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Health and Wellbeing Board

Date: **TUESDAY, 28 JUNE 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 Raymond Puddifoot MBE (Chairman)
Councillor Philip Corthorne MCIPD (Vice-Chairman)
Councillor David Simmonds CBE
Councillor Jonathan Bianco
Councillor Douglas Mills
Councillor Keith Burrows
Councillor Richard Lewis
Dr Ian Goodman (Chair - Hillingdon CCG)

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

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

Published: Monday, 20 June 2016

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Agenda

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2	Declarations of Interest in matters coming before this meeting	
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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

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Minutes

HEALTH AND WELLBEING BOARD

12 April 2016

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

	Statutory Voting Board Members Present: Councillor Ray Puddifoot MBE (Chairman) Councillor Philip Corthorne (Vice-Chairman) Councillor Douglas Mills Councillor David Simmonds CBE Dr Ian Goodman - Hillingdon Clinical Commissioning Group Stephen Otter - Healthwatch Hillingdon (substitute) **Statutory Non Voting Board Members Present**: Tony Zaman - Statutory Director of Adult Social Services and Statutory Director of Children's Services Dr Steve Hajioff - Statutory Director of Public Health **Co-opted Board Members Present:** Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust Robyn Doran - Central and North West London NHS Foundation Trust Nick Hunt - Royal Brompton and Harefield NHS Foundation Trust (substitute) Dr Reva Gudi - Hillingdon Clinical Commissioning Group (clinician) Nigel Dicker - LBH Deputy Director Residents Services Jean Palmer OBE - LBH Deputy Chief Executive and Corporate Director of Residents Services **Present:** Neil Ferrelly - Hillingdon Clinical Commissioning Group (Officer) **LBH Officers Present**: Kevin Byrne, Gary Collier, Glen Egan and Nikki O'Halloran **LBH Councillor Present:** Councillors Beulah East and Phoday Jarjussey **Press & Public:** 3
40.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Mr Bob Bell (Mr Nick Hunt was present as his substitute), Mr Rob Larkman and Mr Jeff Maslen (Mr Stephen Otter was present as his substitute). It was noted that Mr Maslen had now left his position as Chair of Healthwatch Hillingdon.
41.	**TO APPROVE THE MINUTES OF THE MEETING ON 3 DECEMBER 2015** *(Agenda Item 3)* It was noted that, at its last meeting, the Health and Wellbeing Board felt that it had not

	received enough information in relation to the Hillingdon Clinical Commissioning Group's 2016/2017 Commissioning Intentions to be able to comment. As a result, although the Board's comments were required to be included, this had not been possible. The Chairman requested assurances that this situation would not be repeated in the current year. The Board was advised that it would receive regular updates which would include information about upcoming intentions. The next round of commissioning intentions would start in June 2016 and the team would be asked to ensure that it kept the Board appraised. **RESOLVED: That the minutes of the meeting held on 3 December 2015 be agreed as a correct record.**
42.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that Agenda Items 5 to 13 would be considered in public. Agenda Item 14 would be considered in private. It was noted that current and emerging issues could, where applicable, be included under Agenda Item 14.
43.	**HEALTH & WELLBEING STRATEGY: PERFORMANCE REPORT** *(Agenda Item 5)* The Vice Chairman advised that the Health and Wellbeing Strategy played an essential role in tackling health and wellbeing in the Borough and that it was incumbent on the Board to ensure that the Strategy reflected Hillingdon's needs and priorities. He noted that the Strategy was a living document that needed to be fit for purpose. There had been a number of positive developments over the last quarter including: a joint project to improve access to preventative dental care; a new programme to engage overweight pregnant women in ante-natal exercise; and Orchard Hill College Academy Trust working with Eden Academy to set up specialist college provision on the Pentland Fields site. Hillingdon's smoking prevalence (age 18+) rate was estimated to have increased from 16.2% to 17.1% compared with the England average of 18%. However, although it was thought that the current figures were more in keeping with those that would be expected in the Borough, it was important to keep a watching brief on the situation. It was noted that there had been a significant increase in suicides in the Borough in the last year. This increase had been seen in other boroughs and reflected the national trend of increase. The Vice Chairman had spoken to the CNWL Borough Director about this issue and would liaise further with the Director of Public Health. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the updates in the report and delivery plan; and** **2. notes the outcome performance indicators in the quarterly dashboard.**
44.	**BETTER CARE FUND: PERFORMANCE REPORT (OCTOBER - DECEMBER 2015)** *(Agenda Item 6)* It had been recognised that the BCF pooled fund for the current year would not be enough to cover the burdens of the Care Act. However, it was pleasing to note the progress that had been made against targets such as the reduction in emergency hospital admissions.

	The 2015/2016 BCF Plan Evaluation had demonstrated the value of integration. The Vice Chairman had spent time with a range of staff who had contributed ideas for improvements and displayed enthusiasm regarding partnership working. It was important that the 2016/2017 BCF Plan harnessed these ideas and enthusiasm. It was noted that the Hillingdon Clinical Commissioning Group (HCCG) would be producing its own document which would include assessments by each of the Trusts. HCCG would coordinate this in due course. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the contents of the report; and** **2. agrees that a report on the draft digital roadmap across health and care partners in Hillingdon be brought to the June 2016 Board meeting for consideration.**
45.	**DRAFT BETTER CARE FUND PLAN 2016/2017** *(Agenda Item 7)* It was noted that the detail required in the Better Care Fund (BCF) Plan 2016/2017 was significant and that it would have been useful if the timescales for the BCF and the Sustainability and Transformation Plan (STP) had been coterminous. For 2016/2017, slightly more than the required minimum funding was being provided by the partners. Although progress had been made, it was disappointing that not enough progress had been made to enable the partners to undertake something more ambitious in the subsequent year. This would be an aim for the future. The 2016/2017 BCF Plan would need to be submitted by 25 April 2016 which meant that authority for signing the Plan off would need to be delegated to officers in consultation with members of the Board. It was agreed that, in the interest of transparency, the Chair of Healthwatch Hillingdon be included in those that needed to be consulted in relation to this sign off. Although it was still early days, the BCF offered opportunities to shape the local community. With a growing population, there was an opportunity to liaise with developers and housing providers to provide more appropriate housing for older people. With an increasing number of under occupiers in the Borough, there was a risk of isolation and consideration would need to be given to how these individuals could be encouraged to downsize and be part of a community. It was suggested that the following statement included in the Plan be investigated further: Overall, Hillingdon is expected to have the greatest increase in the proportion of older people with long term conditions compared to other London boroughs making the management of these conditions a significant priority. Whilst a bold and dramatic statement, it was important to ensure that it was also accurate. There were currently a range of plans and strategies being developed, e.g., BCF, STP and Strategic Estates. It was thought that, as they were all linked, it would have been useful to have these combined. **RESOLVED: That the Health and Wellbeing Board:** **1. approves the 2016/17 Better Care Fund plan in principle for submission to the London Regional Assurance Team on 25 April 2016 as described in this report or with any amendments that it requires;**

	2. delegates authority to make any further minor amendments prior to submission, e.g., to reflect feedback from the London Regional Assurance Team and/or Policy Overview and Scrutiny Committees, to the Corporate Director of Adults and Children and Young People's Services, LBH and the Chief Operating Officer, HCCG, with final sign-off by the Chairman of the Board, the Chairman of HCCG's Governing Body and the Chair of Healthwatch Hillingdon; and **3. notes the content of the Health and Equality Impact Assessments.**
46.	**HILLINGDON CCG UPDATE** *(Agenda Item 8)* The timing of the publication of the Health and Wellbeing Board agenda had meant that it included Month 10 figures. Month 11 figures had subsequently been published and were roughly in keeping with the projections. It was noted that the QIPP efficiency programme was expected to be approximately £900k short of its target as the easy savings had already been made. However, over the next five years, QIPP was expected to achieve efficiency savings in relation to the prevention of long term conditions and through negotiation with CNWL regarding mental health services. It was suggested that the Council share its experience of delivering savings with Hillingdon Clinical Commissioning Group (HCCG). HCCG was currently looking at supporting The Hillingdon Hospitals NHS Foundation Trust (THH) through its transition over the next year or two and was starting to work on the five year Sustainability and Transformation Plan (STP) for the Borough. There would be 44 STPs covering the country with a huge variation in the total population that they would represent. Of these, only 10 had identified an individual to lead for their area: 2 Chief Executives, 4 CCG Chief Officers and 4 Hospital Trust Chief Officers. Concern was expressed that the local perspective should not be lost in the STP. It was noted that the Local Government Association would be writing to the Health Secretary about the effectiveness of STPs as it appeared that local authorities were being excluded. It was important that the Board partners work together in relation to the STP to make progress before the Board's next meeting. As such, a draft STP would be discussed at a meeting (comprising the Council, THH and HCCG) on 9 May 2016. The Chairman advised that a Member would attend this group rather than a Council officer. HCCG's 2016/2017 Operating Plan had been submitted on 11 April 2016. Although the Board report stated that there would be a -6.1% mitigated growth in relation to non-elective admissions, following negotiations with NHS England, this had been changed to +1%. Concern was expressed that the terminology used by HCCG was quite difficult to understand and there were a number of funding assumptions made. A request was made that the information be provided in a simpler format in future reports. It was recognised that Heathrow airport had a significant impact on the health of residents in the Borough. To this end, it was suggested that the STP be used to acknowledge the impact that Heathrow expansion would have on residents' health. Clean Air Action Zones had been proposed in the East Midlands and London where the EU safety limit had been exceeded. Although the Board would not make the decision about whether or not Heathrow was expanded, it would have a statutory responsibility to do something about it. It was suggested that consideration be given to what further action could be taken by GPs and the Council and whether lobbying should be

	undertaken to add further weight to arguments about motorway and airport expansion in the area. HCCG would be provided with information regarding the impact that the airport had on the health of local residents. **RESOLVED: That the Health and Wellbeing Board to note the update.**
47.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 9)* The Chairman placed on record the Board's thanks to Mr Jeff Maslen for the superb job he had done in representing Healthwatch Hillingdon (HH). It was noted that HH was now looking for a new Chair. The *Shaping a healthier future* consultation had resulted in promises relating to the level of consultant cover. HH had fed back its disappointment regarding the outcome. With regard to the Sustainability and Transformation Plan, concern was expressed that, although the Plan should cover local issues, centrally pushed issues would have a major impact. **RESOLVED: That the Health and Wellbeing Board notes the report.**
48.	**UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 10)* It was noted that all of the time limited s106 funding had been allocated to eligible schemes. In December 2015, the Hillingdon Clinical Commissioning Group had advised that NHS England had set aside a budget of £250m in 2015/16, to be invested in primary care premises to help manage the increase in demand for primary health care service in England. All local practices were now able to submit requests for funding in a second round of bidding for a further £250m in 2016/17. It was noted that the process had been prolonged. **RESOLVED: That the Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.**
49.	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE** *(Agenda Item 11)* It was noted that the Local Transformation Plan had been signed off by NHS England in December 2015. Waiting times for the CAMHS clinic had been identified as a priority and, although 75% of young people were now seen within 18 weeks for a routine appointment, this was falling short of the 85% target. Work had been undertaken in schools to identify gaps in service provision and good practice had been embedded in a number of schools. It was recognised that there were a number of schools that were less inclined to engage. As the Council lacked influence with schools, the Chairman of the Safeguarding Board would be exploring the issue. It was confirmed that the CAMHS funding had now been absorbed into the base budget but would still be allocated for the same purpose. Although the report stated that good progress had been made in recruiting staff for new

	services, this had been challenging. Working with fewer staff had impacted on waiting times and, even with additional funding, the service needed to be embedded in schools. The King's Fund had undertaken research in relation to CAMHS and had provided a breakdown of referrals and services from a national to a local level. The Director of Public Health was asked to provide further information in relation to this for an informed discussion. In February 2016, a meeting of Primary and Secondary Heads had taken place (with 50% attendance) to commence active discussions with the schools forum, offering training and support to recognise and develop services. The schools forum had been very active in engaging schools and the Healthy Schools Programme publicised good practice. In addition, a revised/refreshed good practice guide for schools was being developed and consideration was being given to achievement awards. It was recognised that children's mental wellbeing in schools was now part of schools' core business. Although there was a national level of concern regarding children's mental health, further discussions were needed in relation to what was happening in Hillingdon and what further action could be taken. Consideration would also need to be given to the thresholds that were often not being met when children were referred to the CAMHS service. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the progress against the implementation of the agreed 2015/6 Local Transformation Plan;** **2. continues to request regular performance updates against the partnership plan over its remaining 4 years , including detail of metrics, such as reducing waiting times, training of the workforce and of financial spend against workstreams to enable it to monitor progress and risks; and** **3. notes proposals for further developing the plan from 2016/17 and for the next four years in light of progress and changes to funding streams. The 2016/17 plan will be approved by HCCG and by Health and Wellbeing Board and submitted as part of the Sustainability and Transformation Plan in June 2016.**
50.	**STRATEGIC ESTATES DEVELOPMENT: UPDATE** *(Agenda Item 12)* It was essential that service and estates planning were integrated to ensure that quality estate was available to deliver high quality services and make well informed investment decisions. It was anticipated that this strategic approach would facilitate the best use of existing property and ensure that new estate developments met service need. The Hillingdon Clinical Commissioning Group (HCCG) was aware that there were a lot of GP premises within the Borough which were in need of an upgrade or redevelopment. As there was capacity in a number of Children's Centres, clinics and other community facilities around the Borough, it was suggested that these venues could be used to relieve the pressure described by the HCCG. Furthermore, the Council was open to discussions with the HCCG about alternative premises that it might have identified. In addition, it was suggested that consideration be given to providing a confidential report to a future Board meeting overlaying the upcoming residential developments in

	the Borough (by type) with the associated GP pressures. **RESOLVED: That the Board notes the progress being made towards the delivery of the Hillingdon CCG's strategic estates plans.**
51.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 13)* It was agreed that the meeting scheduled for 5 July 2016 be moved to either 28 or 30 June 2016. As the Hillingdon Clinical Commissioning Group's 2016/2017 Commissioning Intentions would need to be submitted by 1 October 2016, they would be considered by the Health and Wellbeing Board at its meeting on 29 September 2016. **RESOLVED: That, subject to rescheduling the July 2016 meeting, the Board Planner be agreed.**
52.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 14)* The Board discussed a number of issues in relation to the Commissioning Intentions, the contraception service, home care and the NHS pharmacy review. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 3.54 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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HEALTH AND WELLBEING STRATEGY: PERFORMANCE REPORT

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

HEADLINE INFORMATION

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

RECOMMENDATIONS

That the Health and Wellbeing Board:

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

INFORMATION

Supporting Information

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

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

Key highlights from the Delivery Plan under each of the priority areas are detailed below:

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

1.1 **Smoking cessation.** The estimated prevalence of adult smoking in Hillingdon has risen by 1% and remains slightly below the England average. Action to encourage quitting is being

taken through work with GPs, Pharmacies and specialist advisers. Training has been provided to 60+ healthcare professionals to increase the capacity to support residents wanting to quit. 45 out of 52 pharmacies in Hillingdon are now trained to provide stop smoking medication.

1.2 **Helping adults with a Learning Disability find employment.** Work is underway to design supported internships to increase the number of young adults with LD in paid employment.

1.3 **Children's Health**. Integrated GP Paediatric Consultant led clinics are bringing specialist expertise into GP practices. The new clinic will see children requiring observation, short-stay investigations and low-level observation enabling families to receive specialist care without being admitted to hospital.

1.4 **Reducing obesity.** Results from a 12 week adult weight loss pilot programme are being collated with initial results from the programme with pharmacies and Weightwatchers appearing to be positive. 376 people have completed the programme with good results in losing weight and reducing their waist measurement, and increased levels of physical activity. The 'This Hillingdon Girl Can' mother and daughter physical activity programme offered 29 free exercise sessions across the borough over 20 weeks. More than 500 people took part.

2 Priority 2 - Prevention and early intervention

2.1 **Reablement and Rapid Response.** 132 referrals were received during Q4 2015/16. 51 referrals came from the community, representing potential hospital attendances and so avoiding hospital admissions. 45 people were discharged from reablement with no further social care needs. 926 people were referred to the Rapid Response team during the quarter.

2.2 **NHS Health Checks.** Final figures for the programme in Hillingdon show that first offers increased by 2,084 (22%) compared to 2014/15. 7,700 checks were completed, an increase of 1,153 (17%) on the previous year. Health checks were provided at 7 community events, with over 230 carried out in Hillingdon libraries.

2.3 **Long term conditions.** Extra posts in Heart Failure Nursing and Cardiac Rehabilitation have been filled. Atrial Fibrillation and 24hr blood pressure monitoring pilot schemes are being reviewed, with the aim of improving care planning for patients, improving outcomes and reducing unplanned attendances and admissions. A new scheme to reduce the number of people found to have cancer following an unplanned attendance is in development. A new project to improve the care of people with several long-term conditions is also being explored.

2.4 **Reduce the number of children with one or more decayed, missing or filled teeth**. Two new NHS dental practices are planned in Harefield and West Drayton to increase the accessibility of NHS dentistry.

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

3.1 **Early identification of people susceptible to falls, social isolation and dementia**. A review was undertaken of the falls prevention classes being delivered by the Council's Wellbeing Service under its exercise and referral programme. This twelve week programme

is intended to support people who have fallen to regain their confidence by assisting them to be as active as their ability allows and therefore reduce the likelihood of further falls occurring. As a result of the review, a further three classes a week will be delivered from Q1 2016/17.

3.2 **End of life care.** A proposal has been developed by the CCG on behalf of the multi-agency End of Life Forum. If the proposal is successful, it could see the injection of an additional £1.5m over three years to produce a more integrated model of end of life care for Hillingdon residents. The results of the submission are likely to be known in August 2016.

3.3 **Home adaptations**. In Q4 2015/16, 24 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 43% of the grants provided. 55% (31) of the people receiving DFG's were owner occupiers, 36% (20) were housing association tenants, and 9% (5) were private tenants. The total DFG spend on older people (aged 60 and over) during Q4 2015/16 was £167K, which represented 36% of the spend during the quarter (£461k).

3.4 **Carers Strategy.** A successful presentation event to recognise the contribution made by Carers was held on 10 May. All those who were nominated and their cared for person were presented with framed certificates and flowers. Further engagement events are being planned for the next few months to seek Carers' views. The new contract for the Carers' service is due to start in September 2016.

4 Priority 4 - A positive experience of care

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

4.2 **Improve social care service user experience**. The target for the percentage of people who felt that they found it easy to gain access to information and advice about access to services and/or benefits was exceeded by 2%.

Financial Implications

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

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

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

Consultation Carried Out or Required

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

Policy Overview Committee comments

None at this stage.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

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

Hillingdon Council Legal comments

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

BACKGROUND PAPERS

NIL.

Appendix A Health and Wellbeing Strategy Delivery Plan Update

Priority 1 - Improving Health and Wellbeing and reducing inequalities				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
1.1 Protect 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 per week of 6. Priority is given to women with a BMI 30+ but the session is open to all. • To end March 2016, smoking prevalence at time of delivery is at 8.0% compared with national 12%. • Total number of women referred into the service in 2015/16 is as follows: 163 referrals, 65 engaged, 21 quits.
	1.1.2 Develop a Children's Health Programme Board to agree with partners the strategic direction for children's health provision	CCG		• A Paediatric Business Case been developed and includes the development of: • Integrated GP Paediatric Consultant led Clinics, bringing specialist expertise into GP practice to provide clinics that are accessible. 7 new patients will be seen in the morning and 5 case discussions will take place in the afternoon in a Multi-Disciplinary Team meeting, to include health education & social care as relevant per

Page 14				case. This moves clinics out from the hospital into community. • Ambulatory care pathways – the new Paediatric Assessment Clinic will see children who require observation, short stay for investigations and low level interventions. Families will be able to receive specialist care without being admitted to hospital. • Implementing the Asthma pathway - Asthma Allergy the roll out of the successful pilot. Children are seen in community/school. Practice nurses are trained in Asthma diploma, building the level of expertise and management into community. This implements the Asthma quality standards. • Critical Care Level 1 it is proposed to develop this service to provide quality care for the more complex sick child. This will enable to hospital to deliver care against London wide standards. Preparing for level 2 in the future. This will enable to hospital to care for these children close to home without transferring the, to other hospitals. • Meetings of the children's health partnership have paused while CCG appoints a new Clinical Lead as chair person. However work continues via task and finish groups.
	1.1.3 Deliver a mental wellness and resilience programme	Wellbeing Service		• During Q4, 210 people attended three tea dances. Feedback received from participants continues to be generally positive with older people stating that

				the dances encourage them to be more active, make friends and feel less lonely.
	1.1.4 Deliver a smoking cessation service including supporting the further roll out of Smoke Free Homes in Hillingdon	Public Health	Annually	• Hillingdon's Smoking prevalence (age 18+) rate is estimated to have increased from 16.2% to 17.1% compared with the England average of 18%. • The Smoking cessation target is 1055 quitters. Between April 2015 April 2016, 1389 residents were recruited. 549 of these residents quit through the support of GP's, Pharmacies and specialist advisors. • The national No Smoking Day (week) campaign in March 2016 was used to raise awareness, promote the service with the aim of increasing referrals. Promotions were set up at libraries, local clinics, GP's & Pharmacies. • A regular weekly clinic to support residents diagnosed with mental health conditions is being delivered at Mead House. Currently 15 patients are engaging with the service and we have achieved 2 quits. • A workshop was delivered to the respiratory nurses of the Hillingdon hospital to increase uptake and referral of smoking cessation by in-patients and discharged patients. • Since April 2015, Level 2 smoking cessation training has been provided on three separate occasions to a total of over 60 healthcare professionals within Hillingdon. Qualification has increased the capacity

Page 16				to provide support to local residents who wish to quit. Since February 2016, the format of the training has been changed to an online version. This has been well received by healthcare professionals across the borough as it is convenient and accessible, reducing absence from their practice. • Currently over 60 Pharmacists have been trained to prescribe stop smoking medication. 45 out of 62 Pharmacies deliver this service within the borough. Almost all of the Hillingdon Pharmacies provide COPD screening to patients accessing the stop smoking service. • Specialist advisors have been trained to deliver Nicotine Replacement Therapy directly to the patient at community clinics. A patient search in GP Practices was completed to engage with the smoking population of that surgery. • A new clinic is being trialled at the Harefield Surgery with patients currently with or at risk of developing COPD.
	1.1.5 Reduce prevalence of obesity through a variety of initiatives including the delivery of the Child Measurement Programme, and raising awareness of the importance of physical activity across the life course	Wellbeing Service	Quarterly	• The National Child Measurement programme is underway and it is expected that all eligible children (from Reception year and year 6 in Hillingdon schools) will have been measured by the end of June; well before the final data submission deadline in mid-August. • The children's weight management programme is being delivered across 3 localities and for ages 2-4, 5-7, 7-13 and 13+ with a new cohort having started

				in Jan 2016. • Adult weightloss pilot completed in March. 12 week data being collected after which the pilot will be evaluated. Initial results are encouraging. • The council continues to deliver the 'Walks Scheme' with 3,368 attendances and 98 new walkers during 2015/16. • As part of the 'This Hillingdon Girl Can' mother and daughter physical activity programme, 29 free exercise sessions spread across the borough were delivered over a 20 week period. Over 500 people took part in the programme and more than 90% of survey respondents said taking part had improved their wellbeing.
	1.1.6 Reduce exposure to high levels of air pollution and improve air quality and public health in Hillingdon	LBH	Annually	• The GLA policy and technical guidance in regard to London Local Air Quality Management, and how boroughs are expected to carry out their local air quality management duties, has been published. • The Hillingdon Air Quality Action Plan was adopted in 2004, the new requirement indicates that a review is required. Each borough is now expected to update their Action Plan every five years. The Action Plan review is to be led internally by the Heads of Transport and Public Health to ensure a joint approach to improving air quality. To aid boroughs in this process, the GLA will be providing key environmental information for each borough which can then be used as the basis for the review of individual Air Quality Action Plans. This information will then be provided every four years to

				inform the updating process. The revision of the current Air Quality Action Plan will be informed by the new pollution information and reflect the GLA guidance on the action measures boroughs are expected to consider to reduce pollution.
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	• A new Project Search site offering supported internships for young people with SEND will open in September 2016. This is supported by the local authority and in conjunction with Meadow High School and a local hotel. • An organisation called NEED has agreed to work with the local area to design a range of supported internships aimed at increasing the number of young adults with LD who are in paid employment. • Reviews of Education, Health and Care Plans after age 14 focus on employment as a key outcome for all young people. • All service user care plans evidence the support to access employment or education opportunities. • 24 services users from across the services have been supported to access college course this quarter. 38 service users across services have had the opportunity to undertake unpaid employment opportunities to up skill in readiness for further paid work. • One example of this is that Queens Walk are currently supporting 2 service users to carry out

				work experience within the catering kitchen at Queens Walk supporting catering staff with domestic tasks and meal preparation to enhance their catering skills.
1.3 Develop Hillingdon as an autism friendly borough	**1.3.1** Develop and implement an all age autism strategy	LBH	Quarterly	• The draft Autism Plan has been considered by ASC SMT and will be shared with relevant Councillors in June, prior to a stakeholder event taking place. The stakeholder event will capture residents' views to complete the Autism Plan. It will also support prioritisation of the action plan. • Internal Audit undertook consultancy work to ensure compliance with the duties in the Adult Autism Strategy. The findings will inform the final Autism Plan and the work of the Autism Partnership Board. • The Autism Partnership Board is well attended by all partners.
Priority 2 - Prevention and early intervention				
Objective	**Task and Metric**	**Lead**	**Metric reporting frequency**	**Evidence of activity against task**
2.1 Deliver the BCF workstream 2 - Intermediate Care under Strategy	**2.1.1** Deliver scheme three: Rapid response and joined up Intermediate Care	LBH/CCG	Quarterly	• During Q4 the Reablement Team received 132 referrals and of these 51 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 45 people were discharged from

				Reablement with no on-going social care needs. • In Q4 the Rapid Response Team received 926 referrals, 54% (499) of which came from Hillingdon Hospital, 22% (202) from GPs, 10% (93) from community services such as District Nursing and the remaining 14% (132) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 499 referrals received from Hillingdon Hospital, 381 (76%) were discharged with Rapid Response input, 112 (22%) following assessment were not medically cleared for discharge and 10 (2%) were either out of area or inappropriate referrals. All 427 people referred from the community source received input from the Rapid Response Team.
2.2 Deliver Public Health Statutory Obligations	**2.2.1** Deliver the National NHS Health Checks Programme	Public Health	Annually	• The aim of the programme is the early identification of individuals at moderate to high risk of cardiovascular disease, diabetes, stroke, kidney disease and related metabolic risk. • In 2015/16, 72,893 Hillingdon residents and people registered with Hillingdon GPs are eligible for the NHS Health Check programme. Of these, 14,579 (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 2014/15, the take-up rate was 69%, therefore Hillingdon should be aiming to carry out at least 10,060 (13.8%) checks during 2015/16. • The end of year position for 2015/16, as reported to Public Health England (PHE) on 13th May 2016,

				was: - First Offers: 11,435, an increase of 2,084 (22%) from the 2014/15 figure; - Completed Checks: 7,700, an increase of 1,153 (18%) from the 2014/15 figure. The following targeted actions were taken to increase the take-up rate of NHS Health Checks during 2015/16: • Two NHS Health Check training sessions held for practice and pharmacy staff attended by 44 people; • 12 visits to support practices and pharmacies; • Four presentations made to practice and pharmacy staff at Public Health 'Top Up' sessions; • NHS Health Checks were provided at seven community events including health and wellbeing days at Hayes Islamic Centre, Uxbridge Police Station, Hayes & Harlington Community Centre for Hillingdon Carers and Hayes Mecca Bingo. • Over 230 NHS Health Checks were carried out in Hillingdon Libraries during February's Love Your Heart month. • An Annual Outcomes report for practices to identify the number of patients diagnosed with impaired glucose tolerance, impaired fasting glycaemia, diabetes, chronic kidney disease, hypertension and familial hypercholesterolaemia following their NHS Health Check is in development.

	2.2.2 Deliver Open Access Sexual Health	Public Health	Quarterly	• The review and health and care needs assessment for HIV Support Services has been completed and a revised service specification tailored to meeting the needs of service users has been agreed. • A sexual health needs assessment (including user engagement) has been undertaken. The outputs from the needs assessment is being used to inform the development of a new model of service based on the integration of sexual and reproductive health services. • The service is due to go out to tender over the summer.
	2.2.3 Delivery of information to protect the health of the population against infection or environmental hazards and extreme weather events	Public Health		• There have been a small number of outbreaks of suspected or confirmed Norovirus in schools in Hillingdon in 2015/16. • Norovirus, which causes diarrhoea and vomiting, is one of the most common stomach bugs in the UK. It is also referred to as the "winter vomiting bug" because it's more common in winter, although you can catch it at any time of the year. Norovirus can be very unpleasant but it usually clears up by itself in a few days. • The Local Authority receives notification about outbreaks of Norovirus from Public Health England (PHE) for information. When required the Local Authority is asked by PHE to cascade relevant information for schools and nurseries in the form of

				a 'toolkit' developed by PHE to help prevent and control future outbreaks of Norovirus in schools or nurseries. PHE have recently requested that we cascade the toolkit to schools and nurseries this autumn.
2.3 Prevent premature mortality	**2.3.1** Ensure effective secondary prevention for people with Long Term Conditions including cancer, diabetes and dementia	CCG	Quarterly	The three Integrated Services for Long Term Conditions that were approved in 2015/16 are progressing with an update given below for each: • **Cardiology** – The extra posts for Heart Failure Nursing and Cardiac Rehabilitation have been filled. A pilot around Atrial Fibrillation is underway and the 24hr Blood pressure monitoring pilot is being evaluated. Anti-coagulation services are being reviewed. The aim of these schemes is to improve the planning of care for patients, thereby improving outcomes and reducing unplanned attendances and admissions. • **Diabetes –** Service is due to launch in July and is supported by the Diabetes Primary Care Contract. Discussions with GP Networks are underway about patients will be identified and then supported in a multi-disciplinary way. • **Respiratory** – Service is up and running and is already generating benefits through improved outcomes for patients and therefore reduced unplanned attendances and admissions. Further work is being done in this area focused on supporting children with asthma to improve care.

Page 24				In addition to the three Integrated Services we are also working on the following initiatives to support local patients: • **Cancer –** We are developing a scheme to reduce the number of patients who are detected as having Cancer following an unplanned attendance and also to improve the coordination of care of patients post substantive treatment. We expect this plan to be in place during the Summer and to start generating benefits in early Autumn onwards. • **Empowered Patient Programme –** This highly effective scheme was piloted in 15/16 and is being extended to a wider group of patients and a wider group of conditions for 16/17. The aim is to improve the ability of patients to self-manage elements of their own care and to understand their condition more effectively. This support is provided in a range of languages to meet the needs of our population. • **Complex Patient Management –** Many patients with one LTC often have two or more and there is a need to move to a more holistic model of care that takes into account not only the primary LTC but also the impact of secondary and other LTCs which could include such things as frailty, social isolation, mental health issues or pain and that seriously impact on the quality of life experienced by patients. HCCG is looking into exploring a new project in targeting patients with more than one LTC and co-

				morbidities.
	2.3.2 Reduce the risk factors for premature mortality and increase survival across care pathways	PH/CCG	Quarterly	Increasing the levels of physical activity in the borough amongst those suffering from chronic conditions is being taken forward through the inclusion of 'Let's get Moving' programme in disease care pathways. • 376 clients have completed the 12 week programme. 71% achieved all their goals in the programme and 26% achieved some. Only 3% failed to achieve any of their goals. • An overall reduction in BMI for those whose goal was to lose weight was achieved in 69% of cases. 76% achieved a reduction in their waist measurement. • 66% achieved an increase in the amount of times that 30 minutes of moderate intensity (breathless) physical activity was undertaken each week. The following results were also reported: -Improved fitness: 77% -Reduction in GP visits: 66% -Reduction in pain: 50% -Reduction in depression: 44% -Improved wellbeing: 63% -Less short of breath: 59% -Improved sleep: 49% • New pathways for the following patients have been developed: -Cancer patients - new session to start Sept 2016 -Falls prevention patients - three new sessions

				available -A new generic low level session at Highgrove leisure centre -Parkinson's patients -Post-natal women • The internal Weight Action Programme for Council staff has 28 staff registered. • Get Up & Go for residents from BME groups looking to improve their wellbeing lifestyle and take part in physical activity. One programme in Q1 (8 attendees) and one due to be completed in June.
	2.3.3 Reduce excess winter deaths	Public Health/NHS England		• Local implementation of the Flu Plan 2016-17 and the National Flu Immunisation programme is an important contribution to increasing resilience across the system through the winter period. • As well as all older people, people at risk categories and two to four year olds, the national Flu plan 2016/17 stipulates that vaccination will be offered via NHS providers to all children of school year 3 age. Children of school years 1 and 2 age will remain eligible. Vaccinating children each year means that not only are the children protected, but also that transmission across the population is reduced, lessening the overall burden of flu.
	2.3.4 Reduce the number of children with one or more decayed, missing or filled teeth	Public Health & NHS England		• NHS England and Public Health Team worked on a joint project to improve access to preventative dental care in Hillingdon.

				• Two new NHS dental practices are planned for Harefield and West Drayton to ensure equity of NHS dentistry across the borough • 3,500 school children completed forms as part of the School Oral Health Project.
	2.3.5 Deliver a project to make Hillingdon a Dementia Friendly borough	Mental Health Delivery Group	Quarterly	• Since April 2015 there have been four Alliance meetings. 14 organisations across Hillingdon have joined the Alliance with another four due to come on board. 32 Dementia Friends Champions have been appointed and 3,114 Dementia Friends. • By the end of March 2016, 14 organisations in Hillingdon have signed up to the Dementia Action Alliance and meets quarterly. • A recent Dementia Action Alliance meeting received presentations from the Police and from the Alzheimer's Society project called Connecting Communities. The Connecting communities project has worked in Hillingdon for the past 3 years to raise awareness of dementia in traditionally hard to reach communities. • A Dementia Roadshow was held in February outside the Civic Centre. Enquiries from residents included: where are the local Alzheimer's services; types of dementia; what are the symptoms of dementia; how to manage behaviour; what support is there for carers. • The Dementia coffee mornings in Uxbridge library

				now have an average weekly attendance of 12 – 15 per week, raising awareness each week.
	2.3.6 Improve pathways and response for individuals with mental health needs across the life course including the provision of Child and Adolescent Mental Health Services (CAMHS)	CCG	Annually	• Single Point of Access - a Business Case was approved to develop a single point of access in the mental health urgent care pathway for Adults. The service has been operational from 2nd November 2015. In addition, community services has been reconfigured into two hubs and the home Treatment Team now operates out of hours with two members of staff on duty. This service commenced January 2016 and the impact will be evaluated with a report expected in September/ October 2016. • Improving Access to Psychological Therapies - a Business Case was been approved to expand IAPT Services to target hard to reach groups and those with Long Term Health conditions such as Diabetes. CNWL has recruited additional staff to expand the service to ensure 15% access target is maintained 16/17. The Access target was met for 15/16 and the Recovery target was achieved in for the final two quarters of 2015/16 The targets have continued to be achieved in the first two months of 2016/17. The Children's Emotional Health & Wellbeing Board has been established to oversee the Hillingdon Transformation Plan and Implementation Plan and the NHSE/DH Local Transformation Plan, the latter of which has additional funding for five years to transform CAMHs. The additional funding will be used to develop the following: • A CAMHs self-harm, crisis and intensive support Team.

Page 29				• Specialist Mental Health provision for Children and young People with Learning Disability and Challenging Behaviour Team, with an integrated pathway with LBH Disability Team. • A Community Eating Disorder Service. • Additional resources to reduce waiting times for treatment. • A Business Case to develop a CAMHS Deliberate Self-harm Team has been approved at the HCCG Governing Body in November 2015. • The provision of Liaison Psychiatry services has been expanded to improve access to specialist mental health services for those patients presenting at A+E and receiving clinical services for other conditions in an Acute Hospital setting. A Business Case has been approved by Hillingdon CCG Governing Body to further enhance this service with the continuation of the Mental Health Assessment Lounge as a separate facility from Accident and Emergency department. This service is currently undergoing an evaluation for further review.
	2.3.7 Develop a Vision Strategy for Hillingdon	Vision Strategy Working Group	Annually	• The Vision Strategy has been approved by Adult Social Care SMT and will be presented to relevant Councillors for final approval prior to publication.
2.4 Ensure young people are in Education, Employment or	**2.4.1** Identify those at risk of becoming Not in Education, Employment or Training (NEET) and implementing	LBH	Quarterly	• Work is ongoing between the Council and partners including schools, academies and education and training providers to identify the employment, education and training (EET) status of young

Training	appropriate action to prevent it			people. • Current data to 31st March 2016 shows that the number of 16-19 year old NEETs is 277 young people or 3.30%. The percentage of NEET in September 2015 was 5.87% representing an improvement of 2.57% in six months. In Hillingdon, 10,072 young people 16-19 are in further or higher education or apprenticeships or employment representing 70.8%. • The tracking of young people to verify their current activity is also ongoing, with 1630 young people's EET destinations unknown following a change in their EET status. Destination identification work is ongoing between the Council's Participation Team and education and training providers to determine the EET status of the cohort.

Page 3

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

Objective	Task and Metric	Lead	Metric reporting frequency	Evidence of activity against task
3.1 Deliver the BCF Workstream 1 - Integrated Case Management	**3.1.1** Deliver scheme one: early identification of people susceptible to falls, social isolation and dementia	LBH/CCG	Annually	• A review was undertaken of the falls prevention classes being delivered by the Council's Wellbeing Service under its exercise and referral programme. This twelve week programme is intended to support people who have fallen to regain their confidence by assisting them to be as active as their ability allows and therefore reduce the likelihood of further falls occurring. As a result of the review a further three classes a week will be delivered from Q1 2016/17.

	3.1.2 Deliver scheme two: better care for people at the end of their life (EoL)	LBH/CCG	Quarterly	• A proposal has been developed by the CCG on behalf of the multi-agency End of Life Forum for consideration by Social Finance, a not for profit organisation that partners with the government, the social sector and the financial community to find better ways of tackling social problems in the UK and beyond. • If the proposal is successful it could see the injection of an additional £1.5m over three years to produce a more integrated model of end of life care for Hillingdon residents. The results of the submission are likely to be known in August 2016.
3.2 Deliver the BCF Workstreams 3 & 4 - Seven day working and Seamless Community Services	**3.2.1** Deliver scheme four: seven day working	LBH/CCG	Quarterly	• The comparison in discharge activity at Hillingdon Hospital in Q1 - 4 2014/15 and 2015/16 shows an increase in discharges on Saturdays of people admitted to hospital for planned procedures but similar patterns for people admitted for unplanned procedures.
	3.2.2 Deliver scheme six: Care homes initiative	LBH/CCG	Quarterly	• No update.
	3.2.3 Deliver scheme five: Review and realignment of community services to emerging GP networks	LBH/CCG	Quarterly	• The Metrohealth GP network covering the north of the borough and Clover Health network in the south merged. This means that there are now four GP networks in the borough. The current networks are seeking to merge into a single network by the end of 2016/17.
	3.2.4 Provide adaptations to homes to promote safe,	LBH	Quarterly	• In Q4 2015/16, 24 people aged 60 and over were assisted to stay in their own homes through the

	independent living including the Disabled Facilities Grant			provision of disabled facilities grants (DFGs), which represented 43% of the grants provided. • 55% (31) of the people receiving DFG's were owner occupiers, 36% (20) were housing association tenants, and 9% (5) were private tenants. The total DFG spend on older people (aged 60 and over) during Q4 2015/16 was £167K, which represented 36% of the spend during the quarter (£461k).
	3.2.5 Increase the number of target population who sign up to TeleCareLine service which is free for over 80's	LBH	Quarterly	• As at 31st March 2016, 4,674 people were in receipt of a TeleCareLine equipment service, of which 3,582 were aged 80 years or older. • Between 5th April 2015 and 31st March 2016, 1,326 new service users have joined the TeleCareLine Service.
3.3 Implement requirements of the Care Act 2014	**3.3.1** Develop the prevention agenda including Info and Advice Duty	LBH	Quarterly	• From 1st April 2015 (launch) to 31st March 2016, over 5,500 individuals have accessed Connect to Support and completed 9,910 sessions reviewing the information & advice pages and/or details of available services and support. • The online social care self- assessment went live on 1st July 2015 and in period to 31st March 2016 and 58 online assessments have been completed and 39 were by people completing it for themselves and 19 by carers or professionals completing on behalf of another person. • 17 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. The carers' online assessment was launched in conjunction with the Council's Carer Awareness Campaign in early February 2016 and up to the end of March 2016, 8 assessments were submitted.
	3.3.2 Develop a Carers Strategy that reflects the new responsibilities and implementation of the Care Act 2014	LBH/CCG	Biennially	• An evening presentation event was held on 10 May for all those who were nominated and their cared for person. Framed certificates and flowers were presented to the recipients. • Further engagement events are being planned for the next few months to seek Carers' views. • The new contract for the Carers' service is due to start in September 2016.
	3.3.3 Deliver BCF scheme seven: Care Act Implementation Task: To implement the following aspects of new duties under the Care Act, primarily in respect of Carers: a) increasing preventative services; b) developing integration and partnerships with other bodies; c) providing quality information, advice and	LBH/CCG	Quarterly	• As at 31st March 2016, Connect to Support Hillingdon had 202 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. A range of activity to engage more local providers and voluntary organisations in the site started in February 2016. • Between 1st April 2015 and 31st March 2016 444 carers' assessments were completed. This is 29% (135) more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 192 carers have been provided with respite or other carer services in the period between 1st April 2015 and 31st March 2016 at a total cost of £907k. • The programme of staff training on new policies and

	advocacy to residents; d) ensuring market oversight and diversity of provision; and e) strengthening the approach to safeguarding adults.			procedures continues as required.
	3.3.4 Engage with providers through the development of the Market Position Statement to maintain a diverse market of quality providers that offers residents choice	LBH	Quarterly	• The Market Position Statement has been agreed and published on the website.
3.4 Implement requirements of the Children and Families Act 2014	**3.4.1** Implement the SEND reforms including introducing a single assessment process and Education, Health and Care (EHC) Plans and joint commissioning and service planning for children, young people and families	LBH/CCG	Quarterly	• There are 748 Education, Health and Care Plans of which 491 are transfers from previous Statements. This is in line with the Transfer Plan. • Internal Audit reviewed the Local Offer during Q4 to ensure compliance with the Regulations. The Action Plan has been updated to reflect the recommendations where appropriate. A working group is overseeing these improvements. • The self evaluation template has been populated and an evidence bank created. A survey has gone out to parents of children and young people with SEND. A child friendly version will be created and sent out over the summer. All education settings have been invited to complete a compliance checklist. Training has been provided to Special

				Educational Needs Co-ordinators and further support will be provided. • Disabled Go have prepared the list of venues to be surveyed, in conjunction with residents and staff.
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 is set to open in September 2016 and young people have been allocated places. • OHCAT has submitted an application for a Free Special School for pupils with social, emotional and mental health difficulties on the YPA site (essentially replacing YPA and Skills Hub in the process). • Eden Academy has submitted expressions of interest to establish two new Free Special Schools; a secondary school in the north of the borough probably on the Grangewood school site; a primary school in the south of the borough (site options unknown at this stage). These schools, if agreed, will provide the additional capacity required to enable children to attend school locally and continue to reduce the number who travel long distances to school.
	3.5.2 Develop a short breaks strategy for carers of children and young people with disabilities	LBH	Quarterly	• The draft Short Break Strategy is going through the approvals processes. The Short Break Statement is also being reviewed.
3.6 Assist vulnerable people to	**3.6.1** Provide extra care and supported accommodation	LBH	Quarterly	• Two new six bed services are currently being planned.

secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	to reduce reliance on residential care			

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 engaged in the BCF scheme implementation	**4.1.1** Improve service user experience by 1%	LBH/CCG	Annually	• The target for the percentage of people who felt that they found it easy to gain access to information and advice about access to services and/or benefits was exceeded by 2%.
	4.1.2 Improve social care related quality of life by 2%	LBH/CCG	Annually	• There was an increase in the number of people responding positively to questions about their quality of life compared to 2014/15 but the 2015/16 target was not achieved.
	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 plan from April 2016.

	4.1.4 Improve social care quality of life of carers	LBH/CCG	Annually	Key actions arising from a focus group of Carers that took place in Q4 include: • Involving Carers in reviewing the carers' assessment process. • Creating a help-sheet for use by the Carer at the start of each carer's assessment that outlines its purpose and what to expect from it.
4.2 Ensure parents of children and young people with SEND are actively involved in their care	**4.2.1** Develop a more robust ongoing approach to participation and engagement of Children and Young People (C&YP) with SEND	LBH	Quarterly	• A children and young people participation network has been established, making use of existing groups e.g. special school councils, pupils attending SRPs, Merrifield House, voluntary organisations. • This will be kept under review to ensure it is an effective way of increasing participation giving young people a voice in the review and design of services.

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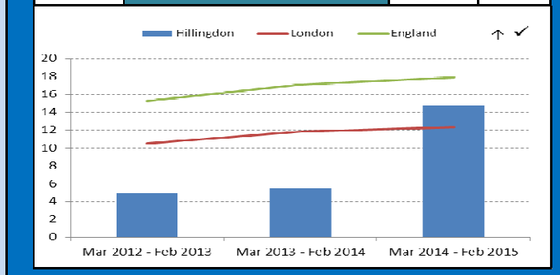
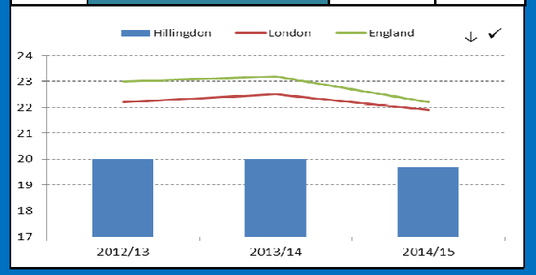
Health & Wellbeing Board - 28 June 2016

PRIORITY ONE

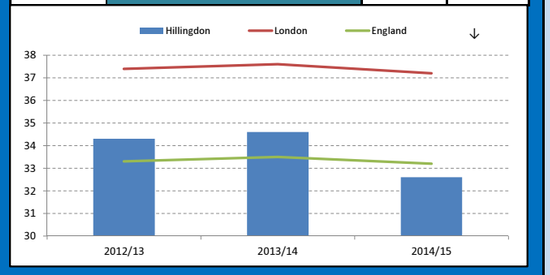
PHOF 1.16	Utilisation of outdoor space for exercise/health reasons	Mar 2014 - Feb 2015	14.7
		Mar 2013 - Feb 2014	5.5



PHOF 2.06i	Excess Weight in 4-5 and 10-11 years old - 4-5 years olds	2014/15	19.7
		2013/14	20.0



PHOF 2.06ii	Excess Weight in 4-5 and 10-11 years olds - 10-11 years olds	2014/15	32.6
		2013/14	34.6

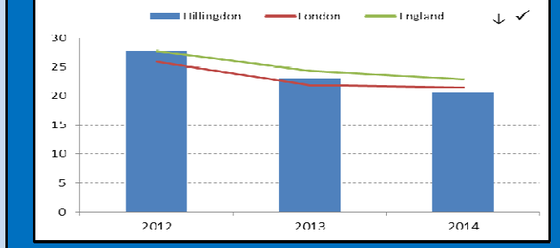


PRIORITY ONE

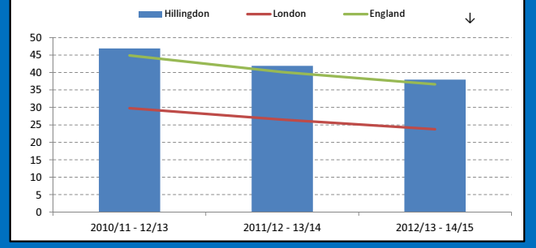
PHOF 2.01	Low birth weight for babies	2014	3
		2013	3

PRIORITY TWO

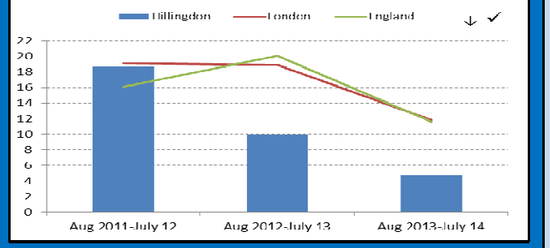
PHOF 2.04	Under 18 conceptions	2014	20.5
		2013	23



LAPE	Alcohol specific hospital admissions in under 18s	2012/13 - 14/15	38
		2011/12 - 13/14	41.9



PHOF 4.15i	Excess winter deaths index (all ages, single index)	Aug 2013-July 14	4.8
		Aug 2012-July 13	9.9

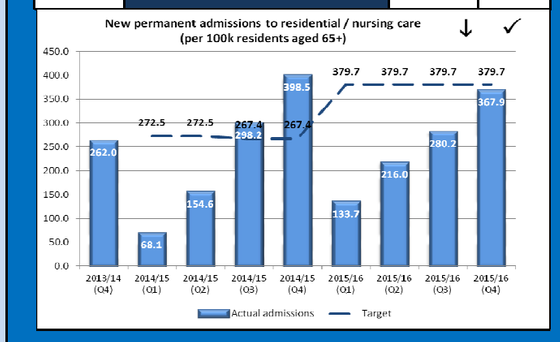


PRIORITY TWO

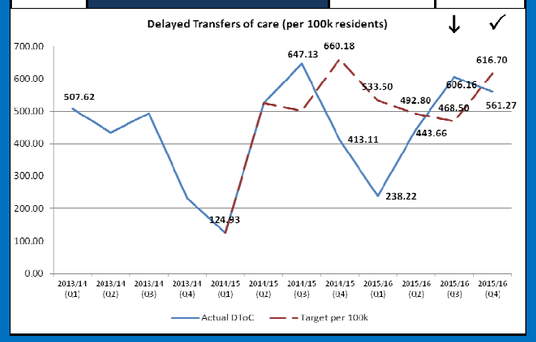
PHOF 2.18	Admission episodes for alcohol related conditions - persons	2014/15	553
		2013/14	558
PHOF 4.04i	Under 75 mortality rate from cardiovascular diseases (persons)	2012 - 14	78.3
		2011 - 13	78

BETTER CARE FUND METRICS

Perm admissions	Perm admissions per 100,000	2015/16	367.9
		2014/15 (FYr)	398.5



Delayed transfer of care (DToC)	DToC per 100,000 residents	2015/16 (Q4)	561.3
		2015/16 (Q3)	606.2



Perm admissions	Number of permanent admissions to residential / nursing care for residents aged 65+	2015/16	145
		2014/15	155
Perm admissions	Annual target for number of perm admissions	2015/16	104
		2014/15	104
Perm admissions	Target for number of permanent admissions to residential / nursinge care per 100,000 residents aged 65+	2015/16	367.9
		2014/15	398.5
Delayed transfer of care	Total number of days in quarter	2015/16 (Q4)	1287
		2015/16 (Q3)	1,369
Delayed transfer of care	DToC per 100,000 (Qtrly Outturn)	2015/16 (Q3 to Nov)	561.3
		2015/16 (Q2)	606.2
Delayed transfer of care	Quarterly target for delayed discharges (total number of days)	2015/16 (Q4)	616.7
		2015/16 (Q3)	468.5

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)	2015/16	4,674
		2014/15	4,166
LBH (Local Measure)	Number of people in receipt of TeleCareLine (80+)	2015/16	3,582
		2014/15	3,179
LBH (Local Measure)	Number of people in sign ups to TeleCareLine	2015/16	1,326
		2014/15	1,346
PHOF 2.24i	Injuries due to falls in people aged 65 and over (per 100,000 population	2014/15	2,205
		2013/14	2,308

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

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BETTER CARE FUND: PERFORMANCE REPORT (JAN - MARCH 2016)

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
Report author	Paul Whaymand, Finance Tony Zaman, Adult Social Care Kevin Byrne, Policy and Partnerships Caroline Morison, HCCG
Papers with report	Appendix 1) BCF Monitoring report - Month 10 - 12: Jan - March 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (April - March 2014/15 and 2015/16) Appendix 3A) Hillingdon Hospital Discharges Before Midday (April - March 2014/15 and 2015/16)

HEADLINE INFORMATION

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

RECOMMENDATION

That the Health and Wellbeing Board notes the contents of the report.

INFORMATION

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

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

3. The key headlines from the monitoring report are:

- The month 12 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the s75 for the management of the pooled funds. This shows an outturn pressure of £374k against the pooled budget of £17,991k.

- In 2015/16, there were 10,406 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling of 10,620. This means that there were 5% (599) fewer admissions than in 2014/15, a better performance than the 3.5% (388) 2015/16 plan target.

- There were 763 falls-related emergency admissions during 2015/16, which slightly exceeded the ceiling of 761.

- Delayed transfers of care - There were 4,196 delayed days during 2015/16 against a ceiling of 4,790. The overall performance for the year was therefore better than projected.

- There were 145 permanent admissions of older people to care homes in 2015/16 against a ceiling of 150, which means that performance was slightly better than projected.

- Performance against the target for people aged 65 and over still at home 91 days after discharge from hospital to reablement confirms that the improvement on the 2014/15 results previously reported but the 2015/16 target was not achieved.

- The target for the percentage of people completing the Adult Social Care Survey saying that they found it easy to access information and advice about services was exceeded.

- The target for people completing the Adult Social Care Survey indicating that they had a better quality of life was not achieved, although the performance was better than in 2014/15.

- From 1 April 2015 (launch) to 31 March 2016, over 5,500 individuals have accessed Connect to Support and completed 9,910 sessions reviewing the information and advice pages and/or details of available services and support.

- In Q4, 24 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs). DFGs funded adaptations to the homes of 148 older residents during 2015/16.

- Between 1 April 2015 and 31 March 2016, 466 carers' assessments were completed. This is 29% (135) more than were completed in 2014/15.

Governance Audit

4. A firm of independent auditors called Baker Tilly was engaged on behalf of the Brent, Harrow and Hillingdon (BHH) collaboration of CCGs to undertake an audit of BCF governance arrangements. The audit was undertaken in Q4 and there were two issues identified:

- *Forecast overspend of £553k at M9 as reported to the HWB* - This was mainly in respect of community equipment and it was noted that measures were already in place to address this issue.

- *Regular performance reports not being considered by the CCG's Governing Body* - This has now been addressed. The Q4 performance report will be considered by Governing Body at its July meeting.

2016/17 BCF Plan

5. Hillingdon's 2016/17 BCF plan was formally submitted on 9 May 2016, after minor amendments to it to reflect feedback from the Regional Assurance Team were approved by the Chairman, the Chair of the CCG's Governing Body and the Chair of Healthwatch Hillingdon's Board. This was in accordance with the Health and Wellbeing Board's decision at its April meeting.

6. At time of drafting, notification of the assurance status of Hillingdon's 2016/17 plan had not been received from NHS England (NHSE). The Board will receive a verbal update should this change by the time of the meeting. Irrespective of this, the focus of attention will now be on the plan's delivery and on development of the 2017 to 2020 BCF plan, which will be shaped by discussions about the emerging Sustainability and Transformation Plan (STP). The next performance report to the Board will be on Q1 of the 2016/17 plan.

Financial Implications

7. The BCF monitoring report attached as **Appendix 1** includes the financial outturn on each scheme within the BCF for 2015/16. This shows an overspend of £374k against the pooled budget of £17,991k. Each partner bears the cost of any overspends that fall to them (£195k to CCG and £179k to LBH).

8. There is currently an overspend against both the Council and CCG's shares of the pooled funds which relates to the supply of community equipment and adaptations to residents. This is a reflection that more people with complex needs are being supported in the community in line with agreed priorities. Both partners are working together to implement improvements that will enable the existing equipment budget to go further and potentially reduce the pressure.

9. There is also an overspend on the Care Act new burdens budget from the cost of providing support and care to Carers as a new responsibility following the implementation of the Act. The Council has used a corporate contingency provision to fund any overspends relating to the implementation of the Care Act responsibilities.

10. The Council has switched the funding source of telecare equipment expenditure (£167k outturn in 2015/16) from revenue to capital to utilise the annual Social Care Capital Grant to fund this expenditure.

11. The overspends identified against existing BCF schemes will be addressed by the Council and CCG respectively through their respective year end outturn for 2015/16 (£195k to CCG and £179k to LBH).

Digital Roadmap

12. The Board agreed at its April meeting that a report on the draft digital roadmap across health and care partners in Hillingdon be brought to the June 2016 Board meeting for consideration. This section updates the Board on progress.

13. The Local Digital Roadmap (LDR) is intended to demonstrate how the ambition set out in the *Five Year Forward View* (NHSE Oct 2014) of being paperless at the point of care by 2020 will be delivered. The intention behind this is that professionals have access to digital information that will assist them to address the care needs of residents more effectively regardless of care setting. This plan directly contributes to the delivery of the *Technology and Innovation* theme of the STP and the *Developing the Digital Environment for the Future* enabling programme of the Hillingdon chapter.

14. As with the STP, the footprint of the LDR is North West London (NWL) and the robustness of the overall plan will determine access to the £1.8m (capital and revenue) that is being made available nationally over the next five years to support implementation and delivery. Confirmation is currently awaited from NHSE about the criteria for accessing for this funding.

15. The main focus of the guidance on the development of LDRs has been on interfaces between NHS providers, although engagement with local authorities is required. However, the approach being taken by NWL reflects an appreciation of the critical importance of the relationship between health and social care in delivering better care for residents and the role of technology in supporting this and the broader health and care system.

16. Work was undertaken by health providers across NWL in completing digital maturity self-assessments in Q3 and 4 2015/16 using NHSE provided templates. For Hillingdon, this included Hillingdon Hospital, CNWL and the Royal Brompton and Harefield. The Council was one of 79 local authorities across England to complete a self-assessment using a template developed jointly by the Local Government Association and NHSE. The results of these self-assessments will feed into the final submission which will coincide with the submission of the STP at the end of June 2016. Local involvement in the development of the roadmap has been coordinated through the multi-agency Pan-Hillingdon Joint IT Board, which includes representation from the Council's Corporate IT Team and also from Adult Social Care.

17. The main components of the LDR are:

- **Automate clinical workflows and records**: This is primarily focused on secondary care settings, e.g., Hillingdon Hospital, with the intention of removing the reliance on paper and supporting the transfer of care through interoperable IT systems.
- **Build a shared care record across all care settings**: This is intended to deliver the integration of health and care records required to support new models of care, including the transition away from hospital care to the community.
- **Extending patient records to patients and carers**: Enabling patients and carers to take an active role in their own health and providing them with the tools to manage their own health conditions.
- **Use of real-time data analytics to inform care decisions:** Supporting integrated health and social care through better use of data.

18. The key deliverables within the roadmap for 2016/17 and 2017/18 are shown in the Table 1 below.

Table 1: Digital Roadmap Deliverables 2016/17 and 2017/18	
2016/17	**2017/18**
• Improve access to Shared Care Records • Develop plans for digitally enabled self-care* • Develop plans for use of real time data in decision making	• Eradicate use of fax in care services • Deliver robust Shared Care Record that is highly utilised • Real time use of data used to inform patients

*For example, mobile apps that enable people to monitor their blood sugar level and/or blood pressure.

19. Next steps include clarification of the local resource requirements to deliver the digital roadmap and completion of NHSE provided submission templates.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

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

Consultation Carried Out or Required

21. The 2015/16 BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents. HCCG, Hillingdon Hospital and CNWL have been consulted in the drafting of this report.

22. A focus group of carers to test their experience of carers' assessments following the implementation of new responsibilities towards Carers under the Care Act was undertaken in January 2016. The focus group has resulted in a number of actions that have been reflected in the 2016/17 BCF plan and these include:

- Involving Carers in reviewing the assessment process with officers.
- Creating a help-sheet for use at the start of each carer's assessment that outlines the purpose of the assessment and what to expect from it.

Policy Overview Committee comments

23. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

24. Corporate Finance has reviewed this report, confirming the outturn position outlined above and noting the Council's share of the pressure on Community Equipment has been contained within wider Social Care budget provision.

Hillingdon Council Legal Comments

25. 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 CCG 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: June 2016	**Period covered:** Jan - March 2016 - Month 10 - 12
Core Group Sponsors: Caroline Morison/Tony Zaman /Paul Whaymand/Jonathan Tymms/ Kevin Byrne	
Finance Leads: Paul Whaymand/Jonathan Tymms	

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

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

A. Financials

Key components of BCF Pooled Fund 2015/16 (Revenue Funding unless classified as Capital)	**Approved Pooled Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective	10,032	10,227	195	139	56

performance fund)					
Care Act New Burdens Funding	838	1,372	534	432	102
LBH - Protecting Social Care Funding	4,712	4,357	-355	(315)	-40
LBH - Protecting Social Care Capital Funding	2,349	2,349	0	(17)	17
BCF Programme management	60	60	0	0	0
Overall BCF Total funding	**17,991**	**18,365**	**374**	**239**	**135**

B. Plan Delivery Headlines

1. 1 This report includes the financial outturn position on each scheme within the BCF for 2015/16. The reported financial position at 31st March 2016 was an overspend of £374k against the budget of £17,991k. The overspends identified against existing BCF schemes have been addressed by the Council and CCG respectively through their respective financial revenue outturns for 2015/16 (£195k to CCG and £179k to LBH)

1.2 In 2015/16 there were 10,406 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling of 10,620. This means that there were 5% (599) fewer admissions than in the 2014/15, a better performance than the 3.5% (388) 2015/16 plan target.

1.3 There were 763 falls-related emergency admissions during 2015/16; the ceiling was 761. The 2014/15 outturn was 871.

1.4 Delayed transfers of care - There were 4,196 delayed days during 2015/16 against a ceiling of 4,790. The overall performance for the year was therefore better than projected.

1.5 There were 145 permanent admissions of older people to care homes in 2015/16 against a ceiling of 150, which means that performance was slightly better than projected.

1.6 Performance against the target for people aged 65 and over still at home 91 days after discharge from hospital to reablement confirms that the improvement on the 2014/15 results previously reported but the 2015/16 target was not achieved.

C. Outcomes for Residents: Performance Metrics

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

1.8 **Emergency admissions target (known as non-elective admissions)** - There were 2,612 emergency admissions in Q4, which was slightly above the ceiling of 2,524 for the quarter, although the total outturn for 2015/16 of 10,406 was 5% below the planned ceiling of 10,620.

1.9 **Delayed transfers of care (DTOCS) -** There were 1,287 delayed days during Q4, which was below the ceiling of 1,414. The total performance for Q1 to Q4 was 4,196 delayed days against a ceiling of 4,790. Table 2 provides a breakdown of the delayed days during Q4.

Table 2: Q4 and 2015/16 Total DTOC Breakdown				
	Q4 DTOC Breakdown			2015/16 DTOC Breakdown
Delay Source	**Acute**	**Non-acute**	**Total**	**Total**
NHS	416	336	752	2,590
Social Care	197	192	389	1,293
Both NHS & Social Care	0	146	146	313
Total	**613**	**674**	**1,287**	**4,196**

1.10 52% (674) of the delayed days concerned people with mental health needs and of these 85% (579) arose due to difficulties in securing suitable placements, which includes beds in secure rehabilitation units and care home settings for people with challenging behaviours. Nearly 94% (631) of the non-acute delayed days concerned patients in beds provided by CNWL.

1.11 Nearly 66% (407) of the 613 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.

1.12 Table 3 shoes the breakdown of delayed days by NHS trust for Q4 and for the whole of 2015/16.

Table 3: Distribution of Delayed Days by NHS Trust		
Trust	**Number of Delayed Days (Q4)**	**Number of Delayed Days (2015/16)**
Bucks Healthcare	31	31
Chelsea & Westminster	0	14
CNWL	631	2,577
Hillingdon Hospitals	378	735
Imperial College, London	5	92
North West London (Northwick Park and Ealing)	212	585
Oxford University Trust	0	12
Peterborough & Stamford	0	12
Royal Brompton and Harefield	22	52
West Hertfordshire	8	8
West London Mental Health Trust	0	70
West Middlesex University	0	8
TOTAL	**1,287**	**4,196**

1.13 **Care home admission target** - Period 1st April 2015 to 31st March 2016 there were 145 permanent placements against a target for 2015/16 of 150. There were 23 new permanent placements during Q4.

1.14 It should be noted that the new permanent admissions figure in paragraph X.X above is a gross figure that does not reflect the fact that there were 170 people who were in permanent care home placements also left during the period 1st April 2015 to 31st March 2016. As a result, at the end of Q4 there were 420 older people permanently living in care homes (202 in residential care and 218 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q4 and were, therefore, counted as older people.

1.15 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - The target for 2015/16 is 95.4%, which was determined by NHSE. The national sample period for this metric was Q3 and during this period there were 200 discharges and 88% (175) were still at home 91 days after discharge. This is a slight improvement on 2014/15 when the outturn was 85%. Of the 25 not still at home after 91 days 10 passed away. Improvements to the collection of management information in 2016/17 will allow for easy, electronic identification of other reasons for people ceasing to at home after 91 days, e.g. readmission to hospital either for a reason related to the original cause of admission or another reason.

1.16 **User experience metric: Ease with which service users have been able to fund information and advice about services/benefits** - This metric was tested through the national Adult Social Care Survey undertaken in Q4 2015/16. The target for 2015/16 was 73% and a higher performance of 75% was achieved.

1.17 **User experience metric: Quality of life** - This metric was also tested through the national Adult Social Care Survey undertaken in Q4 which asks questions about such things as control over daily life, personal care, food and nutrition, social contact and dignity. The maximum score for this metric is 24 and this is related to weightings attached to set response options available within the survey. Hillingdon's 2015/16 target was 19 but the result was 18.4, which is an improvement on the 2014/15 performance of 18.1. They key questions that resulted in a lower score concerned access to social contact, control over daily life and being meaningfully occupied.

1.18 Addressing social isolation is included within scheme 1 of the 2016/17 Better Care Fund Plan and is also one of the priorities of the Sustainability and Transformation Plan.

2. Scheme Delivery

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

Scheme 1 Funding	Approved Budget	Spend Outturn	Variance at Outturn	Variance as at Month 9	Movement from Month 9
	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non elective performance fund)	180	180	0	0	0
Total Scheme 1	**180**	**180**	**0**	**0**	**0**

Scheme Financials

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

2.2 Outturn expenditure is in line with CCG profiled budget which relates to value contracts (Age UK's Falls Prevention Service and GP networks) that are evenly phased (divided equally over 12 months).

Scheme Delivery

2.3 A review was undertaken of the falls prevention classes being delivered by the Council's Wellbeing Service under its exercise and referral programme. This twelve week programme is intended to support people who are at risk of falls and those who have fallen to regain their confidence by assisting them to be as active as their ability allows and therefore reduce the likelihood of further falls occurring. As a result of the review a further three classes a week will be delivered from Q1 2016/17.

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

Scheme 2: Better care at the end of life					
Scheme 2 Funding	**Approved Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non- elective performance fund)	100	100	0	0	0
Total Scheme 2	**100**	**100**	**0**	**0**	**0**

Scheme Financials

2.4 Outturn expenditure is in line with CCG profiled budget which relates to a value contract that is evenly phased (divided equally over 12 months).

Scheme Delivery

2.5 A proposal has been developed by the CCG on behalf of the multi-agency End of Life Forum for consideration by Social Finance, a not for profit organisation that partners with the government, the social sector and the financial community to find better ways of tackling social problems in the UK and beyond. If the proposal is successful it could see the injection of an additional £1.5m over three years to produce a more integrated model of end of life care for Hillingdon residents. The results of the submission are likely to be known in August 2016.

2.6 An end of life dashboard was developed that includes the following information:

- Place of death, e.g. home, hospital, care home, hospice.
- Death by gender and age.

- Deaths added to Coordinate My Care (CMC) against total predicted deaths.
- Deaths in hospital against total predicted deaths.
- Deaths in preferred place of death.
- Source of additions to CMC, e.g. GP, acute trust, community health trust, hospice.

2.7 This data will be reported to the End of Life Forum at its bi-monthly meetings in order to give a clearer picture of the management of the end of life experience for Hillingdon's residents.

Coordinate My Care Explained

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

Risks/Issues

2.8 This scheme has been RAG rated as amber because action plan tasks such agreeing the end of life pathway and identification of the key issues for carers of people at end of life were not completed. These will roll forward into the 2016/17 plan.

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

Scheme 3 Funding	**Approved Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	4,099	4,151	52	39	13
LBH - Protecting Social Care funding	686	687	1	(18)	19
Total Scheme 3	**4,785**	**4838**	**53**	**21**	**32**

Scheme Financials

2.9 The Council's share of the funding of this scheme relates mainly to the cost of placements in particular bed based intermediate care and Hospital Social Workers. The outturn position shows an overspend for Intermediate of £5k and an underspend of £4k for Hospital Social Workers.

2.10 The HHCCG spend is showing an increase cost of pressure relieving mattresses partly due to transition costs to a new supplier and increased demand for mattresses.

Scheme Delivery

2.11 During Q4 the Reablement Team received 132 referrals and of these 51 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 45 people were discharged from Reablement with no on-going social care needs. For the whole of 2015/16 the Reablement Team received 1,023 referrals and 67% (685) of these were from hospitals (primarily Hillingdon Hospitals) and the remaining 33% (338) were from the community. Of the 1,023 referrals 918 people went on to receive reablement. 71% (272) of the people entering reablement who had not previously been accessing a long-term social care service left the service not requiring a long-term service, which is an improvement on the 2014/15 outturn figure of 69.1%. This is a significant achievement when considering that the practice during 2015/16 has been for there to be an open pathway into reablement regardless of the extent to which a person is able to respond to being reabled.

2.12 In Q4 the Rapid Response Team received 926 referrals, 54% (499) of which came from Hillingdon Hospital, 22% (202) from GPs, 10% (93) from community services such as District Nursing and the remaining 14% (132) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 499 referrals received from Hillingdon Hospital, 381 (76%) were discharged with Rapid Response input, 112 (22%) following assessment were not medically cleared for discharge and 10 (2%) were either out of area or inappropriate referrals. All 427 people referred from the community source received input from the Rapid Response Team. Table 4 below summarises the source of referrals to the Rapid Response Service during 2015/16.

Table 4: Source of Referrals to Rapid Response Service 2015/16

TOTAL REFERRALS	Hospital	Community Services*	GP	Others**
3,710	2,154	450	653	515

*Includes District Nursing, Community Rehab
**Includes London Ambulance Service, care homes and self-referrals.

Scheme Risks/Issues

2.13 This scheme is RAG rated amber because of the overspends identified. However, the overspends are addressed by contingencies within both the Council and HCCG.

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

Scheme 4 Funding	Approved Budget	Spend Outturn	Variance at Outturn	Variance as at Month 9	`Movement from Month 9
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care funding	753	729	(24)	(18)	(6)
Total Scheme 4	**753**	**729**	**(24)**	**(18)**	**(6)**

Scheme Financials

2.14 This budget is split between Reablement (£653.6k) and Mental Health Teams (£100k). The outturn for reablement is an underspend of £21k and for the Mental Health Team, the underspend is £3k, an improvement of £6k since month 9.

Scheme Delivery

2.15 **Appendix 3** shows the comparison in discharge activity at Hillingdon Hospital in Q1 - 4 2014/15 and 2015/16. This shows similar discharge patterns for people who have been admitted for planned (also known as elective) procedures and unplanned (or non-elective) procedures in both years, e.g. an uneven distribution across the week. However, there has been an increase in discharges on Saturdays for people admitted for planned procedures.

2.16 **Appendix 3A** shows the comparison of discharges taking place before midday in Q1 - 4 2014/15 and 2015/16. Discharges taking place before midday provides a better experience of the discharge process for residents as they are able to return home earlier in the day. Appendix 3A shows that performance improved during 2015/16.

2.17 The care home specification for the dynamic purchasing system (DPS) tender being undertaken by the West London Alliance of eight London boroughs, including Hillingdon, was amended to include a requirement that providers have available suitably qualified staff to enable them to undertaken assessments seven days a week. This will enable them to accept referrals seven days a week where a care home setting is the most appropriate way of addressing a resident's assessed need. The DPS will enable the Council to comply with procurement regulations for the spot purchase of care home beds.

Scheme Risks/Issues

2.18 Options to support social care staff being permanently based on the Hillingdon Hospital site are still being investigated. It has not been possible to resolve this issue in 2015/16 and a resolution will be sought in 2016/17.

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

Scheme 5 Funding	**Approved Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	5,605	5,748	143	100	43
LBH - Protecting Social Care funding	3,272	2,941	(331)	(279)	(52)
Total Scheme 5	**8,877**	**8,689**	**(188)**	**(179)**	**(9)**

Scheme Financials

2.19 This scheme also includes the expenditure on HCCG's full community equipment budget and £125k of the Council's share of the spend. The balance of the Council's community equipment budget (£486k) is currently held outside of the BCF section 75.

2.20 The key LBH variance for the scheme relates to a forecast underspend on the TeleCareLine service of £293k including the impact of the Council switching the funding source of Telecare equipment expenditure from revenue to capital to utilise the annual Social Care Capital Grant to fund this expenditure going forward.

Scheme Delivery

2.21 In Q4 2015/16 24 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 43% of the grants provided. 55% (31) of the people receiving DFG's were owner occupiers, 36% (20) were housing association tenants, and 9% (5) were private tenants. The total DFG spend on older people (aged 60 and over) during Q4 2015/16 was £167K, which represented 36% of the total spend during the quarter (£461k).

Scheme Risks/Issues

2.22 This scheme is identified as amber because of the identified overspend against community equipment.

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

Scheme 6 Funding	**Approved Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**`Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	48	48	0	0	0
Total Scheme 6	**48**	**48**	**0**	**0**	**0**

Scheme Financials

2.23 Outturn expenditure is in line with planned activity

Scheme Delivery

2.24 There is no update on this scheme for Q4 2015/16.

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

Scheme 7 Funding	**Approved Budget**	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
Care Act New Burdens Funding	838	1,372	534	432	102
Total Scheme 7	**838**	**1,372**	**534**	**432**	**102**

Scheme Financials

2.25 The outturn expenditure on delivering the responsibilities under the Care Act is £1,372k, an overspend of £673k. This overspend arises from additional demand has been funded by other corporately held Council contingency funds.

Scheme Delivery

2.26 As at 31st March 2016, Connect to Support Hillingdon had 202 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. A range of activity to engage more local providers and voluntary organisations in the site started in February 2016.

2.27 From 1st April 2015 (launch) to 31st March 2016, over 5,500 individuals have accessed Connect to Support and completed 9,910 sessions reviewing the information & advice pages and/or details of available services and support. The online social care self- assessment went live on 1st July 2015 and in period to 31st March 2016 and 58 online assessments have been completed and 39 were by people completing it for themselves and 19 by carers or professionals completing on behalf of another person. 17 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. The carers' online assessment was launched in conjunction with the Council's Carer Awareness Campaign in early February 2016 and up to the end of March 2016 8 assessments were submitted.

2.28 Between 1st April 2015 and 31st March 2016 444 carers' assessments were completed. This is 29% (135) more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 192 carers have been provided with respite or other carer services in the period between 1st April 2015 and 31st March 2016 at a total cost of £907k.

2.29 A focus group of Carers to test their experience of carers' assessments following the implementation on new responsibilities towards Carers under the Care Act was undertaken in January 2016. This identified a number of issues including the following:

- Confusion about the purpose of the carer's assessment.
- Carers not being sure when they are receiving a carer's assessment, e.g. if it is joint with the person they care for or if they are being assessed in their own right.
- The length of the assessment form and wording of some of the questions making it difficult for Carers to follow.
- Accuracy of some assessments suggesting assessor training needs.
- Follow up after an assessment was inconsistent in terms of how quickly it happened and also the quality of the response.

2.30 All 8 Carers who attended the focus group are working with officers to deliver the actions arising from it that are reflected in the 2016/17 BCF plan, including:

- Involving Carers in reviewing the carer's assessment process.
- Creating a help-sheet for use by the Carer at the start of each carer's assessment that outlines its purpose and what to expect from it.

Financial Costs not in schemes					
	Approved Budget	**Spend Outturn**	**Variance at Outturn**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
Disabled Facilities Grant (Capital)	1,769	1,769	0	154	(154)
Social Care Grant (Capital)	580	580	0	(171)	171
BCF Programme Management	60	60	0	0	0
Total	**2,409**	**2,409**	**0**	**(17)**	**17**

2.31 The outturn for these BCF activities has come in on budget for the year 2015/16.

3. Key Risks or Issues

Joined-up IT Systems

3.1 Joined-up and inter-connected IT systems are key enablers to delivering integrated care and to limiting the number of occasions that residents have to repeat their story. The fact that health and care providers and Adult Social Care are all using different IT systems was always going to make this a challenging issue to resolve and this has proved to be the case during 2015/16. The causes can be summarised as follows:

- *Technological* - There is no one single IT system on the market that will satisfy the functionality requirements of all the partners involved in meeting the health and care needs of residents.

- *Information governance* - Ensuring that appropriate information sharing agreements are in place across all relevant partners is time consuming. It also requires some cultural change amongst organisations not accustomed to sharing resident/patient information and who are concerned about the potential risks involved.

- *Cost* - Charges being levied by system suppliers to link up with other IT systems across partners is prohibitively expensive.

3.2 To address the technological issue the Board was made aware during 2015/16 of the Care Information Exchange pilot intended to enable different IT systems to be linked up and the information from them accessed through a single web-based portal. It was initially intended that this would allow the medical care plan and the social care support plan to be viewed by care professionals as well as the resident/patient themselves. A combination of technical and information governance issues have prevented this pilot from starting during 2015/16. However, these issues have now been resolved and the pilot is due to start in Q1 2016/17.

3.3 The Board should be aware that Hillingdon is in a good place as all partners are committed to moving forward with IT interoperability and there has been progress in the electronic sharing of information between health partners. The development of the Digital Roadmap may also enable Hillingdon to access additional funds that could assist in addressing some of the cost issues arising from connecting up different IT systems.

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Better Care Fund

Period: 01/04/2015 to 31/03/2016
Month Number: 12

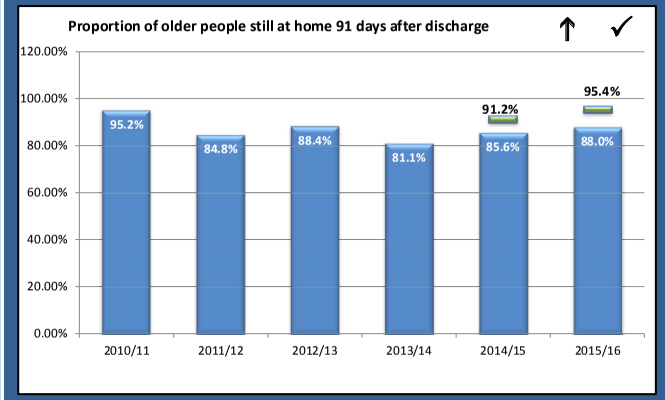
For further information please contact:
LBH Tony Zaman - 01895 250506 Gary Collier 01895 250730
CCG Ceri Jacob

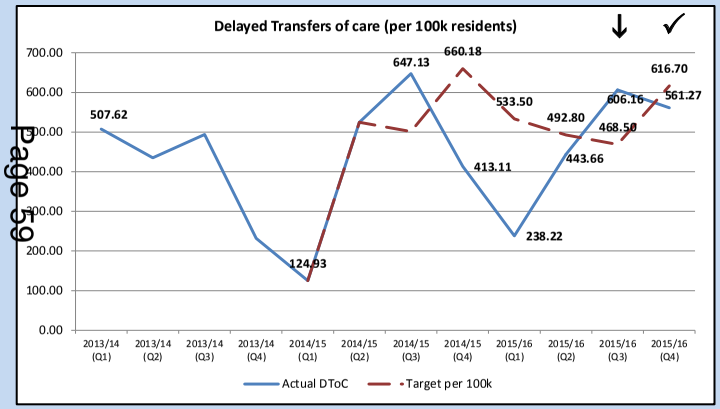
High Level Summary

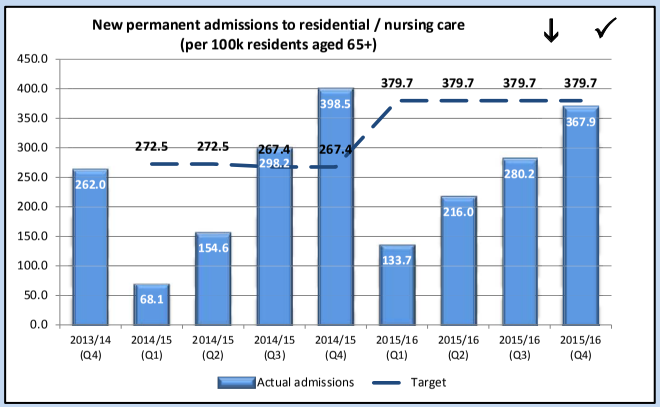
Non-Elective Admissions		Pay for performance period Q1 (Apr - Jun)	Q2 (Jul - Sept)	Q3 (Oct - Dec)	Q4 (Jan - Mar)
Non-elective admissions in to hospital (general & acute), 65+.	2014 Actual	2,818	2,756	2,815	2,616
	Req, Reduction for 2015	99	96	98	92
	Target for 2015	2,719	2,660	2,717	2,524
	Actual 2015	2,663	2,571	2,560	2,612
	Difference from Target	-56	-89	-157	+88
	Target	P4P annual change in admissions			-388
		P4P annual change in admissions (%)			-3.5%
		P4P annual saving			£578,598
	Projected (Based on available and target)	P4P annual change in admissions			599
		P4P annual change in admissions (%)			7.3%
		P4P annual saving			£0

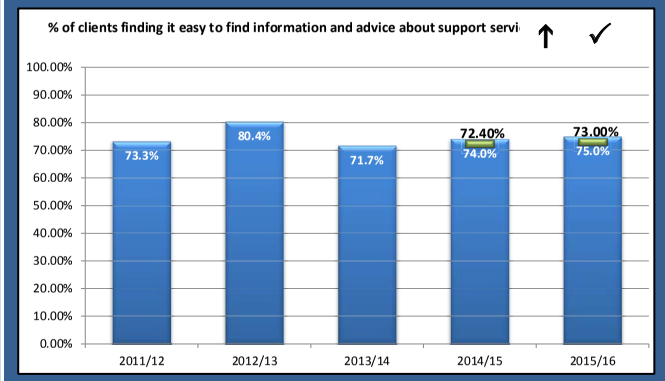
Key components of BCF funding 2015/16	Budget	Outturn	Variance
	£000's	£000's	£000's
HCCG Commissioned services funding (including non elective performance fund)	10,032	10,227	195
Care Act New Burdens Funding	838	1,372	534
LBH - Protecting Social Care Funding	4,712	4,357	- 355
LBH - Protecting Social Care Capital Funding	2,349	2,349	0
BCF Programme Management	60	60	0
Overall BCF Total funding	17,991	18,365	374

Annual Measures



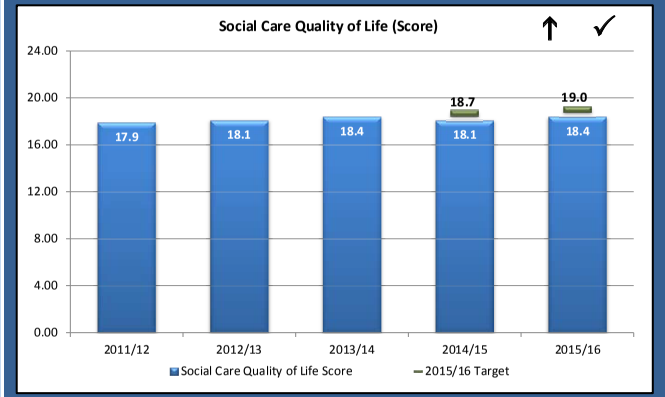






Delayed Transfers of Care (There is a 1 month time lag on the availability of the data)	To the end of period	Number (1/4ly)	Residents	Per 100k
	Baseline (2013/14)	3,666	219,259	1,672.0
	2014/15 (Q1)	278	222,521	124.9
	2014/15 (Q2)	1,168	222,521	524.9
	2014/15 (Q3)	1,440	222,521	647.1
	2014/15 (Q4)	933	225,846	413.1
	2014/15 (Full Year)	3,819	225,847	1,691.0
	2014/15 (Target)	4,053	225,847	1,794.6
	Variance from Target	-234	225,847	-103.6
	2015/16 (Q1)	538	225,846	238.2
	2015/16 (Q2)	1,002	225,846	443.7
	2015/16 (Q3)	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)	4,790	229,303	2,088.9
	Variance from Target	- 594	229,303	-259.0

Permanent admisisons to Residential / Nursing care (residents aged 65+)	To the end of period	Number (Cum)	Residents	Per 100k
	Baseline (2013/14)	100	36,655	272.8
	2014/15 (Q1)	26	38,169	68.1
	2014/15 (Q2)	56	38,169	146.7
	2014/15 (Q3)	116	38,169	303.9
	2014/15 (Q4)	155	38,895	398.5
	2014/15 (Target)	104	38,895	267.4
	Variance from Target	+51	38,895	131.1
	2015/16 (Q1)	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	367.9
	2015/16 (Target)	150	39,500	379.7
	Variance from Target	-5	39,500	-11.8



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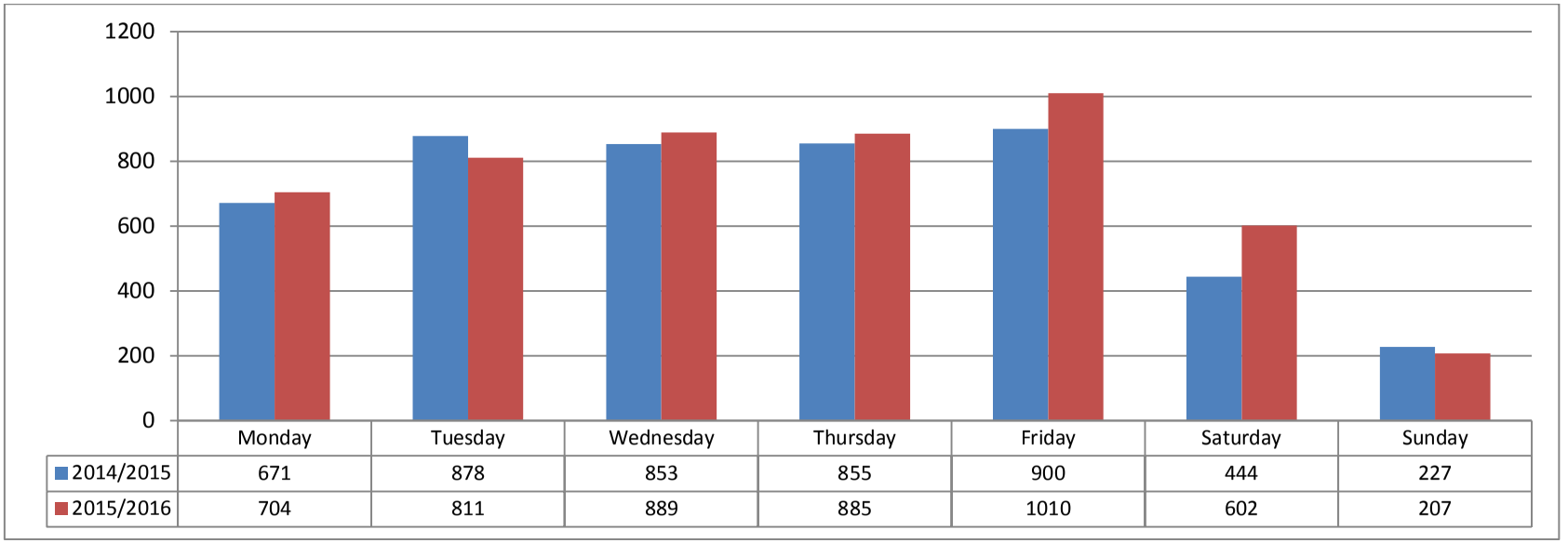
Appendix 3A

Hillingdon Hospital Patients Discharged before Midday 2014/15 and 2015/16 Compared



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015	671	878	853	855	900	444	227
2015/2016	704	811	889	885	1010	602	207

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HILLINGDON CCG UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Joan Veysey; Jonathan Tymms; Mark Eaton
Papers with report	Update Paper Executive Summary of 16/17 Commissioning Intentions

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • Commissioning Intentions 17/18 • Update on QIPP 16/17 • Finance • Planning Guidance -Operating Plan 16/17 • Children's services at Hillingdon Hospital • Update on ACP development • Annual Report and Accounts
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital (local services) strategy • Financial strategy • Shaping a Healthier Future
Financial Cost	Not applicable to this paper
Relevant Policy Overview & Scrutiny Committee	External Services
Ward(s) affected	All

2. RECOMMENDATION

The Health and Wellbeing Board to 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 Commissioning Intentions for 2017/18

The CCG is preparing to start drafting its 2017/18 Commissioning Intentions which will be published in October 2016. This will draw on feedback we have received during the year through our engagement work and feedback from our partners from across health and social care.

This year we will be focusing on a smaller number of 'Transformation Themes' such as the transformation of Older Peoples' Services. This will include emergency and non-emergency care, mental health and end of life services as well as continuing to look at how we work with social care for the benefit of residents. This approach reflects the increasingly complex and interconnected nature of health and social care provision.

Building on our engagement work for the Sustainability and Transformation Plan (STP) we will be holding another public event on 13 July to discuss our plans with the public and seek feedback from them on our priorities and how we can continue to deliver our efficiency and quality targets during the coming year. The developing Commissioning Intentions will also return to the Health and Wellbeing Board for review prior to publication and following further engagement with partners including LBH.

3.2 QIPP (Quality, Innovation, Productivity, Prevention)

During 2015/16 a Net QIPP saving of £7.033m was delivered against the QIPP target agreed in the CCG Operating Plan which was set at £5.523m (variance of positive £1.51m). The CCG also set an internal target of £7.746m and therefore underperformed against this target by £713k. This is largely attributable to performance of our CATs and community services (in particular pain, dermatology and cardiology) which we have addressed through our schemes for 2016/17 detailed below.

The 2016/17 Net QIPP saving target is £8.645m and this has been agreed with NHS England.

Highlights of some of the major initiatives that will deliver this saving are identified below:

- **CATS (Community Assessment & Treatment Services) –** For 2016/17 we have agreed with The Hillingdon Hospitals NHS Foundation Trust (THH) that we will enhance the specification that will see more work undertaken in a community setting at a lower tariff. We are also seeking to introduce new CATS for Gastroenterology and Neurology services during 2016/17. This involves making the patient journey smoother, by ensuring appropriate treatments and tests are carried out in primary care prior to referral to the hospital, avoiding unnecessary hospital visits.

- **Community Services (Pain & Dermatology) –** The Dermatology Community Service is now the single point of referral for GPs for all non-2 Week Wait referrals related to Dermatology and represents a better value service for non-urgent appointments. The service is providing patients with clinics in five locations spread across the Borough, improving access for patients and bringing care closer to home for them.

- From July, we will have a new Pain Service mobilised that will provide support to the many patients suffering with chronic pain who previously only had recourse to a spinal injection. The new pain service is likely to operate from at least 3 locations with one in each of the three localities across the Borough.

- **Ambulatory Activity & Intermediate Care –** We have agreed an increased number of patients who can be treated appropriately and safely without being admitted following a presentation at A&E. We are also seeking to secure a tariff reduction for both the new Clinical Decision-making Unit Beds/Chairs and also the Paediatric Short Stay Unit where medical staff can observe patients to ensure they are improving rather than admitting them, thereby also releasing savings. We are investing in additional Care of the Elderly Consultant support to both help patients remain in their normal care setting and also to avoid being admitted if they do arrive at A&E wherever it is in the patient's interests and is safe to do so.

- **Community Contract QIPP –** We have secured a 3 year contract with CNWL which will realise a total of £1.25m of QIPP for the CCG over the 3 years (£356k in 2016/17). Building on good working relationships with CNWL, this gives us both additional continuity and certainty over a 3 year period, allowing us to work with them to genuinely redesign and improve services.

- **End of Life Transformation –** We are seeking to transform services for people in the last phase of life, possibly using funding from Social Finance, through better integration of services including a single point of referral for patients, their families and clinicians including nursing cover 24/7 for patients where needed. This workstream aligns with BCF 'scheme 2 – better care for people at the end of their life', and will ensure that more patients die in their preferred place of death and experience more coordinated care.

- **Primary Care –** The majority of Primary Care Contracts (PCCs) for 2016/17 include an element of QIPP and this will be managed via the Primary Care Support Team (PCST) that replaced the PCI programme.

- **Long Term Conditions (LTCs) & Prevention –** Work undertaken by Libera Partners for the CCG has identified a number of schemes associated with LTCs that need to be worked up, including focusing on managing patients with LTCs more holistically rather than taking a condition specific approach. This work will reinforce the focus on proactive and preventative care undertaken as part of our integration work and will support the eventual roll out of new models of care beyond the Over 65 population.

- **Empowered Patient Programme –** The EPP delivered significant improvements to the quality of lives for patients living with LTCs during 2015/16 and we need to build on this and expand the range of conditions supported.

Further schemes are being worked up as 'stretch' on our target and also in preparation for the 2017/18 Commissioning Intentions referred to above that will be published in October 2016.

3.3 Financial Position

In order to comply with NHS England business rules, the CCG is required to make an annual surplus (excess of allocation over spend) and hold contingency. In 2015/16, the CCG completed the financial year reporting an in-year surplus of £7,525k, which comprises a £6,455k surplus at year end on programme budgets and a £1,070k surplus on running cost budgets.

The surplus of £7,525m is £43k higher than the CCG's control total of £7.482m and £4.043m higher than the CCG's original financial plan. The additional surplus will be carried forward into 2016/17.

At month 12, the CCG reported an underlying surplus of £2m. The difference between this and the reported in-year surplus of £7.5m is accounted for by a combination of one-off factors, e.g., additional in-year allocations, slippage on investment plans (including the underspend on enhanced primary care services), balance sheet gains from 2014/15 and other non-recurrent underspends.

The turnaround in the CCG's financial position from a historic underlying deficit to an underlying surplus at the end of 2015/16 is largely due to higher growth in its resource allocation (the CCG received a 7.6% increase in 2015/16).

By the end of 2015/16, the CCG's distance from its funding target has reduced to 4% under target (from 9% under at the start of 2014/15).

The full budget report is available at http://www.hillingdonccg.nhs.uk/publications2.

3.4 HCCG Operating Plan 16/17

The CCG submitted its 2016/2017 operating plan to NHS England at the end of May. We are awaiting formal confirmation of assurance. However, early indications are that it has been received positively and is one of the few in London to be fully compliant with NHS England requirements.

3.5 Update on Transition of Children's Services

The Shaping a Healthier Future programme, led by local clinicians, proposed changes to services in North West London that would transform and improve the quality of care and services for the local population. Proposals for new models of care included reconfiguring the way in which children's in-patient care is delivered in North West London.

These changes will consolidate children's inpatient services from six sites to five sites in North West London resulting in the closure of children's in-patient services at Ealing Hospital and the re-distribution of Ealing's children inpatient and Accident and Emergency activity to the major hospital sites in North West London. This includes the introduction of new short stay Paediatric Assessment Units at the major acute hospitals. Agreement to proceed with the transition of children's services on 30 June 2016 was taken on 18 May 2016.

The programme of work to ensure a safe transition of children's services has been subject to robust assurance processes which include approval to the transfer by Hillingdon Hospitals NHS Foundation Trust at their trust board in April 2016, and assurance by HCCG Governing Body members following discussion on the proposed model of care, activity flows and developments with staffing prior to the decision.

What changes will happen?

The Accident and Emergency department at Hillingdon is being rebuilt and enlarged and will open in July 2016. This will include the development of a Paediatric Assessment Unit. Paediatric Assessment Units, staffed by specialist children's doctors, are being introduced at the major hospitals across North West London. There is currently a high proportion of children who are admitted to wards in North West London because they have been assessed in Accident and Emergency but cannot be discharged home as they require further observation and/or assessment. The paediatric assessment unit will provide a more effective clinical service for children who require a period of observation and assessment and ensure children do not stay in hospital longer than they need to. In September 2016, the Hillingdon Hospital will also open an additional 4 children's inpatient beds.

Initial modelling of expected patient flows indicated that between 18-23% of children who currently receive Accident and Emergency and inpatient care at Ealing will attend Hillingdon Hospital. This equated to approximately 1,400 children a year attending Hillingdon Accident and Emergency with around 230 children a year being seen in the new Paediatric Assessment Unit and 325 a year being admitted to an inpatient bed. Revised projections based on the growth in Ealing activity to date indicate that the number of attendances may be closer to 1,800. A significant proportion of these will be for UCC (or 'Type 3') activity which can still be managed at Ealing. We are putting measures in place to monitor and manage the impact of the change including weekly activity monitoring and monthly quality reports focussed on paediatric flows. The Hillingdon Hospital Trust has confirmed that the investment in clinical models, staffing and physical environment will enable them to manage this level of activity effectively.

A detailed communications strategy and accompanying implementation plan are in place to accompany the transition and this includes active communication with GPs and residents of Hillingdon Borough.

3.6 Accountable Care Partnership (ACP) Development

The Hillingdon vision for Accountable Care is that, by 1 April 2017, Hillingdon will have a formally constituted ACP Joint Alliance, comprising four partners (H4All, the Hillingdon GP Network, CNWL and THH) ready to receive an outcome based capitated contract from the CCG for delivering integrated care for people over 65 years. The aim is to develop this Alliance to become an organisation that can deliver Hillingdon health and care services for agreed populations through a fully capitated budget.

What will this mean for the people of Hillingdon?

- A primary care focused model of care, where care is joined up to meet peoples' health and care needs jointly, delivered at locality level and better supporting GPs to care for their local populations.

- More use of third sector social support- an emphasis on prevention of ill health and self care- keeping older people independent, fit and healthy for longer.

- Delivery of outcomes that people tell us matter to them; better quality of coordinated care plans and delivery, keeping people in their own homes longer.

- Value for money and productivity – providers working together, utilising the resources and people we have to greater effect, efficiency, less duplication and separate business cases. Doing more, better and for less.

- Reductions in pressure on the acute hospitals with lower unplanned attendances and admissions and shorter stays when admission is needed.

- Hillingdon recognised as a great place to receive care.

There is a considerable work plan to be undertaken in the next 9 months for both the CCG and partner providers to deliver an outcome based contract and an ACP that delivers this vision. This includes design and agreement of an ACP contract to provide integrated health services for the over 65s from April 2017. Financial modelling needs to show how the changes will deliver financial viability both for the four partners and for the CCG. In order for the CCG to have confidence to contract with a new vehicle, from 1 April 2016, a fully-ready shadow contract arrangement should be in place by 1 October 2016, and provider due diligence process completed.

Development of whole systems integrated care is a key element of Hillingdon CCG plans to deliver the Five Year Forward View, to commission high quality care to improve health outcomes for Hillingdon patients and to set the scene for how services will be reshaped by 2017 -2020. HCCG is committed to testing new care models and commissioning these via an ACP from April 2017, subject to an appropriate due diligence process. This aligns with our local STP and Local Service (Out of hospital) plan to enable high quality care and a sustainable health and care economy.

3.7 Annual Report and Accounts

The CCG Annual Report and Accounts have been formally signed off by external auditors who are assured that they:

- give a true and fair view of the financial position of NHS Hillingdon Clinical Commissioning Group as at 31 March 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Direction issued thereunder.

They are available to view at:
http://www.hillingdonccg.nhs.uk/publications2?media_item=7276&media_type=10#file-viewer

3.8 Chief Operating Officer

Caroline Morison has joined the CCG as Chief Operating Officer following Ceri Jacobs moving on to a new role at NHS England. Caroline has previously worked within the NWL Collaboration of CCGs and at Tower Hamlets CCG and PCT.

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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Executive Summary of Hillingdon CCG's 16/17 Commissioning Intentions

Introduction

The CCG is required to produce its Commissioning Intentions in the October of each year to give providers six months' notice of any forthcoming changes. The document sets out the local context (growth, demand changes, funding etc) and then how the CCG will respond to these changes.

This short document summarises the 16/17 Commissioning Intentions that were published in October 2015.

Contract Line and Provider	What Will Change	Why Will It Change	Benefits To People in Hillingdon	Measuring Success	Timeline
The Hillingdon Hospital (THH) and Central & North West London (CNWL) NHS Foundation Trusts	Improve access to and usage of Shared Care Record across all providers.	Current information flows introduce delays and potential gaps in records for patients.	Improved communication between people supporting their care.	Via Clinical Quality Groups (CQGs)	Throughout 16/17
THH, CNWL and Third Sector Partners Represented by Hillingdon for All	Development of an Accountable Care Partnership in Shadow Form.	The current system is unsustainable based on growth in demand and new models of delivery are needed.	New, more integrated services that reduce barriers, delays and costs.	Via Shadow Board & Governing Body	Shadow ACP Established by Dec 16
The CCG and London Borough of Hillingdon (LBH)	Deliver the agreed BCF and HWB Strategies and seek to integrate services across health and social care as appropriate.	The current Better Care Fund has increased in scope and scale in 16/17 which will assist in development of a more integrated services across health and social care.	A shift to planning for anticipated care needs rather than reactive provision of services, delivered in a way that is integrated and seamless from a service user point of view, in their usual place of residence.	BCF delivery group, Governing Body and HWBB.	Throughout 16/17
End of Life Services delivered predominantly THH, CNWL and Harlington Hospice	Improve integration of services for Patients and their families at End of Life.	Current service provision is fragmented and has identified gaps.	Improved care on a 24/7 basis for patients and their families at End of Life.	Via End of Life Forum	Strategy by Jul 16 but new system by Dec 16
Pain: Kent Community	Move more activity out of hospital focusing on	THH is constrained	Care provided more	Via CCG	Some in

Services Dermatology: Concordia Others: THH	Pain and Dermatology with new providers and working with THH on other services.	physically and cannot continue to absorb the rate of growth in demand.	locally, more flexibly and more cost effectively.	Governing Body & THH CQG	place already but rest by Mar 17

Community Services delivered by CNWL	Transformation of Community Services to set this up for the future including defining new service specifications and restructuring services to better match demand.	Current services are poorly defined and also services are not well integrated between Community Services and other providers.	Reduced overall cost for better defined services that are more effectively integrated.	Via CNWL Clinical Quality Group (CQG)	Already achieved.
Supported by General Practices across Hillingdon and via the Community Contract with CNWL	Reducing the demand for hospital based unplanned care needs through better provision in the community and helping patients to self-manage elements of their care.	There is significant growth in demand that is creating an unsustainable pressure on the Emergency Department.	Better outcomes through better planning of care and improved performance within the Emergency Department when a need does arise.	Via System Resilience Group (SRG)	Various actions are already in place. Rest to be delivered by Mar 17
111 Service and GP Out of Hours delivered currently by Care UK but may change. The Urgent Care Centre delivered by Greenbrook	Create an integrated unplanned care system for Hillingdon including procuring a new 111 Service, a locally focused Clinical Advice Service and improved support from our Urgent Care Centre.	The current system is fragmentary and has gaps in provision.	Improved coordination of care for unplanned care needs.	Via System Resilience Group (SRG)	Various actions are already in place. Rest to be delivered by Mar 17
Integrated support from THH and both the Community & Mental Health Services commissioned from CNWL	Develop a new model of support to patients in care homes and similar settings to ensure consistent medical and clinical support is available and that patients with End of Life and/or Mental Health needs are better supported.	Currently care home support is fragmentary and complex and there is a need to improve care (and access) for patients at End of Life or with Mental Health needs.	Improved coordination of care for people in care homes and similar settings including for those at End of Life or with Mental Health needs.	Via Older Peoples' Delivery Group	New model to be developed by Oct 16 and then implemented

Predominantly THH and the Community Services commissioned from CNWL with some input from Royal Brompton and Harefield (RBH) NHS Foundation Trust	Improving outcomes for patients with Long Term Conditions through developing Integrated Services across health providers and also focusing on supporting patients with multiple Long Term Conditions more effectively.	Patients with Long Term Conditions represent the largest expenditure for healthcare and by focusing on improving management of this cohort the NHS can make savings whilst also improving outcomes.	Improved long term outcomes with more independence through people better able to manage elements of their own care.	Via Long Term Conditions Transformation Group	Integrated models in place. Further work required in 16/17
The Mental Health Services commissioned from CNWL	Improve support provided to people with a Mental Health need including providing a single point of access for advice and help and also improving support for their unplanned care needs.	There is a need to reduce the complexity of current provision as well as improve productivity within existing services.	Better, more coordinated care for people living with Mental Health needs.	Via Mental Health Transformation Group	Single Point of Access in place. Rest to follow in 16/17
The Mental Health Services Commissioned from CNWL	Implement the Dementia Action Plan and improve access to Talking Therapies as part of the overall coordinated approach to improve support to people with mental health needs.	There is a strong link between physical and mental health so improved support for people with mental health needs will also contribute to improved physical health.	Improved access to early support and high quality care, and a workforce that is trained to support people with mental needs.	Via Mental Health Transformation Group	Actions are already in place which will be further progressed in 16/17
Across all providers and service lines	Ensure we have both the workforce and a financially sustainable system for delivering the short and longer term objectives.	The workforce needs will change as demand moves into new settings. NHS income is not growing as fast as demand.	An NHS that continues to be able to deliver necessary planned and unplanned care services.	Via Governing Body	QIPP Plans in place for 16/17. Five years plans being worked up

HEALTHWATCH HILLINGDON UPDATE

Relevant Board Member(s)	Stephen Otter, Acting Chair
Organisation	Healthwatch Hillingdon
Report author	Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon
Papers with report	None.

HEADLINE INFORMATION

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

RECOMMENDATION

That the Health and Wellbeing Board notes the report received.

1. INFORMATION

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

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

2. SUMMARY

2.1. The body of this report to the London Borough of Hillingdon's Health and Wellbeing Board summarises the outcomes, impacts and progress made by Healthwatch Hillingdon in the delivery of its functions and activities for this period. It should be noted that a comprehensive report is presented by the Chief Executive Officer to the Directors/Trustees at the Healthwatch Hillingdon Board meetings and is available to view on our website: (http://healthwatchhillingdon.org.uk/index.php/publications).

3. 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 fourth quarter.

Recognition

One area which has been particularly pleasing for the whole Healthwatch team has been the recognition we have received from Healthwatch England (HWE) for our delivery of the Local Healthwatch model.

This quarter they recommended us to Dulwich Hamlets Council and the Department of Health as a best practice model and we hosted both organisations on extended visits to look at our governance and operation.

As a result of our work on Children and Young People's Mental Health and Emotional Wellbeing and our presentations to The Mental Health Foundation and The Change Programme National Conference, we have now been invited to participate in a strategic programme with NHS England.

Safeguarding Boards

Another positive outcome for us during the quarter was the successful advertising campaign we carried out, on behalf of both the Children's and Adults' Safeguarding Boards, for new lay members. There had previously been some difficulty in attracting applicants but, following our involvement, the good response led to the Council being able to recruit to all available positions.

3.1 Information, Advice and Support

During this quarter, we recorded a total of 227 enquiries relevant to our function. 170 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	50	29
Refer to a voluntary sector service	27	16
Requesting information /advice	44	26
Requesting help / assistance	3	2
General enquiry	46	27

Table A

Table B shows the source of these enquiries.

Source of enquires	Number	% of source
Shopper	91	62
Engagement and outreach activity	0	0
Promotional / Advert	3	2
Voluntary or health sector referral	21	14
Website	5	3
Known/existing clients	20	14
Other / Unknown	7	5

Table B

For the 4th quarter, direct access via the shop was recorded as the main point of contact for our information, advice and support service. It was, however, pleasing to note that returning customers and referrals were jointly the source of over 25% of enquiries for the 2nd month running.

By the nature of the service, reasons for contact remain widely spread across health and social care. We have seen a slight rise in referrals to Hillingdon Carers this quarter, having identified a number of residents who care full time. The most popular leaflet taken by residents from the shop has been for CNWL NHS Talking Therapies, which provides an adult counselling service that people can self-refer.

We have also been working very closely with an NHS organisation this quarter to sensitively safeguard a very vulnerable person with complex needs who visited the shop on a number of occasions. There have been a number of learning points reflected upon during this time and some new staff processes introduced.

Concerns and complaints

Healthwatch Hillingdon recorded 57 experiences, concerns and complaints in this quarter. The areas by organisational function are broken down in Table C.

Concern/complaint Category	Number	% of recorded
CCG	2	4
Primary care: GP	10	18
Primary care: Pharmacy	0	0
Primary care: Optician	1	2
Primary care: Dental	4	7
Hospitals	21	37
Mental Health Services	4	7
Community Health	2	4
Social Care	4	7
Care Agency	2	4
Care Home	1	2
Patient Transport	3	5
Community Wheel Chair Service	3	5

Table C

Referring to Advocacy

7 referrals were made during this period to support residents. 3 to VoiceAbility (independent NHS Complaints Advocacy), 2 to CNWL Perinatal Service and 1 each to LBH Safeguarding and NHS England.

Overview

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

Dental

Although low in number, complaints have been similar about dental services. Patients reported they have been advised the dentist no longer carries out NHS services and that all future treatment would have to be private. We have escalated each case to NHS England. This has resulted in some dentists reinstating NHS charging. Evidence collated by Healthwatch England would suggest this practice is a trend which has been increasing nationally over the last year.

GP Registration

As we have previously reported, we have been working to assist residents who are refused registration at a GP practice. We have had a number of people contact us from the Heathrow Villages who have been having particular problems registering because they fall outside of any GP catchment area. Each resident has been registered and we are working very closely with Hillingdon CCG and NHS England to find a permanent solution.

Hospital Discharge

We were informed of 2 separate cases where residents were discharged without appropriate care being in place at home. Hillingdon Hospital has been made aware of these incidents. Discharge was also raised by residents at the recent Older People's Forum when it was asked whether something could be done about the elderly being discharged to an empty house, without the heating being on and essentials such as bread and milk not being available. This is certainly an area we will be investigating as part of our hospital discharge project.

Outpatient appointments for people with sensory impairment

We had a case of a man who was sent an appointment for an eye clinic who came into Healthwatch very stressed because he wanted to change the appointment but did not know how to. Both he and his wife were deaf and mute and did not have another person who could help them. The only method shown on the hospital letter was the telephone. We contacted outpatient appointments on the gentleman’s behalf and rescheduled the appointment.

With new Accessibility Standards in health and social care to become law in July 2016, we have raised a number of points with the hospital around sensory impairment and are working with them to look at communication, BSL interpretation, the appointment making processes and how a person’s hospital record can be flagged to ensure that methods of communication can be appropriate to their disability.

In addition to this, we have liaised with the Council's Engagement Team to change the June Disability Forum to focus solely on accessibility. The Council will be informing delegates on how they are preparing for the changes and Hillingdon Hospital will be holding a workshop to give attendees the opportunity to influence how changes are implemented at the Trust.

3.2 Strategic Working

CCG Conflict of Interest Guidance

Over the past 12 months Healthwatch Hillingdon has been working closely with Healthwatch England and NHS England to review the CCG Conflict of Interest Guidance. This work has now led to the publication of strengthened national guidance on the Conflict of Interest by NHS England. We are pleased with the content of the guidance and that many of our concerns were appropriately addressed. With our presence on the Hillingdon CCG's Governing Body and Conflict of Interest Panels, we will continue to evaluate the implementation and effectiveness of the new guidance as primary care co-commissioning is further developed.

NHS Continuing Health Care (CHC)

Healthwatch Hillingdon continues to support a number of individuals to navigate the CHC process, which is both complex and lengthy. As part of this work, we have highlighted the lack of independent advocacy support and accessible information for people to be able to make informed choices as they are assessed for CHC.

We are working with Healthwatch England and NHS England CHC National Lead on a strategy to develop a long term solution. Our involvement is ensuring that the needs and experience of people are central to the outcome.

We are also working closely with the Brent, Harrow and Hillingdon CCGs to explore how this national vision for independent CHC support can be developed locally. Until national guidance is produced, this is also likely to be a long term work-stream. However, we would like to see an interim solution put in place that benefits residents in the short term.

Shaping a Healthier Future Programme (SaHF)

Response to the recommendations we had made to the SaHF Clinical Board following the transfer of maternity services from Ealing have been positive. A commitment has been made to improve the consultant presence on maternity wards, to meet the Royal Colleges standards. This will result in helping to ensure that the clinical outcomes for mothers and new born babies will be improved for 29,000 mothers per year across NWL. Healthwatch Hillingdon will continue to monitor the delivery of these commitments.

3.3 Engagement Overview

As expected, with a new Volunteer and Outreach Officer, in post we saw a rise in engagement figures. In total, 354 people were directly engaged during this period. Indirect engagement remains strong. We recorded nearly a million hits to our website from over 150,000 visits by year end. Promotional materials are spread widely across the Borough and media publicity is high.

Events

15 engagement events were attended during the 4th quarter of the year. These events provided an opportunity to promote Healthwatch, network with external organisations and meet and engage with local residents.

As a result of participating in these events, 29 residents expressed an interest in volunteering with Healthwatch Hillingdon (of which 15 have been placed) and 2 local residents shared their experiences of using local NHS services.

Volunteers placed with Healthwatch are involved in a variety of areas of work including data entry, administration and assisting us with the distribution of our marketing materials to local GP surgeries, libraries and voluntary and community groups. With the assistance of our office based volunteers, we have now updated the experience database which previously had an entry backlog. Our volunteers are also helping to update the Health, Wellbeing and Social Care Directory on our website.

As part of our project work on maternity care and hospital discharge, we have recruited volunteers who will support our projects by gathering patient experiences at Children Centres and on the wards of Hillingdon Hospital.

Use of Media

The successful focus on volunteer recruitment has enabled us to look at the ways in which we raise awareness of Healthwatch Hillingdon and how we invite residents to inform us of their experiences of care.

The coordinated use of media has been one way in which we have been able to achieve this. During February, we had a number of articles published in the local paper on specific issues, asking residents to come forward with their experiences. We enhanced these with the publication of a number of corresponding infographics via social media and direct e-mailings. This led to receiving some very rich feedback, especially on women's experiences of fertility treatment.

4 PROJECT UPDATES

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

Healthwatch Hillingdon continues to monitor the delivery of the transformation plan through our seat on the Children and Young People's Emotional Health and Wellbeing Steering Group.

We acknowledge that progress on a number of initiatives has been made, but we are increasingly frustrated by the speed at which this progress is being achieved and find it disappointing that currently almost all of the work-streams within the plan are RAG rated as amber.

We understand the challenges involved and appreciate the efforts being taken to reduce the waiting lists in Tier 3 CAMHS, but until we see the implementation of initiatives to offer early help and prevention, system pressures will remain and those young people who do not meet Tier 3 thresholds will struggle to find support.

Following our presentation to the Change Programme National Conference on CAMHS, we met with NHS England's CYP Mental Health programme lead. Subsequently we have been invited to sit alongside them on the CYP Mental Health Coalition Steering Group. This Group has been tasked with monitoring the implementation of Transformation Plans across England and we have been asked to report directly to NHS England and Healthwatch England on the progress of the Hillingdon Transformation Plan at the meeting being held in July 2016.

4.2 Maternity Care and Hospital Discharge

In March, we decided to recruit dedicated coordinators to lead on, and deliver each project. The Healthwatch Board agreed to a new approach and we advertised for expressions of interest from skilled freelance people to deliver time limited projects during 2016-17. We received a number of applicants and, after a difficult selection process, have appointed 2 people who both started their roles in the first quarter of 2016-17.

Volunteers have been recruited to help carry out the engagement programs for both projects. The first training sessions have been completed and individual's DBS Checks are being undertaken, prior to the role out of the programs.

5 ENTER AND VIEW ACTIVITY

Hillingdon Hospitals Trust

During January and March, 9 Assessors committed to over 200 hours of volunteering to complete 7 full day assessments at both Hillingdon and Mount Vernon hospitals.

6 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 2015/16

*Targets are not set for these KPIs as measure is determined by reactive factors.

KPI no.	Description	Q1		Q2		Q3		Q4		Accumulative Totals		Impact this quarter	Relevant Strategic Priority
		Target	Actual	Target	Actual	Target	Actual	**Target**	**Actual**	Target	Actual		
1	Hours contributed by volunteers	525	**550**	525	**625**	525	**462**	525	729	2100	**2366**	•	SP4
2	People directly engaged	300	**354**	300	**333**	300	**250**	300	354	1200	**1291**	•	SP1, SP4
3	New enquiries from the public	125	**232**	125	**402**	125	**241**	125	227	500	**1102**	•	SP1, SP5
Page 82	Referrals to complaints or advocacy services	N/A*	**9**	N/A*	**14**	N/A*	**7**	N/A*	7	N/A*	**37**	•	SP5
5	Commissioner / Provider meetings	50	**49**	50	**60**	50	**54**	50	72	200	**235**	•	SP3, SP4, SP5, SP7
6	Consumer group meetings	25	**22**	25	**25**	25	**10**	25	22	100	**79**	•	SP1, SP7
7	Statutory reviews of service providers	N/A*	**0**	N/A*	**0**	N/A*	**1**	N/A*	0	N/A*	**1**	•	SP5, SP4
8	Non-statutory reviews of service providers	N/A*	**7**	N/A*	**4**	N/A*	**3**	N/A*	7	N/A*	**14**	•	SP5, SP4

UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS

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

1. HEADLINE INFORMATION

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

2. RECOMMENDATION

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

3. UPDATE ON PROGRESS

1. Since the last report to the Health and Wellbeing Board in April 2016, a further meeting has been held between officers from NHS Property Services (NHSPS), Hillingdon Clinical Commissioning Group (CCG) and the Council's Director of Public Health and S106 Monitoring and Implementation officer, to discuss progress and to work to bring schemes forward.

Proposed new health centre in the Yiewsley and West Drayton area

2. NHSPS is continuing to search for a suitable property/site to provide a new health centre in the Yiewsley/West Drayton area. This has so far proved difficult. Kirk House in High Street, Yiewsley, which is currently leased by NHSPS, remains the only site option currently being explored, but this will be subject to negotiation with the land owners. NHSPS has so far

"earmarked" a total of £360,715 from four separate s106 health contributions currently held by the Council towards a suitable scheme.

3. In the meantime, the CCG is proposing some short term investment in the existing Yiewsley Health Centre in order to help deal with the immediate pressures on primary health care and GP services in the area (see paragraph 11). In the longer term, however, the existing building has limited capacity to expand and, going forward, is no longer fit for purpose.

Clinical improvements to Otterfield Health Centre,Yiewsley

4. In addition to the short term investment proposed at the existing Yiewsley Health Centre, Hillingdon CCG has also requested that funds from the s106 contribution held at H/23/209K (£37,723) are allocated and released towards a scheme to provide clinical improvements at the Otterfield Medical Centre in Otterfield Road Yiewsley (Cabinet Member Approval received 15/02/2016). This investment will help ensure that the premises continue to be fit for purpose and can deliver healthcare services until a new health centre can be provided.

5. The scheme to upgrade GP consulting rooms and refurbish the existing facilities to modern standards where practicable is currently under way. It is anticipated that the works will be completed in July 2016.

Proposed new health hub for Uxbridge (St Andrews Park)

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

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

8. In April, NHSPS advised that VSM has now come forward with a proposal for a 1,500 sqm standalone health centre, with associated parking in the North West of the site. Discussions are continuing with VSM with regard to possible heads of terms and lease options, should the proposal go ahead.

9. Proposals for a future health facility on the St Andrews site have not been discussed with the Council's Planning Service. Any proposals will be subject to obtaining the relevant planning permissions, consistent with the outline planning permission for the wider Town Centre extension.

S106 health contributions held by the Council

10. Appendix 1 attached to this report details all of the s106 health facilities contributions held by the Council as at 31 March 2016. The Council has not received any new contributions since the last report to the Board in April. As at 31 March 2016, the Council holds a total of £1,111,371 towards the provision of health care facilities in the Borough.

11. Officers are continuing to work with the CCG and NHSPS to allocate health contributions towards eligible schemes. In April, Hillingdon CCG advised that NHS England had set aside a budget of £250 million in 2016/17 to be invested in primary care premises across the country. However, HCCG has received only five nominations which meet the criteria for practices to receive funding and from these, two are now recommended to go forward to bid for funding. These are:
    - Yiewsley Health Centre - Bid for short term investment to enable the practice to cope with increased demand for GP services in the area.
    - Investment in a new GP premises to replace the former surgery on Shakespeare Avenue, Hayes. The GP Practice has been housed in temporary accommodation in Elers Road since the building was sold in June 2015.

12. It was the intention of HCCG to work with practices that were unable to secure funding from NHS England but had a viable scheme to identify proposals which might be eligible to benefit from s106 funding. However, due to the lack of appropriate schemes coming forward, HCCG has decided that, in order to obtain best value from the s106 funds available, the funds should be earmarked towards the delivery of a "hub" service to support a wide range of primary care and out of hospital services across the Borough.

13. The new "hub" service is proposed to be delivered as part of Hillingdon CCG Estates Strategy and to support Hillingdon CCG Strategic Service Delivery Plan (SSDP). The Plan intends to provide a health hub service of between 2,700 and 3,600 m2 split over three locations across the Borough as follows:
    - Uxbridge /West Drayton hub (St Andrews Park)
    - North hub (Mount Vernon site)
    - Hayes & Harlington (Hesa Medical Centre)

14. The CCG is therefore proposing to "earmark" the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. A total of £533k from s106 contributions has already been allocated and spent towards the provision of the Hesa health hub which was completed in November 2015. A request to allocate individual contributions towards further schemes will be submitted as each scheme is brought forward.

15. All of the s106 health contributions which had a spend deadline in 2015/16 have now been allocated and spent towards eligible schemes. There are currently no deadlines for spending s106 health contributions in 2016/17.

FINANCIAL IMPLICATIONS

As at 31 March 2016, there is £2,148,819 of Social Services, Housing, Health and Wellbeing s106 contributions available, of which £1,037,449 has been identified as a contribution for affordable housing. The remaining £1,111,370 is available to be utilised towards the provision of facilities for health and £511,218 of these contributions have no time limits attached to them.

The Yiewsley Health Centre development project is not going ahead and £360,715 was previously formally allocated to this scheme. These contributions have no time limits and therefore can be re-allocated to suitable schemes as and when they are identified.

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

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

LEGAL IMPLICATIONS

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

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

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

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

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

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

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

BACKGROUND PAPERS

None.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
H/8/186D *54	Yiewsley	92-105, High St., Yiewsley 59189/APP/2005/3476	15,549.05	0.00	2015 (Apr)	Spent: HESA	Contribution received towards the cost of providing additional primary heath facilities in the Borough. Funds not spent by 20/04/2015 must be returned. Funds originally earmarked towards the fitting out costs associated with the new Yiewsley Health centre development. Due to spend deadline, funds have been allocated towards the HESA scheme (25/2/2015). Funds transferred to NHS PS 29/04/2015. Scheme complete.
H/9/184C *55	West Ruislip	31-46, Pembroke Rd, Ruislip 59816/APP/2006/2896	21,699.53	0.00	2015 (Jul)	Spent: Uxbridge H C	Contribution received towards primary health care facilities within a 3 mile radius of the development. Funds not spent by 01/07/2015 must be returned to the developer. £8,560 allocated towards additional consulting room at King Edwards Medical Centre (Cabinet Member Decision 6/12/2013). Funds transferred to NHS PS Feb 14. Remaining balance of £13,115 allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Balance transferred to HCCG July 2015.
H/10/190D *56	Uxbridge	Armstrong House & The Pavilions. 43742/APP/2006/252	43,395.00	0.00	2015 (Jul)	Spent: Uxbridge H C	Contribution received towards primary health care facilities in the borough. Funds must be spent within 7 years of receipt. Funds not spent by 29/7/2015 are to be returned to the developer. Funds allocated towards capacity improvements at Uxbridge Health Centre Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.
H/11/195B *57	Ruislip	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494	3,156.00	3,156.00	No time limits	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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
H/21/237D *73	Eastcote	Bishop Ramsey School (lower site), Eastcote Road, Ruislip. 19731/APP/2006/1442	22,455.88	0.00	2016 (Feb)	Spent: Uxbridge H C	Contribution received towards the provision of primary health care facilities in the Uxbridge area. Funds to be spent within 5 years of receipt (February 2016). Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.
H/22/239E *74	Eastcote	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 & 10622/APP/2009/2504	7,363.00	7,363.00	No time limits	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/23/209K *75	Yiewsley	Tesco, Trout Road,Yiewsley. 60929/APP/2007/3744	37,723.04	0.00	2016 (Mar)	Spent: Otterfield HC	Contribution received towards the provision of local health service infrastructure in the Yiewsley, West Drayton, Cowley area. Funds to be used by the Council by March 2016. **Funds allocated towards clinical improvements at Otterfield Medical Centre (Cabinet Member Decision 15/02/2016). Funds transferred to HCCG (Feb 2016).**
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
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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
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.
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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
H/40/306D *98	Hillingdon East	Fmr Knights of Hillingdon, Uxbridge 15407/APP/2009/1838	4,645.60	0.00	No time limits	Spent: Uxbridge H C	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.
H/41/309D *99	Uxbridge South	Fmr Dagenham Motors, junction of St Johns Rd & Cowley Mill Rd, Uxbridge 188/APP/2008/3309	12,030.11	0.00	2020 (Oct)	Spent: Uxbridge H C	Funds received towards the provision of healthcare services in LBH as necessitated by the development. Funds allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). Funds transferred to HCCG July 2015.
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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
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.**
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

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid May 2016)
			AS AT 31/03/16	AS AT 31/03/16			
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).
		TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES	**1,514,925.37**	**1,111,370.59**			

HILLINGDON SUSTAINABILITY AND TRANSFORMATION PLAN

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Chief Operating Officer, HCCG, Mark Eaton, AD Transformation HCCG
Papers with report	Appendix 1. : DRAFT Hillingdon Chapter for STP Appendix 2 : Summary Overview of the local Five Year Financial Challenge

1. HEADLINE INFORMATION

Summary	The Health and Wellbeing Board ,on 12 April 2016, received an update from Hillingdon Clinical Commissioning Group (HCCG) on the development of the proposed Sustainability and Transformation Plans (STPs). A base case submission was submitted to NHS based on an agreed North West London (NWL) footprint on 18 April. Feedback offered across partners pointed to a need for greater input at borough level and the opportunity to ensure democratic input and local governance of the process. In line with that feedback, partners have been working on developing the NWL themes against a number of existing and other local plans to ensure they work for Hillingdon. The first take on those local priorities is included in Appendix 1 and set out in this report for Board comment. The Hillingdon STP will then form part of the overall NWL submission to NHS England, with a draft sought on 30 June.
Contribution to plans and strategies	The Hillingdon STP will provide a new strategic direction for the next five years and it therefore includes a number of existing plans and will influence the development of others, in particular : • HCCG Commissioning Intentions 2016/17 and for 2017/18. • The Better Care Fund delivery in 2016/17 and future plans. • HCCG Five Year Financial Strategy. • Local Services Strategy (previously the Out of Hospital Strategy). • Hillingdon's Health and Wellbeing Strategy. • The North West London overarching STP.
Financial Cost	There are no costs directly applicable to this plan - a successful plan should, however, facilitate access to new transformation funding for the local heath economy.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **endorses the draft Local Hillingdon STP chapter for submission to NHS England on 30 June as part of the North West London STP, noting the work undertaken to date to develop local priorities including the input of partners, residents and clinicians.**
2. **provides any commentary and feedback as to how the Board wishes to see the plan develop to further reflect partner priorities in Hillingdon.**

3. INFORMATION

Supporting Information

1. The Hillingdon 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) with the ambition to deliver a genuine place based plan for the residents of Hillingdon.

2. Advice from NHS England (NHSE) is that the 30 June date is for a checkpoint submission, where the STP is an interim document without the need for any formal commitment. Further submissions will be made over the following months tightening up the specification. Oversight of the further development of the Hillingdon STP will be through the Hillingdon Transformation Board and the Health and Wellbeing Board (HWBB), which is required to approve the final STP plan later in the year.

3. The Hillingdon STP forms part of wider North West London (NWL) STP based on a foot print across 8 boroughs. The process for completing the NWL STP is set by NHSE and Appendix 1 complies with the template required so far.

4. The key part of this slide pack sets out the Hillingdon transformation priorities (see slides 15 to 20 in Appendix 1). In essence, these state where we want to get to, how we will get there and how we know we have been successful. It is against these that the Board is especially invited to comment. In summary these are:
   - Transforming Care for Older People
   - New Primary Care Model of Care
   - Integrating Services for People at the End of their Life
   - Integrated Support for People with Long Term Condition (LTCs)
   - Effective Support for People with a Mental Health need and those with Learning Disabilities
   - Integrated Care for Children & Young People
   - Integration across Urgent & Emergency Care Services
   - Prevention of Disease & Ill-Health
   - Transformation in Local Services

5. These are supported by six cross-cutting enabling programmes (slides 16-18) which are summarised below:
   - Developing the Digital Environment for the Future
   - Creating the Workforce for the Future
   - Delivery of our Statutory Targets

- Medicines Optimisation
- Redefining the Provider Market
- Delivering the RightCare Programme

6. The proposed Hillingdon Transformation Programmes above have been reviewed against the nine NWL STP priorities in the base case (April) submission and again against the Local Services Plan (formerly the Out of Hospital Strategy) initiatives. They align well and are mutually reinforcing. Slide 15 maps this out.

7. This Hillingdon Plan will be aggregated up to a North West London Strategic Partnership Group level for submission to NHS England. We await the NWL draft which is expected on, or shortly after, 10 June 2016.

8. The NHS Shared Planning Guidance notes that decisions on the allocation of a related Sustainability and Transformation Fund (STF) are partly dependent on completion of comprehensive Sustainability and Transformation Plans and delivery against these plans in the coming years. However, further detail on this including the allocation mechanism is to be defined. Any STP Transformation Funding available for Hillingdon will be dependent on the NWL STP plan. The NWL plan could be expected to attract something in the region of an additional £148m from the STF, although it is unclear at this time how that funding will be apportioned across the 8 boroughs.

9. No assumptions have been made at this early stage as to what additional Transformation Fund investment could be available to support initiatives within the final Hillingdon STP plan.

Financial Implications

10. A draft HCCG 5 year financial plan is also attached as Appendix 2, which includes information on:
    - Allocation assumptions used for the STP planning
    - Five Year Financial Plan-Planning Assumptions
    - Overall 5 year financial gap 2016 – 2021
    - 5 Year Financial Plan-Expenditure Changes

11. The financial plan has made realistic planning assumptions around level of Demographic and Non-demographic growth. Over the 5 year period, Resource Growth for the CCG of £67.5m is offset by additional costs of £100.2m before QIPP (a recurrent gap of £32.7m by year 5). Hillingdon's 5 year plan is predicated on delivery of £42m of net savings.

12. The planning assumptions are aligned to developing investment plans in alternative pathways and other local services but no specific investment is included at this stage.

13. In addition, the plan will also need to reflect the financial challenges faced by the Local Authority, especially the need to protect services in social care and the social care funding gap. It should also to bring in the financial plans from NHS England commissioned services.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The Sustainability and Transformation Plan will support how Hillingdon will achieve the best possible outcomes for people in the next five years, through addressing the health and wellbeing gap and by closing the care and quality gap. This will be achieved by transforming how care is delivered in key priority areas identified.

Consultation Carried Out or Required

A Hillingdon STP public event was held on 18 May 2016 to explore what we are already doing and what else we need to do to develop Hillingdon's 9 local priorities over the next 2 -5 years. The outputs of this consultation have shaped the Hillingdon plan attached as Appendix 1.

Further consultation and Patient engagement will form part of the development of plans and service changes.

Policy Overview Committee comments

None at this stage.

5. BACKGROUND PAPERS

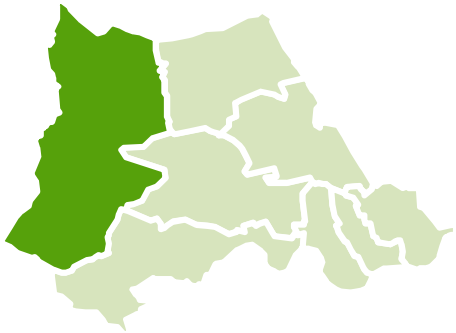
NIL.

Hillingdon Executive Summary

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

This is a working document and content is not final

The Local Picture in Hillingdon



The Sustainability and Transformation Plan (STP) sets out our shared plans for the next five years to 2020/21. The STP brings together providers and commissioners of care (both local government and NHS) to deliver a genuine place based plan for the borough.

309,300 People (16/17 Estimate)

£347.8m (16/17 CCG Allocation)

46 GP Practices and 4 GP Networks

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 actively work together across health and local authority services to deal with our shared responsibilities including around 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..

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
- 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 STP is founded on strong public and partner engagement which is also central to the development of the above plans and strategies. We are currently in the midst of an extended period of engagement on local the local Hillingdon STP and current content and thinking is subject to 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 in Hillingdon

The most likely growth assumptions over the next five years will see ~21% more activity being needed to be funded and to respond to this growth we will need to generate a total of **£42.5m of net savings** ('QIPP') to close the CCG's Financial Gap.

16/17	17/18	18/19	19/20	20/21
(£8,646)	(£9,137)	(£7,510)	(£8,435)	(£8,811)

In £000s

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.

Reduce Childhood Obesity

Levels of excess weight and obesity are a growing threat to population health. In 2012/13, over 21% of Reception year and 34.6% of year 6 children in Hillingdon were overweight or obese.

Reduce Smoking Prevalence

8% of mothers in Hillingdon smoke at the time of delivery, compared to 13% in England and 6% in London.

The estimated prevalence of smoking is 16.2% of the population aged over 18. This is lower than the England average of 18.4% and the London average of 17.3%.

Increase Physical Activity

The gap in male life expectancy between Eastcote and East Ruislip in the north of the borough and Botwell in the south of the borough is 8.5 years.

Help Improve Peoples Mental Health

During 2013/14, 3,035 referrals were made to Central North West London NHS Foundation Trust for Mental Health issues with 1,660 accepted into services.

In 2013/14, 1,150 people in Hillingdon were diagnosed with dementia according to the GP register

Reduce Social Isolation

2,397 residents aged over 65; 2,095 received community based packages of care (i.e. Day Care, Home Care, Meals on Wheels), 205 were in residential care homes and 190 were in nursing homes.

Support to Manage LTCs

Circulatory diseases and cancers are the two major causes of death in Hillingdon accounting for 31% and 29% of all deaths respectively.

Hypertensive disease is the most prevalent condition recorded on GP registers (13%), followed by obesity (9%) and diabetes (6%).

Reduce Alcohol Admissions

Approximately 50% of all Mental Health related non-elective admissions are related to alcohol or have alcohol as a contributory factor.

Make Every Contact Count

The 2013-14 Adult Social Care Survey found that 57.2% of users of care and support services said they were 'extremely satisfied' or 'very satisfied' with their care and support. This relates well to the London average of 60.2%.

The 2021 Vision for Care & Support in Hillingdon

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

Health & Wellbeing

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

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

Care & Quality

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

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

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

Finance & Efficiency

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

The 9 North West London Priorities & Our Local Plans

Our Plans For Delivering the 9 North West London (NWL) Priorities

The next slides outline the key local activities underway against each of the 9 North West London (NWL) priorities along with details of our plans specifically for 16/17.

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	Key 16/17 Plans
	• Focus on people at risk of falls. • Deliver the Care Home Initiative. • MH Wellbeing Programme. • Deliver the next phase of the Empowered Patient Programme. • Integrated community health and social care support. • Collectively provide an extensive range of health and social care services • New organisational form to support integration – initially around frail elderly- Hillingdon ACP (Accountable Care Partnerships) • BCF - evaluation of the effectiveness of interventions / schemes, and assessment of impact of benefit realisation on the NHS and LA • Support development and implementation of our local Prevention Strategy • Push forward with delivery of our Personal Health Budgets (280 by 2020/21) • Expand Medication Reviews in GP Practices with Pts • Re-Run the Parent Education Programme • Implement Remaining Cancer Stratified Pathways • Demography and reaching out to ethnic communities regarding management of self limiting conditions and wider engagement with health and social system • Redeveloping pathways for heart failure and diabetes in community services, in partnership with other local providers • Continued improvement of services and support designed to create a better quality of life for older people in Hillingdon.

2. Reduce social isolation	Key 16/17 Plans
	• Implementation of new Hillingdon Carers Strategy • Proactive early identification of those at risk of social isolation. • Early identification at GP practices and other primary care services • Review DTOC monitoring and Section 117 joint funding agreements to ensure patient progress seamlessly through the care pathway. • Work with NWL CCGs on the NHS 111 Procurement • Implement Patient Champions in Urgent Care Centre • Improve Access to Online Advice • Expand Community Outreach Programme • Take part in assessment of impact of 24/7 mental health Single Point of Access • Psychological support to people with long-term conditions • Better engagement with voluntary and community sector via Hillingdon4All • Embed frailty tool linked to risk stratification and care planning • Embedding health and being gateway and Patient Activation Measures, and primary care based care connection team as part of core primary care MOC • Embedding of memory clinics and links to primary care • Deliver of Future in Mind / Like Minded

Our Plans For Delivering the 9 North West London (NWL) Priorities

The next slides outline the key local activities underway against each of the 9 North West London (NWL) priorities along with details of our plans specifically for 16/17.

	Key 16/17 Plans
3. Improve children's mental and physical health and well-being	• Enhanced wellbeing programme including training programme for schools • Development of a Suicide Prevention Strategy • Roll out a service for young people with eating disorders and embed enhanced crisis and urgent out of hours service for CAMHS • Develop a 24/7 single point of access (SPA) for young people • Develop CYPIAPT service children & young people and their parents/carers • Improve Perinatal mental health service provision along with the development and implementation of perinatal strategy. • Delivering Improvements in Children's Asthma • Implement primary /community care based consultant led clinics • Joint physical activity strategy with LBH • Implement crucial care standards linked to resident consultant model of care • THH audit of Neo-natal births & babies screening programmes

	Key 16/17 Plans
4. Ensure people access the right care in the right place at the right time	• 8 month engagement plan with GP membership to co-design new wrap around contract • Development of primary care estates strategy • Implementation and full utilisation of IT and analytics technologies • THH working with GPs and community providers to pilot new models of acute care using a networked approach • Finalise Local Services Strategy for Hillingdon • THHFT Estates Master planning for new hospital build • Continuously develop outcomes achieved from anticipatory care planning and coordinated care • Develop new consultant led escalation model for enhanced care linked to optimised community intermediate care services • Development of capitated payment model linked to outcomes via shadow accountable care partnership • Development of a range of focused programmes targeting Care Homes population

	Key 16/17 Plans
5. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population	• Develop service to support people in Care Homes with Serious Mental Health needs. • Development of methodologies capturing incidence and prevalence rates of co-morbidity • Develop and implement Health Promotions Programme • Community Living Well service – WSIC • Development of all age Early Intervention Services • Review Community mental health team model and skill mix • Develop the implementation plan for the Like Minded Strategy • Embedding CRHT–rapid response • Take part in evaluation of 24/7 mental health SPA • Closer post discharge follow up • Implement new Community LD Service including ASD, ADHD packages of care to provide enhance health planning and community based services

Our Plans For Delivering the 9 North West London (NWL) Priorities

The next slides outline the key local activities underway against each of the 9 North West London (NWL) priorities along with details of our plans specifically for 16/17.

6. Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	Key 16/17 Plans
	• Develop integrated service model for Hillingdon. • Ensure that mental health support to people with LTCs and at End of Life is integral to the ACP programme • Publish and then implement new joint EoL Strategy (aligned to BCF). • Continue with EoL Forum and focus on expanding access to Coordinate My Care. • Increase access/use of Co-ordinate my Care within Primary Care • Primary Care incentivisation • Integration of Co-ordinate my Care and Primary Care clinical systems

7. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed	Key 16/17 Plans
	• Focus on the 4 Acute Standards and seek selective delivery of services in other settings as per the strategy. • Mainstreamed 7 day therapy in HICU (intermediate care) • Develop dashboard to monitor outcomes and activity over 7 days to be reviewed via SRG. • Developing work with Buckinghamshire University in partnership with THH, CNWL and others to produce the necessary workforce • Increase in student numbers (nursing) via Bucks New University with more community based pathways • CNWL leadership programme for all new Band 7 and 8a posts • Implement National Cancer Vanguard Programme in partnership with Royal Marsde

8. Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	Key 16/17 Plans
	• Deliver integrated services for Cardiology, Respiratory and Diabetic Services. • Development of Hillingdon ACP • Development of the strategy for adults and children with autism • Develop a programme to focus on management of co-morbidities and high users of services. • Capturing incidence and prevalence rates of co-morbidity which will support development of assertive treatment models, risk stratification, targeted service design and economic evaluation, which are not currently routinely collected • Enhancement of primary care systems through clinical decision support functionality to help GPs refer patients to the most appropriate pathway • Effective informatics and analytics systems to enable GP practices to work together to discuss and reduce variation

9. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	Key 16/17 Plans
	• Implementation of Cancer Improvement Strategy including an outcome based dashboard. • Cancer vanguard programme as a part of London Cancer Alliance • Develop outcome based dashboard for LTC Strategy and develop action plan. • Develop Pathways for Long Term Conditions • Implement Older People Integrated Care (including WSIC) • Implement Intermediate Care 'In Reach' from Community/Third Sector • Review of Homesafe Programme (Early Supported Discharge) and expand Integrated Discharge Planning • Development and implementation of the air quality management duties of the council.

What are we doing in 2017/18 against the 9 NWL priorities.

Against the 9 Priorities for North West London (NWL) we are currently planning on implementing the following for 17/18:

Prevention	1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves.	• xxx • xxx • xxx
	2. Reduce Social Isolation	• xxx • Xxx
	3. Improve children's mental and physical health and wellbeing	• xxx • xxx • xxx • xxx • xxx
Integration	4. Ensure people access the right support in the right place at the right time	• xxx • xxx • xxx • xxx • xxx • xxx
	5. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population.	• xxx • xxx • xxx
	6. Improve the overall quality of care for people in their last phase of life and enable them to die in their place of choice	• xxx • xxx
	7. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.	• xxx • Xxx
Technology &	8. Reduce unwarranted variation in the management of long term conditions	• xxx • xxx • xxx
	9. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	• xxx • xxx • xxx

What are we doing in 2018/19 against the 9 NWL priorities.

Against the 9 Priorities for North West London (NWL) we are currently planning on implementing the following for 18/19:

Prevention	1. Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves.	• xxx • xxx • xxx
	2. Reduce Social Isolation	• xxx • Xxx
	3. Improve children's mental and physical health and wellbeing	• xxx • xxx • xxx • xxx • xxx
Integration	4. Ensure people access the right support in the right place at the right time	• xxx • xxx • xxx • xxx • xxx • xxx
	5. Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population.	• xxx • xxx • xxx
	6. Improve the overall quality of care for people in their last phase of life and enable them to die in their place of choice	• xxx • xxx
	7. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed.	• xxx • Xxx
Technology &	8. Reduce unwarranted variation in the management of long term conditions	• xxx • xxx • xxx
	9. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	• xxx • xxx • xxx

Main Challenges Facing Delivery

The following is a summary of the challenges facing Hillingdon in the delivery of the 9 NWL STP Priorities.

Hillingdon Health & Wellbeing Gaps	• Local challenges • Xxx • Xxx • Xxx • Xxx • Xxx • Xxx • xxx
Hillingdon Care & Quality Gaps	• Xxx • Xxx • Xxx • Xxx • Xxx • Xxx • xxx
Hillingdon Finance & Efficiency Gaps	• Xxx • Xxx • Xxx • Xxx • xxx

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 information 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. Effective Support for People with a Mental Health need and those with Learning Disabilities	X	X	X		X		X			X	X	X			
6. Integrated Care for Children & Young People	X		X				X			X	X	X	X	X	X
7. Integration across Urgent & Emergency Care Services	X		X	X	X		X	X	X	X	X	X	X	X	X
8. Prevention of Disease & Ill-Health	X	X			X			X	X	X	X	X			
9. Transformation in Local Services	X			X			X			X	X	X	X	X	X

Our Transformation Programmes in Detail

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

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
4. Integrated Support for People with Long Term Condition (LTCs)	• Reducing prevalence growth for core LTCs and significant progress made in closing key prevalence gaps • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Significant progress in patient activation and the numbers of patients self-managing elements of their care • Increase access to and usage of Personal Health Budgets (PHBs)	• Long Term Conditions Strategy • Dementia Action Plan • Better Care Fund • Prevention Strategy • Cancer Improvement Plan	• XX% Reduction in prevalence growth • XX% Reduction in prevalence gap • XX% Reduction in unplanned events for people with LTCs • XX% Reduction in the costs associated with supporting people with LTCs • XX% Increase in people with an LTC who self-manage elements of their care • XX% Increase in people with an LTC who have an anticipatory care plan • Achieve 280 PHBs by 2020/21	• Refresh Long Term Conditions Strategy • Rollout Integrated Services for Respiratory, Cardiology (HF) and Diabetes and seek to expand to cover AF and Stroke • Rollout new Empowered Patient Programme • Develop plans around co-morbidity management and support to complex service users • Develop plans around management of MH related LTCs • Finalise rollout of Cancer Stratified Pathways	• Expand usage of Patient Activation Model (PAM) • Embed AF and Stroke Services • Improve support for patients with MH related LTCs • Rollout programme for complex users • Rollout actions from Cancer Improvement Plan • Proactive engagement with groups at high risk of developing LTCs • Expand access to and use of online advice • Implement MH support for patients with a physical LTC • Expand ICP to wider cohort
5. Effective Support for People with a Mental Health need and those with Learning Disabilities	• Reduction in inequalities associated with the care of people with one or more LD • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population	• Learning Disability Action Plan • Dementia Action Plan	• XX% Reduction in the mortality gap • XX% Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD • XX% Reduction in unplanned care needs arising for people with a known mental health condition	• Rollout of 24/7 SPA for people with MH needs • Develop all age early intervention service • Review Community MH Teams • Develop and rollout MH Rapid Response Service • Implement post discharge follow ups	• Expand ICP to include people with MH Conditions • Rollout new model of Community MH Support • Rollout Community LD Service
6. Integrated Care for Children & Young (CYP)	• Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people	• CAMHS Action Plan • Children's Transformation Plan	• XX% Reduction in the need for secondary care activity associated with CYP • XX% Reduction in unplanned care needs for CYP • XX% Reduction in the costs associated in managing CYP per capita	• Develop eating disorder support for CYP • Develop 24/7 SPA for CYP • Implement Consultant Led Acute Model with support to Primary Care & Community Services • Rollout Paediatric Asthma Programme	• Rollout SPA for CYP • Implement crisis and Out of Hours support for CAMHS • Rollout Joint Physical Activity strategy with LBH

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
7. Integration across Urgent & Emergency Care Services	• Coordination of support across all Urgent & Emergency Care services • Increase in the number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay	• Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care	• XX% Reduction in rate of growth for unplanned attendances at hospital • XX% Increase in people accessing non-hospital based support for their unplanned care needs • XX% Reduction in the costs per capita managing unplanned care needs • XX% Reduction in Zero-Length of Stay and Unplanned Admissions • XX% Reduction in Length of Stay following an unplanned admission	• Develop plans for new 111 Service and Primary Care Triage Service • Expand Urgent Care Centre capacity • Rollout Patient Education Programme • Expand Intermediate Care Services and integrate with Homesafe	• Rollout new 111 Service and Primary Care Triage Model • Expand access to and use of online advice • Embed Patient Education Programme
8. Prevention of Disease & Ill-Health	• Reduction in prevalence gap for key conditions • Reduction in the rate of growth in prevalence • Reduction in the variation in management of conditions	• Prevention Strategy	• XX% Reduction in the prevalence gap for key conditions • XX% Reduction in the rate of growth of prevalence • XX% Reduction in the management of people with LTCs	• Develop Prevention Strategy • Develop Suicide Prevention Strategy • Develop plans to close Hypertension and Diabetes Prevalence Gaps • Rollout Air Quality Review with Public Health	• Rollout of Prevention Strategy • Rollout of Proactive Case Finding in Primary Care • Work to close prevalence gaps
9. Transformation in Local Services	• Reduction in the rate of growth in hospital attendances and admissions for planned care needs • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support	• Local Services Strategy	• XX% Reduction in growth rate for planned attendances and admissions • XX% Increase in planned care provided in non-hospital based settings • XX% Reduction in the planned care costs per capita	• Deliver 4 Priority Acute Standards for 7 Days • Rollout 7 Day Services in HICU • Develop 7 Day Services Dashboard • Reestablish CATS and rollout to Gastro and Neuro Services • Rollout Pain and Dermatology Services to more patients	• Implement post discharge follow ups • Focus on additional 7 Day Standards

Our Enabling Programmes in Detail

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

Our Enabling Programmes in Detail

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

Draft 5 Year Financial Plan

Health & Wellbeing Board

June 2016

Hillingdon CCG

Neil Ferrelly, BHH CFO

Allocation Assumptions

- The figures used within the model are the published allocations produced by NHS England (3 year fixed and 2 years indicative).
- The allocation assumes the CCG population will increase from 304,533 in 2015/16 to 327,121 by 2020/21
- In total the CCG will receive recurrently an additional £67m over the next five years
- In 2016/17 the CCG allocation is 3.2% below the NHS E target allocation, by 2020/21 this will reduce to 2.9% below the target allocation
- These plans do not include Primary Care: Medical contracts, which are co-commissioned with NHS England

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Population projection	304,533	309,364	313,971	318,521	322,875	327,121
Population growth		1.60%	1.50%	1.40%	1.40%	1.40%
Programme Resource Allocation (£m)	324,462	343,399	352,389	362,744	373,919	391,863
Distance from Target (%)	-4.3%	-3.2%	-3.5%	-3.4%	-3.2%	-2.9%

Five Year Financial Plan-Planning Assumptions

- Tariff assumption for next 4 years assumed to be 0%
- Inflation uplifts have been assumed for Continuing Care and Prescribing
- The CCG has applied Demographic / Non-Demographic growth assumptions
- 5 Year Financial Plans have been developed to meet NHS Business Rules as follows:-

  1% in-year surplus

  0.5% Contingency

Planning Assumptions					
	16/17	17/18	18/19	19/20	20/21
Acute provider efficiency	-2.00%	-2.00%	-2.00%	-2.00%	-2.00%
Acute provider inflation	3.50%	2.00%	2.00%	2.00%	2.00%
Demographic Growth	1.60%	1.50%	1.40%	1.40%	1.40%
Acute Non-Demographic Growth (POD level)					
A&E attendances	2.50%	4.00%	4.00%	4.00%	4.00%
Non-Elective spells	3.00%	4.00%	4.00%	4.00%	4.00%
Ordinary Elective Spells	1.00%	2.00%	2.00%	2.00%	2.00%
Day Case elective spells	1.50%	2.00%	2.00%	2.00%	2.00%
First outpatient attendances	2.50%	3.00%	3.00%	3.00%	3.00%
All subsequent outpatient attendances	2.00%	2.00%	2.50%	2.50%	2.50%
Weighted Acute ND Growth	2.20%	2.61%	2.80%	2.78%	2.76%
Non-demographic Growth	16/17	17/18	18/19	19/20	20/21
Mental Health	3.00%	3.00%	3.00%	3.00%	3.00%
Community	1.50%	1.50%	1.50%	1.50%	1.50%
Continuing Care Services (All Care Groups)	4.40%	2.75%	2.75%	2.75%	2.75%
Local Authority / Joint Services	1.00%	2.75%	2.75%	2.75%	2.75%
Funded Nursing Care	1.00%	2.75%	2.75%	2.75%	2.75%
Prescribing	3.40%	2.50%	2.50%	2.50%	2.50%

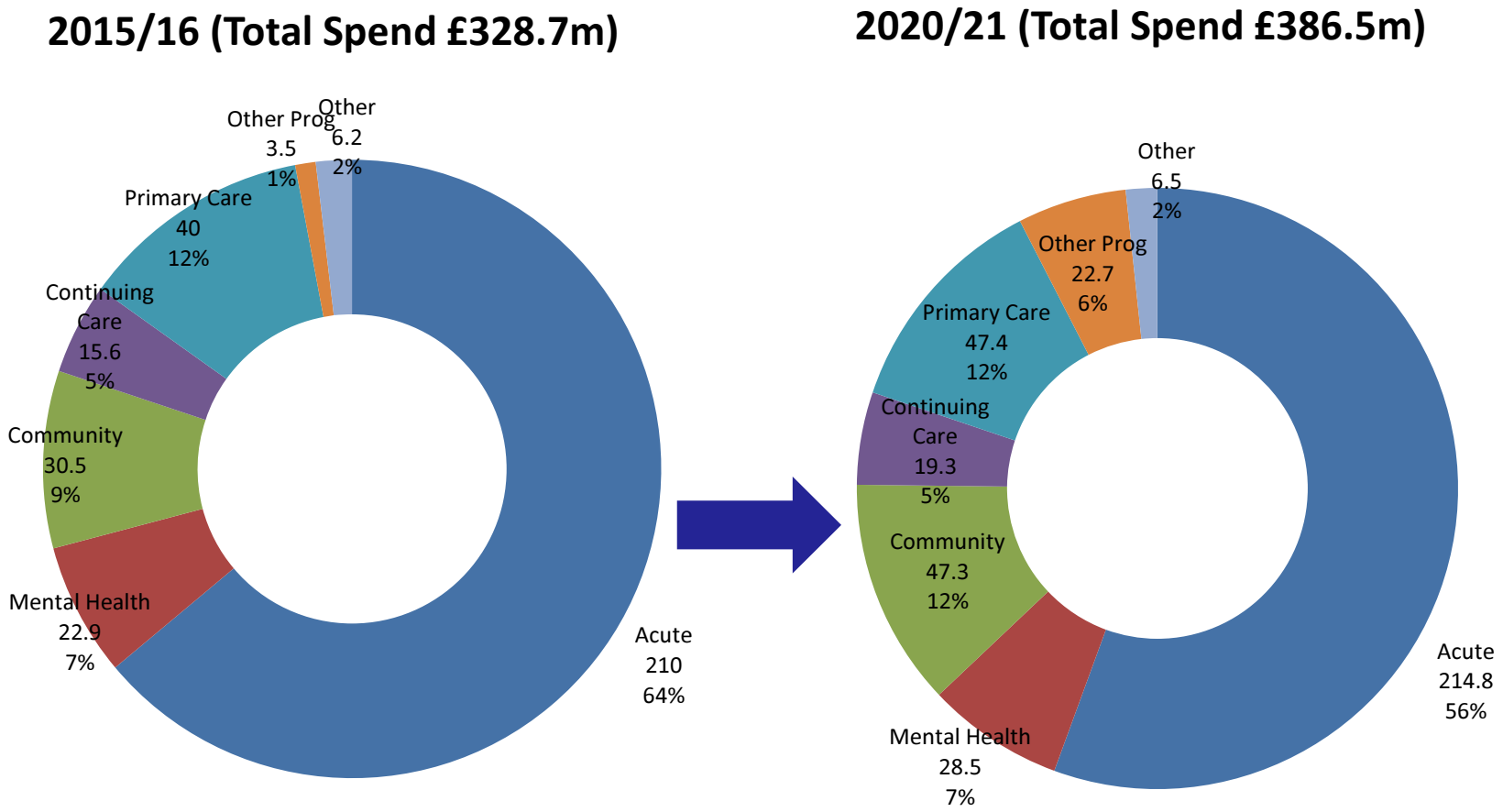
Overall Financial gap- 5 Years

- Over the 5 year period Resource Growth for the CCG of £67.5m is offset by additional costs of £100.2m before QIPP (a recurrent gap of £32.7m by year 5)

- The model has then projected QIPP savings of £42.5m (net) over the 5 year period based on combination of assessment of current opportunity and to provide sufficient headroom to meet NHS Business Rules and other NR requirements each year;

Financial summary (£K)	2016/17	2017/18	2018/19	2019/20	2020/21	TOTAL
Resource Increase	19,022	8,922	10,399	11,217	17,984	67,544
Inflation (Net)	(4,939)	(1,037)	(1,060)	(1,089)	(1,118)	(9,243)
Demographic growth	(5,266)	(4,696)	(4,762)	(4,859)	(4,618)	(24,201)
Non-demographic growth	(7,459)	(8,112)	(8,602)	(8,694)	(8,807)	(41,675)
Other cost pressures	(4,962)	(47)	(2,644)	(4,942)	(12,540)	(25,135)
Recurrent Gap	(3,604)	(4,971)	(6,669)	(8,367)	(9,099)	(32,711)
Net QIPP	8,646	9,137	7,510	8,435	8,811	42,539

5 Year Financial Plan-Expenditure Changes



- The CCG plans assume a higher level of investment in local community services with a lower level of growth in Acute costs
- These plans do not include Primary Care: Medical contracts, which are co-commissioned with NHS England

Next Steps

- The financial plan has made realistic planning assumptions around level of Demographic and Non-demographic growth
- Over the 5 year period Resource Growth for the CCG of £67.5m is offset by additional costs of £100.2m before QIPP (a recurrent gap of £32.7m by year 5)
- Hillingdon's 5 year plan is predicated on delivery of £42m of net savings
- The planning assumptions are aligned to developing investment plans in alternative pathways and other local services

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Elaine Woodward, HCCG
Papers with report	Appendix 1 - CAMHS Transformation Plan Appendix 2 - CAMHS LTP 2015/6 (31/3/16) Appendix 3 - CAMHS LTP Year 2 2016/17 – Draft Appendix 4 - Hillingdon pathway for Children & Young Peoples Emotional Health & Wellbeing

1. HEADLINE INFORMATION

Summary	This report provides the Board with the fourth and final update on the delivery of Hillingdon's 2015/16 CAMHS Transformation plan.
Contribution to plans and strategies	Hillingdon's Health and Wellbeing Strategy 5 year strategic plan Sustainably and Transformation Plan Hillingdon Joint Children and Young Persons Emotional Health and Wellbeing Transformation Plan
Financial Cost	NHS England identified additional funding of £524,623 for 2015/16 provided to HCCG from December 2015 on receipt of a Local Transformation Plan. The funding was for the development of a Community Eating Disorders Service (£149,760) and Service Transformation (£374,863). NHSE confirmed that the 2015/16 plan met the requirements to release the funding. From April 2016, CAMHS funding for the remaining 4 years will no longer be provided by NHSE, i.e., this is not new funding but part of CCG baselines (non-ring fenced). NHSE will continue to monitor the implementation of the LTP, which will form part of the CCG assurance process for CCGs.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Board:

1) **notes the progress against the implementation of the agreed 2015/16 Local Transformation Plan.**
2) **continues to request regular performance updates against the partnership plan including detail of metrics, such as reducing waiting times, training of the workforce and of financial spend against work streams to enable progress and risks to be monitored.**

3. INFORMATION

In August 2015, NHSE/Department of Health (DoH) published guidance for CCGs and Local Authorities on the development of a 5 year CAMHS Local Transformation plan (LTP). The first plan was submitted in October 2015. The Hillingdon LTP was assured in December and with it additional funding of £524,623.

The Hillingdon LTP contained 10 projects which were agreed by and overseen at the monthly Steering Group. The focus of the LTP was to fund new services based in the JSNA which had been undertaken in the spring of 2015 and user consultation, including the report undertaken by Healthwatch Hillingdon. The LTP also included: updating of the Family Information Service; undertaking a training needs analysis; engagement with children, young people and their families; and engagement with schools. The full details of this project are available in the Appendices.

Based on the 2015/16 LTP, a plan for 2016/17 has been developed which aims to build upon the outcomes and developments commence last year as well as accelerating the transformation of services. This LTP is to be endorsed at the Steering Group on 9 June. The draft plan is available in the appendices.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

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

Consultation Carried Out or Required

The 'Future in Mind team' has undertaken consultation across NW London, including Hillingdon, in 2015, prior to the submission of the NHSE/DoH CAMHS LTP. There has also been consultation undertaken with children and young people in Hillingdon at the Youth Council, forums and through schools. The annual children and young people's mental health event is taking place on 16 July at Brunel University, 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 business case for the new self harm service.

Feedback from Hillingdon children and young people, to date, has included:

- There is a need for parental advice and support
- High incidences of bullying
- Stigma- e.g., wouldn't want to receive services in schools or LINK or CAMHS
- Would like Hillingdon specific information, e.g., on line website
- Would like peer support/advice from CYPs who have experienced services
- On-line services
- Local help line
- Awareness raising events

Policy Overview Committee comments

None at this stage.

5. IMPLICATIONS

Finance comments

This report outlines use of £524, 623 funding for 2015/16 to transform emotional wellbeing and mental health services for children and young people in the borough.

6. BACKGROUND PAPERS

NIL.

Programme: Children & Young People's Emotional Health & Wellbeing	
Date: May 2016	**Period covered: Quarter 4 2015/ 2016**
Core Group Sponsors: Joan Vesey; Reva Gudi; Ian Goodman	
Finance Leads: Jonathan Tymms	

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

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

A. Financials 2015/6

CCG funding 2015/6- *not including LTP funding*		
CNWL Contract (CAMHS)	£2M	Recurrent
CAMHS Out of Hours Pilot	£131K	Pilot
CAMHS LD	£198K	Recurrent
CAMHS waiting times initiative	£121K	Non recurrent
TOTAL	**£2,450,00**	

LBH Funding 2015/6	
LINK Counselling (for ages 13-25)	£83.4K
LAC	£397K
TOTAL	**£480.4K**

NHSE CAMHS LTP Funding from December 2015

Projects	**2015/6**	**2016/7**	**2017/8**
Training Needs analysis	£4,995	0	0
Training the workforce	0	£30K	£20K
LD-extended remit	£50K	£108K (plus £50k roll over)	£158K
Self harm, crisis and intensive support service	£100K	£96K (plus £100K rollover)	£196K
Waiting list initiative- CNWL and LINK	£132K	£0	£0
Communication & Engagement	£25K	£30K	£20K
Community Eating Disorders	£149K	£149K	£149K
TOTAL	**£461K**	**£413K**	**£543K**

B. Plan Delivery Headlines

Ten projects were agreed as part of the 2015/6 CAMHS LTP; by the 31st March 2016 the projects delivered: (see Appendix 2)

1. Outcomes- rated Amber as although CNWL CAMHS staff undertake outcome and evidence based practice with CYPs; there is no outcome based contracting undertaken by LBH with LINK counselling. Data collected by LINK is based on number seen and interventions offered rather than the outcome of treatment, for children and young people.

2. Information for users, families, stakeholders- rated Amber as the updated Family Information Service (FIS) has not yet been reviewed and/or shared with families or the children's workforce in Hillingdon FIS is available at https://www.**hillingdon**.gov.uk/fis

3.Waiting Times- rated Red as 'routine' assessment at Tier 3 CAMHS treatment waits are, at M11 is 75% seen within 18 weeks- the target is 85% ; CNWL have agreed to reach the 85% target by end Q2, as part of the 2016/7 Contract negotiations. (In April 2016 they reached the 85% target)

4. Self Harm service- as of the 31st March this was rated Amber as not all posts had been recruited.; by May all staff had been recruited

5. LD Challenging behaviour service- rated Green as most of the team are in place and they are working well with the special schools and LBH to provide a service for the most complex LD CYPS in Hillingdon.

6. Training Needs Analysis rated Green as the Training Needs Analysis has been completed and training providers have been commissioned to provide training from June

7. School Engagement rated Amber as significant engagement work with schools has taken place- including mapping of services, 2 meetings and conference on 23rd March- with @170 delegates . The event focussed on sharing good practice and updating the schools on the CAMHS LTP. The agreed next steps include developing regular meetings with schools; school representation on the CAMHS steering group; staff training; development of quality standards for school counselling. This will become Green when we have engaged with more schools, have begun training their staff and have developed an assurance framework for school counselling.

8. Eating Disorders- rated Amber as CYPs have always received a service, which from 1/4/16 is a standalone service ,but it is not yet in line with the national service model and more staff need to be recruited. The service is commissioned to undertake 6 assessments per month and 32 follow up appointments.

9. Early Intervention Well-being service- rated Amber; LBH have developed a paper on proposed service model, which is to be discussed at the CAMHS meeting on 9th June

10. Co-production /Engagement - rated Amber as engagement with CYPs has commenced; it will become Green when we can demonstrate coproduction. Feedback from the CYPs engaged with in the last 4 months (currently 283 responses) included:

- Need for parental advice and support
- Incidences of bullying
- Stigma- eg wouldn't want to received services in schools or LINK or CAMHS
- Would like Hillingdon specific information eg on line website

What works:

- Exercise
- Peer support/advice from CYPs from have experienced services
- On-line services
- Local help line
- Awareness raising events.

Hillingdon CYP Emotional health & well-being : **Summary of Key Findings**
What has worked well in 15/16
• Closer working between HCCG, LBH, health watch, carers, schools, Third Sector, CNWL, with shared outcomes • Schools well-being event in March attended by 50% of schools- sharing of good practice and outcome from school mapping • The additional investment has increased the number of CYPs accessing evidence based treatment • Reduction in waiting times for routine Tier 3 services • New services have commenced: self harm, crisis and intensive support; community eating disorders; challenging behaviour. • Over 200 professionals completed the training needs analysis • CYP participation in patient engagement
Areas for further development.
• There is no counselling service available for those aged under 13 • A workforce strategy to address the issues of recruitment and retention • Support to schools to ensure school bas counselling services meet quality standards • Increased participation of CYPS in service redesign and reviews • Increased capacity in Tier 2 services • Transition

Key Risks or Issues

Risk	Mitigating action
Waiting times for tier 3 treatment meets the target for emergency and urgent interventions but not for routine referrals. The target is 85% but is currently 66% with waits of around 25 weeks. The number of incidents of self harm continues to increase.	Additional funding has been made available to CNWL to increase the workforce and to increase the capacity of the service by the development of new specialist teams- Out of Hours; self harm/crisis/intensive support/LD and challenging behaviour. These teams will significantly increase the capacity of the service. Additional short term funding was also made available to LINK counselling to enable them to support those on the waiting list for Tier 3.
There are a significant number of referrals to tier 3 CAMHS which do not meet the criteria/threshold for treatment. The impact of this is that staff have to spend significant time redirecting referrers and those children, young people and their families will have met with delays to their treatment as alternative provision is sought.	- Development of an improved communication strategy - A Training Needs Analysis has been completed, which has informed the development of a training programme for the children's workforce, in 2016/7 - There are plans to develop an early help/wellbeing service.
Lack of buy-in or support from Schools on role in emotional wellbeing	- In February a meeting of Primary and Secondary Heads took place, with 50% attendance to commence active discussions with schools forum, offering training and support to recognise and develop services. - The lead for Primary and Secondary Heads has joined the Board - Mapping of services has commenced, with an all school event arranged for 23rd March; this will enable direct contact where gaps are identified.
Funding for the remaining 4 years no longer available from the NHSE.	

Development of the 16/17 Plan

The 2016/7 Local Transformation Plan is still in draft, but is based on the 2015/16 Plan and include the following:

- When CYPs and their families need help it is easy to find and access including at times of crisis
- Interventions meet the needs of CYPs and their families
- Early Help, Prevention and Resilience is promoted (non-school based)
- Early Help, Prevention and Resilience is promoted (school based)
- CYPs and their families become experts in their care/Engaging with CYPs and their families/carers in treatment and service reviews and redesign
- The workforce is recruited, retained and well trained
- Develop evidence based community Eating Disorder services
- Transforming Care Partnership- reducing the need for inpatient treatment for CYPS with LD/Autism and MH
- Monitor and review the additional investment in CNWL CAMHS- Community ED/LD & Challenging behaviour/Self Harm & Intensive Support

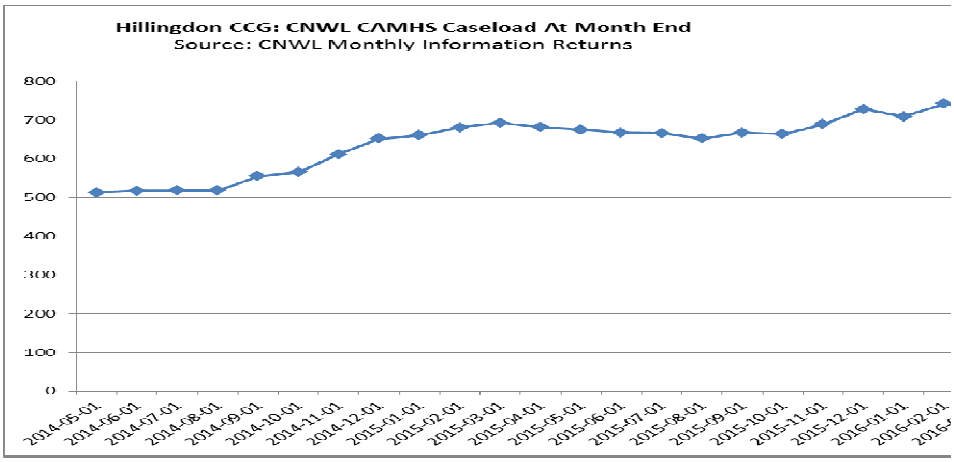
A draft 16/17 plan is attached as Appendix 3. The plan will be completed by the CAMHS steering group in June 2016, and will be agreed by with HCCG in July 2016.

C. Outcomes for Residents: Performance Metrics

The main service provision for children and young people with a mental health issue in Hillingdon is the CNWL CAMHS service. This service is largely commissioned by the CCG, with LBH commissioning a Looked After Children's service. The data below illustrates the rise in the number of children and young people on the caseload, which has increase from around 500 in May 2014 to around 700 by March 2016. The number of referrals has fluctuated from 60 to 116 per month during the same period.

Given the rise in demand there is a waiting time for assessment and treatment for non urgent and emergency referrals. The CCG has set a target that 85% of children and young people are seen within 18 weeks and this was achieved in April 2016; prior to this the percentage seen was around 70.

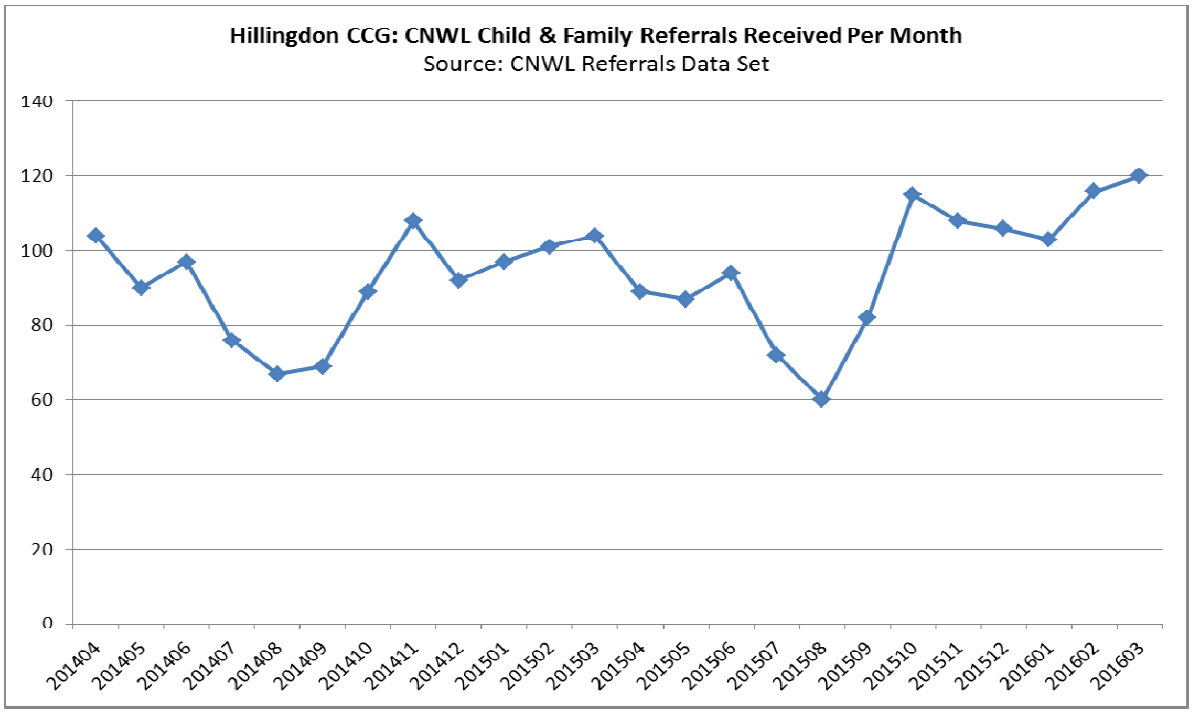
Hillingdon CCG: CNWL CAMHS Caseload At Month End
Source: CNWL Monthly Information Returns



Month	Caseload
2014-05-01	513
2014-06-01	517
2014-07-01	518
2014-08-01	518
2014-09-01	555
2014-10-01	565
2014-11-01	612
2014-12-01	652
2015-01-01	661
2015-02-01	681
2015-03-01	693
2015-04-01	682
2015-05-01	675
2015-06-01	668
2015-07-01	666
2015-08-01	652
2015-09-01	668
2015-10-01	664
2015-11-01	689
2015-12-01	728
2016-01-01	709
2016-02-01	742
2016-03-01	729

Hillingdon CCG: CNWL Child & Family Referrals Received Per Month

Source: CNWL Referrals Data Set



Month	Number of Referrals
201404	104
201405	90
201406	97
201407	76
201408	67
201409	69
201410	89
201411	108
201412	92
201501	97
201502	101
201503	104
201504	89
201505	87
201506	94
201507	72
201508	60
201509	82
201510	115
201511	108
201512	106
201601	103
201602	116

Hillingdon CCG: CNWL Monthly Count of CAMHS Community and Outpatient activity

Year 1: 2015/16

Ref	Areas for Development	What are we going to do	When will this happen	Evidence base	KPIs	KPI Target	KPI Performance Baseline / Dashboard rating	Additional Resources required In 2015/6	Link to National Priorities 1. Build capacity and capability across the system 2. Roll-out the CYP IAPT 3.Develop evidence based community Eating Disorder services 4. Improve perinatal care. 5. Bring education and local children and young people's MH services together	Link to Hillingdon CAMHS Strategy 2015-18 & Lead THRIVE Categories: 1.Coping 2.Getting help 3.Getting more help 4.Getting risk Support	Update and Comments as of 220316
1.	Embedding the outcomes based model in the CNWL Contract	Using the 2015/6 CQUIN which requires CNWL to move to the principles of	This work started in the 2015/6 contract and will continue into the CNWL	CORC outcomes framework	Compliance with CYP IAPT.	100% of data submissions are validated and submitted on time.	RAG: Amber	This will be undertaken by the HCCG CAMHS and the LBH MH Commissio	Roll-out the Children and Young People's Improving Access to Psychological Therapies	2.Getting help 3.Getting more help Lead-CNWL/Elaine Woodward/	In some areas CYPIAPT involves attending 12 month training of a few staff and cascading the training back-in Hillingdon because of the long waits the CAMHS staff haven't been on courses but have shared learning with

		CYPIAPT all CAMHS services will be monitored for outcomes and user engagement in care planning.	contract negotiations for 2016/7 and beyond					ner and CCG Contracting team.	programmes	Sunny Mehmi	other colleagues and have embedded the principles of CYPIAPT ie evidence based/outcome driven interventions. CORC has also worked with them to embed outcome based services. There is also a CQUIN to ensure that the principles of CYPIAT are in place- ends 31/3/16 with reporting on this due in May. In respect of Tier 2 services this is yet to be developed This is rated Amber as CNWL staff undertake outcome base practice with CYPs; there is no outcome based contracting at Tier 2. This will become Green when the staff at Tier 2 services can demonstrate outcome based practice.
2.	Ensuring the service pathways are communicate to the children, young peoples and families and Children's workforce in Hillingdon	Using information from the JSNA, LBH Personalisation Directory and the 111 directory develop a comprehensive Directory. The family Information Service will	May 2016	Future in Mind	Improved access to timely advice, information and specialist support when needed for CYP, parents, professional	Up to date Directory in place	RAG: Amber	Admin and IT	Build capacity and capability across the system	1.Coping 2.Getting help 3.Getting more help 4.Getting risk Support Lead-Philip Ryan	PR to demonstrate FIS at the April meeting; Communications strategy to be developed by HCCG and LBH. This is rated Amber as the updated FIS has not yet been developed or shared with families or the children's workforce in Hillingdon. This should become Green by Q1

		assist with ensure this goes to all relevant bodies in Hillingdon This will include using online resources such as Young Minds									
3.	Long waiting lists for treatment at CAMHS Tier 3	Use the LTP funding to invest in non-recurrent funding to CNWL to enable them to recruit Therapists to work with CYPs on the waiting list	Additional, non recurrent funding January 2015 to 31 March 2016 to work with CYPs on the waiting list for treatment. Additional recurrent funding to increase the capacity of Tier 3 available from December 2015	NICE	Numbers seen; waiting times; numbers receiving NICE treatment.	85% of CYPS waiting no more than 18 weeks for routine treatment - 1 week for urgent treatment - 4 hours for emergency	RAG: RED	£100k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes	2.Getting help 3.Getting more help Lead- CNWL	performance is that 75% of CYPS wait no more than 18 weeks (the target is 85%).CNWL are to agree a trajectory to meet 18 week (85%) target by Q2 2016 Monitored through the CCG Contract meetings and the HCCG Risk register. HCCG funding LINK counselling to support those on the waiting list (non recurrent funding) This is rated Red as not all children and young people who are assessed as needing Tier 3 CAMHS treatment are receiving it within the 18 weeks target. This should become Green by Q2

4.	Lack of self harm, crisis and intensive support service	Use the LTP funding to invest in a team who will deliver across a new pathway for self-harm. Given the co-existence of substance misuse and self harm this will require co-working to be developed	Team to become operational by April 2016	Crisis Care Concordat NICE QS 34 NICE Guidance CG28	All emergency referrals seen < 4 hrs; urgent < 48 hrs; routine < 2 wks; reduction in inpatient admissions and incidences of self harm.	85% of target	RAG: Amber (in-progress)	£100k (Re-current)	-Build capacity and capability across the system -Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes -Bring education and local children and young people's mental health services	2.Getting help 3.Getting more help Lead- CNWL	Band 8a post still vacant; 2 band 7 recruited. The service to commence in April. This is rated Amber as although 2 of the 3 posts have been recruited they haven't begun working yet; this should become Green in April
5.	Lack of services for CYPs with co-morbid MH/LD/Autism Spectre Disorder	Use the LTP funding to invest in additional staff to work in the current MH/LD team who will deliver across a new pathway which will include CYPs	CAMHS LD team to become operational by November 2015 with all staff recruited by February 2016 LBH to recruit to	NICE Transforming Care	Pathway in place with a fully staffed team; including a service specification. Linkage with special schools Referral to	Pathway in place 85% target referral to treatment	RAG: Green (in-progress)	£100k (Re-current)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Bring education and local children and young people's mental	2.Getting help 3.Getting more help Lead- Elaine Woodward/Sunny Mehmi	Team has been operational since November. 2 Psychologists, 0.01 Paediatrician, 0.1 Interim Psychiatrist in place, nurse recruited. Additional Psychologist transferring over 1/4/16. Monthly Forum now meeting to discuss and CYP, to ensure they receive the appropriate interventions /

		with co-morbid challenging behaviour and Autism	PSB posts by May 2016		treatment time is reduced. Reduction in use of residential education. <13 weeks referral to treatment				health services		treatment. Attended by special schools and LBH social care . LBH developing Positive Support Worker roles to support LD CAMHS pathway/service. This is rated Green as most of the team are in place and they are working well with the special schools and LBH to provide a service for the most complex LD CYPS in Hillingdon.
6.	Under developed mental health training packages for the workforce	Undertake a Training Needs Analysis; devise and deliver a training programme based on this	March 2016	Future in Mind	75% of the children's workforce contacted to take part in Training Needs Analysis. Training needs analysis is complete. Training scheme is identified and/or developed. Training programme in place	Publication of training needs analysis. Publication of training opportunities. 75% attendance rate at training programmes. 75% rate as useful.	RAG: Green	£30k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Bring education and local children and young people's mental health services	1. Coping 2. Getting help 3. Getting more help 4. Getting risk Support Lead- Elaine Woodward/Sunny Mehmi/Rob Burton	By 31/3/15 we agreed to undertake and analyse the Training Needs Analysis DASH have received 235 response from the CYP workforce for the TNA This to be analysed and used to develop a Training Programme- 2 national providers of training- Young Minds and MHFA have agreed to deliver training n Q1. This is rated Green as the Training Needs Analysis has been completed and training providers have been

					and training rolled out to children workforce including - Schools - Social Care - Youth Service - GPs - Health Visitors - School Nurses - TSO - Early Help Team						identified
7.	Understanding the role of Schools/College in emotional well-being and commissioning services such as counselling	Use the LTP funding to commence work with local Schools and College to gain this understanding and to support schools to commission emotional well being services	March 2016	Future in Mind	Mapping of current provision in schools and college The Participation Team and PH to undertake engagement to encourage them to embed	100% of special schools engaged with. 30% of mainstream schools engaged with.	RAG: Amber	£20k (Non-Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT -Bring education and local children and young people's mental health	1. Coping Lead- Public Health	Mapping tool sent to schools, the findings to be presented at the event on 23rd March. Meeting for Heads or their reps took place on the 24th & 25th February (50% attendance). Community engagement taking place in schools. Trailing for school staff planned for Q1.

					emotional health and well-being in every school and college. Achieved by sharing good practice from other schools and developing the workforce. Aim for a MH champion/lead in every school who can be provided with funding for CYPIAPT training. Support to school in commissioning high quality emotional well being services;				services		Special schools attending the monthly CAMHS LD Forum. O/S- Quality Assurance of School counselling etc. This is rated Amber as we have undertaken significant engagement work with schools. This will become Green when we have engaged with more schools, have begun training their staff and have developed an assurance framework for school counselling. This may take until Q3.
8.	Lack of a community Eating	Work with colleagues across NWL	April 2016 to April 2017	Access and Waiting Time	CYPs have rapid access to	85% of targets reached.	RAG: Amber	£145k (Recurrent)	-Build capacity and capability	2.Getting help 3.Getting more help	CAMHS ED patients are getting a service but not from a dedicated team yet.

	Disorder service	to deliver a service which is compliant with the NHSE model of care, and ensure pathways are in place with other local mental health services		Standard for Children with an Eating Disorder; NICE guideline CG9; NCCMH Commissioning Guidelines	assessment and treatment, in compliance with the new NICE model of care A new ED service is operational. Referral to treatment time for ED is reduced. Reduction in inpatient admissions. Numbers accessing treatment align with NCCMH/ NHSE guidelines.				across the system -Roll-out the CYP IAPT -Develop evidence based community Eating Disorder services for children and young people -Bring education and local children and young people's mental health services together	Lead- Elaine Woodward/CNWL	Draft service spec developed; Harrow is the lead CCG and has mandate from HCCG to allocate funding to CNWL. Recruitment of staff has commenced; new service to commence in 4/16 with full implementation by 2/17. This is rated Amber as CYPS are getting a service but it is not in line with the national service model; this should become Green by Q4
9.	Development of a new services based on early help/well-being	Develop a pathway and model of care for a non-specialist CAMHS services, with the aim of preventing most CYPS	March 2016	THRIVE/ NICE	Service specification in place to deliver: time limited interventions and advice and support to professionals, with	100% achieved	RAG: Green	£0	- Build capacity and capability across the system -Roll-out the Children and Young People's Improving Access to Psychologica	1. Coping Lead- Chris Scott	By 31/3/16 we agreed to present a new pathway and model of care to the Board. Chris Scott (LBH) presented a paper on the proposed new model of care at the March Board. Board members to feedback to Chris by 31/3. This is rated Green as we

		form developing complex MH issues			ease of access. Service roll-out early 2016/7				l Therapies -Bring education and local children and young people's mental health services together around the needs of the individual child through a joint mental health training programme programmes		have been presented with a new model of care for Tier 2 services- which is currently out for discussion.
10.	Lack of systematic engagement with CYPs and their families	Work with patient and user engagement colleagues in LBH/HCCG/CNWL to establish user and family consultation Develop support for carers/families as CYPs	April 2016	NEF: Co-production in Mental Health. A literature review. OPM: Co-production of health and wellbeing outcomes.	Ensure all CAMHS commissioned services undertake family work, where appropriate Ensure parents/carers receive advice and	Commissioners task & Finish Group to be set up Quarterly sessions/meetings with at least 1 CYP &/or parent rep at each meeting or event.	RAG: Amber	£25k (Recurrent)	-Build capacity and capability across the system -Roll-out the CYP IAPT	1. Coping 2. Getting help 3. Getting more help 4. Getting risk Support Lead- LBH/CCG/CNWL Participation & Engagement Leads	Coproduction yet to commence. Engagement plan to shape engagement in place developed and implementation has commenced. CYP Engagement & Wellbeing event arranged for July, at Brunel University. This is rated Amber as engagement with CYPs has

		regardless of where they are on the pathway Ensure all carers are offered a carers assessment			support which may include a carers assessment and/or referral to MH services such as Talking Therapies Formation of CAMHS Forum Workshops and events held with key stakeholders Outputs from Forum and workshop inform commissioning intentions and service specifications Number of meetings/events with CYP's involvement						commenced; it will become Green when we can demonstrate coproduction has occurred; this should occur by Q3

					in co-production.						

Appendix 3 - CAMHS LTP Year 2 2016/17 – draft

Ref	Areas of Transformation	What are we going to do	When will this happen	KPIs	KPI Target	KPI Performance Baseline / Dashboard rating (RAG) *M1 CNWL data is reported in M3*	Indicative Resources required In 2016/7	Feedback from Users & Carers following Consultation	Update and Comments (monthly updates)
1	**When CYPs and their families need help it is easy to find and access including at times of crisis**	- Regularly update the FIS - Ensure that services are available in location and at times that increase access - Review the current OoH CAMHS	- On-going -On-going -to commence in July	CNWL to operate o/s 9-5 and in venues o/s CAMHS office ant 1st and FUp CNWL Waiting time LINK data Awaited The OoH service is a pilot and operates at A&E 16.30- 07.00	10% 85% seen within 18 weeks Response times Primary diagnosis	**Amber** **M1 data 6.3% 23.2% 14%** **M1 data -85%**	Funding for the CNWL services are part of the block contract- there has been additional investment in 2015/6 and 16/7** Dependent on the outcome of the OoH review (Autumn)	-wouldn't want to received services in schools or LINK or CAMHS -would like Hillingdon specific information, e.g., on line website - Peer support/advice from CYPs from have experienced services - On-line services - Local help lines - awareness raising events for parents &	

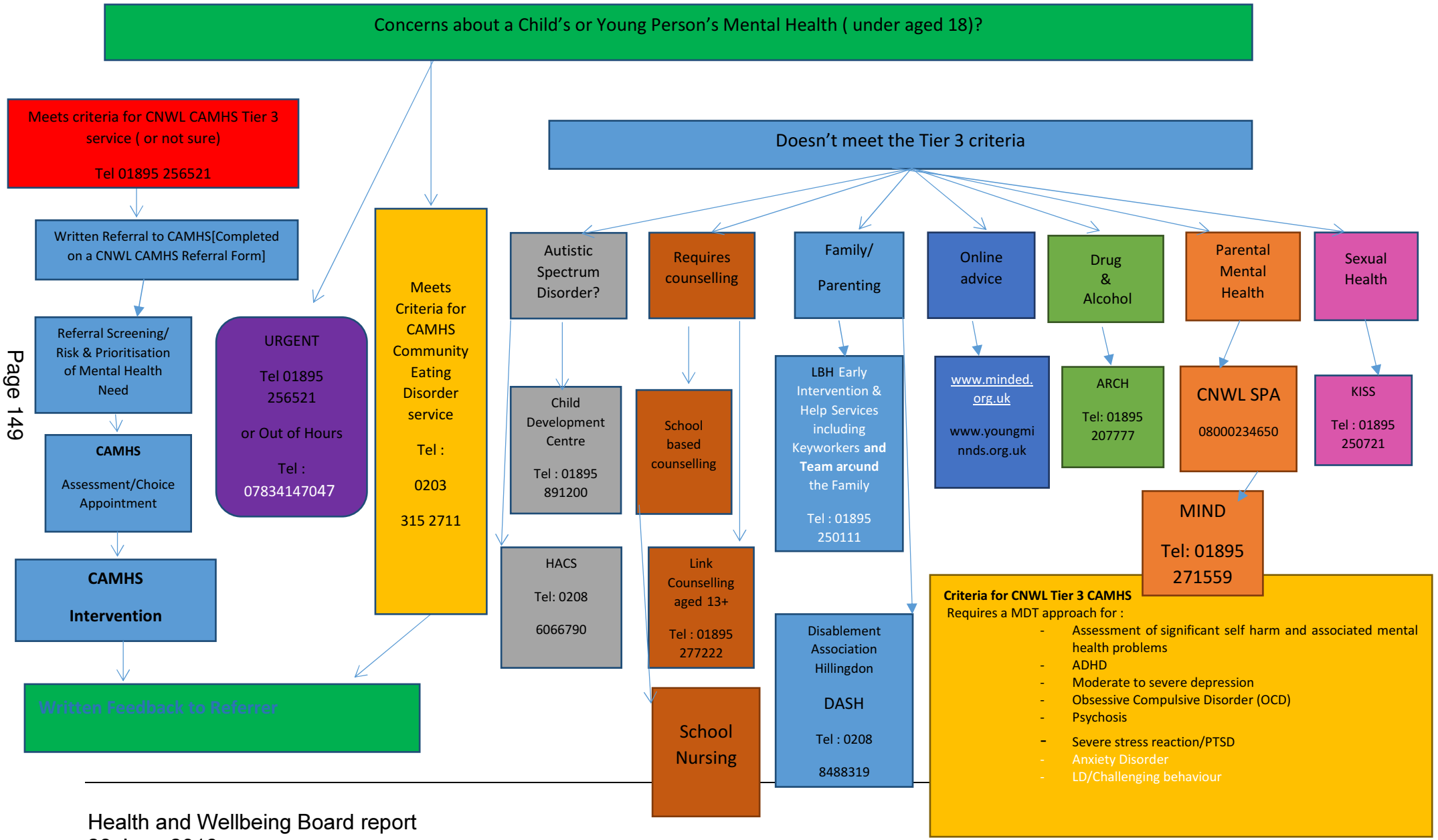
								CYP	
2	**Interventions meet the needs of CYPs and their families**	LINK and CNWL services place CYPs at the centre of their care and treatment LINK to develop Outcome based measures for CYPs and Commissioners Provide digital services	On going	All CNWL clinicians are trained in the use of outcome measures CNWL Care plans evidence that session by session outcome measures are being collected LINK data	85% 80% (by audit)	**Amber**	None	-wouldn't want to received services in schools or LINK or CAMHS -would like Hillingdon specific information eg on line website - Peer support/advice from CYPs from have experienced services - On-line services - Local help lines - awareness raising events for parents /carers 7 CYPS	
3	**Early Help, Prevention and Resilience is promoted (non school based)**	Develop a pathway and model of care for a non-specialist CAMHS services, with the aim of preventing most CYPS form developing	This will depend on the outcome of the review of the proposal from LBH and availability of funding	Numbers seen Waiting times Outcome of treatment Patient Experience		**Amber**	Service currently being reviewed	-wouldn't want to received services in schools or LINK or CAMHS -would like Hillingdon specific information eg	

		complex MH issues for CYPs aged 8-17; building upon the current LINK counselling for those aged 13+						on line website - Peer support/advice from CYPs from have experienced services - On-line services - Local help lines - awareness raising events	
4	**Early Help, Prevention and Resilience is promoted (school based)**	To support schools to promote/improve pupil's emotional health & wellbeing and develop resilience	Following on from the March 2016 conference a T&F group will be set up to share good practice, in Q1	Number of schools with pro-active services/plans Outcome from school counselling eg SDQ; Quality Indicators	To be developed	**Amber**		- Develop training for staff and parents - Peer support -not all CYPs want to be seen at school	
5	**CYPs and their families become experts in their care Engaging with CYPs and their families/carers in treatment and service reviews and redesign**	linked to (2) and extended to include their views and experience into commissioning Continue to engage with a wide of CYPs, families and carers which contributes to commissioning	On-going On-going On-going	Evidence of CYP involvement in commissioning eg: service redesign/review; development of service specs; attendance at meetings	Evidence of co-production on 2 pathways Numbers engaged with	**Amber** Baseline to be developed			

		Attendance at the Steering Group Annual event in 16/17	July						
6	**The workforce is recruited, retained and well trained**	There are significant issues in recruiting and retaining MH staff, inc CAMHS. As a result , LBH and HCCG are developing an all age MH Workforce T&F group.	MH Workforce T&F group to be set up in Q1	Recruitment and retention rates	10 Training events undertaken	**Amber**	Training costs tbc (£30K)		
7	**Develop evidence based community Eating Disorder services**	Additional ring fenced money was made available to develop a community ED services, to be NICE compliant by 2017/8.	In 2016/7 the service model to be fully developed and implemented, including recruitment/ co-production	• Waiting time for treatment • NICE compliant treatment • Outcome of treatment • Patient experience • Numbers admitted to T4 inpatients		**Amber**	£149k funding is CNWL baseline contract	-would like Hillingdon specific information - Peer support/advice from CYPs from have experienced services	
8	**Transforming Care Partnership- reducing the need for inpatient treatment for CYPS**	Continue to work with CYPs , families, schools, Social care to increase the	On-going	• Numbers in T4 or at risk of admission		**Green**	Ongoing funding of the service from CNWL- CCG		

	with LD/Autism and MH	services available in the community for those at risk of admission					and LTP funding		
9	**Monitor and review the additional investment in CNWL CAMHS- Community ED/LD & Challenging behaviour/Self Harm & Intensive Support**	Review performance through the CCG contracting process. Attendance at the NWL CAMHS/CNWL Transformation and commissioning meetings	On-going	• Numbers seen • Response times • Stakeholder engagement • Compliance with NICE • Outcomes (CYPIAPT)	Various- as CNWL contract	**Amber**	On-going funding from LTP funding		

Appendix 4 - Hillingdon pathway for Children & Young Peoples Emotional Health & Wellbeing



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TRANSFORMING CARE PARTNERSHIP PLAN FOR PEOPLE WITH LEARNING DISABILITIES, AUTISM AND CHALLENGING BEHAVIOUR

Relevant Board Member(s)	Councillor Philip Corthorne Councillor David Simmonds CBE
Organisation	London Borough of Hillingdon
Report author	Pranay Chakravorti, Learning Disability Programme Manager London Borough of Hillingdon and Hillingdon CCG
Papers with report	Appendix 1: North West London Transforming Care Plan Appendix 2: Hillingdon TCP Local Annex

1. HEADLINE INFORMATION

Summary	This report is to provide an update to the Health and Wellbeing Board on progress made to date within the North West London 'Transforming Care Partnership Plan' (TCP) that focuses on improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with learning disabilities, autism, and challenging behaviour. To deliver our aspirations we require a multi-agency and lifelong approach. Attached to this report is information on the development of both the Hillingdon and North West London Transforming Care Partnership Plan for people with learning disabilities, autism, and challenging behaviour.
Contribution to plans and strategies	Transforming Care Partnership Plan for People with Learning Disabilities, Autism and Challenging Behaviour.
Financial Cost	There are no direct financial costs associated with the recommendations of the report.
Ward(s) affected	All

2. RECOMMENDATION

The Health and Wellbeing Board endorses the direction of travel and priorities in the North West London Transforming Care Partnership Plan noting that a final implementation plan will not be agreed until confirmation regarding any additional funding and the conditions is confirmed.

3. INFORMATION

Supporting Information

Background

Building the right support is a national plan set out in October 2015 by LGA, ADASS and NHS England to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. This will be an All-age programme focussing on the providing effective support to individuals in the community. The overall aim is to prevent new admissions and reduce the time people spend in inpatient care by providing alternative care and support in the community. The intention is to shift money into community services reducing usage of inpatient provision by approximately 50% over the coming three years.

To achieve the systemic change required, 49 Transforming Care Partnerships (TCPs) - commissioning collaborations of local authorities, CCGs, and NHS England's specialised commissioners - have been designated. They will work with people who have experienced current service provision, their families and carers, and key stakeholders to agree joint transformation plans by April 2016 and then deliver on them over three years. An alliance of national organisations will support these TCPs.

The London Borough of Hillingdon and Hillingdon CCG are part of the North West London TCP, comprising 8 CCGs.

It is expected that, by late 2018 / early 2019, no area will need capacity for more than 10-15 inpatients per million population in each CCG area for CCG commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low, medium or high-secure services). In April 2016, Hillingdon had 11 patients in inpatient settings.

TCPs have been organised to build on existing collaborative commissioning arrangements and local health economies of services for people with a learning disability and/or autism. The aim is for commissioning at sufficient scale to manage risk, develop expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive. There will be a focus on early intervention and preventative models built with Learning Disability Community Service Specifications.

TCPs require strong leadership and sound governance, engagement and commitment to joint working amongst a range of stakeholders. The North West London Senior Responsible Officer (SRO) is Jan Norman, Director of Quality and Safety for Brent, Harrow and Hillingdon Federation of CCGs.

A coordinated approach across our 8 LA/CCGs areas will be required to develop and implement plans. The Strategy and Transformation Team for the North West London CCGs will have a key role in leading this work stream, with much intelligence and expertise coming from Local Authority and CCG leads.

TCPs were required to draw up a joint Transformation Plan by 8 February 2016. North West London TCP met this deadline. The final draft North West London Transforming Care Partnership Plan with the local borough annexes was submitted to NHS England by the deadline of 11 April. The final Plan reflected feedback from NHS England and more detailed

local work. The submission included the TCP North West London Plan and contains 8 borough/CCG specific annexes. These have been developed over the last few months by working at a local and collaborative level with Local Authority and NHS colleagues. While the involvement of social care commissioners has been the main area of LA engagement, the delivery of the Plan impacts on a wide range of LA services especially housing, leisure, education and community safety.

Central Government has made a commitment to make available £30 million revenue and £15 million capital to support the learning disability transformation agenda. Confirmation is awaited on whether these allocations will be as total amounts over the 3 year period or if they will be recurrent allocations over each of the 3 years. In addition, the methodology for allocation nationally is still to be outlined. It is expected that the revenue funding will be matched by CCGs but further details are awaited. CCGs will be expected to invest in local services out of their existing baselines prior to any funding announcements. This commitment has been met by Hillingdon CCG with its Governing Body in May 2016 approving further investment in the Learning Disability Community Health Team.

Local TCPs are being asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care differently to achieve better outcomes. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model will be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. Some services, such as local Community Learning Disability teams, will be locally funded and some services, such as community forensic or specialist “bed based” services, may be commissioned on a collaborative basis.

Funding should become increasingly personalised (personal budgets, personal health budgets, and integrated personal budgets as well as Educational, Health and Care Plan personal budgets). Local transformation should be aligned with existing requirements for Local Authorities and CCGs to set out a ‘local offer’ on personal health budgets and Special Educational Needs and Disabilities.

Current situation

The attached plan for both North West London and the Hillingdon annex describe current services and key population data.

The Hillingdon financial template shows that the local priority areas for additional funding are:

- Specialist Community LD Health Team
- LD CAMHS
- LD Employment Services
- Providing Community support for People with Autism
- Increased support for Community Day provision.

Further detail regarding the North West London wide priorities, some of which may be collaboratively commissioned are within the North West London Plan, although two areas which are of note are additional proposed investment in Forensic services and Crisis Support.

Both Hillingdon’s and the North West London TCP plan builds on the progress already made in each of the boroughs; it brings together the best practices to share the learning and, where it makes sense, brings together resources, capabilities and expertise to develop collaborative

solutions where there is agreement to alignment. Where there are differences and a local nuance, this will be outlined in the London Borough of Hillingdon Local Plan.

The Local and North West London wide Transforming Care Partnership Plan will continue to develop to address some of areas that are not yet finalised and cannot be until further information is available on central funding; amounts and conditions.

Main options

The North West London Plan builds on the progress already made in each borough and across North West London there is alignment on commissioning plans:

- Community support including the utilisation of more skilled staff to manage more complex / challenging behaviour;
- Tailored local housing options for people with learning disabilities and/or autism;
- Respite services for families and carers, regardless of the age of person being cared for;
- Crisis care, available 24 hours a day 7 days a week that ensures that people with a learning disability and/or autism receive care and support that meets their needs in time of crisis;
- An All-age service that removes the need to transition between children and adult services;
- North West London service for people with a forensic history or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area; and
- Co-ordinated care across the health and social care pathways.

The Local Plan will continue to develop, building on the final submission to NHS England and addressing any areas which are not yet finalised.

Financial Implications

The overall financial model and assumptions underpinning the Transforming Care Partnership plan is currently being finalised by NHS England and will be agreed in line with the delegated authority to approve the local and North West London Plan. Further notifications are expected in July 2016.

There is an expectation under the Transforming Care model that the London Borough of Hillingdon and Hillingdon CCG provide a joint commitment towards Supported Housing arrangements. To this end, Hillingdon CCG has increased investment in community clinical support within the Community Learning Disability service specification model and the London Borough of Hillingdon has a programme in place for increasing Supported Housing for people with learning disability and/or autism.

The costs of the future model will be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism.

Risk Management Implications

The following key risks have been identified within the NW London Plan and are monitored by the Project Lead and Board.

Risk description	Probability (High, Med, Low)	Impact (High, Med, Low)	Mitigation
Provider Response: The market does not develop as envisaged. The system may not support new entrant to any market development.	Med	High	Clear market position statements signalling commissioning intentions Good on-going provider engagement including actively working with providers to invite solutions, resolve issues and concerns.
Workforce skills: required workforce skills and capacity do not develop sufficiently. Staff not available/cannot afford to live in London.	Med	High	Clear workforce development plans Work with HENWL on workforce development models. Sufficient funding to develop workforce skills and recruit appropriate staff.
Pooling budgets: nationally changes are not made to allow specialised commissioning spend to be pooled. Locally there is still some reluctance to pool health and LA spend.	High	Med	Raise nationally as a key issue. Leadership and use of the Better Care Fund and section 75 agreements

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

Across North West London, people continue to be placed in out of area settings. The TCP will develop a model of care that will ensure that people with Learning Disabilities and/or Autism are able to live life with the same access to opportunities that any other member of our community is able to access. There will be a focus on care that is close to home where the service user is actively involved in planning and selecting elements of their care model. Importantly the new care model will focus on the least restrictive option available for the individual and commit to 'Putting our residents first'.

The cohort will have:

- An opportunity to learn;
- Appropriate employment or volunteering opportunities that may lead to work;
- Choice and control;
- A home to call their own;
- Community participation;
- A sense of being part of the local community; and
- A chance to manage their health with the level and quality of support that they need.

There will be a clear focus on the management of need in the community ensuring access to Primary Care is improved with the number of health checks and screening reaching best practice levels. It is imperative an effective register of Learning Disability service users are maintained. The recent CCG approval of increased investment in the Community LD Health

Team will place a clear focus on these areas with CNWL held to greater account to ensure effective delivery.

Consultation Carried Out or Required

An Equality Impact Assessment has not been carried out but the TCP programme is about a group known to be disadvantaged with the submitted plans seeking to address this. It should be noted that an Independent review of Hillingdon LD Disability Services conducted in April 2015 did include extensive consultation which led to the development of an enhanced LD service specification which has been approved by Hillingdon CCG Governing Body in May 2016. The Hillingdon Transforming Care Plan has been developed to further address the recommendations of the Independent review. A planned North West London wide consultation with service users and carers has been commissioned from Certitude and will begin later in 2016. The Hillingdon Learning Disability Partnership Board has service user representation sitting on the Board.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Legal comments

Social care legislation requires local authorities to work in partnership with health organisations with a focus on delivering preventative services, increased personalisation and less restrictive options for care. There are no other legal issues arising out of the proposal.

6. BACKGROUND PAPERS

Nil.

North West London Clinical Commissioning Groups and Local Authorities

Transforming Care Plan

In response to *Building the Right Support*

February 2016

Supported by Like Minded – The Mental Health and Wellbeing Strategy for North West London

Joint transformation planning template

Planning template – NORTH WEST LONDON

Executive Summary

This document sets out the vision of the North West London (NWL) Transforming Care Partnership (TCP) for improving the care and support available for the people of NWL with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging. This is an all ages plan to address the needs of people with a learning disability, people with autism (including those with Asperger's syndrome) who do not also have a learning disability, and people with a learning disability and/or autism whose behaviour can lead to contact with the criminal justice system.

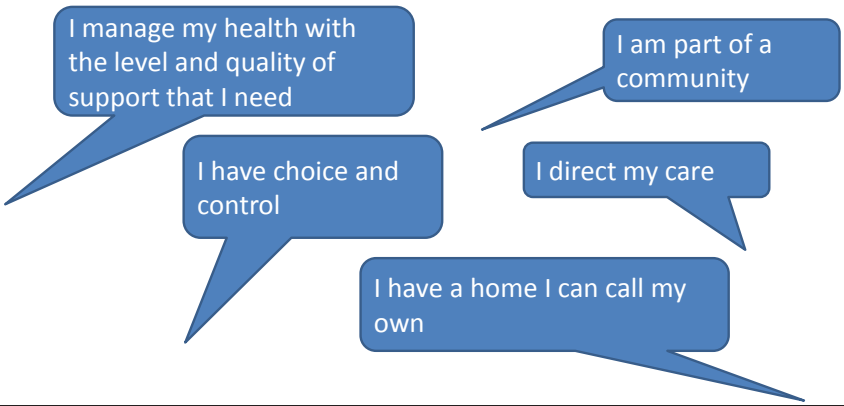
This draft plan provides a shared picture of:

- The North West London area
- The services currently commissioned and provided across our areas
- Our shared vision for how future services will be commissioned and provided
- What we need to change to achieve our vision and how we intend to do this

At the date of submission of our first draft – 8th February 2016 - we are, as a system aware that our current plan does have a number of areas which we will continue to work on and develop over the next few months ahead of the final submission on the 11th April. We welcome the opportunity to receive feedback on our current plans to reshape services for people with a learning disability and/or autism away from institutional models of care and develop support in the community. Across North West London, there is agreement to continue to collaborate on knowledge sharing and working towards the same strategic vision rather than having a preconceived set solution in place to deliver care.

This plan contains a broad over-arching vision, developed through extensive discussion with the learning disability, disability, and mental health commissioning leads, housing teams, and finance colleagues in CCGs and Local Authorities across our 8 North West London boroughs. This builds on work at a local level to understand the views of service users and their families/carers.

Our vision is that in North West London, people with a learning disability and/or autism and their families will be able to say:



We will achieve this vision by developing pathways and services that:

- Are community based where appropriate, with a reduced reliance on inpatient facilities;
- Have staff with the right skills and experience to manage complex cases, including managing the complexity of competing demands across health and social care;
- Provide respite for families and carers to maintain, wherever possible, at home placements and strong family relationships;
- House people with a learning disability and/or autism locally wherever possible and appropriate;
- Meet the needs of people of all ages – not defining support by age but instead responding to care and support needs and reducing the differences in services for children, young people and adults

These services and pathways will help us to achieve:

- Timely access to assessment and treatment for learning disability and/or autism;
- Reduced numbers of admissions to hospitals (both secure and non-secure), and shorter stays when admitted;
- Improved health and educational outcomes;
- Improved quality of life;
- Improved experience of services.

Our NWL plan builds on the progress already made in each of the boroughs; it brings together the best practices to share the learning and where it makes sense bring together resources, capabilities and expertise to develop collaborative solutions where there is agreement to alignment. Where there are differences and local nuances, these are outlined in each borough's local annex (attached to this plan). However across NWL we are aligned on our plans to commission:

- **Community support**, including the utilisation of more skilled staff to manage more complex/challenging behaviour. This may involve moving staff from inpatient facilities into community services, and vice versa, to share learning.
- Tailored **local housing options** for people with a learning disability and/or autism who have challenging needs. This will include short term housing options for people in crisis where there is a risk of placement breakdown.
- **Respite services** for families and carers, regardless of the age of the person being cared for. This will include short breaks, day centres, longer break provision and family support services.
- **Crisis care,** available 24 hours a day, 7 days a week that ensures that people with a learning disability and/or autism receive care and support that meets their needs in times of crisis, including when this crisis occurs outside of standard working hours.
- An **all ages service** that removes the need to transition between children and adult services.
- A NWL level **service for people with a forensic history** or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area.
- More services to support people with a learning disability and/or autism to access training, work experience, apprenticeships, and voluntary and paid employment.
- **Co-ordinated care** across the health and social care pathways, ensuring that primary care clinicians are involved in early identification and signposting, and all partners are engaged in on-going care and support.

In some areas it contains detailed proposals for how services will look different in the future but there is further work that will be required in a number of areas. In addition we know that it will take time to turn our vision in to reallty and that more detailed planning and clear measureable implementation plans will be needed. We have included within this document a more detailed plan of the next steps required and how we intend to agree the next level of detail.

Finally, as this is a draft plan the details contained in this document and appendices have been developed locally - but have not undergone a thorough assurance and governance process within each of the represented organisations. Further immediate assurance work is needed to test the finance assumptions and review of the finance in more detail. Equally there is immediate work to do on the implementation planning, for the April submission we will address the gaps in this draft of the document and ensure that the plan has been through the appropriate governance processes within North West London.

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

North West London Transforming Care Partnership covers all residents of North West London, and comprises eight CCGs and Local Authorities of: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. The CCGs and Local authority boundaries are coterminous in 6 of our 8 boroughs. West London CCG covers the borough of Kensington and Chelsea, and the Queens Park and Paddington areas of Westminster. Central London CCG covers the remainder of Westminster. The geography covered by our Transforming Care Partnerships is shown in the diagram below:

Boroughs of NW London Transforming Care Partnership

To ensure an appropriate balance between economies of scale and the necessary local focus on the commissioning of health services, the eight CCGs manage their operations in two groups:

- BHH Federation of CCGs, covering the CCGs of Brent, Harrow and Hillingdon
- CWHHE Collaborative of CCGs, covering the CCGs of Central London, West London, Ealing, Hammersmith and Fulham and Hounslow.

NWL has four community health providers, two mental health trusts, and nine acute and specialist trusts. There are also a number of hospices, rehabilitation centres, residential care homes, and nursing homes. There are also a vast number of third and independent sector provided service.

The Kingswood Centre is an inpatient unit located in Brent that provides specialist learning disability service for people with acute mental health needs, autism and severe challenging behaviours, including forensic histories, and a recovery service. The majority of the CCGs spot purchase beds from Kingswood Centre; however Brent CCG has a contract with the Kingswood Centre.

There has been work undertaken in the last 6 months to review and develop a specification for the range of services provided by the Kingswood Centre with associated performance metrics and transparent pricing structure for the different aspects of the service.

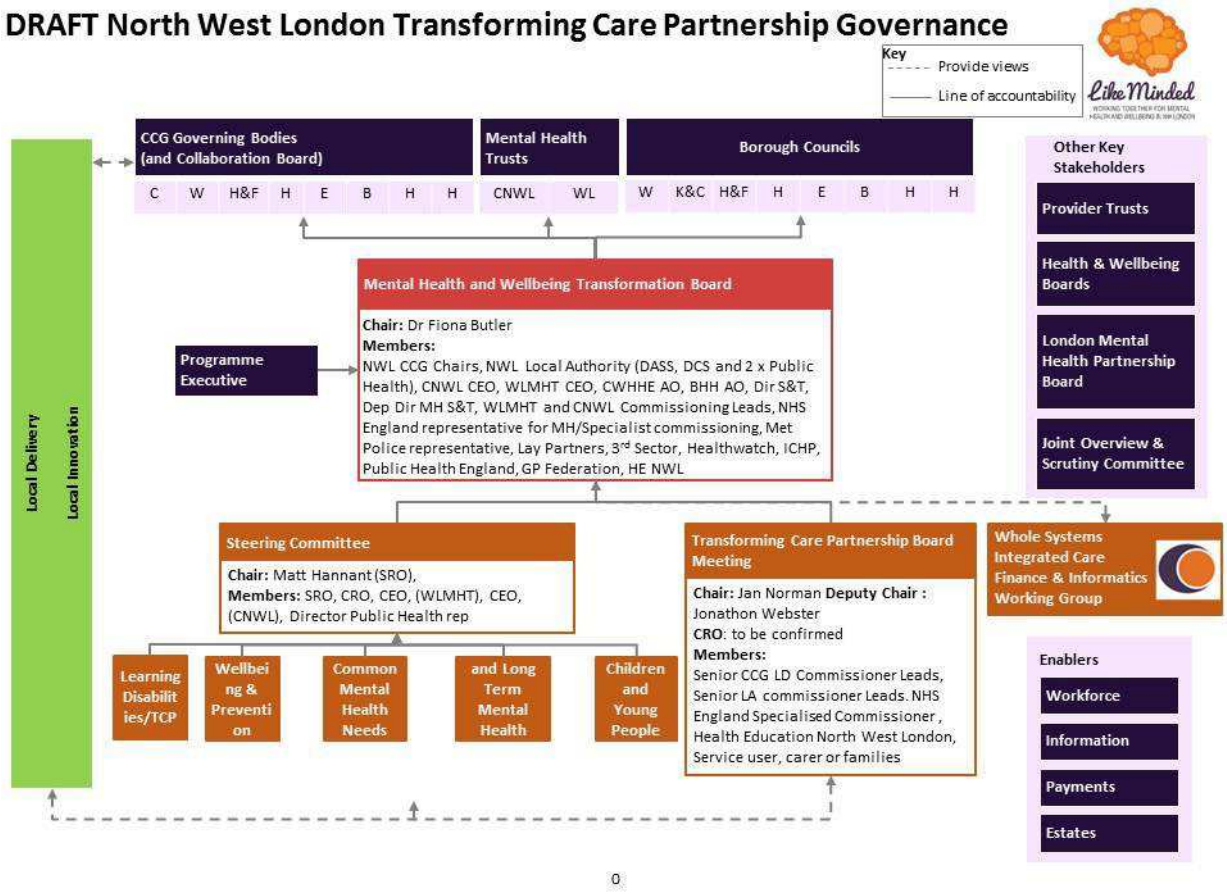
Out of area beds are commissioned by NWL CCGs on a case by case basis using spot purchase contracts, using a person centred, and needs-based approach.

There are a number of different approaches to collaborative commissioning arrangements; there are joint commissioning arrangements in place for Ealing, Hillingdon and Hounslow, and for the three boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster with less formal relationships in Harrow. Brent CCG and Local Authority have just recently appointed a joint Leaning Disabilities commissioner.

This plan has been developed with considerable input from key representatives from our 8 North West London clinical commissioning groups (CCGs) and local authorities.

Describe governance arrangements for this transformation programme

The North West London Transforming Care Partnership Board provides leadership and assurance on the delivery of the TCP plan and will oversee progress of all the agreed work streams. The Transformation Board is chaired by the Senior Responsible Owner (SRO), Jan Norman, Director of Quality and Safety, Brent, Harrow and Hillingdon CCGs Federation. The Deputy SRO is Jonathan Webster, Director of Quality, Nursing and Patient Safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs. Membership includes senior commissioning representation from learning disability, mental health, and children's commissioners from local authorities and CCGs.



In addition to the Partnership Board, a working group is being developed to drive implementation with fortnightly meetings scheduled. This will feed into the Partnership Board.

The NWL TCP Board is established as a strategic commissioning forum – with agreed routes for wider engagement across our provider base outside of the Board. The TCP Board reports to the NWL Mental Health and Wellbeing Transformation Board which has the senior executive and clinical leads from key partner organisations – including representatives from the West London Alliance from Directors of Adult Services, Directors of Children's Services and Directors of Public Health.

We welcome the membership of NHSE as a full partner and critical member of the Board.

Describe stakeholder engagement arrangements

In developing this plan, consultation has taken place with learning disability, disability, and mental health commissioning leads, housing teams, and finance colleagues in CCGs and Local Authorities across our 8 North West London boroughs. Meetings are on-going as we continue to develop our plans.

In November 2015 there was a well-attended North West London Learning Disabilities workshop with 76 attendees. The attendees included a user representative, representatives from Central North West London FT Learning Disabilities services. West London Mental Health Trust and from all the community learning disability services including LA and NHS

staff. CCG and Local Authority commissioners were also represented at the meeting alongside the quality and safeguarding leads and Health Education North West London.

The aim of the workshop was to explore ways to improve mental health services for people with a learning disability in North West London and increase knowledge and understanding of the wider mental health transformation programme, the NWL Like Minded Programme and the links to:

- Crisis Care; IAPT (psychological therapies); perinatal mental health; Children and Young People's Mental Health Services (CAMHS)

It also provided an opportunity for stakeholders to reflect on how the local Green Light Meetings can be used to take forward these improvements for people with a learning disability and mental health needs.

The workshop helped to identify the number and range of partners involved, from users and carers, commissioners from health and local authorities, the community providers of learning disabilities, mental health trust providers and the housing and community care providers.

The output from the workshop was an agreed action plan which will deliver change and improvement to ensure that people with learning disabilities in need of very specialist mental health services will get the support that they need. Additionally the workshop informed the emerging thinking about what is needed to support those with a learning disability and a forensic background to live safely in the community. This thinking has informed the development of our Transforming Care Plan.

In each of our boroughs, there are existing stakeholder engagement forums and groups, advocacy services and partnership boards that meet regularly and their feedback forms an important part of learning disability and/or autism service and pathway redesign. Before submission of our final plan in April, North West London colleagues will facilitate a number of workshops and events to co-produce this Transformation Plan. For now, the work done to date to influence our planning is outlined below.

Specific examples includes work during 2015 that Ealing and Hillingdon have both undertaken on consultations exercises with service users which highlighted a number of areas for development:

- Not knowing where to go for help
- First step is my GP – but they aren't always helpful
- My GP doesn't give me enough time to explain things, my appointment isn't long enough, I'm only allowed to talk about 1 issue at my appointment
- Being on the waiting list for counselling for a long time means things can change and get worse
- Not everyone can access all the services available
- Not being able to have a choice about where to meet for my support from CTPLD
- Not having a choice about what time I can meet
- Not having enough choice about what I can do in the day to help improve my mental health
- Staff don't always know how to best support someone with a learning disability, sometimes they see the way I am behaving as part of my learning disability, not a part of my mental health being bad
- I can't understand what is happening to me, people aren't explaining in a way that I can understand

- It makes things worse when I get ill as I find it all so overwhelming and difficult to understand what's going on
- I don't understand what my medication is for and why I should take it
- I was told I can't use Improving Access to Psychological Therapies (IAPT) because I have a learning disability – this is illegal and unfair

Within Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster, learning disability representatives of the joint partnership board have identified priority issues of health, housing, choice and control and transport. Within these broad themes key areas of importance to customers are: choice in housing; accessible communication to support decision making; person-centred planning and support; having a say in matching of support staff; employment and access to personal budgets.

A three borough market engagement event on 1st February shared these messages plus the need for skilled approaches to support positive outcomes for people with complex needs and behaviours. On-going engagement with providers will help shape the Transforming Care plan and in particular the responses to the needs of individuals.

These themes have been incorporated into our Transformation Plans – developing our themes of improving choice and control, person centred care, and specialist services.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The involvement of people with a learning disability and/or autism in the shaping of this plan is covered above. We will facilitate a number of workshops and events to co-produce this Transformation Plan during the coming months – we know that the right lead time is needed to allow for appropriate planning, preparation and transport arrangements.

Co-production is also a fundamental element of our Children and Young People's Mental Health Transformation Plan. We worked with stakeholders including children, young people, parents, clinicians, teachers, and youth services to develop that transformation plan. This ensured that our plans reflected what our service users and key partners wanted.

As part of our CAMHS plans, across the eight boroughs we are funding local organisations with particular relevance to local needs, and needs of specific under-served groups, to support young people, parents, and other key stakeholders to be involved in co-production. We aim to develop this further by reviewing co-production for different groups, learning from the work done in other boroughs across NWL and sharing our learning on the engagement approaches that work best for different groups of children, young people, and parents. We are building on the current approach in Hammersmith and Fulham with Rethink – training and supporting young people cross NWL to engage in all children and young people's (CYP) development projects. This will include a youth-led conference on Young People's Mental Health to be held in 2016.

On-going planning will also build on existing coproduction structures through partnership boards, sub-groups, and groups such as the Parents Reference Group and Carers groups. Engagement of care co-ordinators will be key to ensure a realistic focus on the holistic needs of the people they are planning with and the issues or barriers they are facing on the ground.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

Please see attached template.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

2.Understanding the status quo

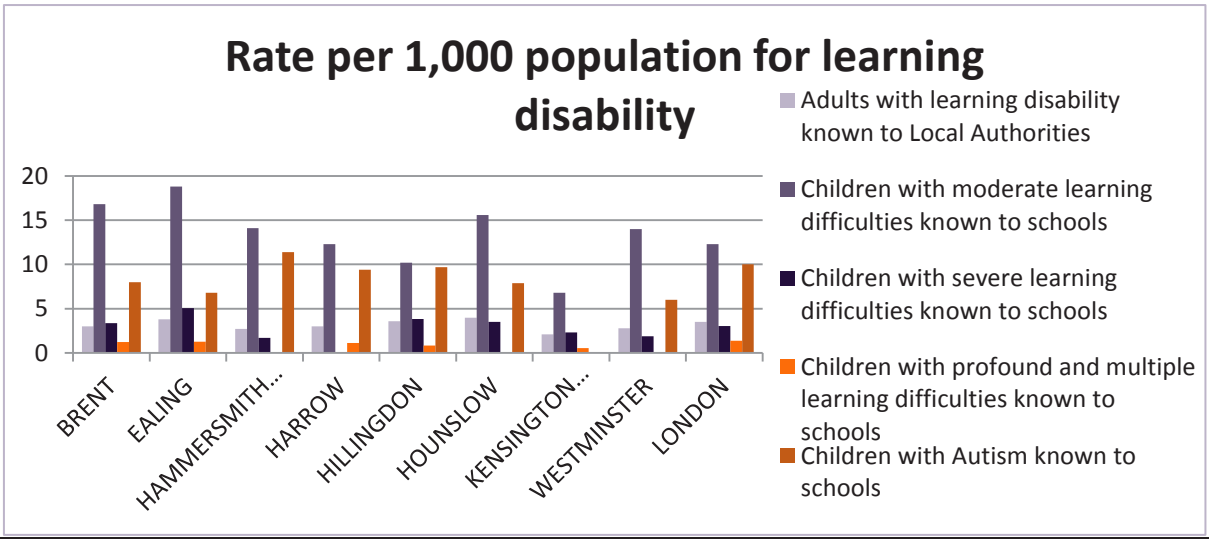
Baseline assessment of needs and services

Provide detail of the population / demographics

Learning Disability in North West London

The cohort of people with a learning disability and/or autism in NWL is diverse, and growing. The below graph shows the latest figures for learning disability prevalence across NWL and the rate per 1,000 population for the whole of London[1].

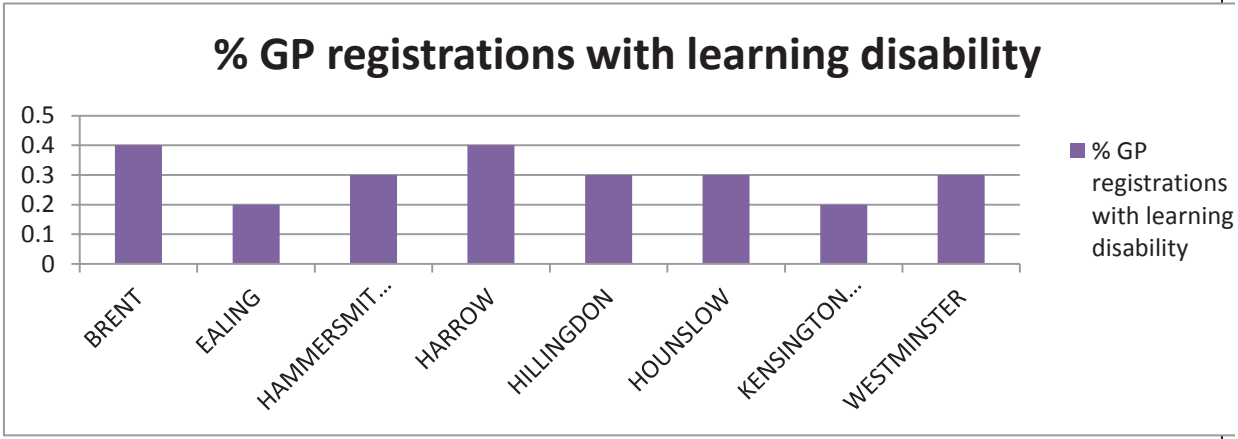
You can see that the rate per 1,000 population for children with moderate learning disabilities known to schools varies across the boroughs from 18.8 in Ealing to 6.8 in Kensington and Chelsea, with the London rate being 12.3[2].



[1] Public Health England Fingertips data 2013/14

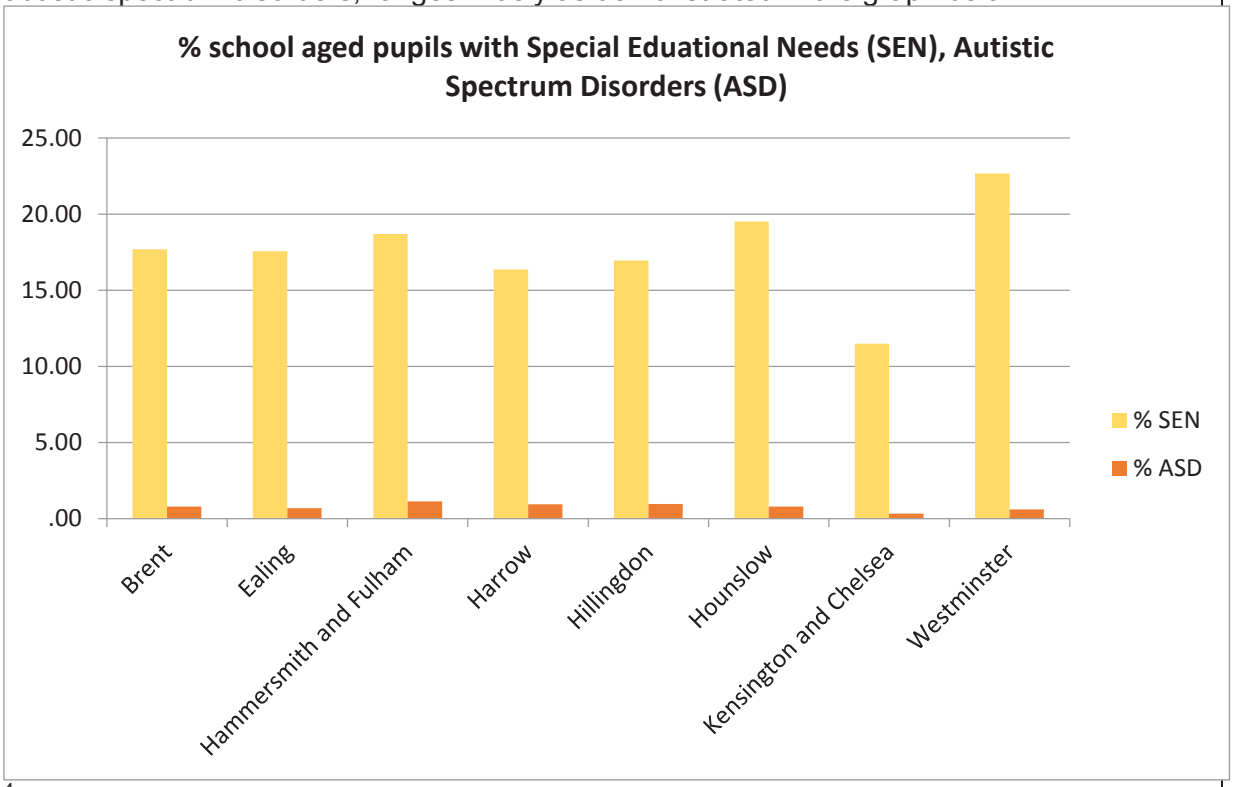
[2] http://fingertips.phe.org.uk/profile/learning-disabilities/data#page/0/gid/1938132702/pat/6/par/E12000007/ati/102/are/E09000020

We also know that the percentage of adults registered with a GP in NWL as having a learning disability varies across the boroughs from 0.2% to 0.4%[3].



In 6 out of our 8 NWL CCG areas, we do not have up-to-date information on the mental health and emotional well-being of our children and young people. We are therefore investing some of our CAMHS Transformation Plan funding in producing needs assessments to further guide our local priorities.

Across NWL, the percentage of school aged children with special education needs, including autistic spectrum disorders, ranges widely as demonstrated in the graph below.



[4]

[3] HSCIC, 2014

[4] Public Health England Fingertips Tool (2014). Accessed at http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/9/gid/1938132753/pat/6/par/E12000007/ati/102/are/E09000005

Many of our NWL boroughs have undertaken LD JSNAs in the last few years. The details below provide a snapshot from these of some of the NWL specific challenges and opportunities:

- In Brent, 2.6% of school children had a learning disability (2014). This was slightly lower than the England average of 2.9%[5]
- Out of 600 individuals with learning disabilities known to local GPs in Hounslow, there are 296 females (45%) and 358 males (55%). The median age for females was 43 and for males was 37 years. Learning disabilities are more common in men than women (for severe learning disabilities an average ratio of 1.2:1, and for mild learning disabilities 1.6:1) and these figures are in keeping with that[6].
- Nearly 10% of adults with a learning disability are in paid employment in Ealing in 2011/12. This is statistically better than England average (6.1%) for the same period[7].
- Numbers in residential care of all ages in Hammersmith and Fulham have been steadily rising over time, with around 50-60 more 18-65 year olds in residential care than is typical for London and England[8].
- Kensington and Chelsea had experienced falls in numbers in residential care but this has risen sharply in recent years, and has 15-25 more than expected in residential care[9].
- Published figures on the spend on residential care suggest it was very high in Hammersmith and Fulham and high in Kensington and Chelsea by virtue of the higher proportion of clients in this type of accommodation[10].

Needs Grouping described in the National Service Model

The National Service Model identifies 5 groups of people with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges;
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neurodevelopmental syndrome where there may be an increased likelihood of developing behaviour that challenges;
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour);
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal

[5] Brent Learning Disability Brief JSNA 2014
[6] This is Hounslow, 2014
[7] Ealing JSNA 2012
[8] Tri borough Joint Strategic Needs Assessment 2013-2014
[9] Tri borough Joint Strategic Needs Assessment 2013-2014

[10] Tri borough Joint Strategic Needs Assessment 2013-2014

justice system;
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Currently, our CCGs and Local Authorities do not collect data that categorises people with a learning disability and/or autism into these distinct groupings. However, we will ensure that our Transformation Plans address the diverse and complex needs of each of these groups of people. We also plan to do further work on risk stratification of our population as part of the continuing development of our plans that will provide more detail on the numbers of people within each of these categories across North West London. This will also require close working with teams from the national criminal justice system, and local partners.

Analysis of inpatient usage by people from Transforming Care Partnership

Please see the attached Finance Template for detail on inpatient usage numbers for NWL.

The activity for our main inpatient unit, The Kingswood Centre, is shown below.

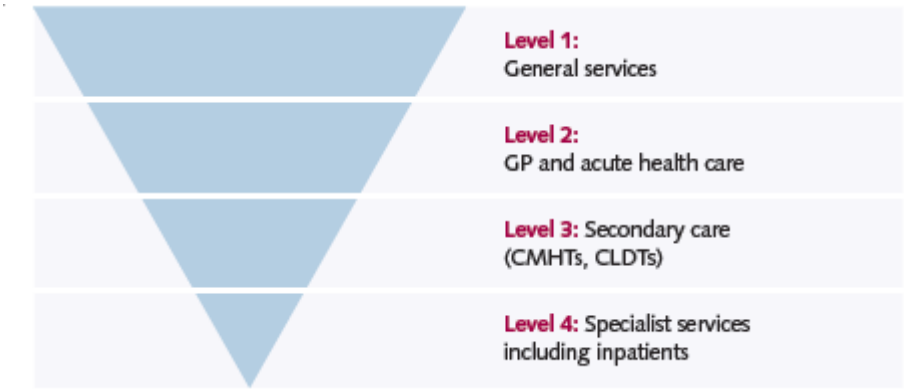
Admissions per year to The Kingswood Centre for NWL Boroughs – 2011 to 2015						
Borough	**2011**	**2012**	**2013**	**2014**	**Q1-2 2015**	**Total**
Brent	4	5	7	7	4	**27**
Hillingdon	2	0	2	4	4	**12**
Westminster	3	3	2	3	1	**12**
K&C	1	3	1	4	0	**9**
Hounslow	2	1	0	1	0	**4**
Harrow	1	5	0	5	1	**12**
Ealing	2	0	6	1	1	**10**
Hammersmith and Fulham	0	0	0	0	0	**0**

These numbers represent people with a learning disability and/or autism who have been an inpatient in our local NWL service. However we recognise that a large number of our NWL residents with a learning disability and/or autism are in inpatient units outside of our catchment area. This is in part due to the range of complex needs of these patients, and our limited estates to support these patients in community settings. Also, we are working with historical contracting arrangements that need to be updated.

The process of implementing our TCP allows us to address these issues as a collaborative across NWL.

Describe the current system

In North West London, people with a learning disability and/or autism can come into contact with a wide range of services. Services supporting people with a learning disability and/or autism can be described in the following ways:



Level 1 These services are primarily focused on improving the health of the whole population of people with learning disabilities. Good access to housing, leisure, education, transport and employment are known to have a positive impact on mental health. Other priorities include neonatal screening, early detection and treatment for conditions such as congenital hypothyroidism and phenylketonuria.

Level 2 People with learning disabilities and/or autism should have good access to mainstream health services. In primary care, this means regular health checks, advice and support on lifestyle factors such as diet, exercise, alcohol consumption and sexual health. Other services include health facilitation to improve access to primary care and health liaison to improve access to acute hospital-based care. Training and support for carers should be made available. Improving Access to Psychological Therapies is included at this level.

Level 3 Community mental health and learning disability teams which provide assessment, treatment and some on-going support for people with a moderate degree of mental health need (significant anxiety and depression, psychotic disorders, and cognitive impairment). These teams have expertise in dealing with perceived behaviour problems associated with these conditions, as well as the whole range of learning disability and coexisting autism and ADHD. In North West London, community services are provided by a range of providers including specialist learning disability providers (e.g. Craegmoor), community healthcare trusts (Central London Community Healthcare) and mental health trusts (Central and North West London Foundation Trust and West London Mental Health Trust). In Kensington and Chelsea there is a Positive Behaviour Support team and in Westminster there is a Flexible Response Service that also partners with a skilled support provider to provide in-reach for people with challenging behaviours.

Level 4 These services have expertise in dealing with people who are a severe risk to themselves and others, often with chronic severe treatment resistant mental illness, behaviour problems and offending behaviour. Services at this level include community-based assessment and treatment using a combination of crisis and home treatment teams, behaviour support services, forensic teams and experts in autism, ADHD, eating disorders, dementia and epilepsy. Inpatient services may also be required where 24 hour assessment and treatment would enable a safe return to well-resourced, community-based packages of care. The appropriate role for psychiatric hospital services for people with learning

disabilities lies in short-term, highly-focused assessment and treatment of mental illness. At present in North West London, these services are mainly provided by The Kingswood Centre with inpatient services being either block purchased (as is the case for Brent) or spot purchased (as is the case for all remaining areas in North West London). Spot purchasing of inpatient services also takes place in many other inpatient facilities across the country.

Residential and special schools also form part of the support available for children and young people with a learning disability and/or autism.

The services within these different levels include:

- Primary care
- Psychological therapies
- Community learning disability services
- Inpatient learning disability services
- Generic mental health services
- Services at the interface (transition services)
- Supported housing, residential care and continuing health care

The level of coordination between different service elements can vary, and can also lead to delay and duplication as well as high costs. These different services have a range of providers across NWL including a number of dedicated learning disability services:

- Integrated health and social care learning disability services (provided by the community health trusts; Central London Community Healthcare; Hounslow and Richmond community Healthcare; London North West Healthcare; Hillingdon) with social care staff from the relevant local authorities
- Autism Diagnostic Clinical Services (provided by Central and North West London Foundation Trust and West London Mental Health NHS Trust)
- CAMHS Learning Disability Services (provided by Central and North West London Foundation Trust and West London Mental Health Trust)

In addition, Local Authorities provide and commission a range of services for people eligible for support under the Care Act including residential care, supported living, respite, homecare, day opportunities, transport, advocacy and outreach, as well as special schools and a range of services and young people with learning disabilities and/or autism and behaviour that challenges.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

A thorough picture of our current estate across residential and supported housing, clinical services, and community support is a gap within our current plan. We are working with our estates teams and providers to map the existing provision, including the areas where we are routinely accessing placements out of our North West London area.

In some of our boroughs, recent work on estates and residential support offers has taken place and there are strategies in place to develop and expand the offer to meet the needs of people with learning disabilities and/or autism. These strategies are included in each borough's appendix, where applicable.

Across many areas, in particular inner North West London, housing planning work has identified a shortfall of accessible property and lack of properties with the specification and

space to meet these needs of individuals and families. As inner London boroughs the cost of land and property is a huge challenge and as a result, there are many people in placements outside of their home boroughs. However there is on-going work to secure property through new build developments and improved pathways to access existing stock.

What is the case for change? How can the current model of care be improved?

The case for change across North West London is clear. The following challenges must be addressed:

- There is widespread recognition that those with a learning disability and/or autism and challenging behaviours are not best served by extended hospital stays, although admission for assessment and treatment will be required from time to time for some people.
- Despite this recognition, due to a lack of alternatives some people with a learning disability and/or autism and challenging behaviour are admitted to hospital in a crisis and remain in hospital for longer than necessary when they could have been supported in the community if 24/7 clinical support was in place.
- The ageing population of those with a learning disability and/or autism require more proactive support that also provides support and treatment for co-morbidities that are more common in later life;
- There is extensive reliance on families and carers to provide support. To prevent burn out and family breakdown, there is a need to ensure that there are both crisis and planned respite services available to avoid hospitalisation;
- There needs to be increased skills in the workforce to support people with a learning disability and/or autism most effectively and similar support for their families and carers;
- The population of North West London is increasing, as is the number of people with a learning disability and/or autism. Our systems and services need to be able to respond to this increase in demand in the most effective and efficient ways possible;
- The cost of housing in London is higher than anywhere else in the UK. This means that people with a learning disability and/or autism are often housed outside of London, which impacts on family and friend relationships and support. More needs to be done to ensure that people can stay in their own homes where possible, and where that is not possible, placements can be made closer to home to ensure support networks can be maintained.

To address these challenges, we need to develop a system and services underpinned by the following principles:

- The needs and preferences of people with a learning disability and/or autism should be at the heart of all we do. Care and support should be person-centred, planned, proactive and co-ordinated across health and social care, allowing people to have choice and control and lead good and meaningful lives;
- Substance Misuse services do not usually screen for learning disabilities – and vice versa – despite co-morbid needs frequently existing
- We need to further develop our system-wide approach across specialised and CCG commissioning, health and social care and other services (e.g. housing) for people in North West London with a learning disability and/or autism and challenging behaviours;
- Care and support services need to be redesigned to minimise inpatient care to when it is the best place for the person concerned. More often, care should be provided in community settings by skilled professionals who can support and maintain independence;

- A 'whole life' preventative approach is needed for care and support with a much greater emphasis on addressing or reducing the impact of challenging behaviours from a young age;
- Significant market development and provider liaison is required to achieve transformational change. The skills and capacity of providers must be increased to better support people with a learning disability and/or autism and challenging behaviour in the community to deal with high levels of complexity. Personalisation/ self-directed care, increasing employment opportunities;
- Advocacy forms part of the support available to people with a learning disability and/or autism to help uphold people's rights and ensure their voices are heard.
- Within forensic pathways commissioned by NHS England there is a need to ensure the appropriate specialist input for service users with Learning Disabilities;
- The green light toolkit framework provides a means to focus on individuals and their needs and requires continued focus and resource to support;
- Court diversion schemes operate in NWL for people with Mental illness. The capability of all members of these teams to respond to the needs of people with a learning disability and/or autism could be strengthened.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Please see attached template.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

For North West London, Transforming Care is a programme that will help us develop our model of care and support for people with a learning disability and/or autism that promotes participation and an improved quality of life, whilst at all times maintains a person-centred approach that recognises and values difference and diversity.

In North West London, people with a learning disability and/or autism and their families will be able to say:

- I have choice and control
- I direct my care
- I have a home I can call my own
- I am part of a community

- I manage my health with the level and quality of support that I need

We will achieve this vision by developing pathways and services that:

- Are community based where appropriate, with a reduced reliance on inpatient facilities;
- Are skilled and experienced to manage complex cases, including managing the complexity of competing demands across health and social care;
- Provide respite for families and carers to maintain, wherever possible, at home placements and strong family relationships;
- Enable people to have choice in accommodation that is suitable to their needs and close to their communities and chosen networks; (acknowledging that for some people they may not choose this to be in their borough of origin);
- Meet the needs of people of all ages – not defining support by age but instead responding to care and support needs and reducing the differences in services for children, young people and adults

These services are pathways will help us to achieve:

- Timely access to assessment and treatment for learning disability and/or autism;
- Reduced numbers of admissions to hospitals (both secure and non-secure), and shorter stays when admitted through effective discharge planning;
- When required and community solutions are not appropriate, timely access to inpatient assessment and treatment;
- Improved health and educational outcomes;
- Improved quality of life;
- Improved experience of services.

How will improvement against each of these domains be measured?

In accordance with the national guidance, we will monitor progress on delivering against the overarching outcomes of the programme using the suggested measures.

For the aim of reducing reliance on inpatient services, we will use the Assuring Transformation Plan data set to monitor progress. This will include defining baselines and setting KPI trajectories and end states in collaboration with our providers and service users for the following:

- Registers of people with a learning disability and/or autism
- Numbers of patients on registers
- Numbers of patients with a care co-ordinator
- Numbers of patients who have had a formal care plan review
- Number of patients with a planned transfer date
- Awareness of Local Authority to up-coming transfers
- Number of patients with an independently appointed Advocate (family member, independent person, formal Independent Mental Capacity advocate (IMCA)
- Numbers of patients admitted to inpatient care
- Number not on at risk of admission registers prior to admission
- Numbers of patients transferred out of inpatient care
- Numbers of patients considered not appropriate for transfer to the community and the reasons why
- Number of readmissions

- Number of readmission resulting in Root Cause Analysis

For the aim of improving quality of life, we will use measures based on the Health Equality Framework tool. All these measures will be further refined as our plan developed. At present, we have some outline ideas on the quality of life areas we want to assess. These include:

- **Social determinants of health**: accommodation, employment, financial support, social contact, and safeguarding (e.g. 10% increase in the number of people with a learning disability and/or autism who are in employment by March 2019).
- **Genetic and biological determinants of health**: assessment and review of health needs, care plans, crisis plans, medication passports, and access to specialist services (e.g. 100% of inpatients in specialist learning disability services have a care plan that has been co-produced with the person and their family/carers).
- **Communication and health literacy**: body and pain awareness, communication of health needs, recognition by others of pain, recognition of health needs and response by others, understanding health information, and making choices (e.g. 100% of patient information leaflets in community learning disability and/or autism services are available in easy read format).
- **Behaviour and lifestyle**: diet, exercise, weight, substance use, sexual health, risky behaviours (e.g. 20% reduction in the number of people with a learning disability and/or autism who are overweight or obese).
- **Access to and quality of healthcare and other services**: reducing organisational barriers, understanding consent, managing transitions, uptake of health screening/ promotion, access to primary and secondary health services (e.g. 15% increase in uptake of cervical screening by women with a learning disability and/or autism).

For the aim of improving quality of care, we will use the suggested basket of indicators, where these are not covered by the measures above. As a start, this will include (but not be limited to) measuring and developing KPIs on:

- The number (and %) of people receiving social care primarily because of a learning disability who receive direct payments or a personal managed budget.
- Readmissions to hospital for people with a learning disability and/or autism.
- Waiting times for new psychiatric referrals for people with a learning disability and/or autism.
- The availability of accessible information in line with new accessible information standards.

In addition to these mandated measures, we will also use local measures to monitor progress against our local objectives. Co-production of these measures with people with a learning disability and/or autism and their families and carers will be an important component in the delivery of our Transformation Care programme.

For us, the most important measure of improvement will be patient reported experience and outcome measures (PREMS/PROMS). We are committed to embedding PREMS and PROMS into all services, drawing on the developing evidence base and guidance for using these measures appropriately for people with a learning disability and/or autism. We will ensure that people are allowed extra time to complete these measures, can complete them at home, and will have the support of someone they trust to complete each measurement tool. All questionnaires will also be provided in easy read formats. We will build on the work in NWL using Patient Knows Best to capture the improvements that matter at a local level.

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

The principles we are adopting in how we offer care and support to people with a learning disability and/or autism who display behaviour that challenges reflect the principles inherent in our current practice, and the ideals we are striving towards that are linked to the Transforming Care agenda. These are:

1. **Personalised**

Person centred care

- We will work with people with a learning disability and/or autism and their families to plan care and support that is focused on the individual and their unique circumstances.
- We will give people more influence over their care and will promote a culture of positive risk taking.
- We will be committed to achieving the outcomes that we co-produce with each person as part of their care planning or Education, Health and Care (EHC) plans. Overall, we will all be working towards supporting people to have good and meaningful everyday lives.
- We will provide people with a learning disability and/or autism, and their carers and families with the right information at the right time to enable them to make informed decisions about care and support. We will ensure that the ways in which this information is provided takes into account the communication needs of the person with a learning disability and/or autism.
- We will ensure people are supported to use personal budgets and direct payments to extend choice, control, and flexibility.

Support for families and carers

- We will provide support to families and carer to enable people with a learning disability and/or autism to live at home or in their community wherever possible.
- We will make training available for families and carers in managing challenging behaviour.
- We will develop our respite offer for families and carers through short term accommodation for people to use briefly in a time of crisis, and paid care and support staff who are trained and experience in supporting people who display behaviour that challenges including positive behaviour support.

Access to mainstream services

- We will encourage the use of mainstream services as a starting point, including employment and leisure opportunities. These services will be available and accessible for people with a learning disability and/or autism.
- We will monitor our mainstream services through quality checks using the Green Light Toolkit and evaluation by people with a learning disability and/or autism and their carers using peer evaluation and inspection where appropriate.
- Where mainstream services are not sufficient to meet a person's needs, we will provide specialist support service in a community setting wherever possible.

Choice and control

- We will ensure that people with a learning disability and/or autism have choice and control over how their health and care needs are met – with information about care and support in formats people can understand and the further development of advocacy services.
- We will provide a choice of housing options, including choice of type of accommodation and tenure, and support to live with families where that is the preferred arrangement.
- Plans and services will be co-produced and evaluated by people with a learning disability and/or autism, their families and carers. The opinions of people who use services will be listened to and their comments will initiate change.

2. Integrated

Co-ordinated care

- We will co-ordinate planning and commissioning of services across health and social care.
- We will encourage and promote cross organisation working.
- We will develop clear service specifications, pathways, protocols, and patient-centred outcomes.
- We will ensure discharge to community is well co-ordinated, guided by Care and Treatment Reviews.

Integrated to mainstream services

- We will improve access to mainstream services for people with a learning disability and/or autism by encouraging reasonable adjustments to services.
- We will work towards increasing access to education, employment and volunteering opportunities.

Lifelong approaches

- We will develop early intervention and preventative support programmes to address challenging behaviour from an early age.
- We will improve the continuity of care across different stages of life.

3. Localised

Community-based care and support

- We will develop local, multidisciplinary community support teams, consisting of a range of professionals to meet health and social care needs.
- We will build on existing services, incorporating evidence-based knowledge and skill development and expertise in the management of challenging behaviour and complex cases.
- We will work as a NWL collaborative to consider our options for developing more local housing options to ensure that our residents have the choice to be housed closer to their support networks.

4. **Specialised**

Specialist support

- We will ensure that people with a learning disability and/or autism are able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary health and social care teams.
- We will develop the support that is available out of hours.
- We will develop the workforce so that all staff working with people with a learning disability and/or autism have the appropriate training, skills, knowledge and expertise to manage challenging behaviour in a supportive way.
- We will develop community forensic health and care across North West London so that people with a learning disability and/or autism have support to reducing their offending and/or antisocial behaviour.
- We will provide high quality assessment and treatment services in hospital settings for those people whose needs cannot be met in community. We will ensure that where a hospital admission is required, it is for the shortest time possible, and pre admission checks ensure that hospital care is the right solution and discharge planning is commenced from the point of admission or before.

Our Transformation Plan for people with a learning disability and/or autism forms part of our overall strategy to improve the mental health and wellbeing of people in North West London. Like Minded is the mental health and wellbeing strategy for North West London. It brings together service users, carers, clinical staff from the statutory services and voluntary groups and other experts to work together to improve mental health and wellbeing across North West London. By working together, our vision is for North West London to be a place where people say:

"My wellbeing and happiness is valued"
"I am supported to stay well"
"My care is delivered at the place and time that is right for me"
"The care and support I receive is joined up"
"I can access support to avoid crisis"

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Please see attached template.

Please note that without financial information from NHS England on the additional funding that will support this transformation programme, it is very difficult to project what finances will be allocated. The assumptions used to guide our planning are included in the spreadsheet.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care

Our new model of care will build upon the successful elements of our existing services to develop our community care and support offer and will look to address some of the challenges we face in NWL with finding suitable housing options. The fundamental elements of our new model of care are:

1. **<u>Personalised: Care and support to meet each person's unique needs</u>**

We recognise that no two people with a learning disability have the exact same care and support needs and preferences, and therefore we will work with each person with a learning disability and/or autism to ensure that they receive care and support that works most effectively for them and their families. When someone is referred to the service, they are offered a comprehensive assessment of their needs. People with a learning disability and/or autism and their family or carers will co-produce a shared care plan that covers their health, social care, and support needs as well as their goals for independent living.

To ensure that we are meeting the needs of all our population with learning disabilities and/or autism, including those who don't currently engage with services, we need to improve our registers. We will develop an all-ages learning disability register for individuals known to community services and inpatients facilities. We will build on this by cross-checking our registers with GP registers for adults and children, and local authority registers of children with additional needs.

To understand the future demand on our community services, we will work with our public health colleagues to understand our prevalence data based on national estimates and our improved registers. We will then work on risk stratifying our population to understand who is likely to need higher levels of support, either in community or inpatient facilities. This information will then inform our service implementation and market development plans.

2. **Integrated: Co-ordinated care and planning**

We will underpin our Transforming Care agenda with a co-ordinated approach to planning and commissioning of services across health and social care. Our communities have a long history of joint commissioning and integrated community team for people with learning disabilities. The local authorities work together within the West London Alliance. We have built on this approach with to develop this plan. We are committed to ensuring that support for people with a learning disability and/or autism is strengthened by cross organisation working. We are working together to develop clear service specifications, pathways, protocols, and patient-centred outcomes. We will continue to work together to monitor and evaluate services and new pathways to ensure our Transforming Care agenda delivers the outcomes we are aiming for. We will also work as a collaborative across North West London to tackle our local housing issues so that wherever possible our residents can live in housing close to their families, if that is their wish.

We will make best use of Care and Treatment Reviews to ensure all our resources are used effectively to avoid admissions where possible and to ensure a clear and on-going focus on well co-ordinated discharge to the community.

Planning of services will also stretch beyond health, social care and housing. We will ensure that people with a learning disability and/or autism are enabled to participate in society in meaningful ways. This means improving access to mainstream services for people with a learning disability and/or autism by making reasonable adjustments, utilising the Green Light Toolkit and other contractual levers. We will also work towards increasing access to education, employment, and volunteering opportunities.

3. **Localised: Community care, close to home**

At the centre of our model of care the multidisciplinary community support team consisting of psychiatrists, nurses, psychologists, social workers, and support workers. Support will also be available from other specialists including speech and language therapists, occupational therapists, physiotherapists, and creative therapists. The team will be built upon the existing services, incorporating evidence-based knowledge and skill development and expertise in the management of challenging behaviour and complex cases. The health services offered by the team will be integrated with social services and will have a single point of access.

Housing options suitable for people with a learning disability and/or autism are problematic in North West London. High land values and a shortage of space makes the development of housing more difficult than in other areas of the country. We are committed to working as a North West London collaborative to consider our options for developing more local housing options to ensure that our residents have the choice to be housed closer to their support networks.

4. Specialised: expert care and support

We recognise that specialist skills are required to provide high quality care and support for people with a learning disability and/or autism. These specialist staff are a fundamental element of our community care teams; we need to develop the expertise of these teams to manage more complex cases and challenging behaviour to reduce our reliance on inpatient facilities and residential school placements. Even with specialist community support, there will continue to be a need for inpatient care in some cases. Our aim is to reduce our reliance on inpatient admissions, and where they are required, to reduce length of stay and ensure that discharge planning commences at admission or before.

Across NWL we recognise the need for more specialised support for people with a learning disability and/or autism who are in contact with, or at risk of contact with, the criminal justice system. Our current community support teams could be further developed with more specialised psychological input for people who offend, linking closely with our court diversion and liaison services. This is one of the areas that we think could benefit from a NWL approach – pooling resource to support the small number of cases across NWL with specialised psychological support.

We also recognise the expertise that exists within the third sector for supporting people with a learning disability and/or autism and our NWL plan includes our third sector partners as an important part of our care and support pathways.

What new services will you commission?

Across North West London we are working towards to same strategic vision for people with a learning disability and/or autism. However, as we are describing a model across eight boroughs it is worth clarifying that in some cases these services will be new services in the boroughs where there is currently a gap; in other cases these services already exist and as such these services may be developed or updated within existing provision. Specifically we will commission:

- **Community support**, including the utilisation of more skilled staff to manage more complex/challenging behaviour. This may involve moving staff from inpatient facilities into community services, and vice versa, to share learning.
- Tailored **local housing options** for people with a learning disability and/or autism who have challenging needs. This will include short term housing options for people in crisis where there is a risk of placement breakdown, and access to shared living schemes.
- **Respite services** for families and carers, regardless of the age of the person being cared for. This will include short breaks, day opportunities, longer break provision and family support services.
- **Crisis care,** available 24 hours a day, 7 days a week that ensures that people with a learning disability and/or autism and their families and carers receive care and support that meets their needs in times of crisis, including when this crisis occurs outside of standard working hours.
- An **all ages service** that removes the need to transition between children and adult services.
- A North West London level **service for people with a forensic history** or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area.
- More services to support people with a learning disability and/or autism to access training, work experience, apprenticeships, and voluntary and **paid employment**.

- **Co-ordinated care** across the health and social care pathways, ensuring that primary care clinicians are involved in early identification and signposting, and all partners are engaged in on-going care and support.

What services will you stop commissioning, or commission less of?

We will commission fewer:

- Assessment and treatment inpatient beds – via both reduced numbers of admissions and reduced length of stay
- Residential school placements
- Out of area placements

This shift in commissioning will be heavily dependent on the development of specialist community support services that are able to manage the increasing demand and complexity of cases and sufficient suitable respite provision to enable families to cope. Therefore, we expect this decommissioning to be gradual over time as the community services embed. Our detailed implementation plan will describe the phasing of decommissioning – ensuring appropriate individual alternatives are in place as we reduce reliance on inpatient/residential care.

What existing services will change or operate in a different way?

Our existing services vary across North West London, so the detail of what will operate differently can be found in each borough's local annex. As general principles across North West London, existing services will change or operate differently in the following ways:

- Current community services will be developed, in terms of capacity, skill mix, and ability to manage complex cases and challenging behaviour. There will also be more in-reach into inpatient services to support discharge and more outreach to other health and social care teams to support more independent living and integration with mainstream services.
- Current day services will be remodelled to provide more respite options and more integration into the local community.
- Crisis response teams will be trained and supported to respond to people with a learning disability and/or autism in crisis.
- Mainstream services will, through training and support for staff and changes in protocols and procedures, have increased awareness of learning disabilities and autism and will be adjusted to provide appropriate care and support.
- Waiting times for an assessment for learning disability and/or autism in CAMHS will be reduced. Children and young people will receive a quicker assessment, diagnosis, and access to support and treatment.
- Quality assurance and service development will be fundamental elements of all services.
- More services will be able to be responsive to people's individual needs with direct accountability to individuals and their families through personal budget and individual service fund arrangements.
- There will be more effective links with the criminal justice system.

Describe how areas will encourage the uptake of more personalised support packages

Across NWL personal budgets are offered to people with a learning disability and/or autism. Currently, the uptake of these offers is generally low; however using a North West London approach we will share learning from areas where uptake is higher (such as Kensington and Chelsea). We recognise the importance of increasing awareness of the benefits of these packages of care, and are cognizant of the need to balance this against the additional support required to help people with a learning disability and/or autism and their carers manage these budgets.

Work has commenced with MENCAP in Brent to explore the barriers around these budgets and to develop guidance and support recommendations to increase uptake. We are committed to working with our local independent sector partners to ensure people with a learning disability and/or autism have access to independent advocacy support to help them understand their budgets and the options available to them.

Work is underway in Hammersmith and Fulham with a provider introducing Individual Service Funds to maximise accountability to personalised approaches and choice and control for customers with learning disabilities.

Each CCG has a commitment in their commissioning intentions to support Personal Health Budgets more widely. We can build on work in Kensington and Chelsea to introduce personal health budgets (supported by MIND) and the processes in place to support payments and appropriate advocacy. We will learn from the demonstrator sites for Integrated Personal Commissioning to plan for local implementation.

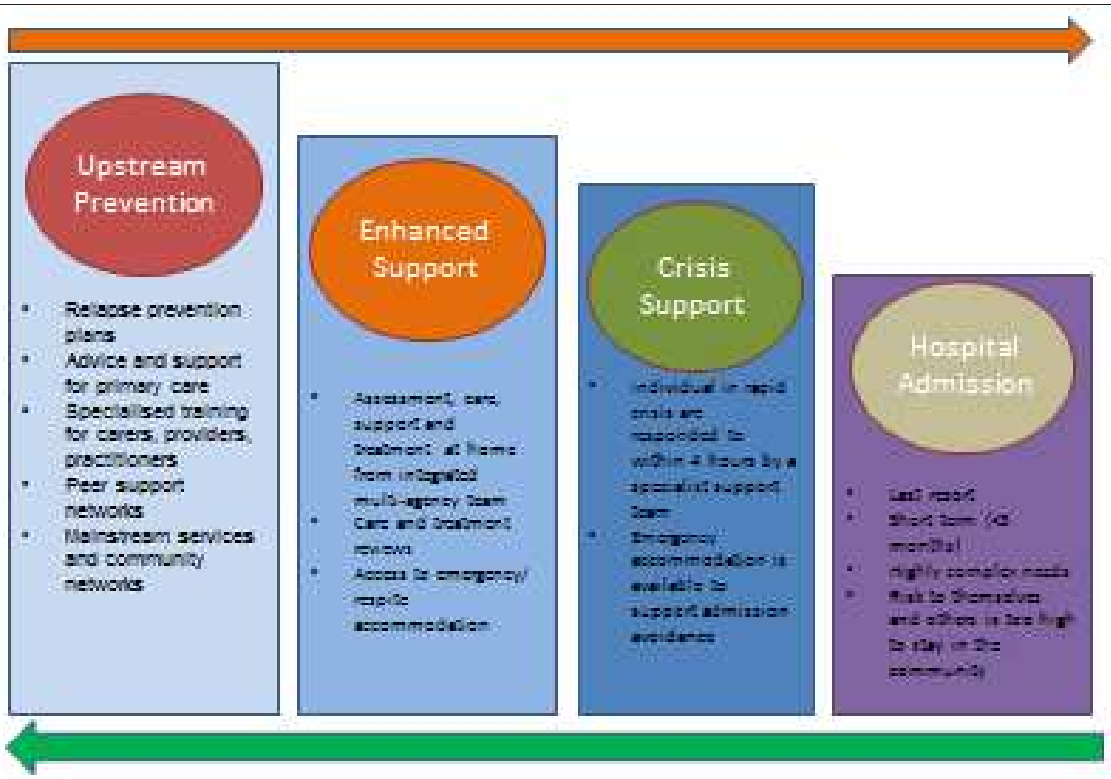
What will care pathways look like?

The overall objective of our TCP is to improve the experience of a small but vulnerable cohort of people across North West London. As we develop these plans we have been reminded frequently that the changes we want to see will be very individual to different people – reflecting the complexity of many of the needs of this population, and their families and carers. The care pathways we will further develop provide a framework but the reality is that each individual will require a tailored plan both for any immediate changes, but also to provide longer term support for the whole variety of needs – physical health, mental health, social care and education for example.

As noted in *Building the Right Support,* people with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. As a result, care pathways can be very diverse and will in every case be dependent on the individual and their family or carers. There are however some over-arching principles that will underlie every care pathway.

Our care pathways will be:

- Planned, in collaboration with the person with a learning disability and/or autism and their family and carers;
- Proactive, considering future care and support needs as well as the current situation;
- Co-ordinated, linking up health, education, social care, and the independent sector to provide a joined up approach to support that meets the range of needs of the person.



- Upstream prevention

Focusing resource, wrapped around the individual and their family and utilising the breadth of skill available in the community will support proactive planning and a holistic approach to avoiding exacerbation of need – and managing some of the drivers of worse outcomes. The GP remains a core member of this team with access to other team members who will be trained to ensure awareness of specific needs of this population

- Enhanced Support

Many of this population will require support at this level routinely. Supporting individuals to remain at home is key and the specialist teams to provide input at this stage in the pathway will focus on coordinating the range of services – to both the individual and the family/carers

- Crisis support

NWL through work on the crisis care concordat has improved access to urgent care for people with mental health needs. This model needs to be sensitive to specific needs of people with learning disabilities and provide pathways which re alternatives to admission

- Hospital Admission

Once admitted planning for discharge will be a priority with a focus on avoiding readmission and putting in place pathways which enable individuals to continue to be cared for in the least intensive setting.

How will people be fully supported to make the transition from children's services to adult services?

Our ambition is to develop an all ages offer for people with a learning disability, removing the need to "transition" from children's to adult services. The needs of service users do change with age; however the fundamental elements of support and care remain the same. In our proposed new model of care, all people with a learning disability and/or autism will have access to support for their health, education, and social care needs regardless of age. On turning 18 they will not be required to be reassessed according to different criteria or change services; instead needs will be assessed on an annual basis and will change with each individual rather than at pre-determined age points.

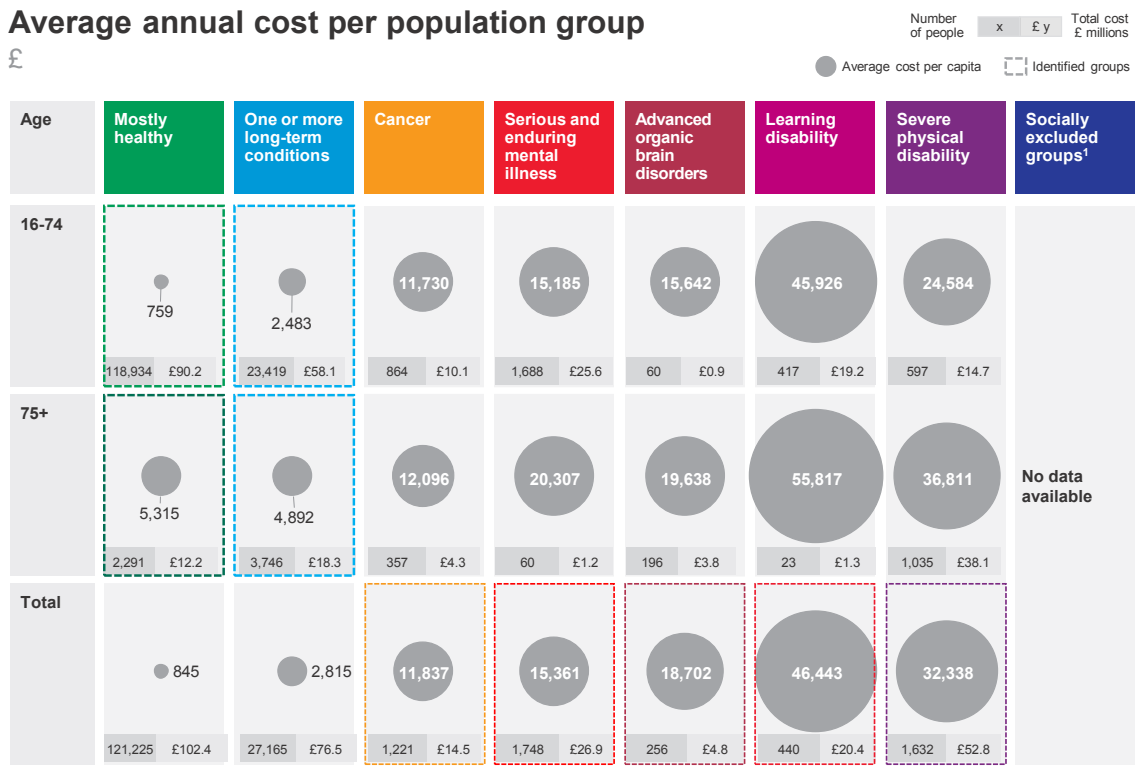
We will build on the Preparing for Adulthood principles and requirements of the Children & Family Act to ensure a local offer, raising aspirations of all young people with care and support needs with an emphasis on improving health, independence and employment outcomes.

As we move towards this new model of care, we will continue to support young people moving through the current system through careful planning and joined up working between social work teams. Our education, health and care plans also provide a bridging step between children's and adult services to assist with transition up to the age of 25.

How will you commission services differently?

Across North West London Local Authorities are working collaboratively with partners in health (commissioning and provision) to develop new models of care (in line with the 5 year forward views) which, whilst putting the patient at the centre, also enable funding to flow differently. Initially work began looking at the holistic needs of our elderly population with multiple long term conditions. In the current round of planning, and indeed with the driver of the Better Care fund and Sustainability and Transformation Plan, we are coming together to agree how we use the same lever for different populations – including those with serious mental illness, and those with learning disabilities. We are aided in this work as significant investment has been in made in the data systems which will enable us to collect the right information – on activity and funding initially, but in future on it comes, for the population segments as below (note the specific segment for learning disabilities).

We will also learn from and build upon the successes of our Section 75 arrangements in NWL to ensure that our commissioning partnerships across health and social care deliver improved outcomes for people with a learning disability and/or autism.



Note: The dataset includes a subset of the population of Hammersmith and Fulham; it represents ~90% of the population of that borough
1 For example, the homeless, people with alcohol and drug dependencies
Source: Integrated data-set from H&F, ICP data warehouse, FIMS 2012/13, CLCH budget, WLMHT budget, LA Budget, McKinsey analysis

How will your local estate/housing base need to change?

Across North West London we are developing our housing and estate plans, with each borough being at a different level of development. Local detail is outlined in the appendices. As we further develop our Transforming Care plan, we will develop a joined-up North West London estates plan that takes account of each borough's local position and uses a combined approach to deliver economies of scale and solutions that can be shared across North West London.

The general requirements for our estates for people with a learning disability and/or autism will include:

- accommodation with sufficient space internal and outdoor space
- consideration to any shared space that best supports people without aggravating or causing them stress
- support for families who want to stay living together but who may have outgrown their living space as a young person reaches adulthood
- location, close to support networks.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

Across North West London, we have been supporting people with learning disabilities and/or autism to resettle into community placements after long periods in hospital for many years. We will build upon our existing step down protocols and procedures, offering more support

from the enhanced community team as part of this transition.

For people who have lived away for many years, additional consideration will need to be given as to their chosen place to settle if they no longer have links with their home borough. It should not be assumed that everyone would want to live in inner London nor leave new links they may have established elsewhere.

We will ensure that people with a learning disability and/or autism and their families and carers are involved in developing their care and support plans, including crisis action plans, well in advance of any resettlement. We will also ensure there is access to more suitable housing to make this transition easier. We are exploring the option of care navigators and support worker roles that will also assist with the resettlement process.

Our detailed implementation plans will address this area at the next submission. We know that to effectively support this population will take time. We can learn from work across NWL and wider – to involve the staff who support people currently, and the communities where people will resettle to. Utilising the key principles above we will take a person-centred approach and build on the breadth of experience of partners across the system.

How does this transformation plan fit with other plans and models to form a collective system response?

i. Local Transformation Plans for Children and Young People's Health and Wellbeing

Both this Transforming Care Plan and the North West London Children and Young People's Mental Health and Wellbeing Transformation Plan have been developed in collaboration with children's commissioners from CCGs and Local Authorities. In the CAMHS Transformation Plan 8 priority areas are identified, one of which relates to Learning Disabilities.

In this plan, one of our main ambitions is to develop an enhanced learning disability service within each of the 8 CCGs, streamlining the current service offering and filling the gaps. The design of the service locally will vary because the starting position is different and the needs of each borough differ somewhat based on prevalence and population. The NWL approach will ensure consistent quality and shared learning.

To achieve our ambition, we will **map local care pathways** for children and young people with learning disabilities and mental health difficulties to ensure a seamless experience of care for all children in their local area. This may involve reconfiguring services or commissioning additional local provision where there are gaps, commissioning an integrated service from CAMHS and Community Paediatrics.

As well as working closely with Community Paediatrics when screening referrals and undertaking assessments, there should be an **effective strategic link** between CAMHS learning disability (LD)/ neurodevelopmental disability (ND) services and special educational needs (SEN) departments, to ensure coordinated assessment and planning of education, health and care (EHC) plans where necessary, and effective transitions for young people with LD/ND across health and education. Multi-agency agreements and monitoring arrangements will be defined with close working amongst frontline services, clearly defined lead professionals and shared care plans.

We will **enhance the capacity of CAMHS** to meet the increasing demand for ASD and ADHD assessments. In some areas this will involve adding additional staffing resource to specialist neurodevelopmental teams.

Specialist support embedded in the network - In some areas such as Ealing the model of co-located services for children with disabilities enables fast access to specialist mental health practitioners for advice, consultation and joint working. This model should be explored in other areas and if physical colocation of entire services is not feasible we will consider embedding mental health practitioners in services that work closely with children and young people with LD.

Specialist mental health practitioners should be available to provide **advice and support to special schools and specialist units** to support early identification of mental health difficulties, advise on behavioural management strategies, and signpost to specialist support if needed.

Vulnerable groups including those with disabilities can find it more difficult **to access specialist services** when they need them, so it is crucial that all measures included in the wider plan to improve accessibility of specialist mental health services (such as single point of access, user involvement etc.) apply equally to young people with LD and neurodevelopmental difficulties.

We will ensure that specialist services for children and young people with learning disabilities, neurodevelopmental disorders and mental health difficulties are **sufficiently resourced** to enable efficient access in line with national waiting time targets, to a workforce with the right expertise to meet their needs.

The **crisis pathway** (Priority 7) developed through this NWL Transformation plan should ensure access to support from staff who are appropriately trained to work with young people with LD, whether through direct access or a consultation model. This will ensure that admissions to residential care are avoided wherever possible and that discharge back to the community is well supported.

There should be clear agreements in place between specialist services and primary care to **support shared care** for young people with LD/ND who require medication.

CCG and LA commissioners will connect with **local independent sector services** and support groups for young people with LD/ND and their families (e.g. parent-run ASD support group).

As part of our redesign of LD and ND services, we will ensure that the principles of Transforming Care are incorporated into our new pathway and service models. Explicitly, we will develop pathways that ensure that when a hospital admission is required for a person with LD or ND, all providers will first ensure that there is no other alternative to admission. Once this challenge has been passed, the person will have an agreed discharge plan developed at the point of admission to ensure they are discharged into community settings as soon as possible. We will also ensure that care and treatment reviews form a fundamental part of our LD and ND pathways and services.

Service Users, providers and commissioners recently came together at an all day workshop to look at adults Learning Disability provision – a key theme of the day is the need to ensure transition is well managed and supported. 35 of the participants volunteered to be part of a

network addressing transition issues – reflecting the commitment to change.

In year one (2015/16) the current service and interdependencies will be mapped out in detail and a service specification will be developed. In year two (2016/17), the service will be revised and redeveloped to become uniform across the 8 CCGs taking into account providers and models of commissioning. Year three (2017/18) to year five (2019/20) will be used to embed the model, develop sustainability and further refine according to borough need.

Our overall objectives for this priority area of our CAMHS Transformation Plan are:

- Children and young people access assessment and treatment for LD and ND in a timely manner.
- Children and young people with LD or ND achieve improved health and educational outcomes.
- Children, young people and parents report an improved experience of engaging with LD or ND services.

ii. Local action plans under the Mental Health Crisis Concordat

In November 2014, North West London became the first place in the capital – and only the second place across the UK – to have its action plan approved for the Mental Health Crisis Care Concordat. The declaration, signed by 25 partner organisations, outlines how organisations across North West London will work together to improve services for two million people, including the 32,000 living with serious mental illness.

This Transforming Care Plan aligns with our local plans to deliver the Mental Health Crisis Concordat. Specifically, the concordat implementation plan includes actions on providing community emergency assessments at home or in safe places 24/7, minimising the use of control and restraint used in inpatient facilities and transport services, and ensuring discharge planning and crisis care plans are routinely created and updated following an episode of crisis. We will also ensure that our crisis care teams are trained to respond appropriately to the needs of people with a learning disability and/or autism in times of crisis as part of our development of mainstream services.

iii. The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)

Personal budgets are currently offered to people with a learning disability and/or autism, however uptake is low. As mentioned previously, some boroughs have plans to work with MENCAP and other local independent sector specialists to provide advocacy and information support services to increase understanding and utilisation of these budgets. We will build on learning from where there is higher uptake and also learning from the introduction of Individual Service Funds.

iv. Work to implement the Autism Act 2009 and recently refreshed statutory guidance

Work to implement the Autism Act 2009 and the updated 2015 guidance is on-going alongside the development of our Transforming Care plan. The awareness training on autism for all staff and specialist training for key staff dovetail with our plans to ensure all mainstream services make reasonable adjustments to meet the needs of people with a

learning disability and/or autism. Also, our development of clear pathways and protocols (including for assessment and diagnosis) will support the work already undertaken in accordance with the Autism Act 2009 in this area, providing an up to date pathway and diagnosis process across North West London in line with SAF submissions.

v. The roll out of education, health and care plans

Across North West London our local authorities have developed operational arrangements and service delivery which better meet the needs of children and young people with special educational needs or disabilities. Published local offers cover the support currently available to children and families with a learning disability and/or autism and these offers will be updated to reflect the changes initiated by this Transforming Care plan. As part of our commitment to transforming health, education, and social care for children and young people with a learning disability, we will work to reduce the waiting times for assessments and develop an all ages service that reduces the impact of transitioning from children's to adult care services. The focus will be on preparation for adulthood in planning for outcomes for well-being, health, independence and employment.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?

We have identified a number of work streams that will be needed to implement this plan. We have summarised these below and will continue to develop the project plans and implementation groups for each of these work stream areas over the coming months.

1. **Pathways and Protocols**: as we co-produce new care and support services across North West London, it will also be important to develop clear service user pathways and protocols for transfer between services to reduce hand offs, share information (with consent) and provide a seamless journey for people with a learning disability and/or autism.
2. **Estates**: covering inpatient beds, community service delivery sites, community team office space, day centres, respite, residential schools, special schools, supported housing. Working closely across North West London to address the challenges with limited estate and high costs unique to London.
3. **Workforce Development**: up-skilling our community teams to manage challenging behaviour and complex cases, to support step down from inpatient care. Redistribution of staffing from inpatient services. In addition to community teams we need to make sure that our teams in urgent care services – including A&E are skilled to support people appropriately. Development of knowledge, understanding, and skills in mainstream services (particularly crisis teams) to make reasonable adjustments for people with a learning disability and/or autism.
4. **Market Development**: working with existing and potential future providers to develop service specifications, staffing requirements, and quality standards that improve the quality of care in the community for people with a learning disability and/or autism, allowing for the support and care of complex cases and challenging behaviour is community settings. This will involve developing the range of providers who are able to provide this care and support to increase quality and improve value for money. We will encourage innovation and tailored solutions for each individual.

5. **Specification of existing services**: work is already underway to update specifications for existing inpatient and community services to ensure clarity of existing offer and that this meets the needs of service users and their families and carers. This will also provide a foundation on which to develop services, providing an understanding of our starting point and any further developments that are required to deliver our Transforming Care Plan.
6. **Green Light:** this work stream will focus on ensuring that people with a learning disability and/or autism are able to access mainstream mental health services, and that mainstream services are able to adapt to meet the needs of people with a learning disability and/or autism. There will be a focus on training, leadership, and staff development.
7. **Communication and Engagement**: this work stream will ensure that a range of audiences are aware of the work being done to deliver our North West London Transforming Care plan. This will include communicating changes with referrers, people with a learning disability and/or autism, families, carers, and other professionals. There will also be a focus on awareness-raising with the general public, improving the understanding of learning disabilities and autism and reducing stigma.

Who is leading the delivery of each of these programmes, and what is the supporting team.

Leads for each of these programmes will be identified as a priority at the next Transforming Care Partnership Board meeting. Leadership will be based on subject area expertise, influence, and capacity to move this work forward.

1. **Pathways and Protocols**:

Each borough in NWL has nominated a lead for a specific area (see page 2) to lead on behalf of the 8 CCGs/boroughs on:

- community support
- local housing options
- respite services
- crisis care
- an all ages service
- service for people with a forensic history
- access to training, work experience, apprenticeships, and voluntary and paid employment
- co-ordinated care

2. **Estates**:

The NWL Estates team are leading this work as part of developing Strategic Estates Plans and working closely with Local Authority leads.

3. **Workforce Development**:

HENWL are supporting the NWL team to develop plans.

4. **Market Development**:

Work has commenced at a local level and the central NWL team will coordinate the implications of this across the wider patch.

5. **Specification of existing services**:

The central NWL team has commenced this work with clinical input from providers and commissioners.

6. **Green Light:**

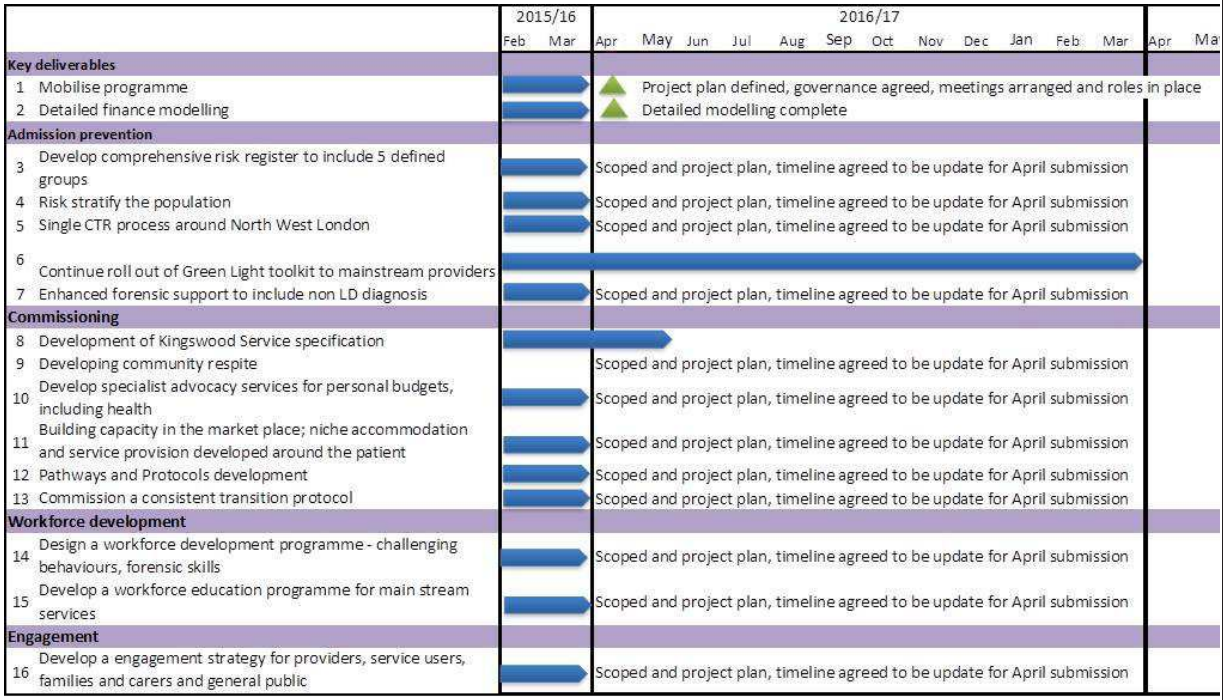
Work is being led at borough level.

7. **Communication and Engagement**:

The central NWL team are supporting development of plans in line with all change programmes.

What are the key milestones – including milestones for when particular services will open/close?

The key milestones for our Transforming Care plan are covered in the project plan below. As we develop clear implementation plans for each work stream, we will develop project plans with timescales for each key milestone.



What are the risks, assumptions, issues and dependencies?

Issues

The timescales to create the initial plans for the 8th February, has meant that we have not been able to undertaken as much focused engagement on the overarching Transforming Care Plan however, from detailed discussions in each of the Boroughs it is clear that local plans for learning disabilities have had service user, carers and family involvement. We do have plans in place to engage more widely with service users, providers and other key stakeholders prior to the next submission on the 11th April as we recognise that there is much more work to do to secure ownership of the plans and as such our plans may change depending on the feedback we receive.

Dependencies

The success of the plan will be dependent on a number of additional factors:

- National changes to allow budgets NHS England for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism. (we need to test out if this is correct with the finance colleagues)
- CAMHS Transformation Plans: the work to transform CAMHS services has commenced across North West London and will include the redesigning of services for children and young people with a learning disability and/or autism. The Transforming Care plan will need to build upon the work done in CAMHS services to ensure that the new pathways and services align.

Assumptions

The following assumptions underpin our Transforming Care plan:

- Joint working across sectors and boroughs is achievable and sustainable.
- Savings will be released by transferring patients to community care settings, and that these savings will then be invested in community care.
- Additional funding will be provided by NHS England to support transformation, including double running of services during transition.

Risks

Risk description	Probability (High, Med, Low)	Impact (High, Med, Low)	Mitigation
Provider Response: The market does not develop as envisaged. The system may not support new entrant to any market development.	Med	High	Clear market position statements signalling commissioning intentions Good on-going provider engagement including actively working with providers to invite solutions, resolve issues and concerns.
Workforce skills: required workforce skills and capacity do not develop sufficiently. Staff not available/cannot afford to live in London.	Med	High	Clear workforce development plans Work with HENWL on workforce development models. Sufficient funding to develop workforce skills and recruit appropriate staff.
Mainstream services do not make the reasonable adjustment to accommodate LD/autism needs.	Med	Med	Senior leadership engaged so mainstream services make adjustments a priority, use contract levers where necessary.

Pooling budgets: nationally changes are not made to allow specialised commissioning spend to be pooled.	High	Med	Raise nationally as a key issue
Pooling budgets: locally there is still some reluctance to pool health and LA spend.	Med	Med	Leadership and use of the Better Care Fund and section 75 agreements
CCGs and LA are not able to afford new packages of care in the current financial climate with cuts to existing budgets.	High	High	Developing the market place and competition would lead to fairer pricing. Develop an effective pricing structure based on the care funding calculator. Consider risk sharing approaches with providers to encourage their investment.
Lack of commissioning leadership and operational service delivery capacity: business as usual (including CTR guideline recommendation and reporting requirements) takes up everyone's time and there is no availability to take forward the Transforming Care work.	High	High	Provide additional support and capacity via short-term funded posts to cover business-as-usual, allowing experienced staff with local knowledge to get involved in redesign and service development planning.
Population growth: the population of North West London is growing, as is the number of people with a learning disability and/or autism. This will impact on the capacity of services to respond to demand.	High	Med	Include modelling of population growth into service redesign and business case development. Delivering a community-based model will help mitigate by providing care at a lower cost than inpatient care.
High needs patients: the very high costs of high need patients may negate any savings made by transitioning patients into community settings.	Med	High	Realistic planning that accepts the non-standard needs of this population. Continued support for high needs patients factored into affordability models.
Culture change: lack of a single vision and aims across all organisations and team	Med	Med	Effective leadership of the TCP Stakeholder engagement to ensure building of positive and effective relationships.
Earlier discharge may result in more readmissions of patients who were not ready to transition to community.	Low	Med	Extensive discharge planning, to commence prior to admission, proactive care plans, coproduced with people with LD and/or autism and their carers, and monitoring of readmissions.

Negative publicity regarding the media coverage of closure of inpatient beds.	Med	High	Effective strategic communications plan which patient stories promoting better outcome for people.
Estates: lack of available, affordable local housing to develop community in Borough accommodation	Med	High	Look at change of use for existing health property. Consider widest range of solutions including private sector, shared lives etc.

What risk mitigations do you have in place?

See table above.

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

End of planning template

Joint transformation planning template

Planning template – Hillingdon

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Historically within Hillingdon there has been a section 75 arrangement in place between the London Borough of Hillingdon and Hillingdon PCT. This agreement has been rolled over from the previous NHS administration to the current NHS administration. It specified that the Council should act as the lead commissioner for learning disability services; it covers commissioning of placements for clients eligible for NHS continuing healthcare and assessment and treatment services. The agreement refers to the arrangement whereby the Local Authority hosts the specialist health learning disabilities team. Following a review of LD service provision in April 2015, HCCG Governing Board approved a key recommendation of the report, namely the transfer of commissioning responsibility of the LD Community Health team from LBH to the HCCG. This process is currently being undertaken.

Hillingdon's health and social care commissioners are committed to collaborative working and developing a more joined up system and strategic approach across health and social care. An appointment of a joint LD Programme Manager across the CGG and LBH is a positive step taken to implement commissioning plans across Hillingdon. The local environment is complex with a variety of providers across statutory, independent and the voluntary sector encompassed within a variety of contracts. Community LD services, delivering the New Model of Care will be provided by CNWL (on a block contract basis), working in an integrated manner across Health and Social Care, based on Council premises. The CCG will be the commissioner of this model, providing a significant amount of new investment to ensure the service delivers positive outcomes for the local population in line with Senate requirements. Inpatient care is commissioned on a spot contract basis from the Kingswood Centre (CNWL). Individual support packages exist in various forms with private providers focussed on person centred needs. Psychiatric support is also commissioned from CNWL, based at the Riverside Unit on Hillingdon Hospital Site and form part of the CCG Mental Health contract the CCG hold with CNWL.

The Independent review of LD arrangements of existing commissioning and delivery of services (April 2015) resulted in an action plan to address the recommendations from the report. Based on this as well as a comprehensive LD JSNA, Hillingdon has made substantial investment in supported housing developments; as well developing plans for an all-age service and to utilise existing strong multi-disciplinary team (MDT) structures more effectively.

Describe governance arrangements for this transformation programme

A strategic level Transforming Care Learning Disability Board will oversee this programme in Hillingdon with senior level representation from LBH and HCCG. It will focus on all areas of the LD pathway across Health and Social Care with a focus on co-production with service users and their carers / families.

The reconstituted Partnership Board has been reframed to ensure that this is an All Ages Board. The Partnership Board is intended to bring together all relevant local agencies and stakeholders involved in services for people with learning disabilities, including representation form people with learning disabilities and their family carers.

The disabilities working group has been established and is developing the principles for joint commissioning across health and social care. These governance arrangements will feed into overall NW London governance arrangements which will have senior level representation from LBH and HCCG.

Overall Governance for LD will be provided by the following groups

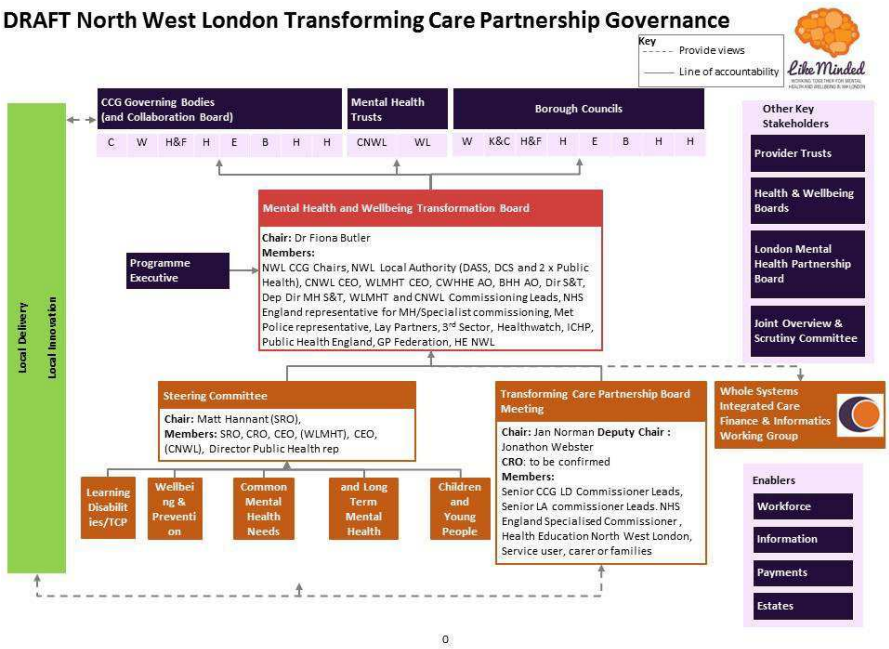
- The LD Programme Board - meets monthly with senior level representation from LBH/HCCG
- Green Light Toolkit Meeting - meets bi monthly with senior level representation from LBH/HCCG/Provider
- Mental Health Transformation Board - meets monthly with senior level representation from LBH/HCCG
- The LD steering group and Mental Health and Transformation Board would provide sign off for the plan overall prior to 11th April. If any quality issues were highlighted in the plan then it would also need to go to the HCCG Quality and Risk Committee.

If investment requires approval it would also need to go to the HCCG Finance and QUIP committee prior to final approval to HCCG Governing Board.

Within London Borough of Hillingdon additional groups exist to provide an additional layer of governance around existing provision. The Care and Partnership Group will review quality issues regarding providers. The Learning Disability Partnership Board will allow service users and carers an opportunity to provide feedback on services / issues.

North West London Transforming Care Partnership Governance

The North West London Transforming Care Partnership Board provides leadership and assurance on the delivery of the TCP plan and will oversee progress of all the agreed work streams.



The Transformation Board is chaired by the Senior Responsible Owner (SRO), Jan Norman, Director of Quality and Safety, Brent, Harrow and Hillingdon (BHH) CCGs Federation. The Deputy SRO is Jonathan Webster, Director of Quality, Nursing and Patient Safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing (CWHHE) CCGs. Membership includes senior commissioning representation from learning disability, mental health, and children's commissioners from local authorities and CCGs. The Strategic Financial Governance will be provided by Neil Ferrelly, the Chief Financial Officer across BHH

The NWL TCP Board is established as a strategic commissioning forum – with agreed routes for wider engagement across our provider base outside of the Board. The TCP Board reports to the NWL Mental Health and Wellbeing Transformation Board which has the senior executive and clinical leads from key partner organisations – including representatives from the West London Alliance from Directors of Adult Services, Directors of Children's Services and Directors of Public Health.

Describe stakeholder engagement arrangements

There is currently engagement with users of learning disabilities services and their carers in Hillingdon. There is both a learning disabilities forum and the patient/carers forum. These will be developed further and strengthened, improving participation and effectiveness, moving from representation to co-production.

Hillingdon are developing the Learning Disability Partnership Board to be all age and include more effective capacity to be involved in meaningful co-production. There is development work currently involving Children and Young People, with the SEND network approach to ensure they are actively involved in co-production.

There is existing co-production with parents/carers of 0-25 with SEND, this is embedded and effective. Our Customer Engagement Team is currently working on developing meaningful approaches to co-production across the 5 cohorts. It is a fundamental requirement that person centred working is central to the way our teams and our commissioned providers support people with LD/autism.

Hillingdon have with their fellow NW London Transforming Care commissioners supported the bid for Certitude to organise and provide a number of engagement events and workshops for People with Learning Disabilities across NW London. The organisations record of improvement in co-production levels whilst operating projects provides confidence that co-production will increase across Hillingdon as well as the wider NW London TCP.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The Learning Disability Partnership Board within the London Borough of Hillingdon has active service user engagement. Plans to improve local provision have taken into consideration service user views at Board as well as at local consultation events. Hillingdon LD Service users are invited to key consultation programmes such as Transforming Care as well as consultation over inpatient settings at Kingswood Unit. Reasonable adjustments are made to ensure LD service users have an active voice.

The council is committed to ensuring that local provision is available for local people and this includes enabling children and young people (CYP) with disabilities and those with special educational needs to have access to good quality local educational provision. Three years ago, the council had very high numbers of CYP attending independent and non maintained schools, approximately 150 (all children as well as LD with 10% having Statements of special educational needs). Since that time, with the real focus on local provision, this has reduced to approx 120 CYP and the majority of these are in day provision which includes 3 schools which are within the borough boundary. This includes the whole range of special needs i.e. not just those with a learning difficulty/disability and/or autism. Many of these are in the older age range and transition planning will take place such that they are able to access local college provision combined with supported living opportunities where appropriate. There is currently one child attending a 52 week residential school where specific planning will be taking place to include health. He already has an Education, Health and Care Plan which will be kept under review.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

A joint Learning Disability Post has been commissioned by LBH and HCCG. HCCG will take over the commissioning responsibility for the LD Community Health Team whilst working jointly with LBH in service delivery with the team working alongside social care colleagues.

Relative spend is different across the Health and Social Care economy with LBH budget exceeding £20 million whilst the CCG inpatient and continuing healthcare budgets being significantly smaller. Please see attached finance and activity template for detail.

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

A number of characteristics of the Hillingdon population might be expected to increase the prevalence of learning disabilities. These include Hillingdon's relatively young population, as learning disabilities are more common in younger age groups; and the higher than average

local population of South Asian origin, among whom higher rates of learning disability have been reported. A higher prevalence of learning disability might be expected in areas to the south of the borough where there are more people from these Black and Minority Ethnic (BME) groups and also higher levels of deprivation.

The 2 main sources of data on the prevalence of learning disability among adults in Hillingdon are GP practice registers, and Local Authority data on people known to services.

Comparing Hillingdon with other areas, the prevalence of adults with learning disabilities recorded by GPs is significantly lower than England, and also lower than London as a whole. The prevalence recorded by Local Authority services is also lower than England, but similar to London.

Number of adults with Learning Disabilities known to LBH by age group and gender, and estimated population prevalence, 2013/14 **People with LD known to Hillingdon council**

Age group	Male	Female	Total	Hillingdon population	Prevalence (Rate/1000 population)
18 - 19	36	19	55	8514	6.5
20 - 29	112	69	181	45865	3.9
30 - 39	62	43	105	43013	2.4
40 - 49	99	49	148	39634	3.7
50 - 59	69	47	116	32373	3.6
60 - 69	53	46	99	23073	4.3
70 +	17	14	31	26079	1.2
Total Adults	448	287	735	218,551	3.4

Data on hospital admissions of Hillingdon CCG patients who probably had learning disabilities, over the 3 years 2011-2014, found that 84% of all admissions in 19-64 year olds were emergencies, rising to 96% in those aged 65-74. 24% of the total in all ages was for ambulatory care sensitive conditions.

In 2013/14 less than 50% of people with a Learning Disability and/or autism had a GP health assessment, which is an increase on the previous years, but still lower than the national average. Evidence shows that uptake of screening is usually lower among people with learning disabilities but locally this information is not captured.

Hillingdon is developing a joint register of adults with learning disabilities. Currently the two main sources of data on the prevalence of learning disability in adults in Hillingdon are GP practice registers, and Local Authority data on people known to services. This will be undertaken across the five cohort groups outlined in the 'New Model of Care'.

- Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
- Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to

contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

- Children, young people or adults with a learning disability and/or autism, often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Analysis of inpatient usage by people from Transforming Care Partnership

Commissioner		Name of Hospital	Location	Total LOS	Avg bed cost per week	Distance from borough	Last CTR	Purchasing arrangements	Over 5 years
NHS England	1	Cygnet Hospital	Harrow			8			
	2	Oaktree Manor	Essex			91			
CCG	1	Kingswood Centre	Brent	4 Yrs	440	13	03/06/2015	Spot	No
	2	Kingswood Centre	Brent	5 Yrs	420	13	30/07/2015	Spot	Yes
	3	Kingswood Centre	Brent	181	390	13	26/06/2015	Spot	No
	4	Kingswood Centre	Brent	202	535	13	02/08/2015	Spot	No
	5	Kingswood Centre	Brent	21	585	13	TBA	Spot	No
	6	Lombard House - Partnerships In Care	Norfolk	251	390	115	16/12/2014	Spot	No
	7	Kingswood Centre	Brent	5 Yrs	390	13	11/03/2015	Spot	Yes
	8	Hertfordshire Partnerships FT	Hertfordshire	15 Yrs	604	25	13/02/2015	Spot	Yes

Describe the current system

Hillingdon has had high numbers of people in residential accommodation but has been working proactively to move people out of institutional settings. The proportion of people aged 18-64 in settled or non-settled accommodation has almost doubled over the last 6 years, and there have been big increases in those in supported housing and in settled mainstream housing with family or friends. However in 2013/14 only 54% were in settled accommodation, a fall from the previous 2 years, and the numbers in non-settled accommodation have increased significantly to 31%.

There has been success in moving people out of institutional settings, with now a programme put in place to review those in residential care settings and move into supported housing where appropriate.

There are currently 8 patients in inpatient settings, 3 funded by NHSE and 5 by HCCG.
2 of these patients will be ready to be discharged into the community within 3 months with a further 3 within the next six months.

National comparative data in 2011/12 showed that Hillingdon had the lowest rates in the country for adults with learning disability aged 18-64 receiving community services, and also had significantly lower than average numbers using Day services. Since then the number receiving community services has increased by one-third, but the number receiving Day services has continued to decline.

In 2014 there are thought to be a total of approximately 400 adults with learning disabilities in Hillingdon living with their parents, of whom 220 are identified as their main Carer, and about one-third of whom are aged 65+.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

In 2013/14 Hillingdon Council spent about £28 million on services for adults with learning disability, about 60% of which was spent on residential care. There is a new programme to target those LD service users in settled accommodation and to move to improved supported housing arrangements.

The Supported Living team have over the last six months worked with Paradigm and Craegmoor to open two Supported Living units for people with Learning Disability which has 22 units.

The Supported Living team have worked with Comfort Care to move a further 12 service users into a shared living environment in 2 smaller properties.

Current usage of Estates and Funding arrangements are outlined below:

Provider	Placement Type	Funding	Placement Number	Placement Commenced	Location
Salisbury Support 4 Autism	S/Living	LA	1	14/11/2014	Out of Borough
Salisbury Support 4 Autism	Residential	LA	1	24/07/2010	Out of Borough
Macintyre Care Homes	Residential	LA	5	31/03/2008	Out of borough
Craegmoor Healthcare	Residential / Nursing	LA	4	31/03/2008	Out of Borough
Jigsaw	S/Living	LA	1	10/12/2013	Out of borough
Accorn Park School	Residential	LA	1	12/05/2011	Out of Borough
Ark Care Homes	Residential	LA	1	11/12/2009	Out of Borough
Accorn Villages	Residential	LA	1	07/04/2003	Out of borough
Action on Hearing Loss	S/Living	LA	1	10/04/2006	Out of Borough
CareTeach Community	Residential	LA	1	22/04/2010	Out of Borough
Care Management Group	Residential	LA	14	04/03/2010	Out of Borough
Care Management Group	S/Living	LA	6	30/05/2011	In the LBH

Provider	Placement Type	Funding	Placement Number	Placement Commenced	Location
Care Management Group	S/Living	LA	1	08/11/2010	Out of Borough
Allied Care Limited	Residential	LA	2	04/03/2010	Out of Borough
Blenheim	Residential	LA	3	29/11/2013	In the LBH
Broadlands Hall	Residential	LA	1	01/08/2015	Out of Borough
Livability	Residential	LA	2	01/10/2007	Out of Borough
Roselock	Residential	LA	2	31/03/2008	Out of Borough
Monica Cantwell Trust	Residential	LA	1	01/07/2006	Out of Borough
Condover College	Residential	LA	1	16/12/2009	Out of Borough
Voyage Limited	Residential / Nursing	LA	3	17/07/2012	Out of Borough
Voyage Limited	Residential / Nursing	CCG	1	31/03/2008	Out of Borough
Voyage Limited	Supported Living	LA	1	09/06/2006	In the LBH
Creedy Court	Residential	LA	1	31/03/2008	Out of Borough
Appleford Ltd	Residential	LA	1	16/03/2008	Out of Borough
Contemplation Homes	Residential	LA	2	31/03/2008	Out of Borough
Derwen College	Residential	LA	1	05/04/2004	Out of Borough
Dorset Residential Homes	Residential	LA	1	01/04/2009	Out of Borough
White Horse Care Trust	Residential	LA	1	03/06/2013	Out of Borough
Community Homes of IC & E	Residential	LA	2	28/07/2008	Out of Borough
Community Homes of IC& E	Residential / Nursing	CCG	1	23/06/2014	Out of Borough
Community Homes of IC& E	Supported Living	LA	1	15/09/2015	Out of Borough
Residential Care Services	Residential	LA	1	15/09/2006	Out of Borough
Grove Care Partnerships	Residential	LA	2	14/12/2007	Out of Borough

Provider	Placement Type	Funding	Placement Number	Placement Commenced	Location
Canterbury Oast Trust	Residential	LA	3	16/04/2009	Out of Borough
Residential Care Providers Ltd	Residential	LA	1	26/04/2006	Out of Borough
Aitch Care Home	Residential	LA	1	23/11/2015	Out of Borough
Heathfield House	Residential	LA	1	06/01/2012	In the LBH
Heywoods Grange	Residential	LA	1	12/11/2010	Out of Borough
United Healthcare	Residential	LA	1	10/04/2006	Out of Borough
Chatsworth Care	Residential	LA	1	11/12/2009	Out of Borough
Sense	Residential	LA	6	31/03/2008	Out of Borough
Hythe House Support Limited	Residential	LA	1	04/01/2010	Out of Borough
The Regard Partnership	Residential	LA	10	07/04/2003	Out of Borough
Freeways Trust Limited	Residential	LA	1	01/05/2010	Out of Borough
Life Opportunities Trust	Residential	LA	2	19/08/2015	Out of Borough
Psycare Limited	Residential	LA	1	31/03/2008	Out of Borough
BUPA Care Services	Residential / Nursing	LA	1	29/04/2013	Out of Borough
Evergreens Partnerships	Residential	LA	1	01/02/2006	Out of Borough
The Meath Trustee Company Ltd	Residential	LA	2	27/08/2003	Out of Borough
Murree Residential Care Home	Residential	LA	1	18/09/2013	In the LBH
NAS Services	Residential	LA	1	01/04/2010	Out of Borough
New Horizon Care Home Limited	Residential	LA	1	20/11/2013	Out of Borough
Lingap Limited	Residential	LA	1	26/08/2015	Out of Borough
Truecare Group Ltd	Residential	LA	2	06/12/2004	Out of Borough
Care UK Community Partnership	Residential	LA	1	08/09/2009	Out of Borough

Provider	Placement Type	Funding	Placement Number	Placement Commenced	Location
SHC Clemsfold Group Limited	Residential	LA	1	10/04/2006	Out of Borough
Ormsby Lodge	Residential	LA	1	01/08/2004	Out of Borough
Purley Park Trust Limited	Residential	LA	1	09/07/2007	Out of Borough
Larkfield Hall Limited	Residential	LA	1	25/01/2008	Out of Borough
Norwood Schools	Residential	LA	2	01/04/2006	Out of Borough
Reach Limited	Residential	LA	2	08/11/2004	Out of Borough
Complete Care Services	Residential	LA	1	14/12/2003	Out of Borough
Renaissance Residential Home	Residential	LA	1	09/10/2005	Out of Borough
Home Farm Trust Limited	Residential	LA	1	01/09/2008	Out of Borough
SeeAbility	Residential	LA	2	31/03/2008	Out of Borough
Autism Sussex	Residential	LA	1	15/06/2006	Out of Borough
Stallcombe House Farm Trust	Residential	LA	1	06/11/2008	Out of Borough
The National Society for Epilepsy	Residential	LA	1	03/01/2010	Out of Borough
The National Society for Epilepsy	Residential / Nursing	CCG	2	01/08/2011	Out of Borough
Autism Hampshire	Residential	LA	2	10/04/2006	Out of Borough
Dignity Group	Residential	LA	1	30/07/2009	Out of Borough
Disabilities Trust	Residential	LA	1	09/04/2007	Out of Borough
Janith Homes	Residential	LA	1	05/10/2012	Out of Borough
Priory Healthcare	Residential	LA	1	06/09/2009	Out of Borough
North East Autism	Residential	LA	1	10/04/2006	Out of Borough
Lifestyle Care plc	Residential / Nursing	LA	2	26/05/2008	Out of Borough
Central & North West London	Residential / Nursing	CCG	5	25/07/2014	Out of Borough
SHC Rapkyns Group	Residential /	CCG	1	09/04/2008	Out of Borough

Limited	Nursing				
Provider	**Placement Type**	**Funding**	**Placement Number**	**Placement Commenced**	**Location**
Hertfordshire NHS Trust Ltd	Residential / Nursing	CCG	1	01/12/2005	Out of Borough
Sussex Community NHS Trust	Residential / Nursing	CCG	1	01/09/2009	Out of Borough
Partnerships in Care	Residential / Nursing	CCG	1	17/06/2015	Out of Borough
Crowthorne Care Limited	Supported Living	CCG	1	08/09/2015	In the LBH
Poppy Cottage	Supported Living	LA	4	06/07/2013	Out of Borough
Seva Care	Supported Living	LA	2	17/01/2011	Out of Borough
Bamford Homes	Supported Living	LA	1	03/01/2010	Out of Borough
Kevin Tyahooa	Supported Living	LA	1	28/06/2010	Out of Borough
Minstead Training Trust Limited	Supported Living	LA	1	12/04/2015	Out of Borough
Coghlan Lodges	Supported Living	LA	2	07/08/2013	In the LBH
Bournemouth Borough Council	Supported Living	LA	1	13/07/2015	Out of Borough
Chailey Heritage School	Residential / Nursing	CCG	1	02/09/2009	Out of Borough
Baytrees	Residential / Nursing	LA	1	28/02/2005	Out of Borough
Linkage Community Trust	Residential	LA	1	11/10/2004	Out of Borough
Craegmoor	Supported Living	LA	55	01/04/2015	In the LBH
Ability	Supported Living	LA	13	17/11/2008	In the LBH
Life Opportunities Trust	Residential	LA	8	31/01/2005	In the LBH
Life Opportunities Trust	Supported Living	LA	13	01/04/2015	In the LBH
Mencap	Residential	LA	4	07/04/2003	In the LBH
Mencap	Supported Living	LA	13	01/04/2001	In the LBH
Certitude (Support	Supported Living	LA	8	01/01/2007	In the LBH

for Living)					
Comfort Care	Supported Living	LA	12	11/08/2014	In the LBH
Comfort Care	Supported Living	LA	1	08/06/2015	Out of Borough

What is the case for change? How can the current model of care be improved?

There is a need to develop the Hillingdon local market to deal with a high level of complexity – to manage inpatient admissions or people based out of borough, to ensure that there are Hillingdon services for Hillingdon people.

Following the independent review of the arrangements for community specialist learning disabilities services there is a need to develop an improved Learning Disabilities service to support the clinical senates' five essential functions:

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

Hillingdon is currently working with Central North West London Mental Health Trust (CNWL) to develop a Joint Children's and Young People's LD Specialist Community Service. This service is for Children and Young People with moderate to severe LD, with autism, mental health and/or display behaviours that challenge. The definitions of LD differ across health, social care and education. For the purposes of this specification we will be looking at the health definition:

1. Significant impairment of intellectual functioning;
2. Significant impairment of adaptive/social functioning;
3. Age of onset before adulthood.

The LD Specialist Community Service will offer a focused, time-limited NICE intervention, consultation and general information, advice and guidance to children's service providers and parents/carers for children under their care. The LD Specialist Community Service will also be expected to refer and signpost providers and parents/carers where appropriate.

Hillingdon are considering investment models from CNWL which will consider increased funding into LD over a 2 year period to increase investment in community provision to support repatriation of service users in the community. This is allied with further LBH supported housing projects which are coming online in 2018 in addition to those that came on stream in 2015.

Hillingdon also plans to develop crisis response services – building up current response teams/home treatment teams to ensure that there is early intervention 24/7 for individuals with LD.

Hillingdon will also develop the forensics market to ensure that patients do not end up in clinical inpatient settings when an alternative would be prevented an admission. Forensic psychologists are needed to support this aim.

Work will also continue with the community safety partnership to ensure effective joint work with the police to prevent hate crime against people with LD.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

- Services have been redeveloped following the All Age Disability review and will continue to evolve to provide a person centred, personalised service. The aspiration is that services become integrated across the Health and Social Care pathway with mainstream health services making reasonable adjustments. There will be continued focus on prevention as well as early intervention.

- Development an integrated community therapy model between HCCG and LBH to facilitate better access and service provision for those service users and families availing OT, SALT, Physiotherapy and other services. This will assist LD service users and their carers navigate through health and social care with more ease, ensuring they do not have to retell their story and better facilitate uninterrupted spells of care. This model will also involve schools and places of further education so that there is a complete pathway for young people until they reach the age of 25 as per SEND regulations and then as they transition into adult services. The Integrated therapy model will be operational by September 2016 and will contribute to the objective of less reliance on inpatient services by practitioners in the community understand the health and social care needs of the individual and providing suitable early interventions.

- All ages learning disabilities register for individuals who are known in the community and services. This register should be expended to include a risk stratified population of those people who may require future services to support service planning and market development. This is expected to be in place by May 2016 and will seek to understand the needs of the local population by the 5 cohort groupings outlined in the New Model of Care.

- Co-ordinated approach to planning, commissioning and monitoring outcomes and quality of services for people with learning disabilities of all ages. Services should be commissioned with clear specifications to achieve defined patient centred outcomes and to improve quality of life for individuals.

- Promoting independent living in the community – increasing the number of people in settled accommodation in the community and reduce the numbers of Hillingdon residents with learning disabilities placed outside Hillingdon, providing Hillingdon

Services for Hillingdon people thus reducing reliance on inpatient care.

- Proactively engage the third sector in support the learning disabilities agenda and reduce the number of patients with learning disabilities who are sent out of borough for services.

- Further Education / colleges will work locally alongside LBH supported housing to provide greater support and opportunity to service users. They in turn will identify those who can be supported into employment opportunities. The LBH Council Strategy Employment Group has outlined this as a key initiative going forward.

- Increase the number of people with learning disabilities in higher education and paid employment. The focus here is to improve the quality of life for people with a Learning Disability and / or autism. Planned investment in 2016/17 to increase employment opportunities. Revised baseline targets are currently being devised.

- The HCCG and LBH will work to ensure that all local providers make provision for reasonable adjustments are for people with learning disabilities entering their services, including the utilisation of the Green Light Toolkit and contractual levers.

- A joint autism plan has been developed in January 2016 focussing on improving quality of life and outcomes for people with autism.

- Ensuring effective local forensic provision.

- Development of crisis prevention services integrated across health and social care.

- .Increase the number of people (including LD) accessing personal health budgets. The target is -
  ASCOF 1c (2a) % clients with direct payments/prepaid cards (Jan 2015 = 14.5%) Target + 5% end 2015/16 = 19.5%, 2016/17 = 24.5%, 2017/18 =29.5%

North West London Transforming Care Partnership aspirations for 2018/19

For North West London, Transforming Care is a programme that will help us develop our model of care and support for people with a learning disability and/or autism that promotes participation and an improved quality of life, whilst at all times maintains a person-centred approach that recognises and values difference and diversity.

We will achieve this vision by developing pathways and services that:

- Are community based, with a reduced reliance on inpatient facilities;
- Are skilled and experienced to manage complex cases, including managing the complexity of competing demands across health and social care;
- Provide respite for families and carers to maintain, wherever possible, at home placements and strong family relationships;
- Housing people with a learning disability and/or autism locally wherever possible and appropriate;
- Meet the needs of people of all ages – not defining services by age but instead responding to care and support needs and reducing the differences in services for children, young people and adults

How will improvement against each of these domains be measured?

- The LD Specialist Community Health Team will be monitored via the relevant schedules of NHS Standard community contract - both in terms of performance and quality
- Care and Treatment review guidance which is crucial to repatriating LD service users into the community will be made a key stipulation within the 'CNWL 2015-16, Service Development and Improvement Plan (SDIP), within the 2015-16 NHS Standard contract.
- The Joint Hillingdon LD Programme Board will review progress against the Hillingdon Transforming Care Plan.

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Participation
Residents with special educational needs and disabilities and their families are involved in shaping, developing and evaluating the services they use:

- The Parents Forum and Partnership Boards are included in all service redesign/ developments and their feedback is listened to and use
- CYP have a mechanism for participating that is meaningful

Valued Uniqueness
The uniqueness of people with special educational needs and disabilities and their families is valued and provided for:

- Personalisation includes the option of personal budgets and direct payments provided in a safe and well supported manner and consistent throughout life
- All partners to ensure person centred approaches are followed in all work with people with disabilities and their families

Working Together
Multi-agency working practices and systems are integrated:

- Agreed pathways involving partners
- Systems to be explored with the vision of seamless process across services
- Information to be shared with the vision of utilising electronic means and reducing the paper requirements

Informed Choices
People with disabilities and their families are able to make informed choices:

- Access to good, up to date information including transition to adulthood
- Access to advice and guidance
- Access to support to manage personal budgets and direct payments consistent throughout the life journey

Planning Partnerships
An integrated assessment, planning and review process is provided in partnership with people with disabilities and their families

- Aim for parent/carers only to have to give their message once wherever possible
- A seamless pathway from early help to statutory services
- A seamless approach from "cradle to grave"

Birth and through Adulthood
Continuity of care is maintained through different stages of a child's life and through adulthood.

- A seamless approach to education, health and care is adopted by partners for people with disabilities throughout their lives

Learning & Development
Children and young people's learning and developments is monitored and promoted and learning is provided throughout adulthood:

- Access to good local educational provision
- Access to support services from partners e.g. health to promote learning and development

Key Working
Service delivery is holistic, co-ordinated, seamless and supported by key working:

- All frontline practitioners understand the key working functions and good quality training is available with on-going supervision

Ordinary Lives
Wherever possible, people with disabilities and their families are able to live 'ordinary' lives:

- Early help offer with emphasis on people being supported to live at home and in their own homes with local solutions
- Statutory services designed to support family life and enable people to live at home and in their own homes with access to appropriate care, education and support locally

Workforce Development
People with disabilities, and families can be confident the people working with them have appropriate training, skills, knowledge and experience:

- All developments are supported by links to the workforce strategy:
    - focus on developing stability in the workforce
    - access to good quality training
    - evidence to good quality training
    - evidence based interventions
    - evidence of the guiding principles being applied

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Please see attached finance and activity template for detailed analysis if current provision.

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care

Hillingdon's Model of Care will be based on the 9 keys areas as outlined in the NHS New Model of Care (2015).

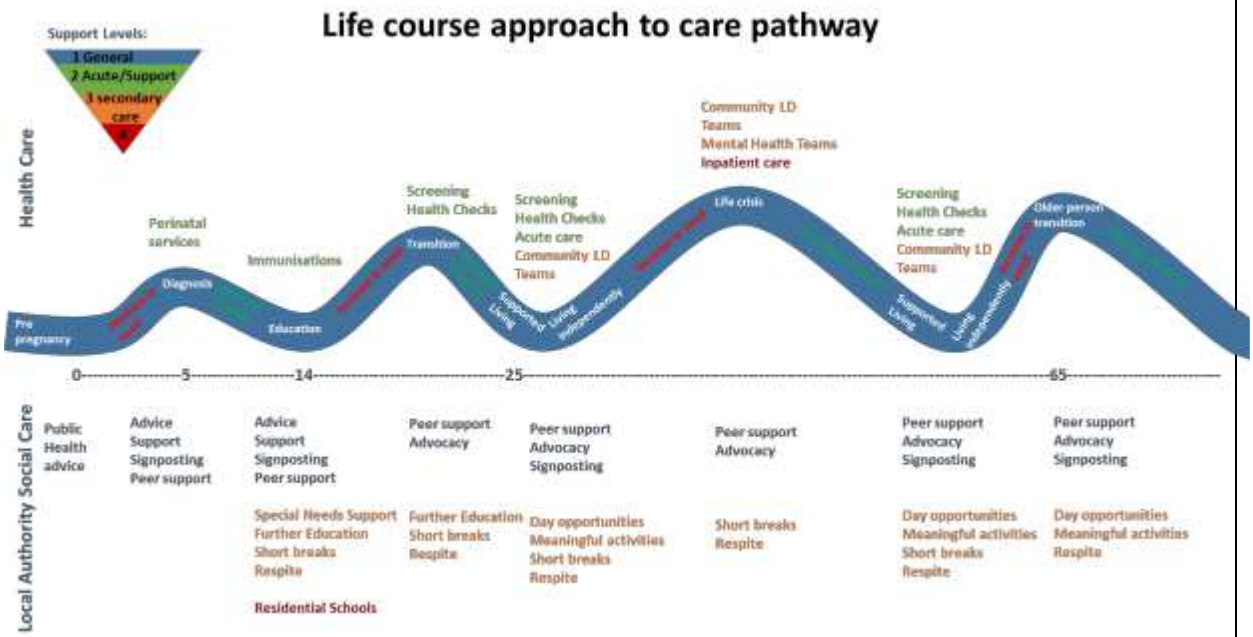
- This will be based on community provision with less reliance on inpatient settings.

- Those with complex needs will be supported with a service model which is 'All Age' and based on a personalisation approach.

- Services will be integrated between Health and Social Care with personalisation and person-centred planning being fundamental aspects.

- Services will be monitored by outcome focused measures within service contracts with health and social care having robust, senior level governance arrangements in place to monitor provision.

The North West London new model of care Our model of care takes a coordinated, life course approach. People with a learning disability and/or autism who display behaviours that challenges, and their families, will be on a journey; from the time of initial diagnosis there will be times during the life course that will naturally be challenging. By developing a care model that plans for these challenges and provides advice, support and care mapping, we are aiming to reduce the number of people reaching crisis and/or needing inpatient or residential care.



What new services will you commission?
As outlined in the Hillingdon finance and activity template there are plans to invest in community provision in the next financial year and onwards. These include substantial investment in the LD Community Health Team, LD Camhs team, providing additional support to the challenging behaviour team, an employment and educational model seeking to provide more opportunities for LD service users as well as a developmental team seeking to provide opportunities for further independence for people with Autism.

What services will you stop commissioning, or commission less of?

We will commission fewer:

- Assessment and treatment inpatient beds – via both reduced numbers of admissions and reduced length of stay
- Residential school placements

- Out of area placements in regulated care (inpatient and residential)

This shift in commissioning will be heavily dependent on the development of specialist community support services that are able to manage the increasing demand and complexity of cases and sufficient suitable respite provision to enable families to cope. Therefore, we expect this decommissioning to be gradual over time as the community services embed. Our detailed implementation plan will describe the phasing of decommissioning – ensuring appropriate individual alternatives are in place as we reduce reliance on inpatient/residential care.

What existing services will change or operate in a different way?

Specialist community health team for learning disabilities, following a recent independent review it was agreed that the service needed to be re-specified

Commission an effective 'All Age' specialist community health team for learning disabilities. Health teams and services should be fully inter-disciplinary with sufficient critical mass to deliver the 5 essential community Learning Disabilities functions.

- Positive access to and response from mainstream services
- Enabling others to provide person centred support
- Direct specialist clinical therapeutic support
- Responding positively and effectively to crisis
- Quality assurance and strategic service development

Hillingdon CCG together with other commissioners in the NW London TCP is reviewing their commissioning arrangements of the Kingswood Unit (CNWL). Hillingdon may continue to use this unit on a spot purchase basis but on the assurance that Average Length of Stay will decrease. By investing in community provision it is believed the Trust will also be supported in repatriating clients to local settings when appropriate for discharge and to reduce unnecessary delays.

Describe how areas will encourage the uptake of more personalised support packages

In Health and Social Care families with service users of most complex needs often leave brokerage elements of personal budgets to practitioners and officers to organise given their experience. Families though do welcome being involved in the initial discussion and organisation of the care plan most and this element often empowers them to feel they have played an active part in the care planning. CCG will look to invest in more coordinators and brokerage staff to help offer families support in choosing certain elements of their care which they may choose to commission differently.

In LBH Direct Payment usage is being developed with initiatives such as the 'Connect to Support' coming on stream to support service users understand opportunities available for use of Direct payments. The aspiration is for all service users to be supported to understand the benefits of utilising a personal budget. It is a mandatory requirement for all social care workers to explain the personal budget options available to LD service users.

A resource allocation system is being tested for children and young people with Education, Health and Care Plans. This currently relates to the educational and care elements of the Plan but this will move on to the health element.

HCCG has personal health budgets, with steady increase in uptake. They are offered to adults and children and managed by the LBH. Pre-paid cards are used to avoid unnecessary

paperwork. CHC and personal transport budgets used. Direct payments are high for children

Everyone with a package of care (adults) will have a personal budget but not everyone wants to take this as a direct payment. However, this is offered as the starting position for all adults. Work is underway to understand how uptake can be increased across health by working with areas such as Hampshire who have undertaken a lot of work in this area.

Learning Disability Usage figures

- 53 = Direct Payment Only
- 27 = Part Direct Payment
- 322 = Personal Budget managed by LBH
- 5 = Services commissioned by LBH (No Personal Budget)
- 402 = No of LD clients with a Personal Budget
- 407 = No of LD clients who are eligible for a Personal Budget (community based services)
- 13.2% = Direct Payment Only
- 6.7% = Part Direct Payment
- 98.8% = Personal Budget managed by LBH

What will care pathways look like?

Health and Social Care pathways will be integrated ensuring health services make reasonable adjustment with people having access to relevant care pathways. Provision must be person-centred, personalised with mainstream service support.

The overall objective of our Transforming Care Plan is to improve the care and support of a small but vulnerable cohort of people across North West London. Each individual will require a tailored plan both for any immediate changes, but also to provide longer term support for the whole variety of needs – physical health, mental health, social care and education.

As noted in Building the Right Support, people with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. As a result, care pathways can be very diverse and will in every case be dependent on the individual and their family or carers. There are however some over-arching principles that will underlie every care pathway.

Our care pathways will be:

- Planned, in collaboration with the person with a learning disability and/or autism and their family and carers;
- Proactive, considering future care and support needs as well as the current situation;
- Co-ordinated, linking up health, education, social care, and the independent sector to provide a joined up approach to support that meets the range of needs of the person.

How will people be fully supported to make the transition from children's services to adult services?

Following a review of transition arrangements a Transition Forum was established as an operational group to manage the data and to find solutions where barriers to successful transition exist. This is also used to ensure no-one can 'slip through the net'.

The Strategic Transition to Adulthood Group is also in place and is currently exploring the pathways across the partnerships aimed at making improvements. The LA Disability Service is all age which supports seamless transition but this is not currently the case in all other areas. The CCG has also set up a Clinical working group with a focus on health pathways.

How will you commission services differently?

Hillingdon is developing a Hillingdon Placement Funding Panel (possible pooled funding arrangement) which is a joint health, social and education care panel and responsible for considering individual applications for funding of care and treatment outside of existing CCG or Council contracted / commissioned activity.
This panel is designed to consider those applications for funding which also fall outside existing joint CCG and LA funding panels:

- Mental Health Complex Care Panel
- Older People's Funding Panel
- Disability Panel
- Access to Resources Panel (Children's Social Care)
- CCG Independent Funding Request (IFR) scope

An integrated therapy model (pooled funding) is being developed between LBH and HCCG to provide a seamless pathway children and young people to access therapy provision across the health and social care landscape. Service models are currently being considered with a view to implementation from 1st September 2016.

Extensive work has been undertaken to jointly commission an integrated pathway (HCCG and LBH) for the LD Camhs service with additional Positive Behaviour Support posts. The rationale for this service is that:

Children with disabilities may present with mental health issues, however, only after an assessment it is determined to be behavioural and vice versa; and Children with disabilities are often known to the same agencies and will be the main refers into the service i.e. SEN, children with disabilities social care and Special Schools.

Hillingdon are keen to promote the use of technology to assist LD service users and their families to be able to make informed decisions on care provision. LBH are currently reviewing telecare provision as well projects such as 'Brain in Hand'.

How will your local estate/housing base need to change?

Planned LBH Estate Developments:

Name	Type	Funding arrangements	Units/bed	When
Planned				
	Shared living / Supported - Extra Care	London Borough of Hillingdon	Grassy Meadows 88 units including a Dementia unit. Park view 60 units. Both Extra Care	Spring 2018

Alongside service redesign (e.g. investing in prevention/early intervention/community services); transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

HCCG have placed specific expectations on its local community provider to work alongside the CCG and LBH to facilitate the resettlement of LD service users in the community. The process will be jointly managed by HCCG and LBH through its LD Programme Board.

How does this transformation plan fit with other plans and models to form a collective system response?

The joint HCCG and LBH Transforming Care Plan sits as part of wider plan within North West London seeking to transform care for people with Learning Disabilities. It is clear that when looking at inpatient settings, effective strategic decision making can only occur collectively, creating pathways across wider geographical areas to which the entire NW London patch can sign up and invest in. When looking at inpatient settings such as the Kingswood Unit, commissioner strength is increased when working together to ensure the provider makes concerted attempts to reduce average lengths of stay and actively participating in discharge planning with the CCG and Councils.

There is a joint, HCCG and LBH CAMHS model of care. LBH are working with HCCG on the Better Care Fund and it is expected that Transforming Care will link into the Better Care Fund and share governance arrangements.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

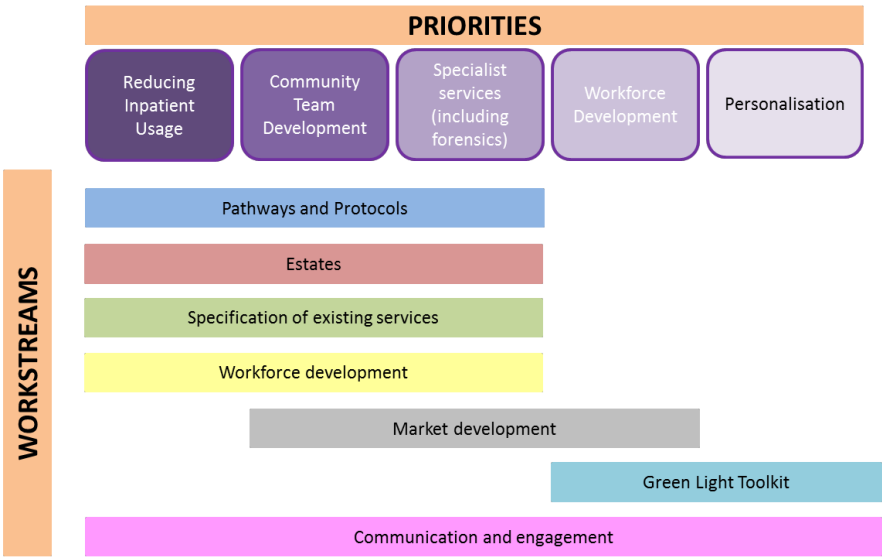
What are the programmes of change/work streams needed to implement this plan?

In Hillingdon this will mean:

- Commissioning a new LD community services, building on the independent review of LD community services
- Developing a joint all ages LD and/or autism register which is aligned to the 5 cohorts
- HCCG and LBH will work together to develop the current Mental Health Learning Disabilities team so that they work with children and young people with complex behaviour, including autism; with bases in Special schools.
- Resettlement of both inpatient and those in the residential settings back in to Hillingdon where appropriate
- Working with North West London Transforming Care Partnership of the development of a community forensic service for individuals with a learning disability and/or autism
- Work with North West London Transforming Care Partnership of the development of a refreshed new service specification for inpatients services provided at the Kingswood centre.

Across North West London Transforming Care Plan

We have identified a number of work streams that will be needed to implement this plan. The diagram below demonstrates how these workstreams map to our priority areas and core principles of our Transforming Care Plan.



The work of each workstream is summarised below and we will continue to develop the project plans and implementation groups for each of these work stream areas over the coming months.

1. **Pathways and Protocols**: as we co-produce new care and support services across North West London, it will also be important to develop clear service user pathways and protocols for transfer between services to reduce hand offs, share information (with consent) and provide a seamless journey for people with a learning disability and/or autism.

2. **Estates**: covering inpatient beds, community service delivery sites, community team office space, day centres, respite, residential schools, special schools, supported housing. Working closely across North West London to address the challenges with limited estate and high costs unique to London.

3. **Specification of existing services**: work is already underway to update specifications for existing inpatient and community services to ensure clarity of existing offer and that this meets the needs of service users and their families and carers. This will also provide a foundation on which to develop services, providing an understanding of our starting point and any further developments that are required to deliver our Transforming Care Plan.

4. **Workforce Development**: up-skilling our community teams to manage challenging behaviour and complex cases, to support step down from inpatient care. Redistribution of staffing from inpatient services. In addition to community teams we need to make sure that our teams in urgent care services – including A&E - are skilled to support people appropriately. Development of knowledge, understanding, and skills in mainstream services (particularly crisis teams) to make reasonable adjustments for people with a learning disability and/or autism.

5. **Market Development**: working with existing and potential future providers to develop service specifications, staffing requirements, and quality standards that improve the quality of care in the community for people with a learning disability and/or autism, allowing for the support and care of complex cases and challenging behaviour in community settings. This will involve developing the range of providers who are able to provide this care and support to increase quality and improve value for money. We will encourage innovation and tailored solutions for each individual.

6. **Green Light:** this work stream will focus on ensuring that people with a learning disability and/or autism are able to access mainstream mental health services, and that mainstream services are able to adapt to meet the needs of people with a learning disability and/or autism. There will be a focus on training, leadership, and staff development.

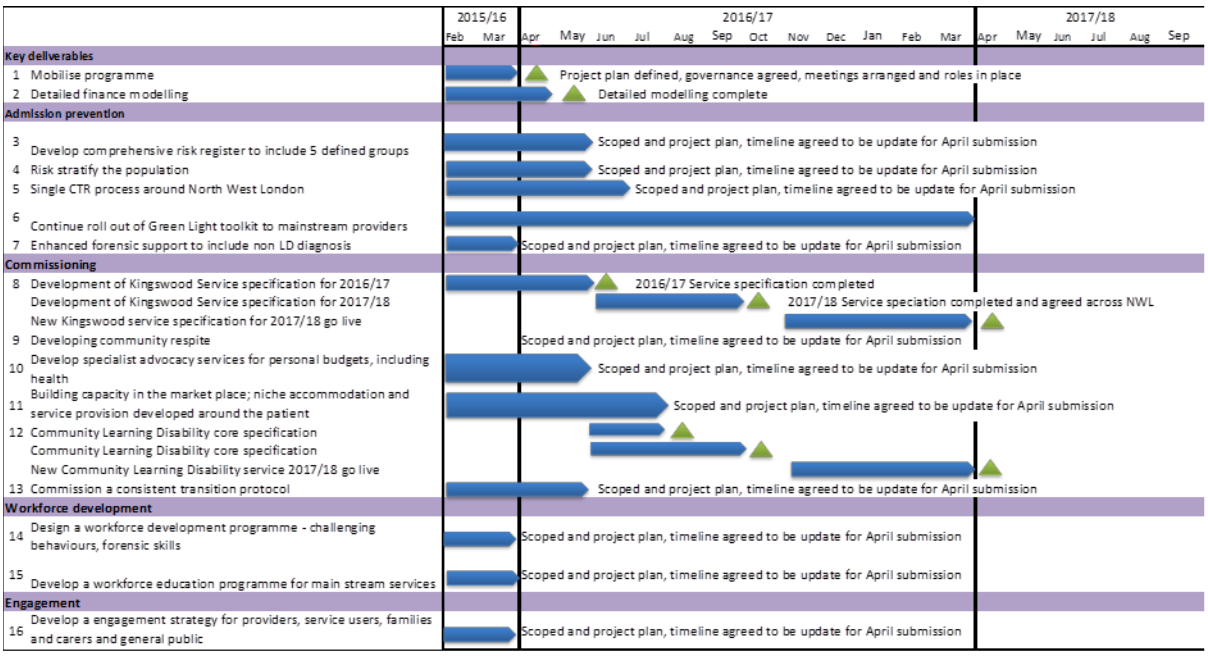
7. **Communication and Engagement**: this work stream will ensure that a range of audiences are aware of the work being done to deliver our North West London Transforming Care plan. This will include communicating changes with referrers, people with a learning disability and/or autism, families, carers, and other professionals. There will also be a focus on awareness-raising with the general public, improving the understanding of learning disabilities and autism and reducing stigma.

Who is leading the delivery of each of these programmes, and what is the supporting team.

Leads for each of these NWL TCP programmes will be identified as a priority at the next Transforming Care Partnership Board meeting. Leadership will be based on subject area expertise, influence, and capacity to move this work forward

What are the key milestones – including milestones for when particular services will open/close?

As we develop clear implementation plans for each work stream, we will develop project plans with timescales for each key milestone.



What are the risks, assumptions, issues and dependencies?

Issues

The timescales to create the initial plans for the 8th February, has meant that we have not been able to undertaken as much focused engagement on the overarching Transforming Care Plan however, from detailed discussions in each of the Boroughs it is clear that local plans for learning disabilities have had service user, carers and family involvement. We do have plans in place to engage more widely with service users, providers and other key stakeholders prior to the next submission on the 11th April as we recognise that there is much more work to do to secure ownership of the plans and as such our plans may change depending on the feedback we receive.

Dependencies

The success of the plan will be dependent on a number of additional factors:

- National changes to allow budgets NHS England for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism. (we need to test out if this is correct with the finance colleagues)

CAMHS Transformation Plans: the work to transform CAMHS services has commenced across North West London and will include the redesigning of services for children and young people with a learning disability and/or autism. The Transforming Care plan will need to build upon the work done in CAMHS services to ensure that the new pathways and services align.

Assumptions

The following assumptions underpin our Transforming Care plan:

- Joint working across sectors and boroughs is achievable and sustainable.
- Savings will be released by transferring patients to community care settings, and that these savings will then be invested in community care.
- Additional funding will be provided by NHS England to support transformation, including double running of services during transition.

Risks

Risk description	Probability (High, Med, Low)	Impact (High, Med, Low)	Mitigation
Provider Response: The market does not develop as envisaged. The system may not support new entrant to any market development.	Med	High	Clear market position statements signalling commissioning intentions Good on-going provider engagement including actively working with providers to invite solutions, resolve issues and concerns.
Workforce skills: required workforce skills and capacity do	Med	High	Clear workforce development plans

not develop sufficiently. Staff not available/cannot afford to live in London.			Work with HENWL on workforce development models. Sufficient funding to develop workforce skills and recruit appropriate staff.
Mainstream services do not make the reasonable adjustment to accommodate LD/autism needs.	Med	Med	Senior leadership engaged so mainstream services make adjustments a priority, use contract levers where necessary.
Pooling budgets: nationally changes are not made to allow specialised commissioning spend to be pooled.	High	Med	Raise nationally as a key issue
Pooling budgets: locally there is still some reluctance to pool health and LA spend.	Med	Med	Leadership and use of the Better Care Fund and section 75 agreements
Money not following the patient	Med	High	Clarification if required urgently from NHS England regarding income following the patient back to community settings to understand the financial impact for LBH and HCCG.
CCGs and LA are not able to afford new packages of care in the current financial climate with cuts to existing budgets.	High	High	Developing the market place and competition would lead to fairer pricing. Develop an effective pricing structure based on the care funding calculator. Consider risk sharing approaches with providers to encourage their investment.
Lack of commissioning leadership and operational service delivery capacity: business as usual (including CTR guideline recommendation and reporting requirements) takes up everyone's time and there is no availability to take forward the Transforming Care work.	High	High	Provide additional support and capacity via short-term funded posts to cover business-as-usual, allowing experienced staff with local knowledge to get involved in redesign and service development planning.
Population growth: the population of North West London is growing, as is the number of people with a learning disability and/or autism. This will impact on the capacity of services to respond to demand.	High	Med	Include modelling of population growth into service redesign and business case development. Delivering a community-based model will help mitigate by providing care at a lower cost than inpatient

			care.
High needs patients: the very high costs of high need patients may negate any savings made by transitioning patients into community settings.	Med	High	Realistic planning that accepts the non-standard needs of this population. Continued support for high needs patients factored into affordability models.
Culture change: lack of a single vision and aims across all organisations and team	Med	Med	Effective leadership of the TCP Stakeholder engagement to ensure building of positive and effective relationships.
Earlier discharge may result in more readmissions of patients who were not ready to transition to community.	Low	Med	Extensive discharge planning, to commence prior to admission, proactive care plans, coproduced with people with LD and/or autism and their carers, and monitoring of readmissions.
Negative publicity regarding the media coverage of closure of inpatient beds.	Med	High	Effective strategic communications plan which patient stories promoting better outcome for people.
Estates: lack of available, affordable local housing to develop community in Borough accommodation	Med	High	Look at change of use for existing health property. Consider widest range of solutions including private sector, shared lives etc.

What risk mitigations do you have in place?

Both LBH and HCCG are committed to improving service provision for people with LD and have identified specific projects in the community so that needs are managed well locally in conjunction with service users and their carers. Strong communication channels have been developed over the last 18 months constituting a senior joint LD Board to ensure organisational agreement on joint processes as we move forward. It is envisaged that this Board will oversee the Transforming Care agenda at the local level as well as feed into the wider NW London partnership. A comprehensive service specification has been developed to monitor LD community provision with a particular focus on improving primary care provision and access to mainstream health services.

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

End of planning template

BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Ray Puddifoot MBE
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 – Board Planner 2016/2017

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

New regular agenda item

Starting with the 12 April meeting, a new regular non-decision item has been added to Board agendas in Part 2, to enable a private opportunity for Board Members to discuss current or emerging issues in relation to health, wellbeing and social care services within Hillingdon that may or may not be sensitive, in commercial confidence or confidential in nature. It will be the last item on the agenda.

Reporting to the Board

The draft Board Planner for 2016/2017, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Chairman's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Chairman.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Chairman, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The Board meeting dates for 2016/2017 were considered and ratified by Council at its meeting on 25 February 2016 as part of the authority's Programme of Meetings for the new municipal year. The dates and report deadlines for the 2016/2017 meetings have been attached to this report as Appendix 1.

Financial Implications

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

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

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

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL

APPENDIX 1

BOARD PLANNER

29 Sept 2016 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 13 September 2016 **Agenda Published:** 21 September 2016
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	HCCG Commissioning Intentions 2017-18	HCCG	
	Core Offer Memorandum of Understanding	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

8 Dec 2016 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 18 November 2016 **Agenda Published** 30 November 2016
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Hillingdon's Joint Strategic Needs Assessment	LBH	
	Local Safeguarding Children's Board (LSCB) Annual Report	LBH	
	Safeguarding Adults Partnership Board (SAPB)	LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

14 Mar 2017 2.30pm Committee Room 6	Business / Reports	Lead	Timings
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 24 February 2017 **Agenda Published:** 6 March 2017
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI) and Draft Better Care Fund Plan 2016/2017	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	HCCG Operating Plan	HCCG	
	Annual Report Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

** SI = Standing Item*

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