33 |
| **Grand Total** | **591** |

Chart 2 below shows the breakdown of delegates attending all LSCB training events in 2014/2015 by different employment areas.

## Chart 2




## ii. Training evaluations

Using the Pan London training evaluation forms Hillingdon LSCB have evaluated all training sessions, using a two step process. Of all courses attended 99% of delegates agreed that the course met its aims and objectives, and 99.6% of delegates agreed that they would recommend the course to a friend. Comments from delegates included:

### iii. E-Learning

Hillingdon LSCB offers the E-learning package "Early Help Assessment and Team around the Family eLearning" with 63 delegates having completed the course in 2014/2015.

With the support of Hillingdon Learning and Development Team Hillingdon LSCB also developed an e-learning package entitled "Introduction to safeguarding children." The e-learning course provides delegates with relevant and clear information to support them to understand the types of abuse and neglect a young person/child may experience and how to identify the tell tale signs, how to respond professionally if you suspect a child is being abused and or when a child/adult discloses abuse and develop reliable methods of keeping accurate records. The package has been very well received by many of our partners with a total of 252 having registered to use the package since its publication in February 2016.

### iv. Developments for training for 2016-17

The 2016/2017 training schedule was released in March 2016 with a number of new and exciting courses being offered. The training programme has been developed to support professionals in working with children and families during the journey of the child. From undertaking Early help assessments, to recognising and respond effectively when action may be needed to safeguard a child from maltreatment, attending child protection case conferences and core groups meetings. This is then complimented with specialist courses in Child Sexual Exploitation, Domestic Abuse and two courses facilitated by the Women and Girls Network in respect of a Trauma focussed approach to Child Sexual Exploitation and understanding the Trauma and Psychological Impact of Harmful Practices (Honour Based Violence, Forced Marriage, Female Genital Mutilation).

A focus on making training localised has been supported by colleagues within children's services who are facilitating training in respect of Signs of Safety, Early Help and Domestic Abuse to support professionals in understanding the context of safeguarding within Hillingdon. Where external facilitators are commissioned the LSCB training and Quality Assurance officer has developed a "making training localised briefing" to enable the facilitators to understand the safeguarding context in Hillingdon and ensure that information provided is consistent with Hillingdon safeguarding policies and procedures.

In 2016/2017 we will be implementing a three step process to include post course evaluation to find out whether the learning from the course has been used in practice to change confidence or attitude of the learner.

## v. Audit

- CSE internal review
- CSE peer review.

### Audit activity 2016-2017

In 2015 Hillingdon LSCB purchased an online auditing tool called Enable. The tool, managed by Virtual College, allows the LSCB to develop its own audits and for multiple users to register for the completion of audits. Section 11 audits have been created and sent to partners, with a report to the board being scheduled for June 2016. Following this the LSCB will continue a biennial auditing schedule in line with "Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004."

A schools safeguarding audit has also been created, with the LSCB Training and Quality assurance officer attending the schools safeguarding cluster meetings to support understanding and use of the tool. It is intended that a report will be made available to the board in September 2016.

The enable audit tools are designed as a self assessment tool, to enable agencies and schools to reflect on, and identify actions to improve their safeguarding arrangements where required. Both the section 11 and section 175 schools audit also includes thematic questions regarding agencies responses to domestic abuse. This is an audit subject that was identified in 2015/2016 and will be reported to the board in September 2016.

In addition to this an audit has been commissioned by the LSCB in respect of the quality of core group meetings, recording and multi-agency attendance, which is hoped to be completed by June 2016.

## 9. Safeguarding Children in Hillingdon

### i. Children exposed to Domestic Violence

The Hillingdon Domestic Violence (DV) Steering Executive has strategic oversight of domestic violence and violence against women and girls (VAWG) strategy across the council. This includes ensuring that Hillingdon Council's Policy on domestic violence continues to be reviewed and updated, ensuring that there is a robust action plan. This includes taking high level policy decisions in relation to DV and VAWG issues. The DV Steering Executive has ultimate responsibility for the DV Action Forum that reports directly to the DV Steering Executive on the work, targets, progress and achievements of the DV Action Forum's individual subgroups.

The DV Steering Executive informs the LSCB of the successful achievements of the subgroups in reducing the risks of DV and VAWG to victims and survivors by continuing to provide equitable access to services, referrals and awareness raising, specialist support and safeguarding, robust data collection to influence change and secure on-going DV/VAWG provision, including joint collaborative partnership working and critical integration of services for an effective victim centred approach. This is notwithstanding Hillingdon's Annual White Ribbon Day Conference, which was an outstanding success and highlighted some of the key themes on FGM, Safeguarding and empowerment of children, young people and vulnerable adults, Trafficking and Partnership working and continues in its commitment to raise the profile of DV/VAWG and to openly state its zero tolerance of all forms of Domestic Violence and other forms of harmful practices.

### ii. Private Fostering

London Borough of Hillingdon previously did not have any designated officer or team for Privately Fostered Children. In December 2014 this gap was identified. At the time, following receipt of notification, an assessment of need was undertaken by a social worker and it would be established whether the situation was a private fostering arrangement. However the case would then be closed if there were no child in need issues or concerns. But if there were elements of child in need then the case would be allocated to a generic social worker who would monitor and provide services.

A Private Fostering Project Lead was appointed in January 2015 and all existing privately fostered open cases were then transferred to the Project Lead who regularised the Private Fostering arrangement assessment and maintained the statutory visits. At the time there were 9 children identified in such placements.

All currently open privately fostered children's cases are allocated and Children's Social Care is maintaining their statutory responsibilities. To date the case numbers remain low, fluctuating between 11 and 5 children. The Project Lead provides expert consultation to social workers and other professionals if they come across such arrangements within their allocated caseload.

Awareness raising within the community and professional groups is a significant part of this role. Unfortunately people are genuinely not aware of these regulations, and as a result, this client group is easily missed and escapes the monitoring and support of such arrangements by the Local Authority. Engaging key agencies and local community groups has not been without challenge but after much perseverance there was success in reaching the early years and school head teacher's clusters together with safeguarding Health visitors group. A link in with Hillingdon hospital's safeguarding training was established and a short slot in their monthly training to a large number of hospital health staff as an ongoing programme was confirmed. Working relationships with the Hillingdon Women's Centre has been created. Posters and leaflets about Private Fostering have been distributed. Work is ongoing in creating links with the different ethnic minority's community groups that exist within the Hillingdon Borough. There has been success in building a link with UKBF at Heathrow airport with the delivery of presentations to their staff group in team meetings or a short slot in training sessions. Contact has been established with the GP subgroup within the Borough and the Project Lead is delivering presentations to seven GP subgroups at seven medical centres within the Hillingdon Borough. As a result of discussions with the school admission service, a few lines have been inserted in the application form about Private Fostering to try and identify if the child is being cared for by parent, relative or a private foster carer. Children's Social Care now receives regular queries from the school admissions service if they identify such possible arrangements through the forms received.

The information on Private Fostering on the London Borough of Hillingdon website and the LSCB website has been updated. The information leaflets for parents, professionals, carers and young people were updated. The Project Lead was being guided and supported by a newly formed Private Fostering Project Board and through this assistance the Project Lead developed the protocol, case workflow and case file audit systems. This project is still being monitored by the project board on a quarterly basis.

### iii. Child Sexual Exploitation

There is commitment of ownership to the Child Sexual Exploitation Prevention and Intervention Strategy from the highest level within all agencies in Hillingdon, the Chief Executive, lead member and elected members to ensure that all children are protected from child sexual exploitation (CSE). A CSE Prevention Manager has been in post since November 2014.

A London Borough of Hillingdon CSE Strategy was implemented in June 2015 and supported by Local Safeguarding Children's Board (LSCB) to ensure that individual agencies work effectively together to prevent CSE, intervene early when risks are identified, help, protect and support children who are being exploited and determinedly pursue the perpetrators. The Strategy aims to build on the pro-active multi-agency work which is already undertaken in Hillingdon by providing a framework for all professionals working with children and young people in the Borough to deliver a programme designed to raise awareness of CSE in age appropriate ways and provide young people with the appropriate life skills in order to prevent them becoming involved in sexual exploitation.

A CSE Action Plan has been incorporated into the CSE Strategy based around the 3Ps model: Prevention, Protection and Prosecution. This Action Plan identifies the work that will need to be progressed and clearly highlights responsibilities that have been agreed by the partner agencies. The Action Plan also includes a requirement to ensure that appropriate pathways and therapeutic support are available for those young people at risk of CSE.

New systems have been implemented to ensure CSE concerns can be registered and monitored. Information gathered in the community about CSE and statistical information provided by partners is now being recorded centrally. It is recognised that this database will need to be built upon to record a range of different data sets to include information in relation to sexual health, police prosecutions and children that go missing from school. The data information gathered is fed into the CSE Sub-Committee of the LSCB. Data currently available has formed a local profile where the trends and themes have enabled a preventive approach to the safeguarding of young people in the Borough as set out in the CSE Strategy.

Children and young people known to be at risk of CSE are tracked and reviewed at the monthly MASE meetings. MASE is chaired jointly by the Assistant Director of Safeguarding and Quality Assurance and a Detective Inspector from the Met Police and is attended by all partners. MASE is the driver for agreeing the appropriate operational activity to tackle CSE threats, linking in with other areas and providing information to inform problem profiles and Hillingdon Local Safeguarding Children's Board. The CSE prevention Manager is alerted to a CSE contact from MASH and all CSE risk assessments.

The LSCB has established a multi-agency Child Sexual Exploitation sub-committee, which includes other areas of concern such as missing children, trafficked children, FGM, radicalisation and serious youth violence and drugs. A number of key agencies including the Police, Children's Services, Education, Health, the voluntary sector and the Youth Offending Service are represented.

A recent internal audit of CSE has been rated as reasonable. Recommendations are:

- A comprehensive Victim Support Policy is being created which will contain post-trial support for victims, as well as witness support which are currently included in the Vulnerable Witness and Victim Strategy.
- A CSE process document which outlines the roles and responsibilities in relation to CSE as a whole process for all professionals.
- Police and CSC to share top 20 CSE risk cases data information, through MASE monthly meetings.
- MASE Tor to be updated to include named representatives and substitutes to attend in the absence of key members to ensure there is adequate representation from all agencies and teams.
- CSE Champions within CSC to be identified.
- A comprehensive information sharing document to be completed and shared with partner agencies to ensure safe and secure information sharing and data.

## iv. Children who go missing from Care, Home and Education

The Department of Education's statutory guidance on children who run away or go missing from home or care advises that local authorities should have an agreed protocol for children and young people who go missing in their area and that this should be agreed and reviewed regularly with all agencies and be scrutinised by the LSCB.

A Missing Children Protocol document launched in May 2015, signed off by the LSCB, which details procedures which should be followed if a child is missing, including children/young people in care and children/young people missing from home. The document includes details in relation to the relevant legislation, roles and responsibilities, how to conduct return interviews with several appendices of the forms required to be completed as part of the missing child/young people process. Independent return interviews have been commissioned to NYAS and will begin in early April 2016.

The missing register is presented to SMT every week and quarterly to the CSE sub-committee for strategic oversight. A recently formed Missing Task and Finish group is reviewing the Joint Missing Protocol, roles and responsibilities of CSC. The CSE Prevention Manager is alerted to missing episodes from EDT, MASH and CSC. A quality assurance review of each missing episode takes place in consultation with the Team Manager and allocated social worker.

The current trend identified from missing strategy meeting information includes the following:

- The grooming process of being encouraged to use/sell drugs and alcohol
- Lack of appropriate parental supervision, guidance and boundaries
- Chaotic home life
- Asylum seekers
- Being unwilling to adhere to reasonable boundaries.
- Returning home past an agreed curfew time.

There is close working together with the virtual school teams, who attend the LAC reviews of young people. Information of missing children is also shared with the IRO and invitations to strategy meetings are sent. In addition, and as part of working together with MISPER Unit, information has been provided to all schools in Hillingdon regarding actions and reporting of a missing child.

## v. Female Genital Mutilation (FGM)

### Mandatory Reporting

The Serious Crime Act 2015 introduced the duty to report female genital mutilation. All regulated health and social care professionals and teachers are now required to report known cases of FGM in girls under 18 identified as part of their work to the police within 1 month.

### Local Multi-agency and Community approach

Tackling the issue of FGM locally and developing strategies to prevent, protect, identify and report FGM are progressed through established multi-agency forums which include the Local Safeguarding Children's Board, the Violence against Women and Girls Sub-group, the Sexual Violence and Public Health sub-group and the Domestic Violence Forum. Membership of these forums include Elected Members, colleagues from across Health (CNWL, Hillingdon Hospital, Public Health and GPs), Community Safety Partnership, Hestia, UK Border Agency (UKBA), Community Group representative and Children's and Adult's Social Care.

Each agency has a strategy for responding to FGM underpinned by the daily activity associated with their profession. Through the multi-agency forums agencies continue to share good practice and raise awareness.

### Awareness and training

Hillingdon LSCB provides training to all frontline staff across partner agencies. This includes an e-learning course 'Introduction to Safeguarding Children' which helps practitioners to understand the types of abuse and neglect a young person/child may experience, including domestic abuse, and FGM and how to identify the tell tale signs, how to respond professionally if you suspect a child is being abused and/or when a child/adult discloses abuse and how to develop reliable methods of keeping accurate records. This training is mandatory for all children's social workers.

A themed training session 'Understanding the Trauma and Psychological Impact of harmful Practices (honour based violence, forced marriage, FGM) is also available to all partner agencies including schools through the LSCB.

Children's Social Care has produced a FGM resource pack for frontline practitioners which is available to all children and young people's services staff, partner agencies and schools.

Some secondary schools have requested specific training from Public Health and information is provided through PSHE however this is not mandatory. The plan is for the Domestic Violence Education Officer who is located in the Safeguarding and Children's Service Improvement Service to include FGM in the Domestic Abuse training delivered to Colleges. This will commence April 2016.

Training on the subject of Domestic Abuse delivered by the Domestic Violence/VAWG Strategic/Lead Co-ordinator across the council includes FGM.

NHS England has produced specific training for health colleagues in identifying and reporting FGM. Health colleagues in CNWL, Hillingdon Hospital (GUM, Midwifery, A&E and Paediatrics), Health Visitors in Children's Centres and GPs have all received this training which is now included in induction and safeguarding training. Local Care Pathways for FGM are followed in local health settings with specific questions for practitioners to ask when seeing patients. Hillingdon has a named GP to refer cases of FGM to who is a member of the Hillingdon Sexual Violence and Public Health Sub-group.

There is established communication between the clinic and local community groups to raise awareness.

### Heathrow

There is a well established relationship between UKBA and Children's Social Care in preventing and deterring FGM through Operation Limelight. Social Workers assist Police, Border Agency and Home. The operation has been declared a success and forms part of an ongoing strategy to protect young women from FGM.

UKBA have delivered training to airline staff to identify possible signs of FGM and have processes in place to report concerns.

### Reporting and Safeguarding Children

All safeguarding training across the partnership includes FGM and the mandatory duty to report FGM. All reports of FGM to the Police will be passed to the dedicated FGM team in the MET.

Where a child or young person has suffered FGM the referral process into Children's Social Care is the same as for any other child abuse concern. The referral is made into the MASH and normal safeguarding procedures are followed.

## vi. Prevent

### Safeguarding children and young people at risk of radicalisation report for LSCB

Safeguarding those who might be vulnerable and at risk to radicalisation is part of the Prevent duty, as required under the Counter Terrorism and Security Act 2015.
In Hillingdon, we have been working in the following areas:

### Partnership working

A local Prevent Partnership group has been in place in Hillingdon since 2008 and works together to develop and implement an annual and local Prevent action plan. This group has a broad membership from both within the Council departments and other local statutory services, including: police, probation, Uxbridge College, Brunel University, schools, mental health and adult services, community health, CCG, Hillingdon and Harefield hospitals, youth offending, children's services, LSCB and safeguarding.

Through this partnership, support and co-ordination of how each organisation is meeting their duties under Prevent are discussed alongside a shared risk assessment and an agreed proportionate approach for the borough.

This group meet quarterly and reports into the Strong and Active Communities Partnership which is a theme group of the local strategic partnership (LSP). Regular updates are also provided to the Safer Hillingdon Board and the LSP Executive as required.

Advice and support to partners is also provided by the Stronger Communities Manager as the Council's Prevent lead.

## Support for vulnerable individuals

The "Channel" process is established in Hillingdon, which consists of a multi-agency process for responding to identified risk and need, and in providing appropriate support to those individuals who are vulnerable.

Through the LSCB we are working collectively with partners to ensure that any safeguarding concerns are managed effectively and in a co-ordinated manner across all agencies.

Local guidance has been provided to partner organisations with regards to the Prevent duty, including how to respond and make referrals when there are concerns.

## Training and awareness raising

A programme of training for staff and other stakeholders in relation to Prevent is ongoing. The facilitation of these sessions has been accredited by the Home Office and delivered by the Stronger Communities Manager. These sessions are open to all Council staff as appropriate and to external partners, including schools.

Approximately 1500 staff from across the council and partner agencies, including schools have received this training since October 2014. Training is undertaken at the council as well as sessions undertaken within agencies venues.

Schools in particular have been increasing their demand for support, advice and training for staff, to ensure that they are able to meet the requirements of the new duty.

### Work with our communities

Engagement with the community is a key aspect of the Prevent work.

Hillingdon Inter Faith Network (HIFN) plays a key role in enabling us to work together with our faith communities in promoting greater understanding and strengthening relationships.

HIFN are a member of the Strong and Active Communities Partnership and there are a number of initiatives that have been developed in partnership with them. These include: the Annual Peace walk, Annual Inter Faith week events, Inter Faith workshops in schools and regular themed network meetings on community issues. We have also established an emergency response network of faith leaders, to support our management of any incidents or community concerns.

Through the Strong and Active Communities Partnership, a broader approach has been established to promoting community involvement, inclusion, access to local services and participation in learning, leisure, arts and culture underpin the aim of building stronger and more resilient communities.

## 10. Key Safeguarding Activities

### i. Early Intervention and Prevention

### Description of service

Working with families who need our support so that they may develop the skills, knowledge and resilience required to be self-reliant and prosper. We do this by securing the following:

- Child and Family Development Services: Securing and providing a range of early learning, childcare and family development services delivered through early year's centres and children's centres;
- Targeted programmes: meeting the needs of families by securing and providing targeted programmes of developmental activity that enables children, young people and families to develop the behaviours, skills and capabilities to avoid or overcome problems and risks;
- Youth Offending Services (LSCB annual report submission provided separately): meeting the needs of young people who have come to the attention of criminal justice agencies by delivering intervention and tracking services with a view to reducing the likelihood of further offending behaviour; and

- Key-working Services: Meeting the needs of families by providing integrated 1-1 support and challenge to enable them to overcome problems including those identified within the terms of the Troubled Families programme, those concerned with school absence and non participation in education employment and training.

## Progress on Safeguarding Priorities

- **Finalising of revised Early Intervention and Prevention Strategy 2016 - 2019:** A revised strategy has been drafted with further work required to ensure that the strategy is co-designed by, and embedded across the partnership.
- **Embedding structural changes within the service:** As previously referenced good progress has been made with all new divisions of service now in place.
- **Full roll-out and embedding of the lead professional, early help assessment (EHA) and team around the family (TAF) process across the partnership:** Good progress is being made with increasing adoption of the lead professional role and application of EHA and TAF by partners.
- **Refining processes for identifying and targeting families in need of early help:** Processes have been refined with progress including a review of the EHA tool. Further work is required at both an operational and strategic level to strengthen these processes.
- **Progressing service development and partnership activity in order to deliver outcome requirements of the extended Troubled Families programme:** Progress continues to be made to transform collaborative work in support of families within the terms of reference of the Troubled Families programme. Progress includes strengthening the use of data analysis to identify families in need of support, developing cross service communication in response to the needs of 'troubled families' and increasing the application of a 'one family, one lead professional, one plan' approach across agencies.

## Priorities for 2016/17

- Finalising and implementing the Early intervention and Prevention Strategy 2016 - 2019 with partners;
- Fully embedding structural changes within the service;
- Leading a process for ensuring the lead professional, early help assessment and team around the families processes are consistently applied by all partners;
- Continuing to progress service development and partnership activity in order to deliver outcome requirements of the extended Troubled Families programme.

## Good news stories

- Good and outstanding judgements secured by Oak Farm Children's Centre and Nestles Avenue and Uxbridge Early Years Centres;
- Over 100 vulnerable children and young people received records of achievement at a celebration event in December 2015 in recognition of their progress and learning through participation in targeted programmes;
- MOPAC funding secured to introduce a new, innovative and interactive theatre and group work-based learning package for secondary schools to enable exploration of pupil attitudes and concerns regarding serious youth violence and knife crime, through a participative drama production and facilitated discussion groups.
- Youth Offending Service Community Representatives winning the Hillingdon Volunteer Team Award in recognition of their role in reducing re-offending and ensuring that young offenders are aware of the impact of their actions on victims and the community in general;
- Resident commendation of the Restorative Justice work of Youth Offending Services;
- 110% increase in application of Team around the Family; and
- 20% increase in use of Early Help Assessment

Hillingdon LSCB have committed to overseeing the implementation of the Early Intervention and Prevention Service to ensure that an Early Intervention and Prevention Strategy is developed and implemented across partner agencies. This is listed as a Board priority for 2016/17.

## ii. Multi Agency Safeguarding Hub (MASH)

The MASH provides the gateway to secure safeguarding services for children in Hillingdon. This multi-agency triage service supports the children's workforce in delivering effective early help and safeguarding intervention for vulnerable children and families.

The MASH is made up of professionals from across the children's workforce and each member of the team is able to use their shared knowledge, skills and networks to ensure that children and families have access to the right services at the right time.

An example of good practice is a visit from Steve Rimmer, Home Office Lead for Crime & Police, to the MASH in February 2016 who noted the following:

- Strong, knowledgeable LA leadership
- Impressive range of partner agencies (other than adult mental health)
- Good metrics underpinning a clear straightforward operating model
- High levels of confidence in the quality and sustainability of early interventions, enabling significant shifts in caseload away from CPPs and S.47s, while overall contacts remain high
- Clear authority from MASH to individual agencies (including at management levels) in terms of decision-taking

The previous LSCB report noted from CYPS that in August 2014 the level of risk in the Children's Social Work Teams was deemed to be unacceptably high. The recovery actions have successfully stabilised the service and the focus going forward will be on improving the quality of practice.

### iii. Corporate Parenting, Children's Rights and Participation

Corporate Parents, which include elected Members, managers and staff in the Children and Young People's Services and its partners, are committed to children's rights and the participation of looked after children and young people and care leavers, in decisions which affect their lives. Our vision as corporate parents is that we will have children and young people at the heart of what we do - involving them in designing, monitoring and reviewing services.

All Looked After Children are consulted about their placement and experiences of being in care, including their health and education, throughout their time in care, Social workers meet with them regularly to seek their views, carers (foster carers or residential staff) are required to discuss and involve children in decision making on a day to day basis; and there is a more formal consultation process that takes place in advance of their LAC Reviews, which includes the Independent Reviewing Officer (IRO) who chairs the Review meeting arranging a time to see the child on their own in preparation for their review.

There are currently three groups that make up the Children in Care Council (CICC) in Hillingdon, each of these groups meet a minimum of once a month with the Participation and the Children's Rights Officers facilitating the groups with the support of Care Leavers.

- **Talkers:** (for 7 to 11 year olds) The sessions are based around fun, creative activities. It is an opportunity for looked after children to come together, meet with other children like themselves; this group took an active part in contributing to the Welcome Pack for children in foster care.
- **Step Up:** (aged 12-15 years) This group aims to be fun; thought provoking for young people and project based. Giving them opportunities to hear about and be consulted re new developments in Hillingdon Children Services.
- **Stepping Out** (16 plus and care leavers) This was a newly formed breakaway group as a decision was made to split the Step Up Group into younger and older as it was difficult for the older talkers to move up to Step Up with so many older young people and care leavers. This has enabled this group to focus more on issues relating to leaving care, training and service developments.

Children and young people from the older groups are trained to deliver training to other children and staff in Hillingdon and get involved in staff recruitment. They also have representation and take an active part in the Corporate Parenting Board meetings with Members and senior officers.

Staff from the Children's Rights and Participation Service regularly engage with foster carers, visit Children's Homes and Semi independent provision meetings with children and young people to get them involved in projects and checking they are happy and feel safe where they are living; where appropriate helping them to access Hillingdon's commissioned independent advocacy service, NYAS who provide individual support to Looked After Children to get their voices heard.

During 2015/16 there have been a range of projects and activities supported and promoted by the Working Groups of the Corporate Parenting Board in consultation with the CICC and facilitated by the Children's Rights and Participation Team to improve outcomes for looked after children. Such as the Care Leavers Conference in June, The Kids in Care Awards 2015, a new looked after children's information pack and we are about to launch a new consultation process 'My Review' to enhance gathering the wishes and feelings of children about being in care.

### iv. Allegations against professionals

#### LADO Role

All organisations that provide services to children, or provide staff or volunteers to work with or care for children should operate a procedure for managing allegations that are consistent with:

- Working Together to Safeguard Children 2015
- Section 11 Children Act 2004 and Section 175 Education Act 2002 – duties on organisations and individuals to safeguard and promote the welfare of children.
- Keeping Children Safe in Education 2015
- London Local Safeguarding Children Board Child Protection Procedures, Chapter 7.

#### Responsibilities

- Prevent unsuitable people working/ volunteering with children and young people
- Promote safe practice and challenge poor and unsafe practice
- Identify instances in which there are grounds for concern about a child's welfare and take appropriate action to keep them safe
- Contribute to effective partnership working between all those involved with providing services for children and young people

## LADO Threshold

A person who works with children is alleged to have:

- Behaved in a way that has harmed or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicated they may pose a risk to children.

## Types of professional referred

- The largest cohort of staff being referred to the LADO is school staff. Schools are a universal service and have the most contact with young people, which is reflected in the referral rate– 61%.
- The second largest cohorts being referred are foster carers with 20%. There are complex reasons as to why some young people, make allegations against foster carer which are unfounded, often due to their own previously emotionally distressing circumstances.
- The third largest cohorts are passenger assistants and drivers of children with additional needs – 10%. This is concerning as these young people are often very vulnerable, with no verbal communication, hence why their support staff need to be outstanding.

## Threads of Investigation/Hillingdon Percentages

- Allegations Against Professionals – 29%. A meeting is held between the LADO, Social Care and the employer to decide next steps.
- LADO Strategy Meeting – 27%. A meeting is held between the LADO, Social Care, Police and the Employer to decide next steps.
- Internal Investigation – 18%. The referral does not meet the LADO threshold but there is a concern surrounding the subject of the allegation's conduct. The employer carries out an Internal Investigation and forwards the outcome to the LADO.
- Information – 20%. There is a concern raised that the LADO will keep on record should any future issues arise.
- Historical – 6%. Agencies requesting information about previous investigations/concerns raised.

## Types of Outcomes and Hillingdon Percentages

### Substantiated – 29%

This is an allegation that is supported or established by evidence or proof. The employer must consult the LADO to discuss whether a referral should be made to the DBS and/or to a professional or regulatory body.

### Unsubstantiated – 20%

An unsubstantiated allegation means that there is insufficient identifiable evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence. Where there is insufficient evidence to substantiate an allegation the employer must consider what further action, if any, must be taken.

### Unfounded – 4%

The term 'unfounded' means that there is no evidence or proper basis which supports the allegation being made and there is evidence to prove that the allegation is untrue. It might indicate that the person making the allegation had misinterpreted the incident or was mistaken about what s/he saw or was not aware of all the circumstances

### False allegations - 2%

The employer, in consultation with the LADO, must refer the matter to Children's Social Care to determine whether the child is in need of services or may have been abused by someone else.

### Ongoing - 29%

Ongoing investigations that are still live and have not yet reached a conclusion.

### Information Only - 16%

Partner agencies will ask for information about historical allegations or schools and organisations will contact the LADO for case discussion and for advice about how to manage staff related incidences that do not meet the LADO threshold.

### Malicious – 0%

For an allegation to be classified as malicious, it will be necessary to have evidence to prove the intention to cause harm. Care should be taken in dealing with such allegations as some facts may not be wholly untrue. Some parts of an allegation may have been fabricated or exaggerated but elements may be based on truth. Children rarely fabricate an allegation. In cases that are deemed malicious, employers should work with the child to discover what was behind the allegation and seek further support for the child from other agencies as considered appropriate.

### Categories of Abuse/Percentage of Referrals in Hillingdon

- Physical Abuse e.g. kicking, hitting, spitting, throwing a missile, using weapons (belt, shoe, ruler) – 37%
- Sexual Abuse e.g. possession of indecent or abusive images, grooming, misuse of power, power imbalance -10%
- Emotional Abuse e.g. persistent sarcasm, belittling children, creating a climate of fear - 6%
- Neglect e.g. inadequate supervision, inadequate care - 0%
- Conduct e.g. where there is no allegation against a specific child but there are concerns about the suitability of an individual to be working with children – 31%
- Information - information about historical allegations or schools and organisations will contact the LADO for case discussion and for advice about how to manage staff related incidences that do not meet the LADO threshold - 16%

### Observations

- 29% of referrals are substantiated and this is likely to increase as 29% are currently still ongoing, which demonstrates that wider agencies have a good understanding of what the LADO role is and when to refer on.
- The majority of referrers are school staff concerned about personnel within their school, again suggesting that schools have a good understanding of the LADO Threshold and when to act.
- There is good attendance/engagement at the Safeguarding Cluster Meetings for schools.
- There is evidence of good attendance at LADO Meetings from mutli-agency professionals including Police, Health, Social Care and school settings.

### Next Steps

- To roll out LADO awareness training to other partner agencies including voluntary sectors and all London Borough of Hillingdon's Foster Carers.
- To market/advertise the LADO Service to a wider audience.
- To build upon the existing recording systems to ensure there is a robust mechanism for storing all LADO information.
- To ensure that the Child Protection Lead for Schools and the Domestic Abuse Lead for Schools roles are working in alignment with the LADO function, to create a service that is time responsive, instils confidence in partner agencies and has demonstrable positive outcomes for children and young people whilst being sensitive to the needs of the Subject of the allegation.

## 11. Participation & Engagement

Following on from the publication of the communication strategy, the Board has continued to develop its public profile. The quarterly e-bulletin continues to be circulated to partner agencies and topics for articles and good news stories are requested of board members. The Board continue to use Twitter (@hillingdon_lscb) as a log of highlighting activities and responses to news alerts.

A group of young people have completed a 'secret shopper' exercise relating to CAMHS services for young people. Once the report has been written, this will be fed back to the Board for action.

In order to ask children and young people what made them feel safe in Hillingdon and what made them feel unsafe, the schools Child Protection Officer led an exercise in primary and secondary schools. This information was presented to the Operational Board who requested that this exercise be rolled out across schools in Hillingdon. The main concern for young people was street lights and groups of other young people.

Hillingdon has also taken part in the DFE campaign 'Together we can tackle Child Abuse' which aims to encourage the public to report cases they are concerned about. The Board acted as a lead within the local authority to ensure that front line services were aware of the possible increase in referrals and that our communications team were briefed. This campaign is proving to be a success with adverts on radio and posters at bus stops.

The Board have recruited a care leaver as a lay member for the Children's Board. We hope this will encourage the voice of the child to be heard and to focus the work of the Board. This is a new appointment and therefore I hope to report on the progress of this role in the next Annual Report.

The Board continues to find ways of improving public awareness of safeguarding issues and of the Board and therefore we are developing a new website that will be easier to navigate and provide more information to children, young people, the public and professionals.

2015/2016 has seen an increased engagement with Hillingdon Library service, with libraries being used as a distribution point for awareness raising material including leaflets for families and carers in respect of private fostering.

## 12. LSCB Sub-Committees

### i. Performance & Quality Assurance

The focus this past year has been on strengthening the governance arrangements to enable the Board to properly scrutinise the work of the partnership and ensure that, when it comes to performance and quality, there is sufficient transparency across the partnership so that priorities and risks can be identified and addressed. The Performance & Quality Sub-Committee comprises key agencies across the partnership. The role of the sub-committee is to promote high standards of safeguarding work; foster a culture of continuous improvement and ultimately to provide assurance to the LSCB Executive Board.

Key items of work in progress include:

- Developing the 'Performance Web' - a structured and meaningful report aligned to the key priorities of the Executive Board. The Performance Web provides an opportunity for the Board to ask the pertinent questions in relation to how performance is being managed and the key targets the partnership needs to achieve. This includes developing an understanding of the cohorts of children and families we are working with, who are we trying to safeguard, measuring the quality of the services we provide, the difference we have made and what 'good' looks like. The web allows the partnership to align these questions with the specific measures that will enable the Board to test the effectiveness of what is done.
- Building transparency across the partnership - the partnership is moving from providing performance reports on single agencies to providing a performance report that covers the partnership as a whole. In the same way as positive practice is often underpinned by organisations working well together, so too are findings that service failure often involve more than one partner. Building transparency across the partnership to ensure key risks can be identified and avoided is therefore a key driver.
- Challenging and driving service improvement - whilst providing meaningful analysis and tracking progress are essential, it is just one part of effective performance management. Equally important are the tangible actions that partners, alone and in collaboration, will take to improve practice. Where warranted, the taking forward of these actions will be driven by task and finish groups with areas of immediate focus including scrutinising underlying reasons for re-referrals to establish key patterns and testing the arrangements for identifying children missing and children missing education. With this approach, the role of the sub-committee will be as much to identify emerging issues and possible future priorities, as well as dealing with the immediate work programme.

## ii. Learning & Development

### Training Subgroup

The focus of the learning and development subgroup has developed this year to wider its role to include representatives from the Safeguarding Children and Safeguarding Adults Board. The new joint subgroup is in its infancy, with Terms of Reference having been drafted and membership being reviewed. The role of the sub-committee is to promote high standards of safeguarding by ensuring that training opportunities are provided and learning and development from serious case reviews and other safeguarding activities are shared. The subgroup is chaired by LSCB training and quality assurance officer, who is also a substantive member of the Pan London LSCB training subgroup enabling sharing of skills and knowledge from across London to inform learning and development in Hillingdon.

Key items of work for the LSCB Learning and Development subgroup include:

- Development and review of the Learning and Improvement Framework
- Development of training needs analysis to inform training programme

## iii. Case Reviews

The case review sub-committee has been arranged in order to review serious case reviews, safeguarding adult reviews and Domestic Homicide reviews, and to ensure what learning is embedded and cascaded into the children and adult services. The sub-committee has representatives from both adult and children services, as learning needs to be disseminated across both service areas.

The sub-committee has met to draw up terms of reference and agree membership. We currently have four serious case reviews, two domestic homicide reviews and two safeguarding adult reviews. Once these have been completed the recommendations will be tracked through the case review sub-committee. Regular reports will then be reported to the Executive Board of both the LSCB and SAB.

### iv. Child Sexual Exploitation

The CSE Sub-Committee was originally formed as a task and finish group, but due to the high priority placed on CSE within the LSCB, it is now a substantive sub-committee that reports directly to the Operational Board. The sub-committee has a robust action plan based on the model of Prevention, Protection and Prosecution.

Its key functions are:

- Scope the scale of the problem within Hillingdon by collecting and monitoring local data
- Share responsibility among members for the coordination and delivery of the CSE action plan
- Report to LSCB on progress, highlighting any specific barriers or areas of risk within the implementation of the action plan
- Raise awareness of sexual exploitation, missing, trafficked and gang related children/young people within agencies and communities
- Encourage the reporting of concerns about sexual exploitation, missing, trafficked and gang related children/young people
- Support the identification of training and awareness needs
- Disseminate guidance and examples of good practice

Its aim for 2016/17 is to ensure that the CSE prevention and intervention strategy is embedded into practice to ensure the risk to young people is reduced.

### v. Child Death Overview Panel (CDOP)

Since April 2008, LSCBs in England have had a statutory responsibility for the child death review process.

The Hillingdon and Ealing joint CDOP receive notifications of the deaths of all children from birth to 18 years. Notifications are usually received from the Hospital or Police.

The CDOP review specified child deaths, drawing on comprehensive information from all agencies on the circumstances of each child's death. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides and deaths from natural causes where there are lessons to be learnt.

From April 2015 to April 2016, Hillingdon CDOP received 25 referrals relating to child deaths, of these, 2 were unexpected deaths and 1 led to a serious case review. Hillingdon CDOP also led the Safer Sleeping in Infants Integrated Care Pathway awareness campaign. This campaign highlighted concerns of parents co-sleeping with their babies which had resulted in a number of deaths. Dr Jide Menakaya, Paediatric Consultant at the Hillingdon Hospital, became the project lead. A multi-agency conference was held for professionals and information stands have been set up in Hillingdon Hospital and clinics to raise awareness to parents of how dangerous it can be to have their baby sleeping in the same bed as themselves.

April 2016 also saw the retirement of Carol Hamilton, the CDOP Manager for Hillingdon and Ealing. Both Ealing and Hillingdon LSCB need to look at the CDOP provision within the next year in light of Carol's retirement but also following recommendations from the current national CDOP review.

### vi. Joint Safeguarding of Children and Vulnerable Adults arriving through Heathrow Airport

This sub-committee is unique to the Hillingdon LSCB and its aim is to continue to strengthen the partnership that we have with Heathrow Airport and the LA. Operations at Heathrow remain a priority for children's social care who support Border Force Officers in preventing child trafficking and potential victims of FGM being taken out of and returning to the UK.

Members of the asylum intake team and MASH delivered training with Border Force to British Airways crew to raise awareness of safeguarding concerns and how to report them. This was a highly successful event and hopefully will be rolled out across other airlines.

The sub-committee now includes information regarding vulnerable adults travelling through the airport and therefore we have representatives from adult services.

## 13. Board Priorities for 2016/17

| Strategic Priority | What does this mean? | Actions |
|---|---|---|
| **To ensure that there are effective arrangements across agencies to respond to early signs of neglect, including risks to unborn babies** | The definition of neglect that the Board will work to is that contained in the statutory guidance; Working Together to Safeguard Children (2013).<br><br>Neglect often takes place in environments in which one or more of the following issues is apparent within the family unit:<br><br>• Domestic Violence<br>• Drug/alcohol abuse<br>• Mental Health issues | • Develop a multi-agency neglect strategy owned by all partner agencies<br>• To improve awareness and understanding of neglect across the whole partnership. This includes a common understanding of neglect and the thresholds for intervention.<br>• Ensure the effectiveness of service provision through key performance indicators, for example, a reduction in the number of children subject to a child protection plan under the category of neglect and length of time of plan.<br>• Ensure the Early Help & Early Intervention programme is used appropriately in the early recognition and identification of neglect. |
| **To ensure that partners work together to protect Hillingdon's children from identified risks to their safety and welfare** | We need to recognise that children and young people may face many risks. These could include:<br><br>• Child Sexual Exploitation<br>• Exploitation through the internet<br>• Children missing from Care, Home and Education<br>• Domestic Violence<br>• Radicalisation<br>• Female Genital Mutilation<br>• Targeted Youth Violence<br>• Drug Abuse<br>• Trafficking<br>• Force Marriage | • Ensure that Task & Finish groups are established where it is identified through local intelligence, or national trends, that targeted action needs to take place to reduce the risk to children and young people.<br>• Ensure that young people are consulted in order that any preventative interventions are meaningful to them.<br>• Ensure preventative measures are directed at young people in order to raise their awareness and more importantly what they can do to protect themselves.<br>• That local strategic plans are regularly reviewed and embedded into local practice.<br>• Partners share a common understanding of risks to children and young people via training. |

| Strategic Priority | What does this mean? | Actions |
|---|---|---|
| **To oversee the implementation of the Early Help & Early Intervention programme in Hillingdon** | To ensure that children and young people receive effective early help and appropriate interventions when needs are identified and/or problems arise.<br><br>The Board will oversee the development of an Early Help/Intervention strategy engaging all partners. | • To ensure an Early Help and Intervention strategy is developed and implemented across partner agencies.<br>• Agree key performance indicators that can be measured against the strategy.<br>• The Board to be satisfied with the Governance arrangements for the Early Help and Early Intervention programme. |
| **To ensure that Hillingdon LSCB can evidence the effectiveness of single agency and multi-agency safeguarding arrangements to satisfy ourselves that risks to children and young people are identified early in order to protect them from harm** | The Hillingdon LSCB is committed to challenging partner agencies to ensure that the Board can be satisfied that children and young people are safe in Hillingdon.<br><br>The Board is committed to listening to the 'voice of the child' in order to learn lessons from practice and to challenge existing practice where necessary.<br><br>The Board needs to be satisfied that all children and young people are seen, heard and helped; with the public and professionals being alert to risks posed to children and young people and how to report this when necessary. | • Effective auditing and quality assurance of partners practice.<br>• Effective single agency and multi-agency training across all agencies and organisations involved in safeguarding children.<br>• Monitoring and analysis of the LSCB Performance Web and the Board to effectively challenge.<br>• Strong governance arrangements across all partner agencies.<br>• An environment in which robust challenge is the norm.<br>• A clear engagement strategy ensuring the voice of the child is heard.<br>• An effective Board improvement plan that is regularly monitored at the Board. |

## 14. Conclusion

2015-2016 has been a very busy year for the LSCB, with the development of the business unit and prioritising a training and quality assurance programme. It is hoped that this report has provided you with reassurance of the effectiveness of local arrangements to safeguard and promote the welfare of children in Hillingdon.

This report demonstrates that safeguarding activity is progressing well and that Hillingdon LSCB has clear agreement on the strategic priorities achieved and what actions need to be taken forward over the coming year. The LSCB is aware of, and working to fulfil, its statutory functions under Working Together to Safeguard Children 2015.

Agency reports in Appendix 3 demonstrate that statutory and non statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

The Board has, throughout the year, begun a programme that has monitored, quality assured and evaluated the quality of services within Hillingdon, and this programme of robust auditing analysis and challenge will continue to ensure that children and young people remain safe.

L F B
LONDON FIRE BRIGADE

healthwatch
Hillingdon

NHS
Hillingdon
Clinical Commissioning Group

London
Probation Trust

HILLINGDON
LONDON

HILLINGDON
HIFN
INTER FAITH NETWORK

cafcass

London Ambulance Service NHS
NHS Trust

ssafa
Lifelong support
for our Forces
and their families

METROPOLITAN
POLICE

The Hillingdon Hospitals NHS
NHS Foundation Trust

## Appendix 1 - Glossary

| Acronym | Meaning |
|---|---|
| CAMHS | Child & Adolescent Mental Health Service |
| CCG | Clinical Commissioning Group |
| CDOP | Child Death Overview Panel |
| CIN | Children in Need |
| CNWL | Central & North West London |
| CPP's | Child Protection Plans |
| CSE | Child Sexual Exploitation |
| CSU | Community Safety Unit |
| CYPS | Children & Young Persons Service |
| DFE | Department for Education |
| ECPAT | End Child Prostitution, Child Pornography & Trafficking of Children for Sexual purposes |
| FGM | Female Genital Mutilation |
| IRO | Independent Reviewing Officer |
| L&D | Learning & Development |
| LAC | Looked After Child |
| LADO | Local Authority Designated Officer |
| LSCB | Local Safeguarding Children Board |
| MASE | Multi Agency Sexual Exploitation |
| MASH | Multi Agency Safeguarding Hub |
| MISPER | Missing Person |
| MPS | Metropolitan Police Service |
| Section 47 | Child Protection Investigation |

## Appendix 2 - LSCB Budget

### Income 2015/2016

| | |
|---|---|
| London Borough of Hillingdon | £198,500 |
| NHS | £62,800 |
| Contributions from outside partners | £29,550 |
| **Total** | **£290,850** |

### Outgoings 2015/2016

| | |
|---|---|
| Staffing | £200,300 |
| Non-Staffing | £51,100 |
| Training | £13,000 |
| Licenses | £9,000 |
| SCR | £25,000 |
| Chairman | £33,000 |
| **Total** | **£331,400** |

**Variance: £40,550 overspend**

## Individual Agency Contribution

## Appendix 3 - CCG

| Name of agency | **NHS Hillingdon Clinical Commissioning Group (CCG)** |
|---|---|
| Description of service | NHS Hillingdon CCG is a statutory NHS body with a range of statutory responsibilities including safeguarding children and adults.<br><br>Like all CCGs, it is a membership organisation that brings together general practices to commission local health services for Hillingdon's registered and unregistered population. One of the advantages of being a clinically led organisation is that the CCG is in the unique position of being able to take account of the experience of patients who are best placed as service users, to know the right services for the area and can comment objectively when new services are commissioned.<br><br>The CCG ensures that Safeguarding is included in all of the services from which it commissions health services. and requires and obtains assurance from all Provider organisations that they are meeting safeguarding requirements.<br><br>Safeguarding forms part of the NHS contract. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | Level 1 – 95%<br>Level 2 – 100%<br>Level 3 – 100%<br>Level 4/5 – 100%<br>PREVENT (WRAP) – 90% |
| Regulator inspection in reporting period and outcomes | No inspections have taken place, however the CCG has been involved in 2 Safeguarding (Children and Adults) audits. Both audits are common to the CCGs in London.<br><br>1. Baker Tilly – Good outcome with recommendations to share best practice regarding our safeguarding children Leaflet and Supervision across our Federation of CCGs<br><br>2. NHS England ( London region) Deep Dive – 4 components were reviewed:<br>a) Governance/Systems/Processes – Assured as Good<br>b) Capacity Levels in CCG – Assured as Good<br>c) Assurance – Assured as Good<br>d) Workforce – limited Assurance – This component reviewed training for both Children and Adults. It was noted that safeguarding children training figures/percentages have not been recorded in the audit. The numbers/percentages for |

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| | adult training is relatively low.<br>Safeguarding Training will continue to be a priority for the CCG and an action plan is currently being developed to reflect this.<br><br>The CCG is also involved in quarterly Assurance meetings with NHS England (London Region) during which the Health economy Safeguarding concerns e.g. Serious Case Reviews, Domestic Homicide Reviews and any gaps in service provisions, are discussed and action plans reviewed.<br><br>The CCG regularly reviews and monitors Safeguarding Children activities of its Provider organisations and will interrogate and review any irregularities. |
| Challenges in the reporting period | Child Protection Information System (CP-IS) has proved to be challenging for unscheduled care providers.<br><br>The provision of information for the 2 Domestic Homicide Reviews (DHRs)<br><br>Completion of a GP Section 11 audit |
| Progress on safeguarding priorities in the reporting period | All Provider Trusts have systems and processes in place for Safeguarding Supervision for relevant staff.<br><br>Safeguarding Children Training has been updated to include Child Sexual exploitation (CSE); Female Genital Mutilation (FGM) and PREVENT. Domestic Abuse is already included.<br><br>We continue to encourage recording and reporting of Interventions with victims of Domestic Abuse and a plan is in place to make this a regular norm.<br><br>See good practice examples.<br><br>Safeguarding Children profile continues to be raised within the CCG<br><br>The CCG is represented on the LSCB (executive and operational) and LSCB subgroups, key pan Hillingdon groups as well as relevant patch, regional, pan London and national groups |
| Safegurding priorities for 2015/16 | Safeguarding Training – maintain and update single and multi-agency training (including specific training for Commissioners)<br><br>Engagement of all Primary Care staff<br><br>Continue GP Section 11 Audit – collating, reporting and bridging any gaps<br><br>Engagement and participation with the North West London |

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| | proposal for a local Sexual Abuse Referral Centre (SARC) for children.<br><br>Participation in the development of a North West London CCGs Safeguarding (Children) Health Outcomes Framework (SHOF)<br><br>To encourage recording and reporting of interventions with victims of : Domestic Abuse; CSE and FGM<br><br>Continue to seek assurance from Provider organisations as regards Safeguarding requirements, arrangements and priorities |
| Good news stories | Links have now been made between GP sub groups and GP networks with Managers from the Multi Agency Safeguarding Hub (MASH); Child Sexual Exploitation (CSE) and the Children's Early Intervention Team. This has led to improved communication/referrals when children, young people and their families are identified and in need of services from Children's Social Care.<br><br>We have now included High Street Dentists in our Level 2 training with good uptake. |
| Good practice examples | Information regarding Child Sexual Exploitation; Domestic Abuse; Female Genital Mutilation; Prevent updated and added to the CCG's Safeguarding Children page on the extranet and cascaded to all staff.<br><br>New CCG Prevent Policy and updated Safeguarding Children Commissioning Organisation Policy approved by the CCG Board and added to extranet.<br><br>All of the above and other Safeguarding Children information cascaded to staff via CCG newsletter |
| Any other comments | Safeguarding Children is now a standing agenda item at all Contract Quality Monitoring and Quality, Safety and Clinical Risk meetings. |

## Appendix 4 - CNWL

| Name of agency | **Central and North West London NHS Foundation Trust** |
|---|---|
| Description of service | CNWL provides a range of physical health, mental health, substance misuse, learning disability, offender care (prison and immigration removal centre) healthcare services across approximately 100 sites. It is one of the largest community facing trusts in England, with approximately 6,500 staff. CNWL provides services to a third of London's population and across wider geographical areas including Milton Keynes, Kent, Surrey, Buckinghamshire and Hampshire. Approximately 40% of services are community health and 60% are mental health and allied health specialties. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | **Level 1**: All staff including non-clinical managers and staff working in health care settings **(93%)**<br>**Level 2**: Minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers **(94%)**<br>**Level 3**: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns **(circa 89% - CNWL not able to retrieve all registers for staff attending LSCB level 3 training)** |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | LSCB Level 1 Introduction- not accessed by CNWL staff<br>LSCB Level 3- The LSCB offered Working Together Initial and Refresher courses until March 2015 and they recommenced in September 2015. CNWL kept their staff up to date with their level 3 training during this period by providing in--house courses that were multi-disciplinary.<br>CSE awareness- this course has been well advertised and a good number have attended.<br>DV- domestic violence is covered in-house as part of all level 1 and 3 training in CNWL. Staff are also able to access DV training via the LSCB although the LSCB training department are unable to provide registers of attendance to CNWL.<br>FGM- The Home Office online course FGM awareness was sent out to staff and feedback was very positive.<br><br>CAMHS staff have an annual update at Level 3 as required. For the year 2015/16 these sessions will cover a number of key areas:<br>• Domestic Violence and Routine Questioning<br>• FGM<br>• Learning from Serious Case Reviews/Learning Lessons Reviews<br>• Sexual Exploitation |

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| | • Neglect<br>• PREVENT |
| Regulator inspection in reporting period and outcomes | The CQC inspected CNWL in February 2015, the results from this inspection showed that overall CNWL is safe but 'requires improvement'. In forming the overall rating, 18 different specialty reports were compiled which were aggregated up to provide an overall rating for the Trust. All our Children's Services within the Trust, including Hillingdon, were rated as 'good.' The rating for all the Hillingdon services provided in CNWL are detailed below: |

| Service | Type | Overall Trust Rating | Local Hillingdon Provision |
|---|---|---|---|
| Community health services | Inpatient services | Good | Hawthorne Intermediate Care Unit, Woodlands |
| Community health services | Children, young people and families | Good | Multiple Hillingdon sites |
| Community health services | Adults | Good | Multiple Hillingdon sites/home care |
| Community health services | End of life care | Good | Multiple Hillingdon sites/home care |
| Community health services | Community Dental Services | Good | Uxbridge and Ickenham |
| Community health services | Community Sexual Health Services | Outstanding | Uxbridge/Hesa |
| Mental health services | Acute wards for adults of working age and Psychiatric Intensive Care Units | Inadequate | Riverside Mental Health Centre |

| | Mental health services | Long stay rehabilitation mental health ward for working age adults | Good | 2 Colham Road |
|---|---|---|---|---|
| | Mental health services | Wards for older people with mental health problems | Requires Improvement | Oaktree Ward, Woodlands |
| | Mental health services | Community based mental health services for adults of working age | Requires Improvement | Pembroke Centre, Mead House, Mill House |
| | Mental health services | Crisis services and health based places of safety | Good | Riverside Mental Health Centre |
| | Mental health services | Community based mental health services for older people | Good | Woodlands |
| | Mental health services | Specialist community mental health services for children and young people | Good | Redford Way |
| | Mental health services | Community mental health services for | Good | LBH/Riverside (not inspected) |

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| | people with learning disabilities | | |
| Mental health services | Community substance misuse services | Not rated | HDAS, Uxbridge |

As a result of the rating, the Trust was required to implement a number of 'must do' actions to provide assurance to the CQC of compliance. One of the areas requiring significant work related to CNWL's Adult MH inpatient services, which were rated as inadequate. The main factor which determined this rating was the over-occupation of many of our wards due to the significant pressure on MH beds across the organisation which impacted on both patient experience and safety.

Over the last year, significant work has taken place to reduce bed occupancy including Trust-wide bed management process, improved discharge planning, reduction in length of stay and use of beds outside of the Trust to assist in management of peaks in demand. Whilst this still remains challenging both locally and nationally, significant improvements have been made.

Following implementation of all of the 'must do' actions required by the CQC, the Trust is now declaring full compliance with all CQC standards.

As part of our on-going focus on safety and quality, CNWL undertakes regular internal peer reviews, which involve multidisciplinary teams inspecting other services to ensure all services are safe and effective.

In addition, in November 2015, CNWL carried out a Trust-wide Quality Inspection of all services involving internal staff, patients, carers, commissioners and other external stakeholders. This provided a transparent framework to review our services and enable learning across all parts of the organisation.

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| Challenges in the reporting period | Workforce<br>On-going challenges in relation to retaining specialist children's/CAMHs workforce in the context of demand outstripping supply.<br>Finances<br>Increasing financial pressures |

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| | <u>Increasing Demand</u><br>Demographic pressures – year on year increase in the number of children in the borough with no corresponding increases in resources to match this. |
| Progress on safeguarding priorities in the reporting period | • *Review of safeguarding children arrangements in Divisional structures, particularly for Mental Health & Allied Specialties and Sexual Health Services*. This was completed, there are safeguarding groups in each division that feed into the trustwide CNWL safeguarding group.<br>• *Review of Prevent training for children's workforce.* CNWL are promoting Prevent training and new trainers have been identified and WRAP trained.<br>• *Complete actions arising from the review of Savile Reports*. The Volunteering Policy was ratified in 2015 and provides explicit guidance with regard to supervising volunteers and how safer recruitment principles apply to volunteers.<br>• *All Health Care Professionals working directly with children, from birth to 18 years of age, will have access to safeguarding children supervision-* completed. All staff working directly with children will receive safeguarding children supervision every 3 months as a minimum. Completed, 95-100% children's services staff have received supervision every 3 months.<br>• All CAMHS staff have monthly formal supervision and have weekly team supervision. There are now supervision groups on Safeguarding in each Borough run by the Safeguarding Nurse Advisor and a social worker in each borough.<br>• *Carry out clinical audits to ensure a safe, quality service is in place and that local and national standards are followed-*<br>Audits undertaken in Hillingdon in 2015-2016:<br>1. Child Protection and Voice of the Child: Are they reflected in children's records?<br>2. Is training well embedded? A small scale study. |
| Safeguarding priorities for 2016/17 | 1. Focus on embedding learning from incidents, management reviews and serious case reviews<br>2. Mental health/substance misuse<br>3. Neglect<br>4. Domestic violence |
| Good news stories | • A permanent MASH Health Practitioner was recruited and commenced in November 2015. |
| Good practice examples | • Health partners across Hillingdon are sharing information with and receiving information from the CSE Multi-Agency Panel |

## Appendix 5 - UK Border Force Heathrow Command

| Name of agency | UK Border Force Heathrow Command |
|---|---|
| Description of service | Joint Safeguarding of children and Vulnerable Adults arriving through Heathrow Airport |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | All Border Force officers receive training in the core skills for protecting children to give a greater understanding of how to identify children in need and the actions to take once you have done so. The Safeguarding and Trafficking Teams are trained to a higher, more expert level than ordinary front-line officers. In 2014 80 Officers and 12 Managers received this enhanced training. In 2015 5 Managers and 61 Officers received the enhanced training, 68 Managers attended a bespoke Safeguarding and Trafficking Managers course and 22 Officers attended a specific Safeguarding and Trafficking awareness session in relation to drug mules, baggage searches and legacy customs work.<br><br>The enhanced training is a rolling programme, and further courses are scheduled for 2016.<br><br>This enhanced training course has been validated by external agencies such as UKHTC and CEOP. This is a joint agency course primarily delivered by Border Force and the Metropolitan Police but incorporates training sessions delivered by Hillingdon Social Services, Salvation Army and ECPAT to provide a rounded experience. Elements of police ABE, (Achieving Best Evidence), training and expertise in areas of exploitation such as Juju, FGM and forced marriage have also been included.<br><br>New e learning to incorporate the Modern Slavery Act and changes to the NRM process is awaiting final approval and will be rolled out as mandatory training for all Border force staff in early 2016. |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | E learning modules cover these topics.<br>Local SAT teams, SAT led Operations, Operational Shift briefs and Heathrow communications all further raise staff and stakeholder awareness. |
| Regulator inspection in reporting period and outcomes | Section 55 Review has historically been conducted every 3 months by Heathrow Safeguarding Coordinator and Action Plan reviewed & updated.<br>This has been superseded by regular internal SAT Assurances conducted by local teams and fortnightly joint meetings between |

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|---|---|
| | the Terminal SAT teams and Hillingdon SS to review & progress arriving cases.<br>Regular visits by the Operational Assurance Directorate review the handling of SAT cases and SAT procedures in place. |
| Challenges in the reporting period | Arranging training courses, consistently maintaining a fully trained SAT team and recruiting others to fill arising vacancies. Joint frontline operations are arranged to address operational challenges such as Operation Limelight to target FGM. |
| Progress on safeguarding priorities in the reporting period | We will continue to build on already considerable achievements of the SAT teams and work with other agencies to carry out frontline operations to identify PVOTs or FGM.<br>A national project is ongoing to develop e learning for roll out to Airlines and stakeholders in trafficking awareness. Pending its development there have been several joint events at the airport including a joint 2 day event to inform British Airways crew. Similar monthly road show events are planned with Heathrow Airport Ltd to engage with their security personnel. |
| Safeguarding priorities for 2015/6 | We will continue to build on already considerable achievements of the SAT teams and work with other agencies to carry out frontline operations to identify PVOTs or FGM. |
| Good news stories | A very successful second year for the Heathrow SAT teams, established in April 2014 to replace Paladin. We have seen increased joint working with Hillingdon, including delivery of expert training, a programme of job shadowing & involvement in joint SAT operations such as Op Limelight (FGM) and Op Jake ( Vietnam Airlines). BF has increased the recruitment of volunteer responsible adults through Heathrow's Ambassador network and NGO organisations. A quarterly joint strategic forum is held with Hillingdon and other stakeholders and fortnightly operational meetings held with SS and each Heathrow terminal.<br>Anti Slavery day was marked again on 18/10 October at Heathrow by a SAT event hosted airside attended by SS and other NGOs. |
| Good practice examples | Designated expert SAT teams. Joint agency working on front line operations. |
| Any other comments | Ref JSSAT Strategic Joint work plan. |

## Appendix 6 - School Improvement Service

| Name of agency | **School Improvement Service** |
|---|---|
| Description of service | • Delivery of statutory duties ref school improvement including support and challenge, formal intervention and coordination of the LA strategy for school improvement. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | • Na (Service currently comprised of external consultants. HoSI has received safeguarding training in schools and led training for previous local authority)<br>• SILs expected to demonstrate understanding of latest KCSIE guidance and related inspection guidance |
| Challenges in the reporting period | • Some queries from schools ref safe schools practice - site safety/visitors etc<br>• Safeguarding duties of governors following recent concerns ref boundaries<br>• Council systems for triangulating information ref safe schools/complaints from parents would benefit from scrutiny and alignment<br>• School Improvement Link reviews of whole-school practice triggered by complaints |
| Safeguarding priorities for 2015/6 | • Ensuring that internal School Improvement Overview Database references safeguarding issues where appropriate in order to gather most holistic picture of individual school strengths and weaknesses<br>• Linking with school leaders inc academies, where systemic concerns are raised by RSC, DfE or local officers |
| Good news stories | • Positive engagement of SILs supporting school leaders with advice including highlighting the need for staff training and signposting into the borough where appropriate<br>• SILs routinely exploring/referencing safeguarding practice in schools (where allocated on the Schools At Risk Register) |
| Good practice examples | • Harefield Juniors - review of practice by SIL welcomed by HT and GB. Useful initial conversations between HoSI and AD Safeguarding<br>• HoSI attendance at SMT to provide links between different areas of the directorate (schools safeguarding practice and challenges)<br>• Highfield Primary School - school leader supported by SIL |

## Appendix 7 - Hillingdon Youth Offending Service

| Name of agency | Hillingdon Youth Offending Service |
|---|---|
| Description of service | Carries out the partner's statutory functions with regards to young offenders (aged 10-18) |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | In 15/16<br>• 11 Staff have or will have undertaken Initial Working Together Training<br>• 5 staff undertook refresher training |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | **Level 3 Working Together Training**<br>Of the permanent staff team<br>• 93% have completed Initial Working Together Training<br>• 50% have completed refresher within the timescale<br><br>Of the sessional staff (casual contracts)<br>• 47% have completed Initial Working Together<br>Because many sessional staff are usually only available to work evenings and week-ends, Safeguarding is included in their core training programme.<br><br>**CSE Awareness**<br>• Completed by 50% of permanent team<br>• Completed by 52% of sessional team<br>**DV**<br>• Completed by 40% of permanent team<br>• Completed by 37% of sessional team<br><br>**PREVENT**<br>• YOS specific briefing delivered to the permanent team on 4.11.15<br>• A similar session is being planned for sessional staff |
| Regulator inspection in reporting period and outcomes | No Inspection during this year. |
| Challenges in the reporting period | • Staff turnover at both practitioner and operational manager levels -higher than normal locum and 'acting up' posts.<br>• This has led to variance in quality of assessments<br>• Implementation of a new national assessment tool requiring all staff to be trained in both the theoretical models upon which it is based and the technicalities of the application within the computerised casework system. This has significantly impacted on time available to do other training and so targets for Safeguarding Training have not been met.<br>• In year grant funding cuts |

| | |
|---|---|
| Progress on safeguarding priorities in the reporting period | • The new assessment tool Assetplus should support improved assessments, risk management and intervention planning however as it was only implemented at the end of November 2015 we have yet to evaluate the impact.<br>• The pre-court system has been reviewed. A more robust assessment tool is being developed with greater emphasis on signposting and referring to targeted prevention services.<br>• The violence and vulnerability (V&V) forum has been developed with partners and is being used to identify siblings of those involved in Serious Youth Violence and support their access to Early Intervention Services.<br>• The YOS has been an active partner in the CSE MAP and MACE forums |
| Safeguarding priorities for 2016/17 | • To ensure all staff are trained to appropriate level in the key areas of working together, CSE and DV.<br>• Audits of Assetplus indicate good quality assessment and analysis of safeguarding and well being issues. |
| Good news stories | • Reduction in custody rate per 1,000 of 10-17 year old population<br>• Reduction in the rate (per 100,000 of 10-17 population) of young people entering the criminal justice system<br>(Data as available January 2016) |
| Good practice examples | Young person on a full care order and placed in foster care was charged with serious sexual offences against a younger girl. This young person was himself the victim of sexual abuse and neglect which had resulted in him being removed from home and the subsequent care order. The offences clearly met the threshold for a lengthy custodial sentence however the concern was that unless some specialist work was undertaken with this young person he would continue to be a risk to others specifically the young and vulnerable. An AIM assessment (sexual offenders) was completed by the YOS and in collaboration with children's social care a specialist service able to offer a highly supervised placement and specialist interventions was identified. The Crown Court accepted the proposal made within the report prepared by the YOS for a community disposal with the placement and treatment as a condition. |

## Appendix 8 - Education

| Name of agency | **Safeguarding Lead for Education - Hillingdon** |
|---|---|
| Description of service | Providing Level 1 Safeguarding Training to Staff in schools and school Governors. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | 20 schools trained.<br><br>Approx 694 staff members trained<br>Approx 42 Governors trained |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | Level 1 Introduction to Safeguarding Training |
| Good news stories | The secondary schools across the borough received "Chelsea's Choice", a drama production delivered to 14-16yr olds to raise awareness of Child Sexual Exploitation. The productions went extremely well with positive feedback from the schools involved. |

## Appendix 9 - MPS Hillingdon BOCU

| Name of agency | **MPS Hillingdon** |
|---|---|
| Description of service | Police Service |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | There has been no bespoke Safeguarding training given to Police with the exception of the limited input within the CSU Investigators Course. I would estimate that 60 % of CSU staff have undertaken this training. |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | Hillingdon has a small team dedicated to Safeguarding Vulnerable adults. Hillingdon CSU has specifically requested CSE awareness training with an outside trainer scheduled to provide this training on the 15/03/16 with Debbie WEISSANG.<br>All Hillingdon CSU officers (with the exception of temporary attachments will have had significant input re DV - both at Corporate and BOCU level.)<br>Training re FGM and knowledge thereof requires updating due to turnover of investigators. |
| Regulator inspection in reporting period and outcomes | Hillingdon CSU and MASH have been inspected internally by MPS. The MASH was considered to be the best in the MPS whilst the CSU was considered to be of the required standard. MASH now has CSE investigators attached. |
| Challenges in the reporting period | During the reporting period Hillingdon CSU has suffered two Domestic Homicides. Both victims had children. |
| Progress on safeguarding priorities in the reporting period | Progress has been made in that -<br>1. Increase in the size of MASH - Two extra CSE Investigators<br>2. Increase in staff to CSU - Bespoke unit for investigating Safeguarding Issues |
| Safeguarding priorities for 2015/6 | 1. CSE<br>2. Safeguarding Vulnerable Persons |
| Good news stories | |
| Good practice examples | MASH considered to be most effective in the MPS and increasing in size and scope |
| Any other comments | More partnership working involving MASH and CSU |

## Appendix 10 - Hillingdon Hospital NHS Trust

<table>
<tr><td>Name of agency</td><td>The Hillingdon Hospitals NHS Trust</td></tr>
<tr><td>Description of service</td><td>The Trust delivers acute medical services for the public. The services covered are Adult and Children inpatient and outpatients services, Emergency Department, Minor Injuries Unit (This is at Mount Vernon Hospital), and Maternity Services<br>Statutory safeguarding children arrangements at the Trust are as follows<br>• Executive Lead for Safeguarding Children<br>• Named Nurse for Safeguarding Children<br>• Named Doctors for Safeguarding Children<br>• Named Midwife for Safeguarding Children<br><br>The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. The Committee is chaired by the Executive Director of the Patient Experience and Nursing.</td></tr>
<tr><td>Safeguarding training undertaken in reporting period. % of staff trained at each level.</td><td>Level 1-3 Safeguarding Children Training Trust target is 80%.<br><br><u>Figures to date 24/02/2016:</u><br><br>Level 1 93.9%<br>Level 2 91.03%<br>Level 3 84.65%<br><br>Safeguarding training is closely monitored by the Trust’s Safeguarding Committee, at Divisional performance reviews and by the Learning and Development department.</td></tr>
<tr><td>Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM<br>Prevent</td><td>These topics are part of the level 1-3 Safeguarding Children training mandatory training.<br>In addition to the mandatory training the topics are also covered as stand alone sessions:<br>• CSE sessions delivered by Child Sexual Exploitation Prevention Manager dates for the whole year available.<br>• FGM is delivered as part of core Safeguarding training, with additional training provided for Midwives and Obstetricians. Staffs have access to FGM online.<br>The Duty to report identified or reported FGM cases has been communicated with all members of staff.<br>• Domestic Violence and abuse(DVA) in the process of arranging training specific to staff who are likely to identify and deal with Domestic Violence.<br>• Prevent WRAP training booked for the year.</td></tr>
</table>

| | |
|---|---|
| Regulator inspection in reporting period and outcomes | The Care Quality Commission(CQC) visit of October 2014 highlighted that the trust needed to:<br><br>• Make sure staff are appropriately trained in safeguarding<br>• Regularly monitor and assess completion of actions agreed at weekly "safety-net" meetings<br><br>When the CQC came back in May 2015 they found that the Trust :<br><br>• Had provided training above its target of 80%<br>• Was monitoring and assessing completion of weekly Child safety net meetings.<br><br>Comments<br>The Child safety net meeting now included Senior practitioner from the MASH team which made and continues to facilitate more effective information sharing.<br>CQC also highlighted the importance of other Safeguarding meetings in the trust to discuss specific children cases.<br>The regulator also highlighted that the trust was working towards ensuring that identified staff working closely with children and families receive Safeguarding Children supervision.<br>The trust has since identified supervisors and provided training. Supervision has commenced in other parts of the hospital including Paediatrics, Maternity and Minor Injuries Unit. Other high risk areas like A and E receive day to day supervision as required from trained supervisors. Formal supervision will commence in A and E and Sexual Health in the first quarter of 2016. |
| Progress on safeguarding priorities in the reporting period | The Trust has strengthened and expanded its provision of Safeguarding supervision. A number of staff have now completed the Supervisor training course to enable them to support the named professionals in Safeguarding Children supervision. Domestic Violence and Abuse is an area of increased focus. A Trust policy has been written and is currently being ratified. A Training Needs Analysis (TNA) is in progress, with needs-specific training to be delivered as identified by the TNA. |
| Safeguarding priorities for 2016/7 | To instigate the learning from Serious Case Reviews and Domestic Homicide Reviews from the last year.<br><br>By the end of the year, the Trust to have established a process of monitoring Safeguarding supervision.<br><br>To increase training and engagement with staff based at and overseeing the Minor Injuries Unit in order to improve reporting and information sharing re vulnerable children and young adults. |

| | |
|---|---|
| | To work with Social Services colleagues to ensure social worker presence at A&E Safety Net meetings. |
| Good news stories | The trust has made significant improvement since our last CQC inspection of 2014. |
| Good practice examples | Multi-disciplinary and multi-agency safety net work towards ensuring that children either suffering or at risk of suffering significant harm are identified and that safeguarding/ child protection processes are put in place:<br><br>• Child Safety Net- A&E and UCC attendances, weekly meetings.<br>• Sexual Health- 4 weekly.<br>• Orthopaedics- 2 weekly.<br>• Maternity Safeguarding meeting – 2 weekly for Hillingdon children.<br>• Maternity Safeguarding meeting- 4 weekly for Ealing children.<br>• Psycho-social meeting- for children admitted with Safeguarding concerns, weekly. |
| Any other comments | As Ealing maternity service has been decommissioned, the Trust has implemented arrangements to Safeguard children who will be born at Hillingdon Hospital. The Named Nurse and Safeguarding Midwives are working closely with Ealing local authority and London North West NHS Trust to ensure that there are clear, robust processes in place to safeguard children.<br>In light of increased numbers of Ealing children attending A&E or being admitted to the Trust, the Lead Nurse for Paediatric A&E has also joined the Trust's safeguarding staff in working closely with Ealing. |

## Appendix 11 - LAS Safeguarding Report 2016 for inclusion in safeguarding board reports

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organization and the Trust is committed to ensuring all persons within London are protected at all times.

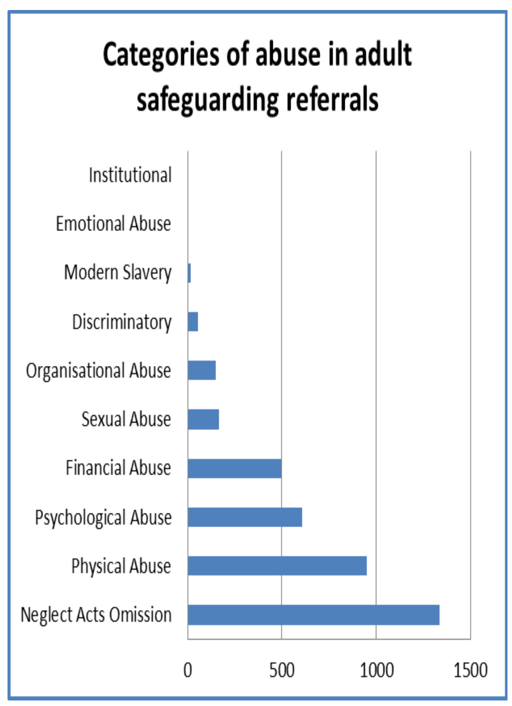
This report provides evidence of the LAS commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

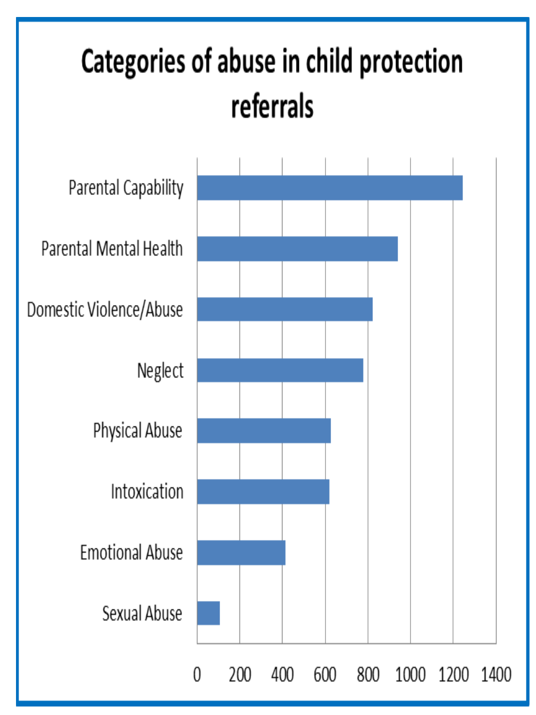
### Referrals or concerns raised to local authority during 2015-16

The LAS made a total to 17332 referrals to local authorities in London during the year.
4561 children referrals, 4331 Adult Safeguarding Concerns, 8440 Adult welfare Concerns

| | Adults Safeguarding | Adults Welfare | Children | Total Referrals | Referrals as % of incidents |
|---|---|---|---|---|---|
| LAS | 4331 | 8440 | 4561 | 17332 | 1.66% |
| | | | | | |
| Barking and Dagenham | 107 | 162 | 189 | 458 | 1.62% |
| Barnet | 144 | 259 | 159 | 562 | 1.34% |
| Bexley | 120 | 326 | 146 | 592 | 2.09% |
| Brent | 157 | 258 | 138 | 553 | 1.40% |
| Bromley | 153 | 317 | 153 | 623 | 1.73% |
| Camden | 109 | 177 | 72 | 358 | 1.05% |
| Croydon | 262 | 458 | 343 | 1063 | 2.26% |
| Ealing | 174 | 319 | 183 | 676 | 1.70% |
| Enfield | 132 | 267 | 217 | 616 | 1.62% |
| Greenwich | 137 | 274 | 220 | 631 | 1.93% |
| Hackney | 128 | 238 | 113 | 479 | 1.67% |
| Hammersmith and Fulham | 89 | 176 | 63 | 328 | 1.48% |
| Haringey | 123 | 238 | 134 | 495 | 1.59% |
| Harrow | 80 | 136 | 92 | 308 | 1.28% |
| Havering | 148 | 205 | 116 | 469 | 1.42% |
| Hillingdon | 148 | 260 | 150 | 558 | 1.32% |
| Hounslow | 165 | 330 | 152 | 647 | 1.98% |
| Islington | 129 | 240 | 91 | 460 | 1.53% |
| Kensington and Chelsea | 72 | 155 | 39 | 266 | 1.42% |
| Kingston upon Thames | 75 | 152 | 69 | 296 | 1.63% |
| Lambeth | 185 | 327 | 188 | 700 | 1.65% |
| Lewisham | 149 | 348 | 194 | 691 | 2.07% |
| Merton | 108 | 171 | 111 | 390 | 1.80% |
| Newham | 143 | 232 | 182 | 557 | 1.38% |
| Redbridge | 121 | 237 | 125 | 483 | 1.46% |
| Richmond upon Thames | 90 | 203 | 62 | 355 | 1.92% |
| Southwark | 191 | 313 | 166 | 670 | 1.62% |
| Sutton | 128 | 223 | 108 | 459 | 2.00% |
| Tower Hamlets | 111 | 194 | 141 | 446 | 1.35% |
| Waltham Forest | 160 | 309 | 136 | 605 | 1.96% |
| Wandsworth | 153 | 238 | 141 | 532 | 1.67% |
| Westminster | 98 | 256 | 58 | 412 | 0.95% |

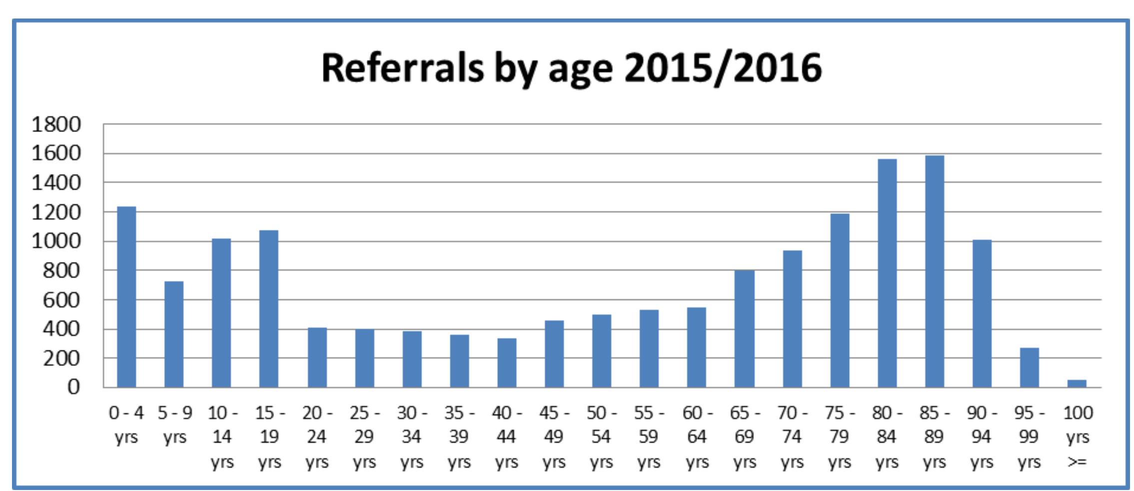
## Categories of abuse




## Referrals by age

Perhaps not surprisingly, the very young and the old are most likely to be the subject of referrals. For children, once out of infancy and their most vulnerable period they are most likely to be the subject of a referral once over 15. Around a third of referrals for all children, according to an in-house audit conducted in Q1 of this year are related to self-harm. The majority of these are in the 15-18 age range.



## Safeguarding Training

The Trust is committed to ensuring all staff are compliant with safeguarding training requirements. The chart below shows staff directly employed by the LAS as well as voluntary responders and private providers who we contract to work on our behalf.

| Training required | Total Staff | Frequency of training | 2014 | Target to be trained 2015/16 | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total trained 2015/16 | % of target 2015/16 | 3 year cummulative - % of total staff trained |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Level One** | | | | | | | | | | | | | | | | | | | |
| Induction | various | on joining | | various | 28 | 10 | 14 | 9 | 0 | 14 | 19 | 19 | 17 | 53 | 0 | 26 | 209 | | |
| E Learning | 1389 | 3 yearly | 672 | 356 | 69 | 220 | 67 | 35 | 18 | 40 | 60 | 34 | 22 | 32 | 33 | 32 | 662 | 186% | 96% |
| **Level Two** | | | | | | | | | | | | | | | | | | | |
| New Recruits | Various | on joining | | various | Nil | 53 | 88 | 31 | 39 | 124 | 13 | 16 | 47 | 27 | 74 | 177 | 689 | | |
| Core Skills Refresher | 3019 | annually | | 3019 | N/A | N/A | N/A | N/A | 310 | 596 | 785 | 936 | N/A | 178 | N/A | N/A | 2805 | 93% | |
| EOC Core Skills Refresher | 443 | annually | | 443 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0% | |
| EOC new staff | Various | on joining | | various | 34 | 10 | 9 | 27 | 4 | 12 | 17 | 0 | 14 | 7 | 12 | 8 | 154 | | |
| PTS/NET | 114 | annually | | 114 | Nil | N/A | 20 | N/A | 25 | 29 | N/A | N/A | N/A | N/A | N/A | N/A | 74 | 65% | |
| Bank staff | 390 | annually | 58 | 390 | | N/A | N/A | N/A | 6 | 8 | 43 | 66 | 0 | 31 | N/A | N/A | 154 | 39% | 54% |
| 111 | 152 | annually | 101 | 51 | 9 | 15 | 3 | 0 | 1 | 2 | 16 | 9 | 5 | 26 | 1 | 6 | 93 | 182% | 128% |
| Community first Responders (St John) | 140 | 3 yearly | 135 | 50 | Nil | 12 | 13 | 10 | 13 | 12 | 12 | 14 | 15 | N/A | 13 | 12 | 126 | 252% | 186% |
| Emergency responders | 150 | 3 yearly | | 100 | Nil | Nil | Nil | Nil | Nil | 29 | 11 | Nil | 69 | N/A | 7 | 10 | 126 | 126% | |
| **Level Three** | | | | | | | | | | | | | | | | | | | |
| EBS | 30 | 3 yearly | | 25 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 13 | 14 | N/A | 27 | 108% | |
| 111 | 11 | 3 yearly | 11 | 0 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | | 100% |
| Local leads | various | 3 yearly | | various | 6 | 5 | N/A | N/A | N/A | 7 | 6 | 12 | N/A | N/A | N/A | N/A | 36 | | |
| **Specific training** | | | | | | | | | | | | | | | | | | | |
| Prevent- clinical staff | 3019 | one off | | 3019 | N/A | N/A | N/A | N/A | 310 | 596 | 785 | 936 | 0 | 178 | N/A | N/A | 2805 | 93% | |
| Prevent- Non clinical | 1389 | one off | | 0 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0% | |
| Trust Board | 17 | 3 yearly | | 17 | N/A | N/A | 12 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 12 | 71% | |
| HR/ Ops managers | Various | | | various | 29 | N/A | N/A | N/A | N/A | 7 | N/A | N/A | N/A | N/A | N/A | N/A | 36 | | |
| Private providers | 450 | 3 yearly | 226 | 112 | 26 | 21 | 13 | 10 | 19 | 16 | 14 | 11 | 6 | 18 | 21 | 13 | 188 | 168% | 92% |
| Other safeguarding | various | as required | | | 104 | 12 | N/A | N/A | N/A | N/A | N/A | 12 | 0 | 0 | 0 | 75 | 203 | | |
| Nil = no figures provided | | | | | | | | | | | | | | | | | 8399 | total | |
| N/A= no course planned this month | | | | | | | | | | | | | | | | | | | |

Emergency Operations Control (EOC ) staff have safeguarding training planned for quarter 1 2016.

Patient Transport Staff (PTS) are also receiving safeguarding training in quarter 1-2 2016.

Bank staff position is currently under review by LAS Executive Leadership Team.

Trust Board training is arranged for May for those outstanding safeguarding training.

All non-clinical staff will undertake Prevent awareness in 2016.

The LAS full safeguarding report for 2015-16 can be accessed via the Trusts website.

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# HILLINGDON SAFEGUARDING ADULT BOARD ANNUAL REPORT.

| | |
|---|---|
| **Relevant Board Member(s)** | Councillor Philip Corthorne |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Steve Ashley, Hillingdon Safeguarding Adult Board |
| **Papers with report** | Hillingdon Safeguarding Adults Annual Report. |

## 1. HEADLINE INFORMATION

| | |
|---|---|
| **Summary** | The Hillingdon Safeguarding Adult board has a statutory duty to publish an annual report on the effectiveness of the safeguarding procedures for vulnerable adults within the Borough. Once agreed by the SAB, the report is submitted each year to the Chief Executive, the Leader of the Council and the Chairman of the Health and Wellbeing Board. |
| **Contribution to plans and strategies** | N/A |
| **Financial Cost** | There are no financial costs relating to the publishing of this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATION

**That the Health and Wellbeing Board notes the report.**

## 3. INFORMATION

### Supporting Information

The annual report lays out the work undertaken by agencies in Hillingdon to safeguard vulnerable adults. At a time of limited resources it is essential that those agencies work together and are properly held to account to make sure that they are delivering safeguarding services to an acceptable level.

There have been considerable changes in how services are being delivered in Hillingdon. In addition, the way in which the Board is managed has had to move forward to ensure that it keeps pace with the increased demand placed upon it, and to develop and improve the way in which agencies are held to account.

The Care Act 2014 has been a significant factor in the way adult safeguarding is regarded amongst both agencies and the public. It seems that at last, safeguarding vulnerable adults is

being considered in the same light as the way we safeguard our children. This has resulted in significant challenges for our agencies and predominantly the Local Authority and Health services. We are facing an ageing population and there are enormous demands on our mental health services. Just providing protection in these two areas and ensuring that people have meaningful and fulfilling lives is an enormous challenge.

The Board has been restructured to provide an Executive Board with the most senior leaders providing strategic direction and an Operational Group where managers agree the work of the Board and drive it forward. We have also put in place a business unit that is developing performance and audit processes and ensuring that training packages are available to all agencies, as well as providing project management support.

We have discussed long and hard the priorities for the Board this year and our focus will be on mental health issues and the neglect of the elderly. These are huge areas of work and we will continue to refine our approach to ensure that each agency is clear about the work expected of them. To ensure that we are successful we need to concentrate our efforts on Making Safeguarding Personal (MSP) which is a national programme aimed at front line staff and encouraging them to understand the role they play in keeping people safe.

There have already been some significant changes to adult safeguarding with the Multi-agency Safeguarding Hub (MASH) now playing a significant role in co-ordinating a response to those adults at risk. I look forward to seeing further improvement over the coming year. I believe that in Hillingdon we are fortunate to have such high levels of commitment from agencies and individuals.

**Financial Implications**

There are no financial implications related to this report.

## 4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

There is no effect to local residents

No consultation required.

**Policy Overview Committee comments**

None at this stage.

## 5. CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

Corporate Finance has reviewed the report and concurs with the financial implications set out above.

**Hillingdon Council Legal comments**

There are no legal issues related to this report. The Safeguarding Adult Board is required to publish an annual report pursuant to schedule 2 Care Act 2014.

## 6. BACKGROUND PAPERS

NIL.

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# 2015-2016

# SAB Annual Report

Andrea Nixon

Safeguarding Adult Board

2015-2016

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## 1. Foreword

Thank you for taking the time to read our annual report. This report provides an overview of the work undertaken by agencies in Hillingdon to safeguard vulnerable adults. At a time of limited resources it is essential that those agencies work together and are properly held to account to make sure that they are delivering safeguarding services to an acceptable level.

I have been in post for a year and have already seen some considerable changes in how services are being delivered. In addition, the way in which the Board is managed has had to move forward to ensure that it keeps pace with the increased demand upon it, and to develop and improve the way in which agencies are held to account.

The Care Act 2014 has been a significant factor in the way adult safeguarding is regarded amongst both agencies and the public. It seems that at last, safeguarding vulnerable adults is being considered in the same light as the way we safeguard our children. This has resulted in significant challenges for our agencies and predominantly the Local Authority and Health services. We are facing an ageing population and there are enormous demands on our mental health services. Just providing protection in these two areas and ensuring that people have meaningful and fulfilling lives is an enormous challenge.

The Board has been restructured to provide an Executive Board with the most senior leaders providing strategic direction and an Operational Group where managers agree the work of the Board and drive it forward. We have also put in place a business unit that is developing performance and audit processes and ensuring that training packages are available to all agencies, as well as providing project management support.

We have discussed long and hard the priorities for the Board this year and our focus will be on mental health issues and the neglect of the elderly. These are huge areas of work and we will continue to refine our approach to ensure that each agency is clear about the work expected of them. To ensure that we are successful we need to concentrate our efforts on Making Safeguarding Personal (MSP) which is a national programme aimed at front line staff and encouraging them to understand the role they play in keeping people safe.

There have already been some significant changes to adult safeguarding with the Multi-agency Safeguarding Hub (MASH) now playing a significant role in co-ordinating a response to those adults at risk. I look forward to seeing further improvement over the coming year. I believe that in Hillingdon we are fortunate to have such high levels of commitment from agencies and individuals.

I would like to thank all of those agencies, and especially the third sector organisations, for their hard work this year in keeping vulnerable adults safe.

I hope you enjoy the report and I would welcome any comments or suggestions you would like to make through our website.

Steve Ashley

## 2. London Borough of Hillingdon - Local Demographics and Safeguarding

Hillingdon is the second largest of London's 32 boroughs, covering 44.6 square miles. Greater London Authority population projections estimate that in 2016 there were 304,000 people living in Hillingdon, of whom 6.9% were aged over 65 years of age and 6.1% over 75. Hillingdon is an ethnically diverse borough with 45% of residents from Black and Minority Ethnic groups, the largest groups being Indian, Pakistani or other Asian.

The proportion of those over 65 is slightly higher than the London average, but lower than that for England as a whole.

The population is projected to increase across all age groups, mainly due to internal migration and an increase in the birth rate and decrease in the death rate. The projected increase is larger than other North West London Boroughs. The proportion of those from black and ethnic minorities is also projected to increase, particularly in the south of the Borough.

The number of those with mental health needs and physical, sensory and learning disabilities are also expected to increase. Adults with learning disabilities who will be returning to the community from long stay settings (in line with Winterbourne recommendations) will contribute to this increase.

Hillingdon has 48 GP practices serving a GP registered population of 301,000 (2015).
There are 64 care homes in the Borough providing a range of services including nursing and dementia care, care for people with learning disabilities and mental health needs.
During 2015-16, Adult Social Care services provided support to 3382 adults, of this total, 2404 were aged over 65, 176 had mental health needs, 2023 had a physical disability, 507 had a learning disability and 649 received support with memory and cognition. A number of adults who receive help fall in to more than one category.

## 3. Governance & Accountability

The Safeguarding Adult Board is a multi-agency partnership comprising statutory, independent and charitable organisations with a stakeholder interest in safeguarding adults at risk. A fill list of members can be found in the body of the report with attendance details for the year.

The Board's objective is to protect and promote individual human rights, independence and improve wellbeing, so that adults at risk stay safe and are protected at all times from abuse, neglect, discrimination, or poor treatment.

### The role of the Board and its members is to:

- Lead the strategic development of safeguarding adults work in the borough of Hillingdon
- Agree resources for the delivery of the safeguarding strategic plan
- Monitor and ensure the effectiveness of the sub-groups in delivering their work programmes and partner agencies in discharging their safeguarding responsibilities
- Ensure that arrangements across partnership agencies in Hillingdon are effective in providing a net of safety for vulnerable adults
- Act as champions for safeguarding issues across their own organisations, partners and the wider community, including effective arrangements within their own organisations
- Ensure best practice is consistently employed to improve outcomes for vulnerable adults

Since November 2011, the SAB has had an independent chairman, who also chairs the Local Safeguarding Children's Board (LSCB). The independent chairman is a member of the London and National Chairs Group SAB. The SAB now comprises of an Operational Board and an Executive Board, which ensures that matters are dealt with at an agreed level of seniority.

In accordance with good practice, an annual report has been produced in previous years and presented to Council Cabinet, the Health & Wellbeing Board, and the Community Safety Partnership. From April 2015, production of an annual report became a statutory requirement (Care Act 2014).

Through common membership, there are links to Multi Agency Public Protection arrangements (MAPPA), the Multi Agency Risk Assessment Conference (MARAC), and the Community MARAC (CMARAC).

## 4. Board Membership & Structure

### i. Members & Lay Members

Hillingdon SAB has recently recruited two lay members for the Board. The role of the lay member is to support stronger public engagement and awareness in local issues affecting vulnerable adults and to promote the referral route for support services if there is a safeguarding concern. The lay members will contribute to an improved understanding of the SAB's work within the community.

Following a robust induction programme, one of the areas that we wish the lay members to assist in is ensuring that we hear the voice of vulnerable adults and we as a board fully understand areas that concern them. In future we intend for the lay members to take a proactive role in sub committees and relevant task and finish groups and support the board in future publications designed for professionals and the public. The overall aim of the role is to ensure that vulnerable adults have a voice.

### ii. SAB Operational Board Members

| Name | Organisation | Job Title |
|---|---|---|
| **Andrea Nixon** | London Borough of Hillingdon | SAB & LSCB Business Manager |
| **Angela Wegener** | DASH | Chief Executive |
| **Ann Nardecchia** | London Borough of Hillingdon | Learning & Development Manager |
| **Anna Fernandez** | The Hillingdon Hospital | Safeguarding Adults Lead |
| **Christine Dyson** | Clinical Commissioning Group | Designated Safeguarding Nurse |
| **Daniel Kennedy** | London Borough of Hillingdon | Head of Business Performance & Policy |
| **Debbie Hun** | London Borough of Hillingdon | Adult & Community Learning Service Manager |
| **Duncan Struthers** | Interfaith Communities | CEO |
| **Erica Rolle** | London Borough of Hillingdon | Domestic Violence VAWG Strategic LEAD Coordinator |
| **Fiona Gibbs** | London Borough of Hillingdon | Stronger Communities Manager |
| **Gill McLean** | London Borough of Hillingdon | Corporate Learning & Development Manager |
| **Glyn Jones** | Metropolitan Police | Detective Sargeant |
| **Graham Hawkes** | Healthwatch Hillingdon | CEO |
| **Helen Smith** | London Borough of Hillingdon | LSCB & SAB Training & Quality Assurance Manager |

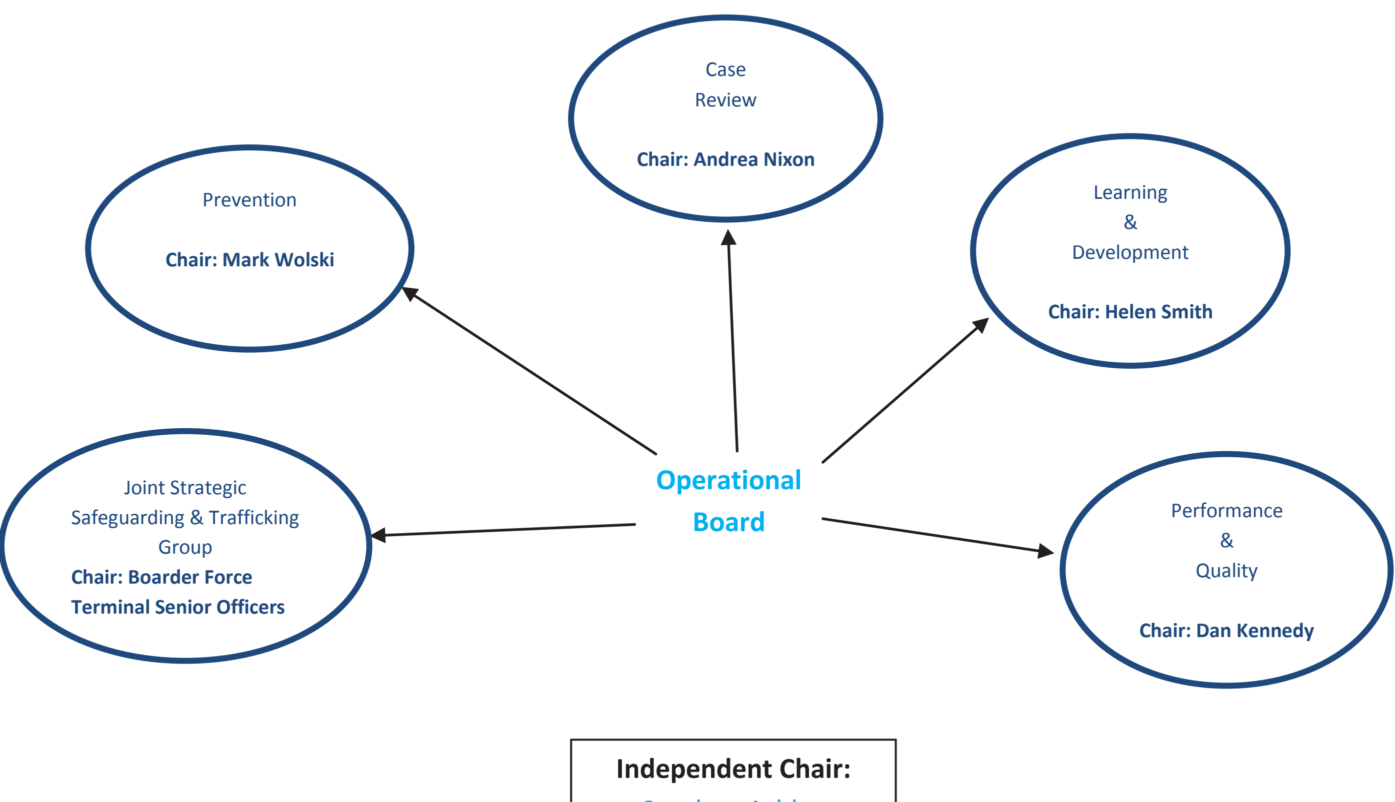
| | | |
|---|---|---|
| **Jackie Bennett** | London Borough of Hillingdon | Safeguarding Adults Manager |
| **John Higgins** | London Borough of Hillingdon | Head of Safeguarding Adults |
| **Julie Simmonds** | Hillingdon Carers | Carers Advisor |
| **Kim Cox** | CNWL | Deputy Director |
| **Dawn Mountier** | LAS | Safeguarding Officer |
| **Liz Hamilton** | Home Office | |
| **Lucy McLeod** | London Fire Brigade | Deputy Station Manager |
| **Mike Norton** | London Borough of Hillingdon | Lay Member |
| **Naveed Mohammed** | London Borough of Hillingdon | Business Performance Service Manager |
| **Paul Alexander** | London Borough of Hillingdon | Performance & Intelligence Administrator |
| **Roger Elliot** | London Borough of Hillingdon | Lay Member |
| **Sally Chandler** | Hillingdon Carers | Chief Executive |
| **Sharon Trimby** | Age UK Hillingdon | Director of Services/Deputy CEO |
| **Stephen Ashley** | London Borough of Hillingdon | Independent Chair |

### iii. SAB Executive Board Members

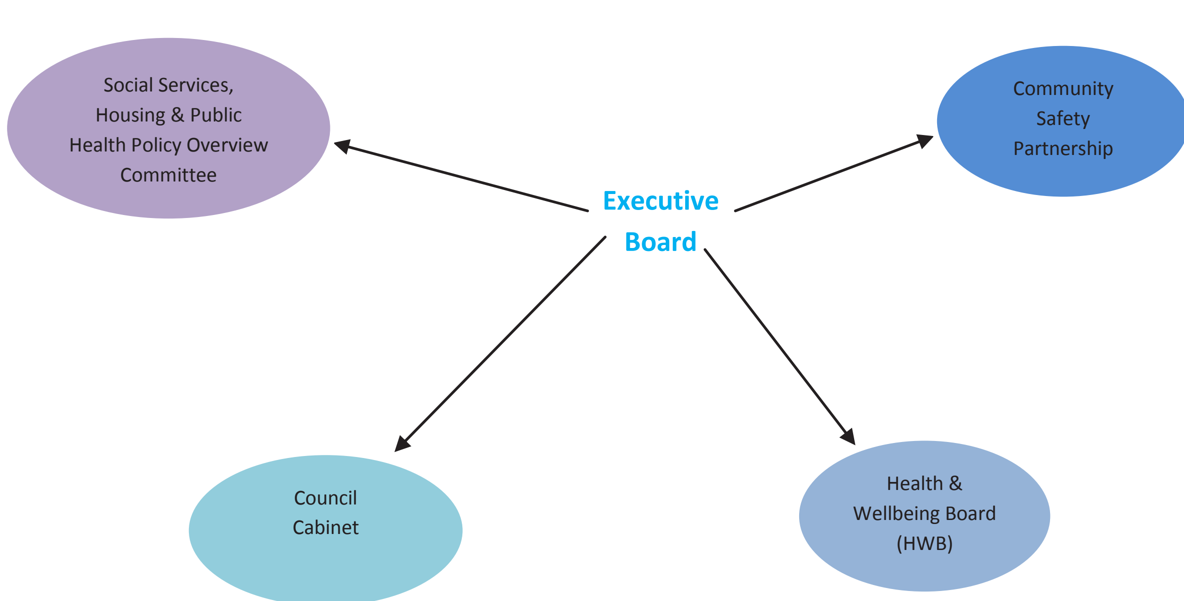
| **Name** | **Organisation** | **Job Title** |
|---|---|---|
| **Andrea Nixon** | London Borough of Hillingdon | LSCB & SAB Business Manager |
| **Antony Rose** | Probation | Assistant Chief Officer |
| **Caroline Morison** | Clinical Commissioning Group | Executive Lead |
| **Christine Dyson** | Clinical Commissioning Group | Safeguarding Adults Lead |
| **Cllr Philip Corthorne** | London Borough of Hillingdon | Cabinet Member |
| **Daniel Kennedy** | London Borough of Hillingdon | Head of Improvement & Performance |
| **Jan Norman** | NHS | |
| **John Higgins** | London Borough of Hillingdon | Head of Adult Safeguarding |
| **Joy Godden** | NHS | Director of Nursing & Clinical Governance |
| **Kim Cox** | CNWL | Deputy Director |
| **Maria O'Brien** | CNWL | Director of Operations |

| Name | Organisation | Job Title |
|---|---|---|
| **Mark Wolski** | London Borough of Hillingdon | Community Safety Team Manager |
| **Nick Downing** | Metropolitan Police | Borough Commander |
| **Reva Gudi** | Clinical Commissioning Group | GP Lead |
| **Richard Claydon** | London Fire Brigade | Borough Commander |
| **Sharon Daye** | London Borough of Hillingdon | Public Health Consultant |
| **Shika Sharma** | London Borough of Hillingdon | Public Health Consultant |
| **Stephen Ashley** | London Borough of Hillingdon | Independent Chair |
| **Steve Hajioff** | London Borough of Hillingdon | Director of Public Health |
| **Theresa Murphy** | The Hillingdon Hospital | Director of Nursing |
| **Tony Zaman** | London Borough of Hillingdon | Corporate Director of Adult, Children & Young People's Services |

## iv. SAB Sub-Committees




**Independent Chair:**
Stephen Ashley



## 5. SAB Achievements 2015/2016

- Revised structure of SAB Operational and Executive Board, including revision of Membership and Terms of Reference
- Development of joint LSCB and SAB Business unit, including appointment of SAB Co-ordinator and Training and Quality Assurance Officer
- SAB Logo developed
- SAB Newsletter produced and will be distributed on a quarterly basis
- Two Lay Members recruited to join the Operational Board
- Pan London Safeguarding Adult procedures adopted by the Board
- Launch of Pan London Procedures organised for June 2016, followed by half day workshops. These are multi agency events
- New audit tool 'Enable' purcahse in order to develop multi agency safeguarding adult audits to reassure the Board
- Tool purchased in order to produce chronologies for SAR's

Performance & Quality SAB sub-committee set up to produce data for both SAB boards using the performance web, and to provide analysis and challenge to partners around data provided

Case review sub-committee to be managed jointly with Children and Adult services in order to learn lessons across disciplines from SCRs, SARs and DHRs

SAR guidance produced and implemented

Learning & Development sub-committee is now a joint sub-committee of LSCB and SAB

Training needs analysis developed for Adult Services to understand what training is currently being provided and future training needs

Development of SAB Prevention sub-committee, chaired by LFB Borough Commander and Community Safety Borough Lead

Joint Strategic Safeguarding and Trafficking sub-committee, chaired and hosted by Border Force at Heathrow, now include vulnerable adults within it Terms of Reference

Introduction of 'Chairs Challenge' following each Executive Board in order to reassure the board members that safeguarding in Hillingdon is effective

## 6. What we have achieved against 2015/16 priorities

### i. Resourcing and developing the Safeguarding Adults Board

Work has been undertaken in the last year to review the structure of the Safeguarding Adult Board. Membership has increased with a real commitment from members to drive the safeguarding agenda forward. There is an Operational Board that supports the work of the sub-committees and an Executive Board that is made up of senior leads across the Borough.

The SAB share a joint business unit with the Hillingdon Local Safeguarding Children Board and have a dedicated SAB coordinator within that team.

The Board recently recruited two lay members who will represent the views of the community and provide challenge to the Board.

The SAB have developed its own logo and now has a quarterly newsletter distributed to front line practitioners.

### ii. Implementing 'Making Safeguarding Personal' across all safeguarding activity and across all partner agencies.

Within Adult Social Care Advanced Practitioners have been identified as Making Safeguarding Personal (MSP) practice champions .They have a key focus on developing a real understanding within Adult Social Care teams about what people themselves wish to achieve: agreeing, negotiating and recording the person's desired outcomes, working out with them (and their representatives or advocates if they lack capacity) how best those outcomes might be realised and then evaluating the extent to which those outcomes have been achieved.

A multi-agency audit is planned for later this year and will report to the Operational SAB on how agencies have implemented the MSP guidance.

The Safeguarding Adult & Quality Assurance Manager oversees the implementation of MSP through the safeguarding case file audits and performance monitoring meetings.

### iii. Deprivation of Liberty Safeguards (DoLS)), ensuring there is an effective model of practice to build upon, including enhancing the functions of the DoLS Supervisory Body:

- Introduced on line application forms which are available of the council's website;
- Given a presentation - followed by a question and answer session - for care home and nursing home managers at the Residential and Nursing Provider forum
- The introduction of a DoLS newsletter
- Task and Finish group (multi-agency) set up to ensure that referrals are being made appropriately.

### iv. Mental Capacity Act (MCA), embedding knowledge and skills across all partner agencies

The Care Act 2014 identified self neglect as a category of abuse. Since this introduction, where staff have identified cases of self-neglect, patients mental capacity is always taken into account. The outcome of this assessment can often be the catalyst in enabling the professional to make the right decision in which would best help the patient.

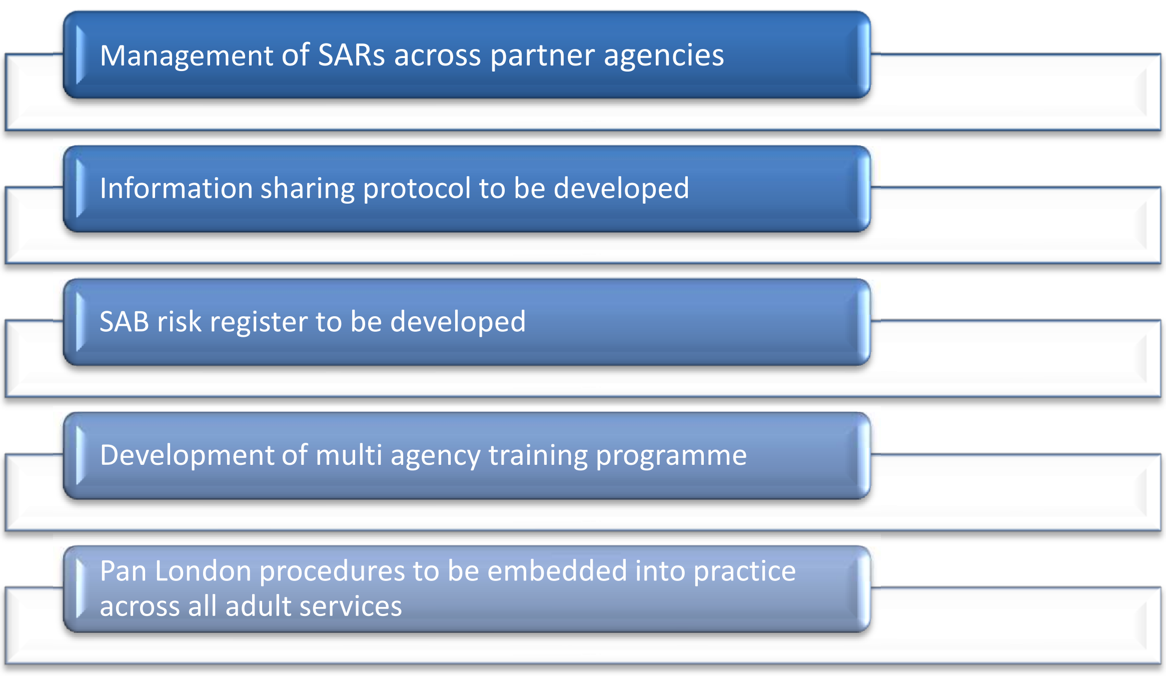
MCA training is provided to multi-agency groups in addition to own agency training. This is evaluated and reported to the Operational Board.

### v. Raising public awareness of safeguarding

Although the Board have not promoted a particular public awareness campaign this year, the development of the Prevention Sub-committee is a positive step forward in order to identify areas of concern and develop public awareness programmes. The business unit are developing a SAB website that will provide up to date information for professionals and the public.

A SAB newsletter has been produced quarterly that practitioners can share with members of public through their work. Practitioners are encouraged to contribute articles for the newsletter and to promote 'good news' stories and events.

## 7. SAB Challenges 2015/2016



## 8. Learning & Development

In December 2015 Hillingdon SAB/LSCB appointed a Training and Quality Assurance Officer, whose role is to coordinate multi-agency training and develop a multi-agency borough-wide picture of training needs, patterns in take up of training and gaps and to evaluate the quality and measure the outcomes of the multi-agency training programme. A multi-agency training needs analysis is being developed with the support of the learning and development subcommittee to inform any further training.

At the current time safeguarding training is undertaken by each individual organisation. There has therefore been no multi-agency training offered by the SAB in 2015/2016. Work is in progress to develop multi-agency half day workshops around the London Multi-Agency Adult Safeguarding Policy and Procedures.

These will be evaluated using a three step evaluation process, to evidence whether the course was pitched appropriately for the audience, has met its objectives and measures what the participant has learned from the training session and whether the learning from the course has been used in practice to change confidence or attitude of the learner. These evaluations will support development of further multi-agency training in the future.

### Planned Audit activity 2016-2017

In 2015 Hillingdon LSCB/SAB purchased an online auditing tool called Enable. The tool, managed by Virtual College allows the LSCB/SAB to develop its own audits and for multiple users to register for completion of audits. An safeguarding adults Audit, consistent with the Safeguarding Adults at Risk Audit Tool developed by the London Chairs of Safeguarding Adults Boards (SABs) network and NHS England London. The audit therefore reflects statutory guidance and best practice. The enable audit tools are designed as a self assessment tools, to enable agencies to reflect on, and identity actions to improve their safeguarding arrangements where required.

## 9. SAB Sub-Groups

### i. P&Q Sub-Committee

The focus this past year has been on strengthening the governance arrangements to enable the Board properly scrutinise the work of the partnership and ensure that, when it comes to performance and quality, there is sufficient transparency across the partnership so that priorities and risks can be identified and addressed. As part of this, the Performance and Quality Sub-Committee was formed - comprising of key agencies across the partnership - the role of the Sub Committee is to promote high standards of safeguarding work; foster a culture of continuous improvement and ultimately to provide assurance to the SAPB Executive.

Key items of work already being delivered include:

- Developing the 'performance web' - A structured report aligned to the key priorities of the Executive - the performance web provides an opportunity for the Board to ask the pertinent questions in relation to how performance is being managed and the key things the partnership needs to achieve. From trying to understand the profile of our customers/clients (who are we trying to safeguard?) through to measuring the quality of the services we provide, the difference we have made and what 'good' looks like - the web allows the partnership to align these questions with the specific measures that will enable the Board to test the effectiveness of what is done.
- Building transparency across the partnership - The partnership is moving from providing performance reports on single agencies - to providing a performance report that covers the partnership as a whole - in particular identifying inter-agency issues/'blockages' that can impact on safeguarding. In the same way as positive practice is often underpinned by organisations working well together - so too is the fact that service failure often involves more than one partner. Building transparency across the partnership so key risks can be identified and avoided is therefore a key driver.
- Challenging and driving service improvement - Whilst providing meaningful analysis and tracking progress are essential - it is just one part of effective performance management. Equally important are the tangible actions that partners, alone and in collaboration will take, to improve practice. The wider direction for the Partnership will be provided by the Executive - with immediate priorities flowing out of this. Amongst the wider work plan for 2015/16, areas for focus included how agencies are managing the issue of pressure ulcers and the sharing of information between agencies. In focusing on these and other areas, the role of the sub-committee will be as much to monitor and report on performance as it will be to identifying emerging issues and possible future priorities.

### ii. Prevention Sub-Committee

The Prevention sub-committee has been created in order to collate themes of issues relevant to preventing abuse and neglect and to develop a multi agency work plan to address any emerging issues through public awareness campaigns, training and development opportunities for staff.

The sub-committee is chaired by the Borough commander for London Fire Brigade and the Service Manager for Community Safety team. There are close links with the Community MARAC and Case Review sub-committee in order to pick up on emerging themes quickly. The intention is that the Lay Members for the Board are represented on this sub-committee so that any campaigns are targeted correctly.

### iii. Learning & Development Sub-Committee

Representatives from the Safeguarding Adults Board have joined colleagues from the Safeguarding Children's Board to wider the remit of the LSCB Learning and Development Subgroup. The new joint subgroup is in its infancy, with Terms of Reference having been drafted and membership being reviewed.

The role of the sub-group is to promote high standards of safeguarding by ensuring that training opportunities are provided and learning and development from serious case reviews and other safeguarding activities are shared across all colleagues. The subgroup is chaired by LSCB/SAB training and quality assurance officer.

Key items of work for the joint SAB and LSCB Learning and Development subgroup include:

- Development and review of the Learning and Improvement Framework
- Development of training needs analysis to inform training programme
- Rolling out half day training sessions for multi-agency staff in respect of the London Multi-Agency Adult Safeguarding Policy and Procedures

### iv. Joint Strategic Safeguarding and Trafficking sub-committee

This sub-committee is unique to Hillingdon LSCB and SAB and its aim is to continue to strengthen the partnership that we have with Heathrow Airport and the LA. Operations at Heathrow remain a priority for children social care who support Border Force Officers in preventing child trafficking and potential victims of FGM being taken out and returning to the UK. Increasingly Border Force are dealing with cases of vulnerable adults that have travelled to the UK and they have seen a sudden rise in issues relating to passengers where there are suspected concerns about their mental health.

Members of the asylum intake team and MASH delivered training with Border Force to British Airways crew to raise awareness of safeguarding concerns and how to report them. This was a highly successful event and hopefully will be rolled out across other airlines and will include information regarding vulnerable adults.

One of the challenges for the coming year is to be clear about the referral route for vulnerable adults entering the UK in order that following assessment they receive the appropriate service for their needs.

### v. Case Review sub-committee

The Case Review sub-committee has been arranged in order to review serious case reviews, safeguarding adult reviews and Domestic Homicide reviews, and to ensure that learning is embedded and cascaded into adult and children's services working practice. The sub-committee has representatives from both adult and children services, this ensures that learning from reviews is disseminated across both service areas.

The sub-committee has met to draw up terms of reference and agree membership. We currently have four serious case reviews, two domestic homicide reviews and two safeguarding adult reviews. Once these have been completed the recommendations will be tracked through the case review sub-committee. Regular reports will then be reported to the Executive Board of both the SAB and LSCB.

## 11. Effectiveness of safeguarding arrangements

### i. DoLs

#### Deprivation of Liberty Safeguards

The wider consequences of the *Cheshire West* ruling in March 2014 continue to emerge and likewise the implications for practice relating to Deprivation of Liberty matters continue to evolve.

In June 2014 it was estimated that, as a consequence of the Cheshire West ruling, the number of DoLS authorisation requests received by Hillingdon Council would rise to over 500 cases per annum; this estimate did not include out of borough and hospital in-patient placements. This figure has been realised for 2014-15 and is set to increase to at least 1200 for 2015-16. Each application can only be granted for a maximum of 12 months therefore these figures will be repeated each year, on top of any new requests received.

In addition to this it has now been identified that the acid test determined by the Cheshire West ruling must also be applied to people who are being deprived of their liberty in the community. This means that people in supported housing settings and people in a domestic setting who receive a care package that is *imputable to the state,* who potentially lack capacity, must also be assessed.

The acid test hinges on two key questions:

1. Is the person free to leave?
2. Is the person subject to continuous supervision and control?

The Deprivation of Liberty Safeguards (DoLS) applies only to residential/nursing care homes and hospital settings; any other form of deprivation must be authorised by the Court of Protection. Thus an application must be made to the Court of Protection in respect of anyone in supported housing, or anyone who is living at home and receiving a care package that is imputable to the state, who lack capacity to make an informed decision about where they reside or what services they need and have been assessed as being deprived of their liberty under the Cheshire West acid test.

In response to the demand created by the above the Council has:

- Established a robust DoLS Supervisory Body that has agreed the forward strategy for DoLS and monitors performance/compliance;
- Streamline processes for accepting and responding to DoLS Authorisation requests including the development of on line forms for Managing Authorities;
- Increased it capacity to complete DoLS assessments by identifying internal staff to train as Best Interest Assessors (BIA) and also by going out to tender for a BIA Provider agency to undertake assessments on the Council's behalf.

The advocacy tender mentioned above will also assist in the timely appointment of advocacy support under DoLS which will assist and support the council in terms of those cases that might go before the Court of Protection.

### Impact for Hillingdon

- 2013/14 Hillingdon received 15 requests
- 2014/15 Hillingdon received 500 requests
- 2015/16 estimated Hillingdon will receive 1000 requests
- Resulted in big increase in number of IMCAs required
- In addition approx. 250 people who require Court of Protection applications to be made each year
- 30+ cases will require application to Court Of Protection due to AK case
- Requires significant additional resources
- Need all residential, nursing homes and hospital providers to be aware of their responsibilities to make applications

### Current Progress

- Allocated significant additional resources
- Increased the DoLS team
- Engaged a number of external BIA assessors and Section 12 Doctors
- Tendering for provider of BIAs and Section 12 Doctors
- Training up existing staff
- Developed performance reports
- Updated ICT
- Training of Social Care Direct
- Briefed Providers

### Next Steps

- Operational Board to receive further updates
- Continue to publicise to providers of residential, nursing and hospital services
- Supervisory body to continue to oversee the delivery of the DoLS responsibilities locally
- Continue to link to London wide networks

## ii. Making Safeguarding Personal

The aim of Making Safeguarding Personal (MSP) is to move safeguarding practice *away* from following a process *towards* the commitment to improving the experience and outcomes for people experiencing abuse or neglect. MSP promotes person-led, outcome-focused safeguarding.

The shift in culture and practice encapsulated by MSP is in response to what is now known about what makes safeguarding more or less effective from the perspective of the adult.

### The Key objectives of MSP focus on:

a) Developing an approach to safeguarding that is based on working with people

Using an outcome focused approach and engaging with the person throughout the safeguarding process can be done. Evidence shows that this leads to better outcomes for the person and can inform practitioners and safeguarding boards of the effectiveness of their work.

**More time invested at the beginning can lead to a quicker resolution.**

b) Improving people's experience/circumstances

Exploring how to support and empower people at risk of harm to resolve the circumstances that placed them at risk and/or manage risks themselves. MSP aims to encourage practice that puts the person more in control and generates a more person centred set of responses and outcomes. In this way the outcomes focus is integral to practice and the recording of practice in turn generates information about outcomes.

c) Utilising Professional Care Skills

MSP asks practitioners to go back to basic professional care skills - engagement, discussion, negotiation - as a means of safeguarding people rather than simply putting people through a process.

Risk and proportionality is potentially more achievable within MSP than within a process driven system.

Audits and peer challenges have established that people do tend to feel driven through a process in safeguarding.

LJ Mumby famously described process driven safeguarding as "ticking the box and missing the point".

d) Benchmarking change

MSP enables all partners to see the benefits of this approach. There is a need to move adult safeguarding from a process driven approach to one that is focused on improving outcomes for, and the experience of, people who are referred to the service.

Within Adult Social Care Advanced Practitioners have been identified as Making Safeguarding Personal practice champions with a key focus on developing a real understanding within Adult Social Care teams about what people themselves wish to achieve: agreeing, negotiating and recording the person's desired outcomes, working out with them (and their representatives or advocates if they lack capacity) how best those outcomes might be realised and then evaluating the extent to which those outcomes have been achieved.

### iii. Pan London

In December 2015 the Pan London Authorities updated their multi agency 2011 Safeguarding Adults Policy and Procedures. The updated procedures support the introduction of the Care Act 2014 and lays the foundation for change in the way that care and support is provided to adults, encouraging greater self-determination, so people maintain independence and have real choice.

There is an emphasis on working with adults with care and support needs who are at risk of abuse and neglect to have greater control in their lives to both prevent it from happening, and to give meaningful options of dealing with it should it occur.

The aim of the procedures are to better safeguard adults at risk of abuse throughout London; and in using this document better encourage the continuous development of best practise.

It covers the legislative requirements and expectations on individual services to safeguard and promote the well-being of adults, and a framework for SABs to monitor the effective implementation of policies and procedures.

Hillingdon SAB agreed to adopt the Pan London Procedures following their launch in February 2016. A series of workshops have been commissioned to inform practitioners and to help in embedding the procedures into practise. The implementation of the procedures will be monitored through the performance and quality sub-committee.

A copy of the procedures can be downloaded from:

http://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures.

### iv. Safeguarding Performance Reports

The Safeguarding Performance Reports are drawn from the ASC database and are now produced on a monthly basis. The reports support understanding of safeguarding performance across Adult Social Care, within individual teams and by individual workers and enable ASC managers to identify areas of good practice as well as identifying issues that need to be addressed either within teams or with individuals. Information presented in the reports are analysed and discussed with ASC managers at monthly performance meetings; month on month improvements are also monitored as part of these meetings.

## v. Domestic Violence

The overall purpose of the Domestic Violence Steering Executive (DVSE) is to have strategic oversight of domestic violence and violence against women and girls (VAWG) in Hillingdon. This includes ensuring that the council's policy on domestic violence continues to be reviewed and updated, ensuring that there is a robust action plan. This includes taking high level policy decisions in relation to DV and VAWG issues. The DV Steering Executive has ultimate responsibility for the DV Action Forum that reports directly to the DV Steering Executive on the work, targets, progress and achievements of individual subgroups.

The DV Steering Executive informs the SAB annual report of the successful achievements of the subgroups in 2014-15 in reducing the risks of DV and VAWG to victims and survivors by continuing to provide equitable access to services, referrals and awareness raising, specialist support and safeguarding, robust data collection to influence change and secure on-going DV/VAWG provision, including joint collaborative partnership working and critical integration of services for an effective victim centred approach. This is notwithstanding Hillingdon's Annual White Ribbon Day Conference, which was an outstanding success and highlights a mention of some of the key themes on Female Genital Mutilation (FGM), Safeguarding and empowerment of children, young people and vulnerable adults, trafficking and partnership working and continues in its commitment to raise the profile of DV/VAWG and to openly state its zero tolerance of all forms of domestic violence and other forms of harmful practices.

The DVSE is working jointly with the Safer Hillingdon Partnership (SHP) in response to the two domestic homicides in the borough. The DVSE and SHP Strategic Boards have considered the recommendations from the DHR Homicide Review, which was conducted for 1 year by Standing Together. There are 21 recommendations from the review and they will be appropriately embedded into the DV Action Plan work stream for 2015-16, across the seven working subgroups linked to the DV Action Forum.

## 12. Case Reviews

There have been no serious adult reviews (SAR) during the period of this report.

Four consideration meetings have been held to discuss whether a case meets the threshold for a serious adult review. For two of the cases it was felt that the criteria was not met for an SAR. One case did meet the threshold but we are not able to progress this yet as the case is under investigation by the Independent Police Complaints Commission. Once this investigation has been completed the SAB will request a report and then consider again whether the case meets the threshold for an SAR.

The fourth case we considered is part of a police investigation. We have agreement from the investigating officer that we can progress the initial stages of an SAR by gathering historical data. Witness statements will be made available to us once the case has been through the court process and we have to be mindful that any information we gather may have to be made available to the Police. At the stage of writing this report the SAB has requested chronologies from agencies.

All cases will be monitored through the case review sub-committee and progress reported to the SAB Operational Board.

## 13. Priorities for 2016/2017

| Strategic Priority | What does this mean? | Actions |
|---|---|---|
| **To ensure that there are effective arrangements across agencies to reduce the risk of abuse and neglect of vulnerable adults in the borough.** | Neglect often takes place in environments in which one or more of the following issues is apparent;<br>• Domestic violence<br>• Drug/alcohol misuse<br>• Mental health issues. | • Develop a multi-agency neglect strategy owned by all partner agencies.<br>• To improve awareness and understanding of neglect and abuse across the whole partnership through training and awareness campaigns.<br>• To analyse key performance indicators to be reassured that appropriate referrals are made and prevention strategies are in place, for example, effective public awareness.<br>• Making Safeguarding Personal is embedded in practice supported through training, awareness raising and audit activity.<br>• Develop meaningful public awareness campaigns. |
| **To ensure that partners understand, and provide an appropriate response to, vulnerable adults who require support with mental health.** | Hillingdon Safeguarding Adult's Board need to be assured that adults requiring the services of mental health receive a prompt and appropriate response. | • Performance sub-committee to analyse source of referrals and primary need and to conduct an audit of cases of people with dual diagnoses.<br>• Adult voices are heard and views recorded during contact with professionals.<br>• To develop multi-agency training with good attendance across agencies. |
| **To ensure that all agencies place the 'Making safeguarding Personal' model at the centre of their response to vulnerable adults.** | To ensure that vulnerable adults are consulted and have a say in the services that they receive, and are part of the planning process from the beginning. | • To develop and implement the 'Making Safeguarding Personal' strategy.<br>• Agree key performance indicators that can be measured against the strategy.<br>• Multi-agency training packages are available to all partner agencies.<br>• Relevant and meaningful public awareness campaigns. |

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| **To ensure that Hillingdon Safeguarding adult Board has the capability and tools to effectively hold agencies to account, in order to satisfy ourselves that vulnerable adults are safeguarded within the borough.** | The Hillingdon SAB is committed to challenging partner agencies to ensure that the Board can be satisfied that vulnerable adults are safe in Hillingdon.<br>The Board is committed to listening to the community in order to learn lessons from practice and to challenge existing practice where necessary.<br><br>The Board needs to be satisfied that all vulnerable adults are seen, heard and helped; with the public and professionals being alert to risks posed to vulnerable adults and how to report this when necessary. | • Effective auditing and quality assurance of partner's practice leads to robust analysis and challenge to come from data presented to P&Q sub-committee.<br>• Multi-agency training is available to all partner agencies.<br>• All practitioners to have received training and Pan London procedures embedded into practice.<br>• Continue to monitor the development of the Multi-agency Safeguarding Hub (MASH).<br>• Audit of agency governance arrangements across all partner agencies undertaken.<br>• Board improvement plan regularly updated and presented to Board. Risk Register developed and regularly monitored at the Board. |

## 14. Conclusion

2015-2016 has been a very busy year for the SAB, with the development of the business unit and prioritising a training and quality assurance programme. It is hoped that this report has provided you with reassurance of the effectiveness of local arrangements to safeguard and promote the welfare of vulnerable adults in Hillingdon.

This report demonstrates that safeguarding activity is progressing well and that Hillingdon SAB has clear agreement on the strategic priorities achieved and what actions need to be taken forward over the coming year. The SAB is aware of, and working to fulfil, its statutory functions under the Care Act 2014 and the Pan London Procedures.

Agency reports in Appendix 2 demonstrate that statutory and non statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

The Board has, throughout the year, begun a programme that has monitored, quality assured and evaluated the quality of services within Hillingdon, and this programme of robust auditing analysis and challenge will continue to ensure that vulnerable adults remain safe.

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Hillingdon

Hillingdon
Clinical Commissioning Group

Hillingdon
Excellence in support

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Central and
North West
London
NHS Foundation Trust

Hillingdon
ageUK

METROPOLITAN
POLICE

The Hillingdon Hospitals NHS
NHS Foundation Trust

## Appendix 1 - Glossary

| Acronym | Meaning |
|---|---|
| ASC | Adult Social Care |
| BIA | Best Interest Assessors |
| CCG | Clinical Commissioning Group |
| CMARAC | Community Multi Agency Risk Assessment Conference |
| CNWL | Central & North West London |
| COP | Court of Protection |
| DASH | Disablement Association Hillingdon |
| DHRs | Domestic Homicide Reviews |
| DoLs | Depravation of Liberty safeguards |
| DV | Domestic Violence |
| DVSE | Domestic Violence Steering Executive |
| FGM | Female Genital Mutilation |
| IMCA | Independent Mental Capacity Advocate |
| LA | Local Authority |
| LAS | London Ambulance Service |
| LFB | London Fire Brigade |
| LSCB | Local Safeguarding Children Board |
| MAPPA | Multi Agency Public Protection arrangements |
| MARAC | Multi Agency Risk Assessment Conference |
| MASH | Multi Agency Safeguarding Hub |
| MCA | Mental Capacity Act |
| MSP | Making Safeguarding Personal |
| SAB | Safeguarding Adult Board |
| SARs | Serious Adult Reviews |
| SCRs | Serious Case Reviews |
| SHP | Safer Hillingdon Partnership |
| VAWG | Violence against Women & Girls |

## Individual Agency Contributions

### Appendix 2 - Age UK Hillingdon

| Name of agency | Age UK Hillingdon |
|---|---|
| Description of service | Local Charity offering a wide range of services supporting older people in Hillingdon to remain safe, secure and independent. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | 35% employees in total: 35% staff and 53% supervisors<br>10% volunteers |
| Regulator inspection in reporting period and outcomes | N/A |
| Challenges in the reporting period | • 97 staff and 271 volunteers currently work for Age UK Hillingdon to support older people and safeguarding training is mandatory for all. We regularly review and audit our policies and procedures to ensure compliance with Safeguarding as well as raising awareness with all staff and volunteers so that there is a clear process for reporting issues.<br>• An increase in staff reporting concerns relating to potential safeguarding cases – referred onto to SCD as appropriate. |
| Progress on safeguarding priorities in the reporting period | • Age UK Hillingdon's Director of Services/Deputy CEO is a member of the SAPB Operational Group<br>• Mental Capacity Awareness training<br>• On-going review of safeguarding issues across our wide range of services<br>• Annual audit of internal safeguarding procedures |
| Safeguarding priorities for 2015/6 | • Keep up to date with new developments in Safeguarding and Disclosure and Barring.<br>• Implement the Care Bills Safeguarding measures as required. |
| Good news stories | Appropriate action/intervention to resolve safeguarding issues at an early stage. |
| Good practice examples | • Safeguarding is a standard agenda item in supervision and appraisal processes and for staff and volunteer meetings.<br>• Information relating to Safeguarding and relevant contact numbers are displayed on our website and in our services brochure. |

## Appendix 3 - CNWL

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| Name of agency | Central and North West London NHS Trust<br><br>The Trust provides both mental health and community services across five London Boroughs and Milton Keynes.<br><br>Operationally, CNWL is managed in three divisions; each headed up by a Director of Operations and supported by a Nursing and Medical Director. They are responsible for all elements of care and delivery within their respective divisions.<br><br>In relation to CNWL Hillingdon services, the Divisional Director of Operations who has responsibility for these services is also the senior lead director for safeguarding and is supported in this role by the Divisional Director of Nursing.<br><br>Each of the boroughs is headed up by a Borough Director and a Clinical Director; they are a key link and member of the local adult safeguarding boards. |
| Description of service | CNWL provide secondary Mental Health Care, IAPT services, Substance Misuse Services, CAMHs services a range of physical healthcare community-led adult and children's services across the borough of Hillingdon.<br><br>Safeguarding Adults Team:<br><br>CNWL have a dedicated adult safeguarding team who are split across each of the 3 divisions of CNWL.<br><br>The 3 staff within the divisional team which supports Hillingdon are responsible for providing expert advice, supervision, education and training on all relevant safeguarding issues. This team also collects and analyses data, carries out audits and delivers training including Prevent.<br><br>All front line staff have direct access to one of the safeguarding team to seek advice/support. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | Safeguarding adults training is mandatory for all staff within the Trust. The training equips staff to have an understanding in their role of identifying abuse and ill treatment of Adults at risk. Training must be refreshed every three years.<br><br>At the time of writing, CNWL have a 95% compliance rate for safeguarding training, this is the same as last years compliance rate. |

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| | Other formal training given by the safeguarding adults team is Health wrap Prevent, MCA and DOLs. They also give opportunistic training and hold surgeries for staff who more indepth safeguarding adults or MCA queries, or would like to discuss one of their cases. |
| Regulator inspection in reporting period and outcomes | The CQC inspected CNWL in February 2015, the results from this inspection showed that overall CNWL is safe but 'requires improvement'. In forming the overall rating, 18 different specialty reports were compiled which were aggregated up to provide an overall rating for the Trust. The rating for all the Hillingdon services provided in CNWL are detailed below: |

| Service | Type | Overall Trust Rating | Local Hillingdon Provision |
|---|---|---|---|
| Community health services | Inpatient services | Good | Hawthorne Intermediate Care Unit, Woodlands |
| Community health services | Children, young people and families | Good | Multiple Hillingdon sites |
| Community health services | Adults | Good | Multiple Hillingdon sites/home care |
| Community health services | End of life care | Good | Multiple Hillingdon sites/home care |
| Community health services | Community Dental Services | Good | Uxbridge and Ickenham |
| Community health services | Community Sexual Health Services | Outstanding | Uxbridge/Hesa |
| Mental health services | Acute wards for adults of working age and Psychiatric Intensive Care Units | Inadequate | Riverside Mental Health Centre |
| Mental health services | Long stay rehabilitation mental health ward for working age adults | Good | 2 Colham Road |

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| Mental health services | Wards for older people with mental health problems | Requires Improvement | Oaktree Ward, Woodlands |
| Mental health services | Community based mental health services for adults of working age | Requires Improvement | Pembroke Centre, Mead House, Mill House |
| Mental health services | Crisis services and health based places of safety | Good | Riverside Mental Health Centre |
| Mental health services | Community based mental health services for older people | Good | Woodlands |
| Mental health services | Specialist community mental health services for children and young people | Good | Redford Way |
| Mental health services | Community mental health services for people with learning disabilities | Good | LBH/Riverside (not inspected) |
| Mental health services | Community substance misuse services | Not rated | HDAS, Uxbridge |

As a result of the rating, the Trust was required to implement a number of 'must do' actions to provide assurance to the CQC of compliance. One of the areas requiring significant work related to CNWL's Adult Mental Health inpatient services, which were rated as inadequate. The main factor which determined this rating was the over-occupation of many of our wards due to the significant pressure on Mental Health beds across the organisation which impacted on both patient experience and safety.

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| | Over the last year, significant work has taken place to reduce bed occupancy including Trust-wide bed management process, improved discharge planning, reduction in length of stay and use of beds outside of the Trust to assist in management of peaks in demand. Whilst this still remains challenging both locally and nationally, significant improvements have been made.<br><br>Following implementation of all of the 'must do' actions required by the CQC, the Trust is now declaring full compliance with all CQC standards.<br><br>As part of our on-going focus on safety and quality, CNWL undertakes regular internal peer reviews, which involve multidisciplinary teams inspecting other services to ensure all services are safe and effective.<br><br>In addition, in November 2015, CNWL carried out a Trust-wide Quality Inspection of all services involving internal staff, patients, carers, commissioners and other external stakeholders. This provided a transparent framework to review our services and enable learning across all parts of the organisation. |
| Challenges in the reporting period | The Home Office via NHS England is requesting that Health Wrap Training (Prevent) be mandatory for all NHS trusts, this will be applied by CNWL in the near future, this has meant that all staff have needed to and are going to attend Health Wrap Training, the time frame is short, quarterly Prevent returns are forward to NHS England and CCG, to prove that this is prioritised by NHS trusts.<br><br>DOLs is currently under review. DOLs training is continuing within MCA training. The final changes to DOLs which is planned to be called 'Protective Care' is hoped to be released during 2016, this will mean ensuring every clinical member of staff has been updated and aware of the changes within this legislation. |
| Progress on safeguarding priorities in the reporting period | **Learn from serious incidents and cases:** (including SARs and domestic homicides) locally and nationally: In the last year CNWL Hillingdon has had services involved in two DHR's, the lessons are discussed with relevant teams as they are identified during the SCR and DHR panel meetings. Policies are changed as needed. The lessons are discussed in supervision with staff as part of reflective practice. DHR's and SCR's are presented and discussed in the overall Trust safeguarding adults meeting and the divisional safeguarding adults meetings. They are anonymised and used in training with individual teams and if suitable within safeguarding adults mandatory training. |

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| | **Respond to cases of self-neglect and/ or non-engagement with services**: Such cases are properly understood and responded to (including issues of capacity and/ or underlying illnesses) to keep people safe whilst respecting choice and independence. Self-neglect became a safeguarding adults category under The Care Act 2014. Since this introduction staff have identified cases of self-neglect, patients mental capacity is always taken into account when identification of self-neglect is made. The outcome of this assessment can often be the catalyst in enabling the health care professional to make the right decision in which would best help the patient.<br><br>**Share the right information with the right people at the right time**: Key information is shared at the right time to enable holistic and comprehensive risk assessment and safeguarding, whilst legal requirements (such as the Data Protection Act and patient confidentiality) are complied with. CNWL prides itself on having good connections with partner organisations. They have signed up to the SAB information sharing agreement. This agreement, with open lines of communication helps to ensure that correct information requested is given within a good time frame to the appropriate person. CNWL has a clinical governance team and trust policy, in which it clearly outlines which information can be shared and with whom, it looks at all aspects of information sharing. |
| Safeguarding priorities for 2015/6 | Priorities for 16/17 are:<br><br>• Make Safeguarding Personal - ensure individuals are kept safe and individuals identify the outcomes that would keep them safe<br><br>• Continuing to work with our partners to implement the new Pan London Guidelines<br><br>• Improving sexual safety on all our Inpatient services<br><br>• Improving the identification and monitoring individuals who have suffered Female Genital Mutilation |
| Good news stories | Much work has taken place with in Hillingdon's mental health services, as part of the section 75 agreement there is now a senior SAM in place. She oversees the safeguarding adults concerns raised, she works closely with CNWL's adult safeguarding & MCA practitioner, who has targeted MH services with Prevent Health Wrap Training, Consent, DOLs etc. |

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| Good practice examples | Safeguarding Adults team keep clear records of all cases, to ensure that statistics, outcomes and feedback are easily and readily available at all times.<br><br>As well as training each team has a visit from a member of the safeguarding team, during this visit a case study is presented which always incorporates MCA, safeguarding and any other safeguarding related topic that is felt to be key at that time. |
| Any other comments | CNWL is committed to safeguarding adults from abuse, they have had a small team in Hillingdon for 7 years, this team is well supported by senior management, and is now part of a larger overarching CNWL team, good practice and new ideas is shared amongst the team, helping the team to keep up to date with constantly changing legislation. CNWL fully supports the local safeguarding adults agenda and recognises the importance of partnership working. |

## Appendix 4 - DASH

| Name of agency | Disablement Association Hillingdon (DASH) |
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| Description of service | Local charity providing information, advice and advocacy for people with disabilities. Also a range of activities including sport. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | All staff receive safeguarding training as part of their induction. All policies and procedures are reviewed annually. All staff are aware of reporting procedures. |
| Regulator inspection in reporting period and outcomes | N/A |
| Challenges in the reporting period | Raising awareness among our service users about Hate crime and how to deal with it. |
| Progress on safeguarding priorities in the reporting period | Contact made with police and marketing material available for promoting Safe Places initiative. |
| Safeguarding priorities for 2016/17 | Promote Safe Places and work with police to get shops and businesses engaged. |
| Good news stories | People are becoming more aware of what is acceptable behaviour through our interventions. |
| Good practice examples | Throughout our sport and activities we teach young people with learning disabilities what is acceptable behaviour at sessions and have had some success with changing behaviours. |

## Appendix 5 - BOCU

| Name of agency | Hillingdon BOCU |
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| Description of service | Metropolitan Police Service |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | Training in Safeguarding is currently limited to departments concerned in Safeguarding.( Missing Person's Unit), (CSU).There has been no bespoke Safeguarding training given to Police with the exception of the limited input within the CSU Investigators Course. There is a constant flux of staff .When on CSU staff are appointed they attend CSU courses .Safeguarding is included within that course.(approx 60% currently trained).<br>A training cycle on Disability hate Crime will commence shortly for all officers in the Borough to identify and report. |
| Regulator inspection in reporting period and outcomes | Hillingdon has a small team dedicated to Safeguarding Vulnerable Adults. Specialising in predominantly carer abuse. All Hillingdon CSU officers (with the exception of temporary attachments will have had significant input re Domestic Abuse /Hate Crime)<br>Training re Safeguarding knowledge thereof requires updating due to turnover of investigators. |
| Challenges in the reporting period | During the reporting period Hillingdon CSU has suffered two Domestic Homicides. Both victims had children. Although in neither case the victims considered within the category of vulnerable. |
| Progress on safeguarding priorities in the reporting period | Progress has been made in that -<br>1. Increase in the size of MASH - Two extra Safeguarding Adult/CSE Investigators<br>2. Increase in staff to CSU encompassing Domestic Abuse - Bespoke unit for investigating Safeguarding Issues |
| Safeguarding priorities for 2015/6 | To increase the reporting and identification of Disability Hate Crime within Hillingdon Borough. To have a Safeguarding Vulnerable Adults Social Worker engage within the MASH. |
| Good practice examples | The weekly Safeguarding Adults clinic is viewed as groundbreaking with other Local Authorities adopting similar focus. Hillingdon MASH is considered to be most effective in the MPS and increasing in size and scope. |
| Any other comments | To reiterate - Direct engagement within the MASH from Adult Social Services is considered paramount in progressing partnership working and best practice. Internally, more partnership working involving MASH and CSU re safeguarding adult investigations. |

## Appendix 6 - Hillingdon Carers

| Name of agency | Hillingdon Carers |
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| Description of service | Provides support to unpaid Carers in the London Borough of Hillingdon, this includes Young Carers aged 5 – 18 years old. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | All members of staff and volunteers have completed Safeguarding Children training<br>All members of staff and volunteers have completed Safeguarding Vulnerable Adults training<br>All staff and volunteers have undergone PREVENT training |
| Regulator inspection in reporting period and outcomes | None |
| Challenges in the reporting period | Increase in number of safeguarding concerns in regards to both carers and the person they care for. |
| Progress on safeguarding priorities in the reporting period | All safeguarding polices have been updated to include prevent<br>Policy attached |
| Safeguarding priorities for 2015/6 | To ensure all staff are fully aware of all safeguarding policies and procedures. That when employing new staff and volunteers we use the safer recruitment procedure, and that all staff and volunteers have up to date DBS checks |
| Good news stories | See Case study<br><br>**Hillingdon Carers case study**<br><br>Mohinder is an elderly Indian lady caring for her husband, she has her own health problems causing mobility problems which mean that she is now struggling to care.<br><br>Safeguarding concerns were first flagged by their home care agency as it was felt the carer was being abused by her son.<br><br>Hillingdon Carers was contacted by local authority to arrange a joint meeting, also attended by the police.<br><br>It was found that indeed, Mohinder was very frail and unwell and she was at risk from physical abuse from her son.<br><br>Several meetings took place at various locations, including at our offices.<br><br>We supported Mohinder with financial advice, emotional support and information about her health and she was eventually offered a place at extra-care housing, which she accepted. |

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| | We supported her to make a statement to the police although this was really difficult for her to do due to mixed emotions.<br><br>The criminal investigation is on-going with a view to prosecuting the son for assault. |
| Good practice examples | See Case study |
| Any other comments | Hillingdon Carers remains committed to the safeguarding of vulnerable adults |

## Appendix 7 - Clinical Commissioning Group

| Name of agency | Hillingdon CCG |
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| Description of service | NHS Hillingdon Clinical Commissioning Group (CCG) is responsible for buying health services in Hillingdon including community health and hospital services. The CCG is a statutory NHS body with a range of statutory duties which includes safeguarding adults and PREVENT. Hillingdon CCG is a member organisation made up of local GPs and health professionals who are best placed to know the right services for our area.<br><br>As a clinically-led organisation, Hillingdon CCG is in the unique position of being able to take into account the first-hand experience of our patients who use health services when new services are commissioned<br><br>Safeguarding forms part of the NHS contract (service condition 32) Commissioners are required to agree with providers how contracts will be reviewed and evidence of compliance with statutory safeguarding duties. |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | Level 1 48%<br><br>Level 2 30%<br><br>Level 3 100%<br><br>Level 4 100%<br>Safeguarding training is mandatory |
| Regulator inspection in reporting period and outcomes | No inspections have taken place, the CCG has quarterly assurance meetings with NHS England. This is an opportunity to review Safeguarding across the health economy using data collected and Serious Case Reviews, Domestic Homicide Reviews and Safeguarding Adults Reviews. |
| Challenges in the reporting period | There have been a number of statutory changes since April 2014:<br><br>• The care Act 2014 introduced fresh definitions of abuse and Making Safeguarding Personal and the Prevention agenda are key components of safeguarding work.<br>• PREVENT became a statutory responsibility in 2015.<br>• Domestic Violence Legislation has changed.<br>• Training materials need to reflect the changes and assurance from providers needs to reflect how organisations are embedding the changes.<br>• Training sessions will be delivered on a regular basis to ensure that compliance against the national target is met. |

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| | • The CCG and Local authority submitted its return on the transforming care plan the NHSE within the required timeframe.<br><br>Written feedback tells us that across the domains all but two have been met or partially met, work is ongoing to achieve the standards required for the final submission in April 2016. |
| Progress on safeguarding priorities in the reporting period | The CCG is represented at the Executive Safeguarding Adults Partnership Board and the Operational Board<br>There is representation at the Hillingdon PREVENT Partnership Group and Partnership Board Subgroups.<br>Care Home Forum, Provider Risk Forum and the DoLs Supervisory Body.<br><br>Attendance at the NHS England PREVENT Forum and the CCG Leads Forum is an opportunity to reflect and influence.<br><br>Raising the profile of Safeguarding Adults within the CCG and supporting and advising staff about the need to pay attention to safeguarding adults at risk when commissioning services and developing contracts.<br><br>Continuing to ensure that all staff receive the appropriate level of Safeguarding Adults, Mental Capacity Act and PREVENT training appropriate for their role. |
| Safeguarding priorities for 2015/6 | • To continue to work in partnership with Hillingdon Local Authority to ensure that the residents of Hillingdon live free from abuse.<br>• NHS Hillingdon Clinical Commissioning Group (HCCG) priority is to ensure that adults at risk remain safe whilst receiving healthcare in Hillingdon. This is achieved through contract monitoring and receipt of assurance through quality monitoring, attendance at provider safeguarding committees, assurance visits and audit.<br>• Training continues to be a priority, sessions are planned and delivered to CCG staff and GP practices covering Safeguarding adults, Mental Capacity Act and PREVENT.<br>• Develop a safeguarding supervision structure offering leads expert advice, mentoring and safeguarding supervision. |
| Good news stories | Joint announced and unannounced 'Quality visits' to nursing homes and clinical areas in provider trusts. These visits enable the team to gain assurance against the Health and Social Care Act 2008 and the Care Quality Commission Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and social care services have the right to expect. These visits have allowed the nursing homes and trusts to develop action plans that can be reviewed through quality committees. |

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| | An External audit of Hillingdon CCG's Safeguarding structure and processes was undertaken in 2015.<br><br>The results were favourable and actions have been achieved. NHS England carried out a London-wide deep-dive of Safeguarding Adults practices in 2016, Hillingdon CCG is looking forward to receiving feedback.<br><br>Policy Update<br>PREVENT policy ratified 2015<br>Safeguarding Adults Policy ratified 2016.<br>Adults Safeguarding Supervision policy in development.<br><br>The CCG has appointed a part time interim Safeguarding Adults Lead. The post will be advertised as a full time substantive 8b post from April 2016. |
| Good practice examples | Safeguarding Adults Intranet and Extranet page has been developed and contains links to key documents and sites. This can be accessed by CCG staff and GP practice staff across the Borough.<br><br>A Safeguarding Adults leaflet has been updated.<br><br>The CCG now has a generic email address that acts a repository for alerts, requests for advice and can be accessed by key people within the CCG Confederation.<br><br>Hillingdon CCG has a named Dr for Safeguarding Adults who supports, advises and offers training to personnel based in GP practices. |
| Any other comments | The Pan London Safeguarding Adults Procedures launch in 2016 has been welcomed. |

## Appendix 8 - Adult Social Care

| Name of agency | London Borough of Hillingdon |
| --- | --- |
| Description of service | Adult Social Care |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | <u>Course Title</u> — <u>Number of staff trained</u><br>Interview & Investigation Skills — 50<br>Safeguarding Adult Managers (SAM) — 30<br>MCA Awareness — 70<br>Safeguarding Adult Thresholds — 20 |
| Regulator inspection in reporting period and outcomes | The Quality Assurance Team carried out approximately 190 visits during the year - these include initial quality assurance visits, follow-up visits and spot (unannounced) visits.<br><br>Some care providers require repeat follow up visits in order to support them to make the improvements necessary to achieve a safe standard of practice. The Council's Quality Assurance Team has been pivotal in monitoring progress and supporting care provider services to improve practice in areas such as management of medication, person centred care planning; recruitment and staff training and leadership and oversight by management. |
| Challenges in the reporting period | • Meeting the demands of Deprivation of Liberty Safeguards (DoLS) authorisation requests following the ruling of the Supreme Court in the Cheshire West case.<br>• Successful recruitment to specialised posts. |
| Progress on safeguarding priorities in the reporting period | **Quality audit of Safeguarding cases by Adult Social Care (ASC)Team Managers**<br>The safeguarding case file audits are now business as usual. Outcomes identified by the audits have resulted in a series of workshops for all ASC staff on accurate/robust recording.<br><br>**Increase Management oversight of safeguarding**<br>Management oversight has been significantly enhanced as a consequence of the case file audits and analysis of the safeguarding conversion rates which has resulted in Safeguarding Threshold workshops being organised for all ASC Team Managers and Advanced Practitioners.<br><br>**Implement Making Safeguarding Personal**<br>The aim of Making Safeguarding Personal (MSP) is to move safeguarding practice *away* from following a process *towards* the commitment to improving the experience and outcomes for people experiencing abuse or neglect. |

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| | MSP promotes person-led, outcome-focused safeguarding. The shift in culture and practice encapsulated by MSP is in response to what is now known about what makes safeguarding more or less effective from the perspective of the adult and is framed around ensuring a positive experience for the adult.<br><br>Hillingdon piloted MSP for a 6 month period from March 2015 and it was rolled out across all Adult Social Care Teams in October 2015. Advanced Practitioners have been identified as the best practice/ MSP champions and are supported within individual ASC Teams by those practitioners who were involved in the pilot.<br><br>The Safeguarding Adult & Quality Assurance Manager oversees the implementation of MSP through the safeguarding case file audits and performance monitoring meetings.<br><br>**Build on the Advanced Practitioner (POC) role**<br>Advanced Practitioners have been identified as Making Safeguarding Personal (MSP) - see above - and best practice champions across ASC and are being supported to embrace this role through Advanced Practitioner Forums.<br>It is anticipated that a Best Practice forum will be a subsequent offshoot of the forum for Advanced Practitioners.<br><br>**Ensure robust Advocacy Services are available and are used appropriately**<br>The council is currently re-tendering for advocacy services and the Safeguarding adults & Quality Assurance Manager has played a key role in the tender process.<br><br>The new contract will be beneficial in terms of establishing a single point of access for all levels of advocacy, improving the timeliness of advocacy referral allocations and the quality of the advocacy work undertaken and facilitating the appropriate use of advocates in both Deprivation of Liberty Safeguards and Safeguarding investigations.<br><br>**Establish a Provider Forum**<br>The forum for nursing & residential care homes in now well established with a significant degree of success. The first half of the forum is devoted to presentations from people who are "experts in their field" and particular areas of relevance e.g. DoLS; the second half of the forum is devoted to sharing local good practice. |

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| | **Introduce robust performance reporting** -<br>Performance reports are now produced monthly and are analysed to identify any issues concern; issues of concern are then addressed at the monthly Safeguarding Performance Monitoring meeting which is attended by all ASC Team Managers and Service Managers and chaired by the Safeguarding Adults & Quality Assurance Manager.<br><br>A *performance report surgery* has been established to assist Team Managers in the analysis of the performance reports. A quarterly report is now presented to the Council's DASS, Chief Executive and lead Cabinet Member.<br><br>**Adapt the Council's IT system for safeguarding in response to practice needs**<br>The current safeguarding module has been adapted to improve the intuitiveness of the workflow and an upgraded version will be in place from April 2016.<br><br>**Deprivation of Liberty Safeguards**<br>The wider consequences of the *Cheshire West* ruling in March 2014 continue to emerge and likewise the implications for practice relating to Deprivation of Liberty matters continue to evolve.<br><br>In June 2014 it was estimated that, as a consequence of the Cheshire West ruling, the number of DoLS authorisation requests received by Hillingdon Council would rise to over 500 cases per annum; this estimate did not include out of borough and hospital in-patient placements. This figure has been realised for 2014-15 and is set to increase to at least 1200 for 2015-16. Each application can only be granted for a maximum of 12 months therefore these figures will be repeated each year, on top of any new requests received.<br><br>In addition to the above it has now been identified that the acid test determined by the *Cheshire West* ruling must also be applied to people who are being deprived of their liberty in the community. This means that people in supported housing settings and people in a domestic setting who receive a care package that is *imputable to the state,* who potentially lack capacity, must also be assessed.<br>The acid test hinges on two key questions:<br><br>1. is the person free to leave?<br>2. is the person subject to continuous supervision and control? |

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| | The Deprivation of Liberty Safeguards (DoLS) apply only to residential/nursing care homes and hospital settings; any other form of deprivation must be authorised by the Court of Protection.<br><br>Thus an application must be made to the Court of Protection in respect of anyone in supported housing, or anyone who is living at home and receiving a care package that is imputable to the state, who lack capacity to make an informed decision about where they reside or what services they need and have been assessed as being deprived of their liberty under the Cheshire West acid test.<br><br>In response to the demand created by the above the Council has:<br><br>• Established a robust DoLS Supervisory Body that has agreed the forward strategy for DoLS and monitors performance/compliance;<br><br>• Streamline processes for accepting and responding to DoLS Authorisation requests including the development of on line forms for Managing Authorities;<br><br>• Increased its capacity to complete DoLS assessments by identifying internal staff to train as Best Interest Assessors and also by going out to tender for a BIA Provider agency to undertake assessments on the Council's behalf.<br><br>The advocacy tender mentioned above will also assist in the timely appointment of advocacy support under DoLS which will assist and support the council in terms of those cases that might go before the Court of Protection. |
| Safeguarding priorities for 2015/6 | • Further refine safeguarding performance reporting<br>• Adopt and roll out of the revised Pan London Procedures<br>• Ensure that MSP is firmly embedded within practice<br>• Adhere to the Council's statutory duty under the Mental Capacity Act/Deprivation of Liberty Safeguards. |
| Good practice examples | Case example that demonstrated working to the adult's wishes within the principles of MSP rather than automatically changing care agency which historically would have been the outcome: |

| | |
|---|---|
| | *Mr A is 80 and is physically frail. He lives alone but is supported to remain in his own home and retain a significant level of independence by through his care plan and the services of a domiciliary care agency.*<br>*As Mr A became more infirm concerns health staff raised concerns about the ability of the current domiciliary care staff to meet his needs and recommended that a change of care provider be considered. However, Mr A informed his social worker that he liked his carers, that he got on well with them and did not want to "start all over again" with another care agency. It was therefore agreed that the staff providing care to Mr A should receive additional training to enable them to meet his increasing need rather than changing care provider services and causing him upset and distress. This arrangement has worked well and Mr A is very happy with the outcome.* |

## Appendix 9 - London Fire Brigade

| Name of agency | London Fire Brigade |
|---|---|
| Description of service | Emergency fire and rescue service |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | All personnel receive safeguarding input twice a year. 100% |
| Regulator inspection in reporting period and outcomes | |
| Challenges in the reporting period | Lack of feedback when highlighting safeguarding concerns.<br>Gaining referrals from partners. |
| Progress on safeguarding priorities in the reporting period | Safeguarding mainstream business for all LFB personnel.<br>VP panel governance brought under SAB.<br>Some increase in referrals for preventative services. |
| Safeguarding priorities for 2015/6 | Identifying vulnerable people in the community, offering our preventative services and referring where appropriate. |
| Good news stories | Improved partner working resulting in multiagency approach to managing cases for vulnerable people.<br>VP panel starting to get direction from SAB Chair. |
| Good practice examples | Instant referrals to LFB resulting in us fitting smoke alarms and providing fire resistant bedding for vulnerable people. |

## Appendix 10 - The Hillingdon Hospital

| Name of agency | The Hillingdon Hospitals NHS Foundation Trust |
|---|---|
| Description of service | • Acute Trust-Provider, including A and E services.<br>• The Executive Director with responsibility for Safeguarding oversees the annual work and audit programmes for safeguarding adults and progress against these is reported to the Trust's Safeguarding Committee which reports to the Quality and Safety Committee (a board committee). |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | • 93.76 % of staff trained as of 18/2/16<br>• Training also delivered to new starters (induction) on a monthly basis.<br>• Safeguarding training includes basic Prevent awareness at Level 1, MCA and DoLs principles, DVA, learning disability awareness.<br>• All staff are eligible for training, including volunteers. |
| Regulator inspection in reporting period and outcomes | • CQC re – inspection: significant progress of enhanced MCA and DolS training for identified staff in Trust via a Training Needs Analysis (TNA). This is monitored via the WIRED dashboard and to achieve 80% compliance by the end of March 2016.<br>• The Trust revised the Key Performance Indicator (KPI) for Learning Disability, which was approved by the Safeguarding Committee. This KPI provide the Trust with assurance in terms of safeguarding governance and is reviewed annually at the Safeguarding Committee.<br>• Quarterly assurance provided by the Trust to Monitor |
| Challenges in the reporting period | • Further raising the awareness/need of DoLs referrals. |
| Progress on safeguarding priorities in the reporting period | • DoLs audit carried out by an external auditor of behalf of the Trust .Results due in quarter four, 2016.<br>• Regular meetings with the Dols lead at LBH and CCG Safeguarding Lead to monitor progress.<br>• Training slides for Prevent updated as the equivalent of level 1 training for all trust staff.<br>• SA awareness training now includes a revised DVA flowchart and a summary of how staff should ask the DVA question to a patient.<br>• DVA policy to be written for adults and children. |
| Safeguarding priorities for 2015/6 | • To further embed the principles of DoLS within the organisation and to increase the rate of DoLS referrals.<br>• To write a trust wide Prevent Policy. Prevent is currently within the safeguarding adult policy. |

| | |
|---|---|
| | • To embed WRAP training within the trust. Key staff identified via a TNA.<br>• Enhanced DVA training to be established<br>• To explore the possibility of a Learning Disability nurse covering hospital and community. |
| Good news stories | • Safeguarding administrator in post within the reporting period to support the work of the Head of Safeguarding and the Named Nurse for Safeguarding Children.<br>• Training consistently above 80% for VA within the reporting period. |
| Good practice examples | • Delivering bespoke training to Trust volunteers on a regular basis in addition to scheduled training. All volunteers also have had a safeguarding adult leaflet posted to them and they have then signed to say they have read and understood its contents. |
| Any other comments | • Regular attendance and contribution to 2 DHR panels within the reporting period.<br>• A member of the Hillingdon Prevent group.<br>• Executive Director representation at the SAB.<br>• Head of Safeguarding attends SAB Operational Group.<br>• Head of Safeguarding a member of the Safeguarding Adults Provider Forum NHSE. |

## Appendix 11 - UK Border Force

| Name of agency | UK Border Force Heathrow Command |
|---|---|
| Description of service | Joint Safeguarding of children and Vulnerable Adults arriving through Heathrow Airport |
| Safeguarding training undertaken in reporting period. % of staff trained at each level. | All Border Force officers receive training in the core skills for protecting children to give a greater understanding of how to identify children in need and the actions to take once you have done so. The Safeguarding and Trafficking Teams are trained to a higher, more expert level than ordinary front-line officers. In 2014 80 Officers and 12 Managers received this enhanced training. In 2015 5 Managers and 61 Officers received the enhanced training, 68 Managers attended a bespoke Safeguarding and Trafficking Managers course and 22 Officers attended a specific Safeguarding and Trafficking awareness session in relation to drug mules, baggage searches and legacy customs work.<br><br>The enhanced training is a rolling programme, and further courses are scheduled for 2016.<br><br>This enhanced training course has been validated by external agencies such as UKHTC and CEOP. This is a joint agency course primarily delivered by Border Force and the Metropolitan Police but incorporates training sessions delivered by Hillingdon Social Services, Salvation Army and ECPAT to provide a rounded experience. Elements of police ABE, (Achieving Best Evidence), training and expertise in areas of exploitation such as Juju, FGM and forced marriage have also been included.<br><br>New e learning to incorporate the Modern Slavery Act and changes to the NRM process is awaiting final approval and will be rolled out as mandatory training for all Border force staff in early 2016. |
| Level 1 Introduction to Safeguarding<br>Level 3 Working Together<br>CSE Awareness<br>DV<br>FGM (online) | E learning modules cover these topics.<br><br>Local SAT teams, SAT led Operations, Operational Shift briefs and Heathrow communications all further raise staff and stakeholder awareness. |
| Regulator inspection in reporting period and | Section 55 Review has historically been conducted every 3 months by Heathrow Safeguarding Coordinator and Action Plan reviewed & updated. |

| | |
|---|---|
| outcomes | This has been superseded by regular internal SAT Assurances conducted by local teams and fortnightly joint meetings between the Terminal SAT teams and Hillingdon SS to review & progress arriving cases.<br><br>Regular visits by the Operational Assurance Directorate review the handling of SAT cases and SAT procedures in place. |
| Challenges in the reporting period | Arranging training courses, consistently maintaining a fully trained SAT team and recruiting others to fill arising vacancies. Joint frontline operations are arranged to address operational challenges such as Operation Limelight to target FGM. |
| Progress on safeguarding priorities in the reporting period | We will continue to build on already considerable achievements of the SAT teams and work with other agencies to carry out frontline operations to identify PVOTs or FGM.<br><br>A national project is ongoing to develop e learning for roll out to Airlines and stakeholders in trafficking awareness. Pending its development there have been several joint events at the airport including a joint 2 day event to inform British Airways crew. Similar monthly road show events are planned with Heathrow Airport Ltd to engage with their security personnel. |
| Safeguarding priorities for 2015/6 | We will continue to build on already considerable achievements of the SAT teams and work with other agencies to carry out frontline operations to identify PVOTs or FGM. |
| Good news stories | A very successful second year for the Heathrow SAT teams, established in April 2014 to replace Paladin. We have seen increased joint working with Hillingdon, including delivery of expert training, a programme of job shadowing & involvement in joint SAT operations such as Op Limelight (FGM) and Op Jake (Vietnam Airlines). BF has increased the recruitment of volunteer responsible adults through Heathrow's Ambassador network and NGO organisations. A quarterly joint strategic forum is held with Hillingdon and other stakeholders and fortnightly operational meetings held with SS and each Heathrow terminal.<br><br>Anti Slavery day was marked again on 18/10 October at Heathrow by a SAT event hosted airside attended by SS and other NGOs. |
| Good practice examples | Designated expert SAT teams. Joint agency working on front line operations. |
| Any other comments | Ref JSSAT Strategic Joint work plan. |

## Appendix 12 - LAS Safeguarding Report 2016 for inclusion in safeguarding board reports

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organization and the Trust is committed to ensuring all persons within London are protected at all times.

This report provides evidence of the LAS commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

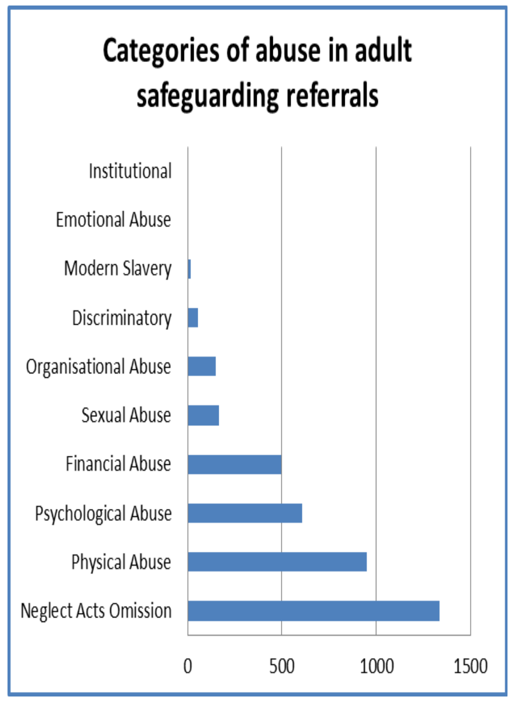
### Referrals or concerns raised to local authority during 2015-16

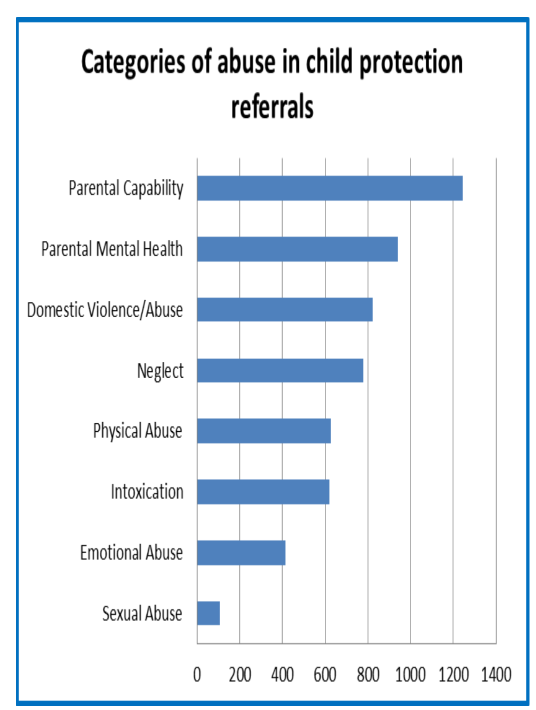
The LAS made a total to 17332 referrals to local authorities in London during the year.

4561 children referrals, 4331 Adult Safeguarding Concerns, 8440 Adult welfare Concerns

| | Adults Safeguarding | Adults Welfare | Children | Total Referrals | Referrals as % of incidents |
|---|---|---|---|---|---|
| LAS | 4331 | 8440 | 4561 | 17332 | 1.66% |
| | | | | | |
| Barking and Dagenham | 107 | 162 | 189 | 458 | 1.62% |
| Barnet | 144 | 259 | 159 | 562 | 1.34% |
| Bexley | 120 | 326 | 146 | 592 | 2.09% |
| Brent | 157 | 258 | 138 | 553 | 1.40% |
| Bromley | 153 | 317 | 153 | 623 | 1.73% |
| Camden | 109 | 177 | 72 | 358 | 1.05% |
| Croydon | 262 | 458 | 343 | 1063 | 2.26% |
| Ealing | 174 | 319 | 183 | 676 | 1.70% |
| Enfield | 132 | 267 | 217 | 616 | 1.62% |
| Greenwich | 137 | 274 | 220 | 631 | 1.93% |
| Hackney | 128 | 238 | 113 | 479 | 1.67% |
| Hammersmith and Fulham | 89 | 176 | 63 | 328 | 1.48% |
| Haringey | 123 | 238 | 134 | 495 | 1.59% |
| Harrow | 80 | 136 | 92 | 308 | 1.28% |
| Havering | 148 | 205 | 116 | 469 | 1.42% |
| Hillingdon | 148 | 260 | 150 | 558 | 1.32% |
| Hounslow | 165 | 330 | 152 | 647 | 1.98% |
| Islington | 129 | 240 | 91 | 460 | 1.53% |
| Kensington and Chelsea | 72 | 155 | 39 | 266 | 1.42% |
| Kingston upon Thames | 75 | 152 | 69 | 296 | 1.63% |
| Lambeth | 185 | 327 | 188 | 700 | 1.65% |
| Lewisham | 149 | 348 | 194 | 691 | 2.07% |
| Merton | 108 | 171 | 111 | 390 | 1.80% |
| Newham | 143 | 232 | 182 | 557 | 1.38% |
| Redbridge | 121 | 237 | 125 | 483 | 1.46% |
| Richmond upon Thames | 90 | 203 | 62 | 355 | 1.92% |
| Southwark | 191 | 313 | 166 | 670 | 1.62% |
| Sutton | 128 | 223 | 108 | 459 | 2.00% |
| Tower Hamlets | 111 | 194 | 141 | 446 | 1.35% |
| Waltham Forest | 160 | 309 | 136 | 605 | 1.96% |
| Wandsworth | 153 | 238 | 141 | 532 | 1.67% |
| Westminster | 98 | 256 | 58 | 412 | 0.95% |

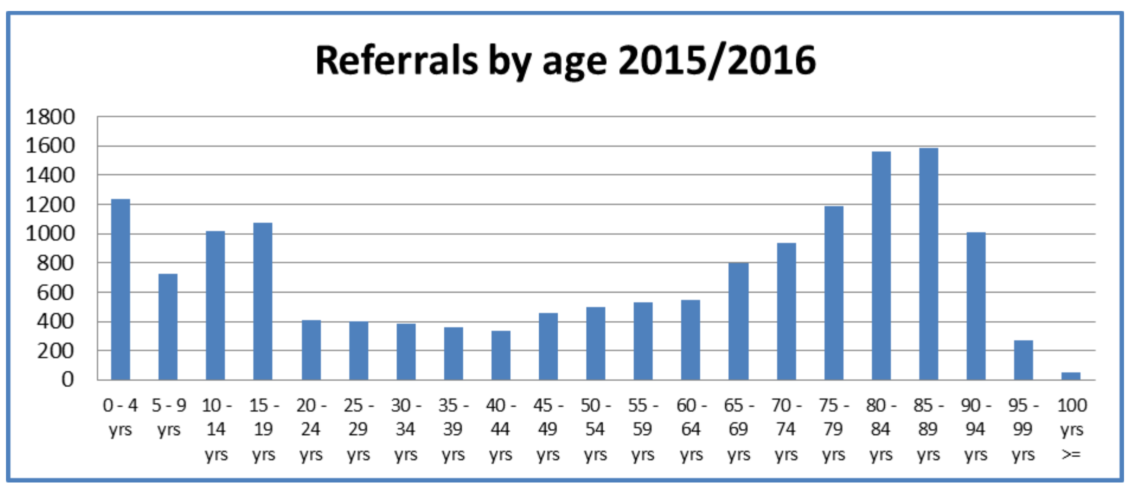
## Categories of abuse




## Referrals by age

Perhaps not surprisingly, the very young and the old are most likely to be the subject of referrals. For children, once out of infancy and their most vulnerable period they are most likely to be the subject of a referral once over 15. Around a third of referrals for all children, according to an in-house audit conducted in Q1 of this year are related to self-harm. The majority of these are in the 15-18 age range.



## Safeguarding Training

The Trust is committed to ensuring all staff are compliant with safeguarding training requirements. The chart below shows staff directly employed by the London Ambulance Service as well as voluntary responders and private providers who we contract to work on our behalf.

| Training required | Total Staff | Frequency of training | 2014 | Target to be trained 2015/16 | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total trained 2015/16 | % of target 2015/16 | 3 year cummulative - % of total staff trained |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Level One** | | | | | | | | | | | | | | | | | | | |
| Induction | various | on joining | | various | 28 | 10 | 14 | 9 | 0 | 14 | 19 | 19 | 17 | 53 | 0 | 26 | 209 | | |
| E Learning | 1389 | 3 yearly | 672 | 356 | 69 | 220 | 67 | 35 | 18 | 40 | 60 | 34 | 22 | 32 | 33 | 32 | 662 | 186% | 96% |
| **Level Two** | | | | | | | | | | | | | | | | | | | |
| New Recruits | Various | on joining | | various | Nil | 53 | 88 | 31 | 39 | 124 | 13 | 16 | 47 | 27 | 74 | 177 | 689 | | |
| Core Skills Refresher | 3019 | annually | | 3019 | N/A | N/A | N/A | N/A | 310 | 596 | 785 | 936 | N/A | 178 | N/A | N/A | 2805 | 93% | |
| EOC Core Skills Refresher | 443 | annually | | 443 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0% | |
| EOC new staff | Various | on joining | | various | 34 | 10 | 9 | 27 | 4 | 12 | 17 | 0 | 14 | 7 | 12 | 8 | 154 | | |
| PTS/NET | 114 | annually | | 114 | Nil | N/A | 20 | N/A | 25 | 29 | N/A | N/A | N/A | N/A | N/A | N/A | 74 | 65% | |
| Bank staff | 390 | annually | 58 | 390 | | N/A | N/A | N/A | 6 | 8 | 43 | 66 | 0 | 31 | N/A | N/A | 154 | 39% | 54% |
| 111 | 152 | annually | 101 | 51 | 9 | 15 | 3 | 0 | 1 | 2 | 16 | 9 | 5 | 26 | 1 | 6 | 93 | 182% | 128% |
| Community first Responders (St John) | 140 | 3 yearly | 135 | 50 | Nil | 12 | 13 | 10 | 13 | 12 | 12 | 14 | 15 | N/A | 13 | 12 | 126 | 252% | 186% |
| Emergency responders | 150 | 3 yearly | | 100 | Nil | Nil | Nil | Nil | Nil | 29 | 11 | Nil | 69 | N/A | 7 | 10 | 126 | 126% | |
| **Level Three** | | | | | | | | | | | | | | | | | | | |
| EBS | 30 | 3 yearly | | 25 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 13 | 14 | N/A | 27 | 108% | |
| 111 | 11 | 3 yearly | 11 | 0 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | | 100% |
| Local leads | various | 3 yearly | | various | 6 | 5 | N/A | N/A | N/A | 7 | 6 | 12 | N/A | N/A | N/A | N/A | 36 | | |
| **Specific training** | | | | | | | | | | | | | | | | | | | |
| Prevent- clinical staff | 3019 | one off | | 3019 | N/A | N/A | N/A | N/A | 310 | 596 | 785 | 936 | 0 | 178 | N/A | N/A | 2805 | 93% | |
| Prevent- Non clinical | 1389 | one off | | 0 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0 | 0% | |
| Trust Board | 17 | 3 yearly | | 17 | N/A | N/A | 12 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 12 | 71% | |
| HR/ Ops managers | Various | | | various | 29 | N/A | N/A | N/A | N/A | 7 | N/A | N/A | N/A | N/A | N/A | N/A | 36 | | |
| Private providers | 450 | 3 yearly | 226 | 112 | 26 | 21 | 13 | 10 | 19 | 16 | 14 | 11 | 6 | 18 | 21 | 13 | 188 | 168% | 92% |
| Other safeguarding | various | as required | | | 104 | 12 | N/A | N/A | N/A | N/A | N/A | 12 | 0 | 0 | 0 | 75 | 203 | | |
| Nil = no figures provided | | | | | | | | | | | | | | | | | 8399 | total | |
| N/A= no course planned this month | | | | | | | | | | | | | | | | | | | |

Emergency Operations Control (EOC ) staff have safeguarding training planned for quarter 1 2016.

Patient Transport Staff (PTS) are also receiving safeguarding training in quarter 1-2 2016.

Bank staff position is currently under review by LAS Executive Leadership Team.

Trust Board training is arranged for May for those outstanding safeguarding training.

All non-clinical staff will undertake Prevent awareness in 2016.

The LAS full safeguarding report for 2015-16 can be accessed via the Trusts website.

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# BOARD PLANNER & FUTURE AGENDA ITEMS

| | |
|---|---|
| **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 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.



** SI = Standing Item*

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.



** SI = Standing Item*

**APPENDIX 1**

# BOARD PLANNER

| **14 Mar 2017**<br><br>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<br><br>**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 | |
| | CAMHS Progress Report (SI) | HCCG / LBH | |
| | 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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of the Local Government (Access to Information) Act 1985 as amended.

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government (Access to Information) Act 1985 as amended.

# Agenda Item 18

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